

this week

SPACE HAIRDRYERS p 423 • **RCP IN CRISIS** p 424 • **WEIGHT MANAGEMENT SERVICES** p 426



BMA to take GMC to court over PAs

The BMA is launching legal action against the GMC over its plans to regulate physician and anaesthesia associates (PAs and AAs) from December, following recent legislation.

The BMA said it was bringing a judicial review claim against the GMC over its use of this term “medical professionals” to describe all of its future registrants, including associates. The BMA said the term should only ever be used to refer to qualified doctors. Alongside the BMA, Anaesthetists United, an independent group of anaesthetists, is planning separate but complementary legal action, relating to the lack of any national regulation of scope of practice for associates.

Chair of council Philip Banfield announced the legal action at the BMA’s representative meeting (ARM) in Belfast on 24 June. He said, “PAs are not doctors, and we have seen the tragic consequences of what happens when this is not made clear to patients. To describe any other staff as medical professionals not only undermines doctors and their rigorous training but also confuses patients.”

ARM delegates also called for the BMA to formally complain to the Charity Commission about the GMC, arguing it had “breached its charitable charter by agreeing to regulate physician associates.” The conference also passed a motion demanding that medical

associate professionals (MAPs) not be used as substitutes for doctors and insisted on a pause in recruitment and deployment of PAs.

The motion affirmed the BMA’s traffic light system for MAPs and said they should not prescribe or see undifferentiated patients. It also said appropriate training must be offered to supervising doctors and called for an urgent public inquiry into reports that MAPs had worked outside their competence.

A GMC spokesperson said it will recognise and regulate doctors, PAs, and AAs as “three distinct professions,” adding, “PAs and AAs don’t have the same knowledge, skills, and expertise as doctors. They are not doctors, but they play important roles within multidisciplinary teams when appropriate and effective clinical governance and supervision are in place.” The spokesperson said the GMC would continue to work with all parties “towards the delivery of safe and effective regulation for these groups.”

Meanwhile, the Royal College of GPs has updated its position to say general practices should stop recruiting PAs immediately until regulation and scope of practice guidance is finalised, after a consultation with members.

● HELEN SALISBURY, p 444

Abi Rimmer, *The BMJ*
Cite this as: *BMJ* 2024;385:q1407

Philip Banfield, chair of the BMA council, announces the judicial review claim at the ARM in Belfast

LATEST ONLINE

- More than 171 000 US women travelled out of their home state for abortions last year
- Consultant tells court that fear of management reprisals stopped him reporting Letby to police
- Manifesto health pledges from main parties are “unfunded commitments,” says IFS



SEVEN DAYS IN



ZOOMAR/CHANNEL PARTNERS/ALAMY

SAS doctors in England accept revised pay offer

Specialist, associate specialist, and specialty doctors in England have accepted a pay offer, after 79% of BMA members voted to back the deal. The BMA's SAS committee has now accepted the offer on behalf of the profession. The first pay offer was rejected in March, when 62% of respondents thought that the deal didn't go far enough.

Under the new terms, doctors on 2021 contracts in England will see an annual pay rise of between 9.5% and 19.4%. The deal also offers a consolidated uplift of £1400 to each pay point for those on 2008 contracts, on top of the 6% awarded for 2023-24.

The deal also includes new proposals to improve career progression and the contracts of locally employed doctors—those employed by trusts on local terms.

Ujjwala Mohite, chair of the committee, said the offer marked "important progress" in helping to retain more SAS doctors in the NHS but added, "The fight for pay restoration and improvements to the working lives of SAS doctors is far from over."

He said, "A combination of burnout, eroded pay, and stunted career progression has seen many forced to leave the NHS. Many SAS doctors also suffer 'grade-ism'—the idea that, because they don't fit into traditional pathways, they are not as important. The next step is seeing what the review body brings and whether it will take us any closer to giving all SAS doctors, on all contracts, what they deserve."

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2024;385:q1347

Junior doctors

PM is offered "final chance" to avoid strike

The co-chairs of the BMA's Junior Doctors Committee in England wrote to the prime minister urging him to take a "final chance" to avert upcoming planned strikes. Junior doctors are due to stage a five day walkout from 7 am on 27 June to 7 am on 2 July, ahead of the general election on 4 July. In their 19 June letter Robert Laurenson and Vivek Trivedi urged Rishi Sunak to make a written commitment to a "detailed pathway" to pay restoration that could be implemented if he forms the next government.

Cancer

UK is "25 years behind" European neighbours

An analysis by the charity Macmillan Cancer Support has shown that the UK's survival rates in several common types of cancer are only now reaching what other European countries such as Sweden and Norway had achieved by the early 2000s. Gemma Peters (right), Macmillan's

chief executive officer, said, "We urgently need the next UK government to prioritise a long term, cross government strategy that revolutionises cancer care and ensures everyone with cancer has access to the care they need."

NHS funding

£38bn a year extra is needed, say experts

The Health Foundation's REAL Centre projected a potential £38bn shortfall in the funding required to improve the NHS by the end of the next parliament. It estimated that NHS funding in England would need to rise by 3.8% a year in real terms over the next 10 years to meet demand and deliver improvements. The centre's director, Anita Charlesworth, said, "The health service is in crisis, and all the main political parties have said they want to fix it—yet the funding they have so far promised falls well short of the level needed to make improvements."

Semaglutide WHO issues falsified medicine warning

The World Health Organization issued a

medical product alert relating to falsified batches of semaglutide (Ozempic) that it had identified. The alert relates to three falsified batches detected in Brazil in October 2023, in the UK the same month, and in the US in December 2023. "WHO advises healthcare professionals, regulatory authorities, and the public [to] be aware of these falsified batches of medicines," said Yukiko Nakatani,



WHO's assistant director general for essential medicines and health products. "We call on stakeholders to stop any usage of suspicious medicines and report to relevant authorities."

NHS demands overhaul of online drug sales

Stephen Powis, NHS England's national medical director, urged pharmacies to stop selling injectable weight loss drugs online without examining patients in person. Powis said that an investigation by the *Times*, where a reporter had Wegovy prescribed by Boots and Superdrug after

entering false information online, raised "serious questions about a lack of safeguards from online pharmacies selling weight loss drugs." In response, Boots said that its Online Doctor weight loss service would now require additional photographs of patients wearing fitting clothing before it approved prescriptions. Superdrug said that its safeguarding protocols were comprehensive and that it relied on patients to be honest when giving personal health information.

Avoidable mortality Rates remain higher than before the pandemic

Figures showing that avoidable mortality in England and Wales remained higher in 2022 than before the covid pandemic need an urgent policy response, said public health leaders. More than a fifth of all deaths in England and Wales in 2022 (the most recent year with complete figures) were avoidable, the Office for National Statistics reported. The Royal Society for Public Health highlighted stark and widening regional inequalities in avoidable mortality, a "heartbreaking" rise in mortality among children and young adults, and rising deaths linked to alcohol and drugs.

