

this week

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Vaginal mesh payouts for 140 women

More than 100 women with complications from vaginal mesh implants have received payouts from three manufacturers in the first successful group claim of its kind in England.

It is understood that 140 women have reached an undisclosed settlement with Johnson & Johnson, Bard, and Boston Scientific, and the total is expected to run into the millions, the *Guardian* reported.

The implants were widely used to treat stress urinary incontinence and prolapse in the UK until 2018, often after childbirth. However, complications included chronic pain, bladder and bowel perforations, and mesh eroding through the vaginal wall.

Some women were left in permanent pain, some unable to walk, work, or have sex. Many needed revision surgery to remove the mesh, and some continue to struggle with pain and other problems. As concerns grew about the scale of complications the routine use of mesh was paused and then suspended.

Payouts have already been awarded in legal action in Australia, Scotland, and the US. Although successful medical negligence claims have been brought against the NHS, a group claim against the manufacturers had not previously been successful.

Calls for the creation of a government led compensation scheme were made in both the

Cumberlege review and a more recent report by Henrietta Hughes, England's patient safety commissioner, which suggested that initial payments of £20 000 be made.

Kath Sansom, who has led the Sling the Mesh campaign since 2015, said that she was "delighted" by what is believed to be the first successful product liability group action in England, but said the women represented only a tiny fraction of those harmed: her support group has almost 11 000 members.

"This is a groundbreaking success where a law firm has had the courage and temerity to take on industry giants," said Sansom.

However, she added, "It is very difficult to know just how positive this news is without knowing how much has been awarded. While 140 women is a drop in the ocean of the number of women harmed, we hope it paves the way for further claimants to succeed.

"The Hughes report in February called for financial redress for mesh injured women to start from 2025, so with a change in government it will be interesting to see if this now gains further traction."

The three companies involved issued statements confirming the action had been resolved without admission of liability.

Jacqui Thornton, London
Cite this as: *BMJ* 2024;386:q1831

Kath Sansom, leader of Sling the Mesh, welcomed the settlements but said only a "tiny fraction" of the women harmed were represented in the cases

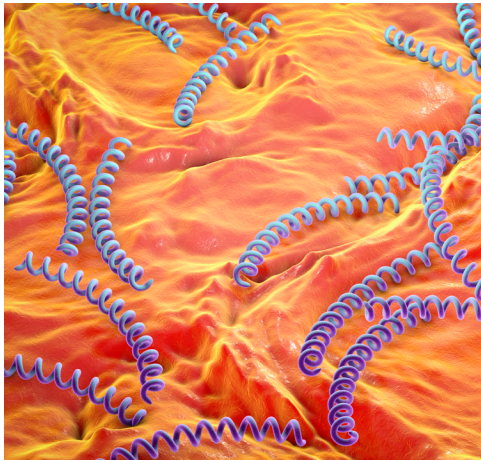
LATEST ONLINE

- GP who was jailed over climate change protests is suspended for three months
- Nearly 2000 attacks on Ukraine's health facilities since invasion, says WHO
- Maternity care: "Things are far from improving," says ombudsman after surge in investigations

Maternity
Out of hours
public entrance
→

SEVEN DAYS IN

Test for syphilis in people with possible symptoms, says UKHSA as cases rise



Public health leaders are reminding doctors to consider testing people for syphilis if they present with symptoms such as ulcers, after 9513 cases were diagnosed in 2023 in England, a 9.4% increase on 2022. There were also 3075 diagnoses of other stages or complications of syphilis, including tertiary neurosyphilis and cardiovascular syphilis.

The UK Health Security Agency said that although diagnoses remained highest among gay, bisexual, and other men who have sex with men (6527 new diagnoses in 2023), the largest proportional rise in 2022-23 was in heterosexual people, with a 29% increase (641 to 825) among heterosexual women and a 17% increase (967 to 1133) in heterosexual men.

Syphilis often begins with an ulcer at the site of infection, which can occur in the genital area, anus, rectum, vagina, or mouth, although many infections are asymptomatic, said the agency. This ulcer typically appears three to four weeks after exposure and may heal without treatment, but the infection remains and can be transmitted to others.

Katy Sinka, head of the STI unit at UKHSA, said, "We want to remind healthcare professionals to consider syphilis in people who present with unexplained ulcers, swollen lymph nodes, or a rash. It is particularly important to look out for symptoms in pregnant women."

Zosia Kmietowicz, *The BMJ* Cite this as: *BMJ* 2024;386:q1801

New treatments

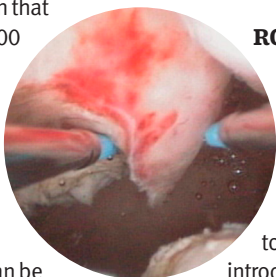
Emergency allergy nasal spray approved in US

The US Food and Drug Administration has approved the first adrenaline (epinephrine) nasal spray, known as Neffy, for the emergency treatment of allergic reactions in adults and children who weigh at least 30 kg (4.7 stones). Neffy is a single dose nasal spray administered into one nostril, although a second dose can be given if there is no improvement or symptoms worsen. The FDA's Kelly Stone said that the availability of epinephrine nasal spray could reduce barriers to rapid treatment of anaphylaxis.

NICE recommends new uterine fibroid treatment

NICE has recommended linzagolix, a gonadotrophin releasing hormone (GnRH) antagonist administered as a once daily tablet, for moderate to severe symptoms of uterine fibroids (below)—an option that could benefit 30 000 adults in England and Wales.

Linzagolix can be offered to adults of reproductive age for long term treatment (at least six months) and can be



taken with or without hormonal add-back treatment. Two in three women develop at least one uterine fibroid during their lifetime, and half of those develop symptoms.

Child health

Drive to increase uptake of whooping cough vaccine

Health officials have again urged pregnant women to ensure that they are vaccinated to protect their babies against whooping cough, as figures showed that cases in England had risen to 10 000 this year. A further infant death occurred in June, bringing the total to 10 infant deaths since the current outbreak began last November. Mary Ramsay, the UK Health Security Agency's director of immunisation, said, "Vaccination is the best defence against whooping cough, and it is vital that pregnant women and young infants receive their vaccines at the right time."

RCPCH calls for family hospital visits fund

The Royal College of Paediatrics and Child Health has called for the rest of the UK to follow Scotland in introducing a fund to help

families with low incomes get to hospital appointments. The Young Patients Family Fund was set up in Scotland in March 2023 to remove some of the financial barriers facing families when visiting a baby, child, or young person in hospital. It allows parents, carers, and siblings aged under 18 to claim some of the related costs.

"Gaza ceasefire is needed" for polio vaccine rollout



The World Health Organization and Unicef have pleaded for a seven day humanitarian pause in Gaza to allow for vital polio vaccines to be administered. Poliovirus was detected in Gaza in July, and three children have since presented with suspected acute flaccid paralysis. The two organisations are planning to launch two rounds of a vaccination campaign at the end of August and September to prevent the spread of circulating variant poliovirus VDPV type 2. They aim to provide two drops of novel oral polio vaccine type 2 to more than 640 000 children under 10.

Vaping

Record number of British adults now vape

Around 11% of British adults use e-cigarettes (vapes)—around 5.6 million people—a survey by Action on Smoking and Health shows. The charity commissioned YouGov to conduct the survey of 13 000 people in February and March this year. It found that 53% of current vapers were ex-smokers, equal to three million people. It also showed that over half of ex-smokers who had quit in the past five years had used a vape when quitting. Of these, around two thirds are still vaping.

Antibiotics

NHS England greenlights subscription model

NHS England has invited drug companies to bid for contracts as part of its antimicrobial subscription scheme, under which companies receive payment in advance based on the value of the products to the NHS rather than how much is used. The NHS and NICE previously ran a pilot focusing on two drugs, which they deemed successful. They are now expanding it nationwide to encourage companies to develop new antibiotics. The scheme is expected to cost £1.9bn over 16 years.