MEDICINE

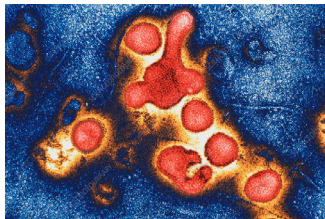
Child health

Experts welcome focus on industry's impact

Public health leaders welcomed a report from the Food Foundation for focusing on commercial factors contributing to children's poor health. Sarah Muckle, a spokesperson for the Association of Directors of Public Health, said, "The fact so many of our children are eating a diet high in fat, salt, and sugar is not down to individual choice. Instead, it is a result of marketing techniques being used by an industry that is seeking to make a profit from selling food we know causes harm."

Infectious diseases

Data show post-covid global surge in cases



A large post-covid global surge in common communicable diseases, including flu (above), measles, TB, and whooping cough, has been identified in an analysis of data from 60 organisations and public health agencies. Since the beginning of 2022, 44 countries have experienced a 10-fold rise from a pre-pandemic baseline in the incidence of at least one of 13 infectious diseases, said the analysis by the UK based disease forecaster Airfinity and the US news website Bloomberg. Analysts said declining vaccine coverage was leaving populations vulnerable and allowing pathogens to spread.

General practice

GPs can't find new posts

Many GPs seeking a new job or locum role are unable to find a post, separate polls by the Royal College of General Practitioners and the BMA showed. Of 2211 RCGP members who responded



A report from the Food Foundation says children's diets are affected by industry marketing

to a survey, 737 said that they had looked for a new role in the past year. Of these, 61% (449) had found it "moderately" or "very" difficult to find an appropriate vacancy. Meanwhile, in a BMA survey of 1852 locum GPs in England, 84% (1350) said that they could not find work.

Labour promises investment if elected

An incoming Labour government would focus on investing in general practice to help "fix the front door for the NHS," said the shadow health secretary. Speaking at an event organised by the Medical Journalists' Association, Wes Streeting said general practice "will do well" under a Labour government that would increase primary care's proportion of the NHS budget and tackle upstream pressures on general practice.

Cyberattack

Hackers publish NHS lab data on dark web

The gang responsible for a cyberattack on a pathology laboratory that led to disruption at several hospitals and GP surgeries in London has published data on the dark web it claims to have stolen. The gang, believed to be based in Russia, is understood to have shared almost 400GB of information, including patients' names, dates of birth, NHS numbers, and descriptions of blood tests. It is not known if test results are included in the data.

Cite this as: *BMJ* 2024;385:q1399

SIXTY SECONDS ON... SPACE HAIRDRYERS



WHAT'S THE BUZZ?

A new device that researchers are calling a "space hairdryer" has been used to help mend broken hearts.

SURELY THAT'S TIME'S JOB?

Perhaps where emotions are concerned. But researchers in Austria have tried using shockwave therapy—sonic waves—to regenerate the heart tissue of coronary bypass graft surgery (CABG) patients.

SOUNDS GOOD

The researchers applied high voltage to two electrodes surrounded by water to create the shockwaves, but the soundwaves created can't actually be heard because they're at inaudible frequencies.

VERY DR FRANKENSTEIN

The electric current is applied to the electrodes in water, not the patient, so they receive a sonic shock, not an electric shock. The researchers explained in the *European Heart Journal* that the shockwaves spread through the heart tissue, "activating the innate immune system of treated cells, leading to increased DNA accessibility and cellular plasticity, together with the secretion of angiogenic cytokines and growth factors . . . inducing angiogenesis in the hibernating myocardium. Newly formed vessels then support the recruitment of chronically undersupplied myocardium."

ALL GOOD ON A CELLULAR LEVEL . . .

There's more. In a trial, 63 patients who underwent CABG also received either shockwave therapy or sham therapy. After a year, left ventricular ejection fraction in patients who received shockwave therapy had increased by 11.3%, compared with 6.3% in the control group. Patients in the shockwave group could also walk further in six minutes and reported a better quality of

life. Lead researcher Johannes Holfeld told the BBC that "for the first time, we are seeing the heart muscle regenerate in a clinical setting, which could help millions of people."

WHO ELSE MIGHT GET THIS THERAPY?

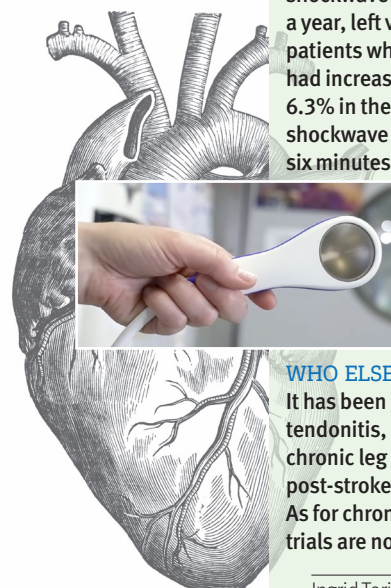
It has been used to treat patients with tendonitis, non-healing bone fractures, chronic leg ulcers and soft tissue wounds, post-stroke spasticity, and spinal cord injury. As for chronic ischaemia patients, larger trials are now planned, said the researchers.

DIABETES

A failure to prevent complications among people with diabetes is costing the UK's healthcare system

£6.2bn a year

[Research commissioned by Diabetes UK and carried out by the University of York]



Ingrid Torjesen, London

Cite this as: *BMJ* 2024;385:q1401

RCP president steps down “with immediate effect” after physician associates row

Sarah Clarke, president of the Royal College of Physicians, is stepping aside “with immediate effect” as the college enters fresh turmoil in the ongoing controversy over physician associates (PAs).

Clarke, who had been asked by members to step down amid widespread criticism over her leadership, will be “available until September to support interim presidential arrangements,” the college said. Its council will meet on 3 July to discuss a longer term solution.

The RCP said in a statement on 20 June that it recognised the need for a reset. “This is an unprecedented situation for the college, and our priority during this period of transition is to ensure stability and continue to deliver the priorities of our members,” it said.

The college has commissioned the King’s Fund to carry out an independent review to learn lessons from its extraordinary general meeting in March, which opened a rift between the RCP’s leadership and many grassroots doctors over its PA policy.



This entire affair has raised fundamental questions about the governance of the college

Martin McKee

Leading RCP figures told *The BMJ* they feared the review’s remit was too narrow and that Clarke was being made a scapegoat for the collective handling of the PA issue. Martin McKee, an RCP fellow and professor of European public health at the London School of Hygiene and Tropical Medicine, told *The BMJ*, “This entire affair has raised fundamental questions about the governance of the college. Once this is over there needs to be a thorough review of how the college is governed. Somebody needs to look at how this situation arose and how it got so far.

“I think the chief executive needs to examine his position. I think there are senior officials in both the GMC

and NHS England who need to be considering their positions too.”

Clarke’s intention to step aside was first revealed in a statement on 19 June. But the next day several leading members who had expressed a lack of confidence in the leadership wrote a new letter to the board of trustees, warning against a delayed departure. They said that with the UK about to elect a new government Clarke would still be in post at a critical moment for the development of health policy, when the college would need a president who could command full support, including among the wider membership.

The 20 June letter, seen by *The BMJ*, said, “A president who has had to bow to pressure to resign cannot credibly represent the voice of physicians in these discussions. The risk of further reputational risk continues for as long as the current president remains in post. For this reason, we ask you, the trustees, to urgently consider how to replace the incumbent with an interim president who commands the confidence of fellows and members with immediate effect.”

Matthew Limb, London

Cite this as: *BMJ* 2024;385:q1383

GP who confronted PM receives many supportive messages

Locum GP Jane Lees-Millais has told *The BMJ* she has received “literally hundreds of messages of support” from fellow GPs since she confronted the prime minister about the state of the NHS during a campaign speech earlier this month.

As Rishi Sunak told Tory members in Wiltshire on 7 June



GPs have been squeezed of money for the last eight years Jane Lees-Millais

that the UK was “on the right track,” with 4000 new doctors coming into the health service, Lees-Millais shouted out, “But the NHS is disintegrating. I’m one of 2500 GPs in this country who are currently unemployed due to your policies. What are you going to do about that?”

Lees-Millais added that “37 000 GPs will not vote Conservative because of the constructive dismissal of general practice due to your policies.”

She had been invited to meet a “senior cabinet minister” by Conservative Central Office at the meeting at Melksham Town Football Club earlier that morning. “I thought it would

be someone like Jeremy Hunt. I prepared a speech in the car on the way there . . . to start the ball rolling about this very, very important issue.”

She said that when Sunak made the “ill advised” boast that the NHS was getting thousands of new doctors she decided to speak out. “I felt that was the time to make the point that there are lots of doctors who are unemployed or about to become unemployed and lots of family doctors who are in a lot of trouble,” she told *The BMJ*.

She said the government was allowing “constructive dismissal” of general practice. “GP surgeries have been squeezed of money

for the last eight years and many close before they go bankrupt,” Lees-Millais told *The BMJ*.

When confronting Sunak, Lees-Millais criticised the government for allowing private healthcare providers to replace GPs with less qualified staff. Expanding on this point, she told *The BMJ* she was referring to documented instances where private firms take over struggling GP surgeries and then sell them. “These companies are not philanthropists. They’re doing it because they can make a profit out of general practice,” she said. “It’s an absolute disgrace.”

Jane Feinmann, London

Cite this as: *BMJ* 2024;385:q1375

Members call on BMA to rename junior doctors “residents”

BMA members have called on the association to end its use of the term “junior doctor” and replace it with “resident doctor” from September.

Representatives at the ARM in Belfast on 24 June voted in favour of a motion calling on the BMA to rename its Junior Doctors Committee the Resident Doctors Committee. The change will also apply to the Northern Ireland, Scottish, and Welsh junior doctors committees and 13 regional junior doctors committees in England.

A majority of junior doctor members it surveyed in February supported a proposal to rename them resident doctors.

BMA Junior Doctors Committee co-chairs Robert Laurenson and Vivek Trivedi said, “There is nothing junior about what we do and there never has been. At last year’s ARM doctors committed to remove this demeaning title and we are delivering on that promise.

“After extensive consultation with our membership, doctors chose the title ‘resident.’ Following today’s motion, all references to junior doctors in the association will be changed to ‘resident’ from September.

“At that time we will officially become the Resident Doctors Committee. In the meantime, we will be preparing the ground with the NHS and other stakeholders to follow us in adopting this far more appropriate title.”

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2024;385:q1410



OTHER MOTIONS PASSED BY THE ARM

Representatives passed a motion calling on the BMA to demand that the NHS urgently implements a “total inclusion plan for sustainability and decreases its carbon footprint faster than the government’s aim of net zero by 2050.” The motion called for the NHS to shift away from single use equipment and fossil fuel derived power, by investing in innovative sterilisation procedures and low carbon energy sources.

Another motion called on the BMA to negotiate an update to all doctors’ terms and conditions to include a provision that means employers would incur a penalty of one day’s pay or annual leave for “every day beyond a reasonable rota issuance deadline (six weeks prior to commencing a post).”



Organisation backed by Philip Morris is targeting stop smoking services

Smoking cessation teams in the UK have been warned against taking funding from a tobacco industry backed organisation boycotted by WHO, *The BMJ* has found.

The warning came after at least two smoking cessation initiatives, at an NHS trust and a local authority, were targeted this month by an organisation funded by Philip Morris International, reported the charity Action on Smoking and Health (ASH).

Global Action to End Smoking (GA), formerly known as the Foundation for a Smoke-Free World, received \$140m from the tobacco giant last year. GA’s mission is “to end combustible tobacco use,” including by running education programmes. Its smoking cessation programme looks at “reduced-risk nicotine tools” and “addressing misinformation regarding the nature and impact of nicotine.”

Elizabeth Starren, a consultant in respiratory and general medicine and lead of the Chelsea and Westminster Hospital NHS Trust’s Smokeless cessation project, received an email from Cliff Douglas, GA’s chief executive, on 3 June, offering to discuss grants and a “new educational effort.” Starren, who was unaware of GA at the time, asked a colleague, “Seems highly unusual to reach out offering funding. I’m aware of a number of shadow companies being supported by tobacco. Do you know anything about this organisation?”

Made aware of the approaches, the National Centre for Smoking Cessation and Training, a partly government funded organisation that supports local smoking cessation services, emailed stakeholders on 7 June, warning that because of GA’s “ties to the tobacco industry any offer made

by them or their representatives should be rejected.” It warned that meeting with or accepting funding from the “tobacco industry or their representatives” would breach WHO’s Framework Convention on Tobacco Control.

A GA spokesperson told *The BMJ*, “We contacted smoking cessation groups in the UK because we are also a smoking cessation organisation.” The spokesperson added that GA supported initiatives across the world, including the UK, Pakistan, and the Philippines.

GA didn’t answer *The BMJ*’s question about how many UK smoking cessation initiatives it had met. It has pledged not to accept any more funding from the tobacco industry or non-pharmaceutical medicinal nicotine products. However, it received a “final charitable gift” of \$140m from PMI in 2023, “effectively funding the foundation at a rate of \$17.5 million per year until 2030”—the annual amount last provided by PMI—according to the Tobacco Tactics project at the University of Bath.

Critics also point out that GA has yet to receive any other funding apart from PMI’s.

On 6 June WHO issued an alert to member states that it would not partner with GA and “strongly recommends that governments and the public health community do the same.” WHO’s statement said, “[GA’s] activities support a broader tobacco industry strategy to mislead the public about the dangers of tobacco and nicotine product use. WHO is particularly concerned about potential efforts to target children and young people, creating a new generation of tobacco and nicotine users.”

Hristio Boytchev, *The BMJ*

Cite this as: *BMJ* 2024;385:q1387

GA received a “final charitable gift” of \$140m from PMI in 2023, “effectively funding the foundation at a rate of \$17.5m a year until 2030

OBESITY: Weight management services' waiting lists close as demand soars

One specialist obesity service in England reached its three year quota of patients in less than 17 weeks. The next government must take note, reports **Elisabeth Mahase**

EXCLUSIVE One in six integrated care boards (ICBs) in England has stopped accepting new patients for specialist weight management services as referral numbers spiral out of control, a *BMJ* investigation has found.

At least seven of 42 ICBs around the country—covering Manchester, Bristol, Suffolk, Leicester, Essex, and much of Yorkshire—have had to close a tier 3 weight management service list in their area, with many warning that demand far exceeds capacity. Tier 3 services involve multidisciplinary teams—including physicians, physiotherapists, dietitians, and mental health specialists—to support patients, sometimes providing access to weight loss drugs such as semaglutide.