MEDICINE

Charity

M&S and charity launch stoma underwear

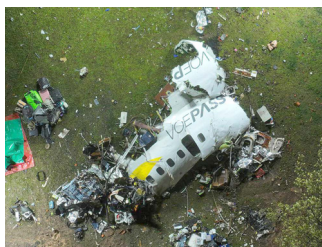
The high street retail chain Marks and Spencer has partnered with a charity, Colostomy UK, to launch an underwear line designed for people with a stoma. Around 100 000 women in the UK have a stoma, but Colostomy UK said that underwear options were very limited and that women often had to resort to specialist online retailers. The charity has worked with M&S to design a more affordable and accessible knicker range that can keep a stoma bag in place throughout the day and night.



Women with stoma can now buy underwear from M&S that will keep their bag secure

Cancer

Eight doctors die in aircraft crash in Brazil



Eight doctors travelling to an oncology conference, including six oncologists and two medical residents, were among the fatalities when a plane carrying 58 passengers and four crew crashed in Vinhedo, Brazil, on 9 August. Reports suggest that 15 doctors were supposed to be on the plane but that seven decided to take an earlier flight. The cause of the crash is still being investigated. Eduardo Baptistella of the Regional Medical Council said, “Unfortunately, we received very sad news and were able to confirm the death of eight doctors. These were people who dedicated their lives to saving others.”

Regulation

Requirements “duplicative and unrealistic”

Regulation needs to take better account of the level of challenge

and risk that trusts are managing and to better enable them to focus on improving care, said Saffron Cordery, deputy chief executive of NHS Providers. Trust leaders in England described regulatory requirements as “unrealistic” and “detached from reality” in the face of continuing pressure on finances, performance, and staffing. Leaders told an NHS Providers survey that duplication of functions and requests was affecting the healthcare system, especially between integrated care boards and NHS England, and that the Care Quality Commission’s credibility and objectivity were questionable.

HIV

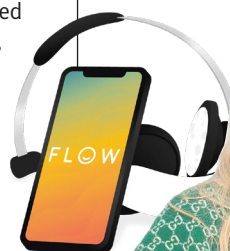
PrEP study raises hope of effective prevention

Landmark results from an African study trialling a twice yearly injectable pre-exposure prophylaxis (PrEP) has raised hopes that the cycle of mass infection in sub-Saharan Africa could finally be broken. The study, published in the *New England Journal of Medicine*, showed no new infections in the group receiving lenacapavir by injection. However, leaders of the UN’s HIV/AIDS programme have warned that, to achieve real change, the prices estimated for such treatments must be significantly lowered. In the US the first two lenacapavir injections are priced at \$42 000 (£32 900).

Cite this as: *BMJ* 2024;386:q1822

GAMBLING

Some 1.65m children in Great Britain are growing up in households where an adult is experiencing problem gambling, making them four times as likely to have similar problems (8%) as children who aren’t affected this way (2%)
[GambleAware]



SIXTY SECONDS ON... ANTIDEPRESSION HEADSETS

PUT ME IN THE LOOP

The UK Advertising Standards Authority has banned an Instagram post promoting a headset to fight depression. Gemma Collins (below), former star of the reality TV show *The Only Way is Essex*, posted a video about the Flow Neuroscience device, a £400 headset that sends gentle electrical impulses to the brain.

THE ONLY WAY IS ‘EADSETS?’

Collins said in the post in May 2023, “I am one week into using my Flow Neuroscience device [...] I’m feeling lighter, I’m feeling brighter, I am loving life now I’m off of [sic] my depression tablets and this has been a real game changer for me.” She added, “It’s like having your own therapist in the comfort of your own home.”

SOUNDS ELECTRIFYING

It’s not electroconvulsive therapy, a treatment sometimes used to treat severe depression. This non-invasive treatment is called transcranial direct stimulation. When people are depressed, Flow Neuroscience says on its website, there are lower levels of activity in the frontal cortex of the brain responsible for regulating mood, sleep, and motivation. “Flow sends gentle electrical impulses into the area that has slowed down. This gets cells firing again and reduces your symptoms of depression.”

THAT’S A SHOCK

In her video, Collins said Flow worked faster and better than antidepressants. The company’s website says 77% of people see a clinical improvement within three weeks.