The rise in obesity and the demand for weight loss injection pens may be fuelling the increase in referrals, experts have said. But they blame a lack of consistent government policy for hindering the ability of weight management services to keep up with the growing demand.

One ICB, NHS West Yorkshire, closed the list for its Leeds service in July 2023, when the service was treating 1323 patients—far more than the 250 new annual referrals estimated when the service was



Services are unequal and very limited, or completely absent in some regions
Nerys Astbury



It is concerning that the provision is unable to keep up with the demand
Alison Moody

recommissioned in 2019. It told *The BMJ* that the availability of such specialist services was “limited” across West Yorkshire and that “waiting lists are long.” It added that access would “widen over time, when our resources allow.”

A month earlier, North Bristol NHS Trust (which comes under NHS Bristol, North Somerset, and South Gloucestershire ICB) had to close its list, citing similar capacity issues. Tim Whittlestone, chief medical officer at the trust, said that it was a “difficult decision” and that the board was “exploring sustainable solutions for the future.”

Nerys Astbury, associate professor of diet and obesity at Oxford University, described the availability of specialist weight management services as “unequal and very limited, or completely absent in some regions.” She told *The BMJ* that, even where services do exist, “they are oversubscribed, waiting lists have been capped, or budgetary limitations mean services are at risk of being decommissioned.”

This is the case in Suffolk, where patients have had no access to tier 3 weight management services since October 2023, when “demand on the service exceeded available NHS places.” A spokesperson for NHS Suffolk and North East Essex ICB said that the board was “exploring new access arrangements.”

Mid and South Essex ICB also had to close its list in March this year after referrals “doubled.” The ICB has said that it is “developing options” to deal with “increases in demand.”

Tightening referral criteria

NHS Leicester, Leicestershire, and Rutland ICB’s pilot tier 3 weight management service has stopped accepting new referrals, county council papers showed last month.

The board told *The BMJ* that the pilot was launched in November 2023 and was expected to treat 560 patients over three years. Instead, it received 580 referrals in just 17 weeks.

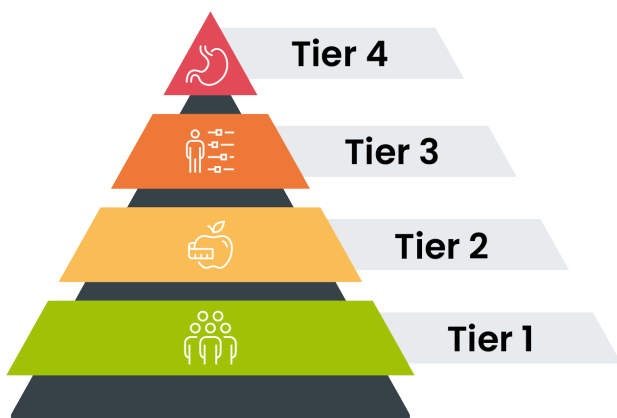
Another ICB, Humber and North Yorkshire, noted on its website that the tier 3 weight management service for Scarborough, Rydale, and Harrogate was no longer accepting referrals, as demand had “exceeded expectations.”

In some areas, adjusting the referral criteria to reduce referrals has failed to quell demand. Greater Manchester ICB has had to pause referrals to its service in Bolton, while other localities remain open but are struggling. Board papers from February show that, even after amending its access criteria in 2022, Trafford’s tier 3 service has been “under significant pressure, with demand far exceeding commissioned capacity, resulting in long waiting times.”

The papers said that the change had “proved insufficient to match capacity to demand, with 383 patients waiting approximately seven months to access the service,” and proposed restricting the criteria further, to patients with the highest body mass index (BMI).

A spokesperson for Greater Manchester ICB emphasised the high prevalence of obesity in the area, affecting more than one in four adults (27.1%; 606 292). “Demand and capacity issues are being experienced throughout Greater Manchester,” the spokesperson told *The BMJ*. The ICB is now conducting a review of its entire obesity pathway.

Throughout England around two thirds (64%) of adults are estimated to be overweight or obese. Alison Moody, health and social policy researcher at University College London, said that in 2010 a million adults in England had morbid



obesity (BMI 40 or above). This rose to 1.5 million in 2019. She warned, “Given the increasing need for weight management services, including specialist multidisciplinary services [tier 3], it is concerning that the provision is unable to keep up with the demand.”

David Buck, senior fellow at the King’s Fund, said that the government had had a “mixed record in the past on supporting health and weight management services, including reducing funding.” He said that a “more strategic response” to tackling obesity was now needed, including specialist services.

In April 2022 the government pulled its £100m funding grant for weight management services in England, which had been shared between the NHS and councils, just a year after it was announced. The funding cut came as the government also U turned on a number of the promises it laid out in the 2020 obesity strategy.

Weight loss injection pens

As well as rising obesity levels, the availability of weight loss injections through tier 3 services may also have contributed to the increasing demand, experts suggest. Last year NICE recommended that semaglutide be provided as an option through “specialist weight management service providing multidisciplinary management of overweight or obesity (including but not limited to tiers 3 and 4 services).”

Astbury commented, “While the increase in obesity prevalence has undoubtedly gradually increased the demand for these services, many services may have seen further increase in demand for their services following the NICE recommendations.”

The good news for tier 3 services is that latest draft NICE recommendations for the weight loss drug tirzepatide have not included the same stipulations, suggesting that it could be provided through primary care as



PHANIE / SIPA PRESS / ALAMY

In **ENGLAND** around two thirds (64%) of adults are estimated to be overweight or obese

long as additional diet and exercise support services are also made available. Astbury believes that this could ease some of the pressure on tier 3 services and widen access to treatment, although she said that it would likely pose its own challenges for the “already overstretched primary care sector,” especially as the number of people who are overweight or obese continues to rise.

However, GPs are already feeling the pressure of the obesity crisis. Samuel Parker, GP and deputy chair of the BMA’s North East Regional Council, put forward a motion for debate at the annual representative meeting on 24 June, highlighting the “increasing pressures on the NHS due to the obesity epidemic, specifically in areas of socioeconomic deprivation,” and demanding an “increase in funding for UK based weight management services paid for by an increase in the sugar tax.”

Parker told *The BMJ* that this money could be used to fund initiatives “aimed at tackling food insecurity and increasing



A higher sugar tax could fund tackling food insecurity and increasing the provision of healthy free school meals

Samuel Parker

A more strategic response to tackling obesity is now needed

David Buck

the provision of healthy free school meals.” His motion also warned of the growing number of patients resorting to overseas weight loss surgery, with many then requiring NHS emergency surgery or presenting to their GP expecting aftercare. *The BMJ* previously revealed that access problems and long waiting lists could be driving as many as 5000 people a year abroad for bariatric surgery.

Bold prevention policy

Buck said the worsening crisis and rising demand for weight loss services would require the government to take “bold action” on measures such as food “reformulation, price, regulation, and planning and advertising to help people to live healthier lives, particularly as demand for support far exceeds what local services are set up to offer.”

He pointed to recent polling by the King’s Fund that had indicated strong public support (65%) for restricting advertising of unhealthy food and drink and for the government to require companies to reduce the salt, sugar, and fat in their products (67% support).

Buck said, “In the long run, prevention policies, including those to tackle obesity, will be far cheaper than treating the symptoms of ill health, and a new government needs to act decisively.”

● OPINION, p 448

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;385:q1356

THE BIG PICTURE

Extreme heat kills 1300 Hajj pilgrims

As water is sprayed on Muslim pilgrims on Mount Arafat in Saudi Arabia (main image), officials announced that more than 1300 pilgrims have died on this year's Hajj.

Around 10 countries have reported deaths of their citizens, mainly caused by the extreme heat, during the pilgrimage to Mecca, one of the five pillars of Islam that all Muslims with the means must complete at least once.

The Saudi national meteorological centre reported a high of 51.8°C this week at the Grand Mosque in Mecca.

On just one day of the 14-19 June pilgrimage, 2764 cases of heat related illness were reported, with many people needing help and medical treatment, including a man at the site of the symbolic "stoning of the devil" ritual in Mina (above).

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2024;385:q1404



FADEL SENNA/GETTY IMAGES





AMIR NABIL/AP/ALAMY

Sterile water injections for back pain in labour

NICE recommendation is based on inconsistent and low quality evidence

Recommendations by NICE¹ regarding the use of sterile water injections for back pain during labour have sparked controversy.^{2,3}

The intrapartum care guideline states that sterile water injections alleviate back pain during labour from 10 minutes after injection for up to three hours.¹ However, the NICE evidence review underpinning these recommendations reveals uncertainty about the effectiveness of the injections and the lack of transparency regarding the associated pain associated is concerning.⁴

NICE evaluated 11 studies (10 randomised controlled trials and one Cochrane systematic review⁵) assessing low risk women who gave birth to a single infant at 37-42 weeks' gestation. Using the GRADE framework,⁶ NICE produced detailed evidence profiles and assessed the overall certainty of evidence for each outcome of interest. These certainty assessments considered five domains: risk of bias, inconsistency, indirectness, imprecision, and publication bias.⁷ Only five trials⁸⁻¹² reported back pain outcomes with a “moderate” or “high” certainty of evidence (versus “very low” or “low”).

Of these five trials, four used saline injections as the control intervention⁸⁻¹¹ while one used dry (sham) injections.¹² Pain profiles for patients in the intervention and control groups varied markedly in direction, magnitude, and duration of response. Two trials observed no difference in mean back pain scores (visual analogue scale, VAS) between the sterile water (intracutaneous or subcutaneous) and saline injection groups.^{8,9} By contrast, three trials reported substantially lower pain scores in the sterile water group compared with the control group,¹⁰⁻¹² although the magnitude and duration of effect varied. For example, pain scores ranged from 1.2-fold to 3.2-fold lower in the sterile water group at 90 minutes after injection.¹⁰⁻¹² The biggest effect size for sterile water was reported in a single centre trial of 168 women using dry



Misrepresenting the effectiveness of a pain treatment and the harms associated with it can undermine trust

injections as the control.¹² The striking reduction in pain scores among women given sterile water was reported from 10 minutes to three hours after injection.¹²

However, these findings should be interpreted with caution as they have not been replicated and both ethics approval and trial registration occurred after study completion. Despite these concerns, data from this trial seem to be the primary basis for NICE's assertion that analgesia from sterile water injections lasts up to three hours.

Rescue analgesia

In the largest published trial to date (1166 participants), sterile water injections were associated with a significant reduction in back pain compared with saline injections, lasting up to 90 minutes.¹¹ Yet, analysis of patient reported outcomes showed that 32% of patients receiving sterile water injections found them “not very” or “not at all” effective and willingness to use the same treatment in a future pregnancy was 60% for the sterile water group compared with 53% for the saline group. Additionally, use of rescue analgesia—which can be considered a less subjective measure of pain severity—was similar in the sterile water and saline groups: nitrous oxide gas (67% v 67%), epidural analgesia (37% v 38%), and intravenous or intramuscular narcotics (18% v 17%).¹¹

These data raise questions about treatment effectiveness as well as the potential for bias because of unblinding. Although this trial incorporated

masking procedures (such as asking midwives to leave the room during the injection), the increased pain and slower rate of absorption of sterile water compared with saline¹¹⁻¹⁴ compromise the ability to maintain blinding.

While the NICE evidence review found sterile water injections were not associated with increased risk of maternal or neonatal morbidity, the review committee noted the importance of clear communication about the pain caused by injections.⁴ The NICE guideline describes the pain associated with sterile water injections as an “initial stinging sensation”¹; however, trials included in the evidence review as well as qualitative studies¹⁵⁻¹⁷ report patients can experience intense pain, lasting from 20 seconds up to 2 minutes.¹³ The pain has been found to be severe enough to discourage women from requesting repeat injections, even among those who report good pain relief following sterile water injections.¹⁸

Given the limited and inconsistent evidence and lack of validation studies, we strongly encourage NICE to offer more cautious recommendations regarding the use of sterile water injections. Misrepresenting the effectiveness of a pain treatment and the harms associated with it can undermine trust between patients and care providers. Guidance should also be context specific, considering the availability of analgesia options and staff experience across different birthing centres, as well as patient preference.

Facilitating genuine patient autonomy necessitates a balanced approach that prioritises evidenced based, shared decision making, and empowers people to make informed decisions that align with their values and preferences.¹⁹ Discussions regarding management of back pain in labour should acknowledge concerns about the consistency and quality of evidence on sterile water injections.

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Breast cancer screening from age 40 in the US

The new recommendation could cause more harm than benefit

The US Preventive Services Task Force has updated its recommendation for the age when all women should start mammography screening, lowering it from 50 to 40.¹ This change immediately affects more than 20 million women and other people assigned female at birth who are aged 40-49,² with repercussions far beyond the US.

Such a momentous change should reflect new randomised trial evidence or concerning cancer mortality trends. But no such trial evidence was found in the commissioned evidence report,³ and mortality has been decreasing, especially among women under 50.⁴ The recommendation seems to be based on two, inter-related, considerations. The first is recognition of the inequality in breast cancer mortality between Black and white US women, and a commitment to reduce this. The second is statistical modelling of a hypothetical population that found screening at 40 would reduce breast cancer mortality, especially among Black women.⁵

The need to make health policy and systems antiracist and more equitable is urgent and compelling. But there is little empirical evidence that lowering the screening age will achieve this. We agree with others' concerns^{4,6} about the task force's increasing reliance on modelling over empirical evidence. The modelling reported a more favourable benefit to harm ratio for all population groups than the trial evidence and made several assumptions that may not represent reality,^{7,8} including few non-progressive or rapidly growing cancers (where screening has no benefit), high adherence, and large mortality benefits, especially for Black women.