AND ASA DIDN’T LIKE THAT CLAIM?

Actually, the watchdog did not formally consider the evidence for the device’s effectiveness. But it said the ad discouraged essential treatment for a condition for which medical supervision should be sought and therefore breached its code. There was a caption stating, “Consult your GP always without fail and do not stop taking your medication before consulting your GP.” But the agency considered that this was not sufficient.

IS THE PLUG BEING PULLED?

The technology has been used in the NHS. For example, Northamptonshire Healthcare Trust’s community mental health team offers Flow to people with depression.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;386:q1784

VALDO CALOCANE: Report on Nottingham killer identifies catalogue of care failings

A series of errors, omissions, and misjudgments at Nottinghamshire Healthcare Foundation NHS Trust (NHFT) meant that Valdo Calocane's mental illness was poorly managed and opportunities to mitigate the risk he posed to the public were missed, a rapid review has concluded.

The Care Quality Commission's review calls on NHS England to produce, within a year, national standards for care of people with complex psychosis and paranoid schizophrenia and for strengthened guidance relating to medicines management in community settings.

In June 2023 Calocane killed Grace O'Malley-Kumar and Barnaby Webber, both aged 19, with a knife as they returned from a night out in Nottingham. He then stabbed to death Ian Coates, 65, who was on his way to work as a caretaker, before stealing his van and crashing into three other people, inflicting serious injuries.

Calocane was convicted of manslaughter in January and sentenced to an indefinite hospital order.



Wider national action is also needed to tackle systemic issues in community mental health

Chris Dzikiti

The review concluded Calocane's records showed he was acutely unwell with symptoms of psychosis. He also had little understanding or acceptance of his condition, and there were early problems with him taking medicines.

There was no single point of failure in his care but a series of errors, the review said. Risk assessments minimised or omitted key details and did not make explicit the serious nature of the risk Calocane posed to himself and others. There was also poor engagement with Calocane's family, who had raised concerns with the trust on several occasions.

Poor discharge planning

A key criticism of the report was that Calocane was discharged back to his GP in September 2022 because he did not engage with mental health services. However, this was without consultation with his family, his GP, or the police. There also did not appear to have been an updated risk summary.

The discharge decision "did not adequately consider or mitigate the risks of relapse and violence or his lack of engagement with services," the

review said. "This reflects the findings from our wider review of NHFT which found that discharge planning was not robust and that there was a 'lack of clarity of thinking' in relation to discharge decisions."

In July NHS England issued guidance to trusts reminding them not to discharge patients with serious mental health issues if they did not attend appointments. The CQC said that, because there was an obvious pattern of Calocane not taking his drugs while in the community and evidence he could present a risk to others when relapsing, he could have been detained under section 3 of the Mental Health Act during his fourth admission to hospital. This would have allowed him to be given depot medication and placed on a community treatment order.

Chris Dzikiti, CQC's interim chief inspector of healthcare, said, "While it is not possible to say the devastating events would not have taken place had Valdo Calocane received support, what is clear is the risk he presented was not managed well and opportunities to mitigate that risk were missed.

Over 800 doctors urge BMA to abandon Cass review inquiry

Doctors and clinical leaders have called on the BMA to abandon its plan to "publicly critique" Hilary Cass's review of gender identity services for children and teenagers and to retract its demand to allow puberty blockers to be given to children in the meantime.

A total of 870 doctors, including 557 BMA members, have signed the letter addressed to Philip Banfield, the BMA's chair of council, saying they are "extremely disappointed" that BMA council members took part in an "opaque and secretive" vote on the Cass review last month. It was this vote that led the BMA to announce it was setting up a "task and finish" inquiry to "publicly critique" what the letter described as the

"most comprehensive review into healthcare for children with gender related distress ever conducted."

The letter has been signed by 57 professors and 22 clinical leaders, including former or current presidents of royal colleges. It was delivered to Banfield and six other council chief officers and co-chief executive officers on 7 August, the same day NHS England launched a two year plan to implement the Cass findings.