The racial inequality in US breast cancer mortality has been observed since wide adoption of screening (and adjuvant endocrine therapy) in the 1980s.⁹ Screening primarily benefits women with cancers that are hormone receptor (HR) positive; HR negative tumours are more aggressive and



Instead of expanding mammography screening to younger women, initiatives are needed to tackle systemic injustices

tend to be diagnosed at later stages, among younger women, and missed by mammography screening.⁶ HR negative tumours are more common in Black women for hereditary reasons and because of social determinants of health.⁹ Instead of expanding mammography screening to younger women, initiatives are needed to tackle the systemic injustices driving racial inequality, especially in access to high quality, timely, and effective care and treatment.^{4,9}

Uncertain evidence

Globally, the US may be an outlier in making a strong recommendation to lower the age of screening.¹⁰⁻¹² The task force's report found uncertain evidence of a potential mortality benefit in women aged 40-49: the 95% confidence interval spanned from six more deaths to 89 fewer deaths per 100 000 screened.³ None of the included trials indicated significantly reduced mortality with screening, including the UK Age trial, the largest (n=160 921) and most recent trial designed to determine the effectiveness of screening women in their 40s.¹³ This small and uncertain benefit needs to be considered against harms.

False positive mammography rates were highest among those aged 40 to 49 years: 12 120 (95% CI 10 560 to 13 870) per 100 000 screened. Recommendations for additional diagnostic imaging were also highest in 40-49 year olds: 12 490 (10 930 to 14 230) per 100 000. Many women will

also have clinical consultations and procedures such as surgical biopsies, creating appreciable costs to the health system as well as potential out-of-pocket costs.¹⁴ Adverse psychosocial consequences, such as anxiety and finding time in busy lives for follow-up, pose additional burdens.

Trial estimates of overdiagnosis (cancers that would have never have caused symptoms or death if left untreated) ranged from 11% to 22% of detected cancers. Most of those overdiagnosed will also be overtreated with surgery (with or without adjuvant radiotherapy) and hormone therapy.^{15,16} They will not benefit from this, but they may be harmed—through adverse effects of surgery and hormone therapy, and through increased risk of coronary heart disease and other cancers after radiotherapy.¹⁵ Finally, although there were no trial data on effects of mammography radiation, a modelling report found that there could be seven additional radiation induced breast cancer deaths per 100 000 women with biennial screening starting at age 40 (12 deaths) rather than age 50 (5 deaths).¹⁷

Decreasing the age for screening offers only possible marginal health benefit for individuals, with substantially increased risk of harm. Screening is also resource intensive for health systems, using up funding,¹⁴ clinician hours,¹⁸ and facilities, all of which contribute to healthcare's carbon footprint.¹⁹ The opportunity costs are even more pressing in low and middle income countries.^{20,21}

Health systems globally need transformation to remove systematic racism and discrimination, and tackle health inequalities. Instead of adopting the new US recommendations, policy makers should work with communities to co-design initiatives that tackle the root causes of the racial inequality in breast cancer care for Black women and other underserved groups.

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Unpicking the general election manifestos on health and care

The promises made by the three main UK parties vary in detail and ambition, **Andy Cowper** reports

In 2016 the US political journalist Salena Zito wrote of the then presidential candidate Donald Trump that “the media take him literally but not seriously; his supporters take him seriously but not literally.”

It’s an observation that offers a neat framework to review the health and care content of the most influential Westminster political parties’ manifestos for the 2024 general election.

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LUCY NORTH/PA/LAMY

Liberal Democrats

The title of the Liberal Democrats’ manifesto, *For a Fair Deal*, hints at the party’s likely best case scenario: returning as a top three Westminster party and influencing the national debate.

The Liberal Democrats’ care offer is significant, which is unsurprising given that the party’s leader, Ed Davey, has spoken publicly about his experience of caring for family members.

They pledge to introduce free personal care, based on the model introduced in Scotland in 2002, whereby provision is based on need, not ability to pay. They also pledge to create a social care workforce plan, establish a Royal College of Care Workers to improve recognition and career progression, and introduce a higher minimum wage for carers.

They pledge to establish a cross party commission to forge a long term agreement on sustainable funding for social care and to give unpaid carers a “fair deal,” including paid carer’s leave and a statutory guarantee of regular respite breaks.

The Liberal Democrats’ headline health pledges include giving everyone the right to see a GP within seven days or within 24 hours if their need is urgent, with 8000 more GPs to deliver on that. They will also



guarantee access to an NHS dentist for everyone needing urgent and emergency care, to end DIY dentistry and “dental deserts.”

The party also pledges to improve early access to mental health services by establishing mental health hubs for young people in every community and introducing regular mental health checkups at key points in people’s lives when they are most vulnerable to mental ill health.

Cancer survival will be boosted, and the party says it will introduce a guarantee for 100% of patients to start treatment for cancer within 62 days of urgent referral.

They will also help people to spend five more years of their life in good health by investing in public health.

The Liberal Democrats’ offer is the most generous of the three national parties, although there is scant detail how they plan to deliver their pledges. They also have plans for the NHS estate: to “implement a 10 year plan to invest in hospitals and the primary care estate to end the scandal of crumbling roofs, dangerous concrete, and life-expired buildings.” However, there is little clarity on how they’d deal with the more than half of the current £12bn NHS capital and maintenance backlog that is already posing risks to the safety of patients and staff.

Labour

Labour's planned spending restraint shapes the party's manifesto commitments on health and care, limiting promises.

Labour's manifesto, *Change*, promises to get a grip on the record waiting list. "We will return to meeting NHS performance standards," it says. "That means patients should expect to wait no longer than 18 weeks from referral for consultant-led treatment of non-urgent health conditions."

The manifesto doesn't give a date by which this will happen, although shadow health secretary Wes Streeting has repeatedly said that he wants this done by the end of the party's first term.

Labour aims to create 40 000 more appointments a week, funded by a tax crackdown and new non-domicile tax measures and delivered by incentivising existing NHS staff to work extra sessions at evenings and weekends.



The party pledges to use spare private sector capacity, of which there is little. The practicality of its idea to "pool resources across neighbouring hospitals to introduce shared waiting lists to allow patients to be treated quicker" is also yet to be proved to work at scale.

The Labour manifesto also describes a new "Fit For the Future" fund to double the number of CT and MRI scanners, allowing the NHS to catch cancer and other conditions earlier and saving lives.

Labour also says it is committed to delivering the new hospitals programme. It is worth noting, however, this is not the same as tackling the £12bn capital and maintenance backlog.

Another pledge offers more power to patients. Labour's plan is to transform the NHS app, putting patients in control. "This will include giving performance information on



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local services and notifications of vaccinations and health checks. Patients will be able to see the medical guidelines for the treatment they should get, to hold health services to account and understand what their choices are." This sounds good, but the track record on the real impact of patient choice is underwhelming.

The manifesto goes on to talk about patient safety and modernising the NHS to become a "neighbourhood health service." There is a mention of shifting resources to primary and community care, but there are no numbers or timelines. There's also an interesting aim to take the pressure off GP surgeries by improving access to services and treatment through new routes.

The manifesto says, "We will create a community pharmacist prescribing service, granting more pharmacists independent prescribing rights where clinically appropriate. We will allow other professionals, such as opticians, to make direct referrals to specialist services or tests, as well as expanding self-referral routes where appropriate."

There are commitments on dental contract reform, mental health, and social care: it is not clear in the manifesto, but Labour has since pledged to match the Conservatives' plan to introduce the £86 000 lifetime personal care cap by 2025. There is also a pledge to "build consensus for the longer term reform needed to create a sustainable National Care Service."

Conservatives

The Tories' manifesto *Secure Britain's Future* describes itself as a "clear plan," but the health and care section occupies just three of its 80 pages. It offers to "increase NHS spending above inflation every year, recruiting 92 000 more nurses and 28 000 more doctors, driving up productivity in the NHS, and moving care closer to people's homes through Pharmacy First, new and modernised GP surgeries, and more community diagnostic centres."

The plan also says it will "return performance to the levels set out in the NHS Constitution by the end of the next parliament" but gives no explanation as to how this will be achieved. Nor is there much clarity on social care, apart from a commitment to "supporting a high quality and sustainable social care system, building on our additional investment of up to £8.6bn over the last two years." The imprecise number relies on local governments putting up council tax. They also laud their dental recovery plan, which has widely been regarded as a costly failure.

The Conservatives also offer to "build or modernise 250 GP surgeries, focused on areas of new housing growth, and build 50 more community diagnostic centres, including in underserved areas, resulting in an additional 2.5 million checks a year." These are funded by a pledge to "cut waste and bureaucracy in the NHS,



LEON NEAL/PA/ALAMY

reducing the number of managers by 5500, releasing £550m for frontline services, and simplifying and streamlining oversight and accountability."

However, by international standards the NHS is undermanaged, with former health secretary Andrew Lansley's 2011 reforms having cut management by 45% from the 2008-9 level.

The Conservatives' pledge to increase community care capacity also has echoes of the 2020 new hospitals programme, the delivery of which has faced criticism from MPs on the Public Accounts Committee and the National Audit Office.



POLITICS

Who are the doctors standing as MPs in the general election?

Doctors working in a wide range of specialties and from across the political spectrum have been out campaigning.

Tom Moberly speaks to some of this year's candidates for parliament



Waiting times are starting to make people think of different options
Bret Palmer

At least 31 doctors are standing for election as MPs in the 2024 general election, including two doctors running in the same constituency.

In the South West Wiltshire constituency, Andrew Murrison, who served as a medical officer in the Royal Navy, is being challenged by Bret Palmer, a consultant in genitourinary medicine, sexual health, and HIV medicine. Murrison has been Conservative MP for the constituency since 2001, while Palmer is running for the Liberal Democrats.

Palmer says that he faces an uphill battle in the seat, as Murrison has a majority of 21 000. "South West Wiltshire has one of the oldest populations in the UK and is very conservative," he says. "However, GP and hospital waiting times are starting to make people think of different options."

For many of the doctor candidates, running for parliament

Many health workers want to make people's lives better. The same is true in politics
Anna Fryer



MALCOLM WILLET

offers the opportunity to improve patients' lives on a larger scale than can be achieved in a single consultation, at a practice or service level, or even through work in public health.

Anna Fryer, a consultant liaison psychiatrist, is standing in Pendle and Clitheroe for the Liberal Democrats. She says the notion that "politics is nothing but medicine at a larger scale"—as the German physician and politician Rudolf Virchow remarked—is still relevant today. "At the heart of it, many health and social care workers want to make a positive impact on patients and carers and make people's lives better," she says. "The same is true in politics."

Others are more blunt about the need for change. "This country is broken," says David Nicholl, clinical lead for neurology at Sandwell and West Birmingham NHS Trust. Nicholl, who is standing for the Liberal Democrats in Bromsgrove,

points to the "lies and deceit that get told in politics." His frustrations with the current political climate led him to stand for election. "I felt it was important to have an adult in the room with a long experience of public service, rather than some special adviser with very limited life experience," he says.

There are no centralised lists of doctors running for parliament. But *The BMJ* has found that at least 31 doctors are standing as prospective parliamentary candidates in the upcoming UK general election. This is fewer than in the December 2019 election, when 51 doctors ran for parliament and 10 were elected.

Of the 10 medical MPs elected in 2019, eight are standing again in 2024. Philippa Whitford, a breast surgeon who was the Scottish National Party MP for Central Ayrshire from 2015 until parliament was dissolved on 30 May this year, is retiring from politics. And Dan Poulter, a mental health doctor

Doctors standing for election as MPs in the 2024 UK general election

| Name | Constituency | Specialty | Party | MP in 2019-2024 parliament |
|---------------------|---------------------------------------|------------------------|------------------------------------|----------------------------|
| Adam Carter | Rotherham | Junior doctor | Liberal Democrats | No |
| Aidan King | Newcastle upon Tyne North | Pharmacology | Liberal Democrats | No |
| Alex Armitage | Orkney and Shetland | Paediatrics | Scottish Green | No |
| Andrew Murday | Skipton and Ripon | Cardiothoracic surgery | Liberal Democrats | No |
| Andrew Murrison | South West Wiltshire | Navy doctor | Conservative | Yes |
| Anna Fryer | Pendle and Clitheroe | Psychiatry | Liberal Democrats | No |
| Anne McCloskey | Foyle | General practice | Independent | No |
| Beccy Cooper | Worthing West | Public health | Labour | No |
| Ben Spencer | Runnymede and Weybridge | Mental health | Conservative | Yes |
| Bret Palmer | South West Wiltshire | Sexual health | Liberal Democrats | No |
| Caroline Johnson | Sleaford and North Hykeham | Paediatrics | Conservative | Yes |
| Carolynn Scrimgeour | Mid Dunbartonshire | Oncology | Scottish Green | No |
| Chandra Kanneganti | Stoke-on-Trent Central | General practice | Conservative | No |
| David Nicholl | Bromsgrove | Neurology | Liberal Democrats | No |
| Fiona Fawcett | Caithness, Sutherland and Easter Ross | Oncology | Conservative | No |
| Gwyn Williams | Swansea West | Ophthalmology | Plaid Cymru | No |
| James Davies | Clwyd East | General practice | Conservative | Yes |
| Kate Crossland | Ealing Central and Acton | Palliative care | Green | No |
| Kieran Mullan | Bexhill and Battle | Emergency doctor | Conservative | Yes |
| Liam Fox | North Somerset | General practice | Conservative | Yes |
| Luke Evans | Hinckley and Bosworth | General practice | Conservative | Yes |
| Pallavi Devulapalli | South West Norfolk | General practice | Green | No |
| Reva Gudi | Feltham and Heston | General practice | Conservative | No |
| Reza Hossain | Chelmsford | General practice | Green | No |
| Rosena Allin-Khan | Tooting | Emergency medicine | Labour | Yes |
| Sally Johnston | New Forest West | General practice | Labour | No |
| Sandesh Gulhane | East Renfrewshire | General practice | Conservative | No |
| Simon Opher | Stroud | General practice | Labour | No |
| Tariq Mahmood | Ealing Southall | Gastroenterology | Liberal Democrats | No |
| Teck Khong | Melton and Syston | General practice | Alliance for Democracy and Freedom | No |
| Will Sapwell | Sheffield Brightside and Hillsborough | Junior doctor | Liberal Democrats | No |



As somebody invested in the future of our children, it's important to do as much as I can to influence climate change policy
Alex Armitage

LISTENING—A TRANSFERABLE SKILL

Working as a doctor has several similarities to working as an MP—and, indeed, running to be one. In both roles, communication skills—listening, understanding, and explaining—are key to successful interactions with people, whether they are patients, constituents, or colleagues, and whether they have differing views or not.

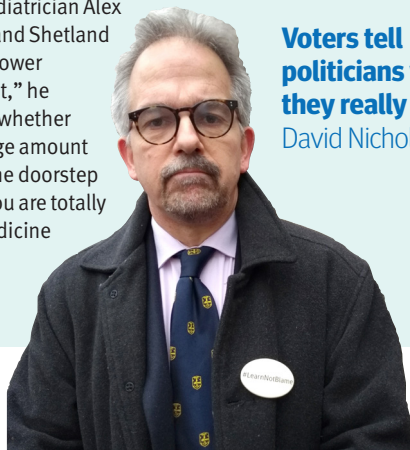
“Good communication skills in politics are as essential as good communication skills in medicine,” says Beccy Cooper, a public health consultant standing for Labour in Worthing West. “I think that skill has definitely held me in good stead—the training that we did, and the ability to listen to people and really hear what they’re saying; that’s really important,” she says.

Neurologist David Nicholl, standing for the Liberal Democrats in Bromsgrove, highlights a key difference between listening as a doctor and as a politician.

“Patients tell you what they think their doctors want to hear,” he says. “Voters tell politicians what they really think—which may not be the same and could be very politically incorrect.”

Another important difference between the roles is in the structure of relationships in the two settings, thinks paediatrician Alex Armitage, standing in Orkney and Shetland for the Scottish Greens. “The power dynamic is completely different,” he says. “In the consulting room, whether you like it or not you have a huge amount of power as a doctor—but on the doorstep asking for somebody’s vote, you are totally accountable to them. Both medicine and politics really test your empathy and communication skills.”

Voters tell politicians what they really think
David Nicholl



and MP for Central Suffolk and North Ipswich from 2010 until parliament was dissolved, is not standing. Poulter was elected as a Conservative candidate in 2019 but moved to the Labour party in April this year.

A wide range of specialties is represented among the medical candidates in 2024. There are 12 GPs, as well as doctors working in cardiothoracic surgery, emergency medicine, gastroenterology, psychiatry, neurology, oncology, ophthalmology, paediatrics, palliative care, pharmacology, public health, and sexual health.

Campaign issues

Some of the doctors standing are focused on a particular issue, such as the climate emergency. “We have to treat climate change with the seriousness that it deserves,” says paediatrician Alex Armitage who is standing in Orkney and Shetland for the Scottish Greens. “As a paediatrician, and therefore somebody invested in the future of our children, I feel it’s important professionally to do as much as I can to influence policy on climate change.”

Palliative care doctor Kate Crossland, who is standing for the Green Party in Ealing Central and Acton, says that the need to tackle the climate emergency was a key reason she put herself forward to stand. “We’ve seen rollbacks on major environmental promises, widening social inequality, and worsening pressure on the NHS in the past five years,” she says. “I want to give electors the chance to vote for a party that has meaningful policies to change that.”

Recent polls suggest that the UK public see health and social care as one of the major challenges that politicians need to tackle. An Ipsos Mori survey in June 2024 found that 41% of people thought that the health system was one of the biggest concerns facing the country.

Junior doctor Will Sapwell, who is standing for the Liberal Democrats in Sheffield Brightside and Hillsborough, says that, because

health and social care are among voters' key concerns in the current political climate, being a doctor has given him political credibility. He also thinks it helps him stand out as a candidate in a crowded field locally. "Voters in my patch have had a lot of names to remember," he says. "The one thing they do remember is 'Oh yes, you're the doctor.'"

Retired cardiothoracic surgeon Andrew Murday, who is standing for the Liberal Democrats in Skipton and Ripon, says he gets "a little bit more respect as a doctor" than he might otherwise, while Nicholl says he's been "welcomed with open arms" during his time out on the campaign trail. "Voters are fed up to the back teeth of the current political discourse," he believes.

Public perception

Among the doctors standing for parliament, men outnumber women—19 are men, and 12 are women—and a wide range of political parties is represented: 11 doctors are standing for the Conservative Party, 8 for the Liberal Democrats, 5 for either the Green Party or the Scottish Green Party, and 4 for the Labour Party. In addition, the Alliance for Democracy and Freedom party and Plaid Cymru each have one doctor among their prospective parliamentary candidates, and one doctor is standing as an independent candidate.

Doctors running for parliament,

It shows that some aspiring politicians really do care deeply about protecting the NHS

Kate Crossland

however, often do not have the opportunity to let potential voters know their backgrounds. Campaigning on the doorstep requires having a brief message to avoid taking up too much of people's time, and so personal details rarely come up, Crossland explains. "I do talk about being a doctor in interviews," she says. "And when I get longer to talk to people, where it is well received as showing that some aspiring politicians really do understand the current pressures and care deeply about protecting the NHS."

Whitford thinks that doctors and other health workers in parliament are "in a very strong place" to understand the root causes of many health problems. "Becoming an MP helps you zoom out and realise that whatever kind of doctor you were, you were probably trying to bail out a boat that has a hole in it," she says. "And actually you need to go way back to the beginning and look at what creates ill health in the first place."

Beccy Cooper, a public health consultant, is standing for Labour in Worthing West, a target seat for the party. She thinks that having representation in parliament from across the medical community is good but that being a doctor doesn't necessarily mean you'll make a good MP. "Doctors are made up of all different types of human beings and, as with all professions, some wouldn't really fit well in politics," she says. "In general, if you're interested in a certain brand of public health or general practice and you're interested in social justice, [and you're] really seeing how inequality really affects people's health, that can drive you into politics."

Whitford says that entering parliament, or politics more generally, is something for doctors to do when they have substantial experience.

"I wouldn't say it's the answer when you've done your foundation years and you're a bit pissed off," she



Really seeing how inequality affects people's health, that can drive you into politics
Beccy Cooper



I get a little bit more respect as a doctor than I might otherwise
Andrew Murday

says. "Because you certainly are not bringing anything to parliament at that stage. But I think when you would have experience and that hinterland to bring to parliament, you then are a contributor."

Realities of the role

Being in parliament is a difficult, intense job that places stress on an MP's relationships and family as well as on their professional life, Whitford points out. "You're away from home for four days," she says. "It's kind of seven days a week, so even when you are at home, you're having to be out and doing stuff in the constituency. It takes quite a toll on your family, particularly if you have a young family."

Palmer says that he has already seen the effects of long hours spent canvassing for votes. "I still work full time as an NHS doctor, so campaigning is done in my own time and at weekends," he says. "Family time has suffered, and I didn't realise how much of a sacrifice your family makes as well—this is a bit of a shock."

These pressures mean that anyone running for parliament must ensure that they know what they are letting themselves in for, Whitford emphasises. "People who go and stand as an MP, you need to do it with your eyes open," she says. "You need to do it with your family's backing. You need to talk to an MP about the realities of what life is like before you make that commitment."

She adds, "You then need to be willing to stand up and speak up for health and wellbeing, and tackling poverty, and social care, and all wellbeing issues that go with that. But you do have the incredible authority to do that."

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The one thing voters do remember is 'Oh yes, you're the doctor'
Will Sapwell