The letter puts the BMA

"Hilary Cass got it right: puberty blockers should be prescribed only under research conditions"

under pressure to abandon what the signatories call "this pointless exercise and to welcome and follow the Cass review" as the royal colleges of psychiatrists, general practice, paediatrics and child health, and the Academy of Medical Royal Colleges have done.

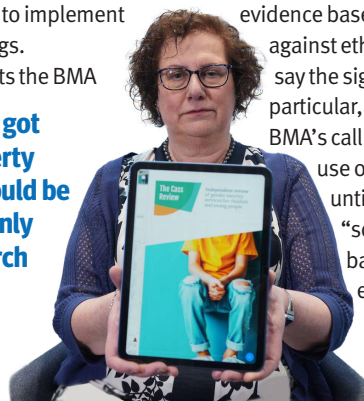
By lobbying against the best evidence available, the BMA is "going against the principles of evidence based medicine and against ethical practice," say the signatories. In particular, they say, the BMA's call to continue the use of puberty blockers until there was a "solid evidence base" is "not an evidence based

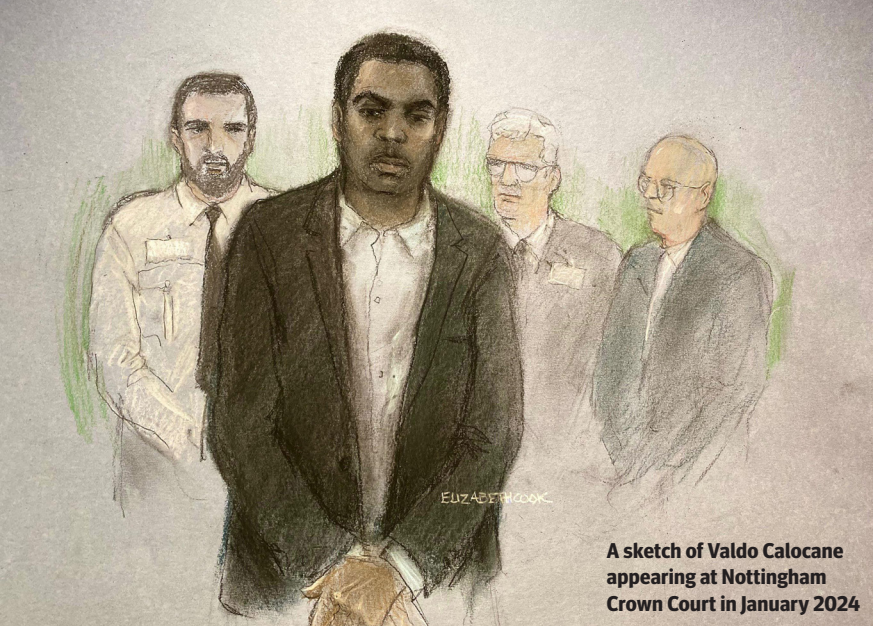
approach [as] the Cass review has got it right when it says that because there is so little evidence about their safety and efficacy, they should only be prescribed under research conditions."

The letter adds that the council vote "does not reflect the views of the wider membership, whose opinion you did not seek."

Banfield defended the BMA council processes, saying the Cass meeting and vote followed due process. "The idea that any review, even on such a sensitive topic, should not be critiqued, is contrary to the very principles" of the scientific process, he said in a two page reply.

Jane Feinmann, *The BMJ*
Cite this as: *BMJ* 2024;386:q1772





A sketch of Valdo Calocane appearing at Nottingham Crown Court in January 2024

ELIZABETH COOK/PALALAMY

“We have made recommendations to improve oversight and treatment of people with serious mental health issues at both a provider and a national level. Wider national action is also needed to tackle systemic issues in community mental health—including a shortage of mental health staff and lack of integration between mental health services and other healthcare, social care, and support services—so that people get the right care, treatment, and support when and where they need it.”

Trust recommendations

The CQC’s recommendations for the trust included carrying out regular reviews of treatment plans, ensuring clinical supervision of decisions to detain people under sections 2 and 3

of the Mental Health Act, improving its discharge policy, and involving patients’ families and carers in care and treatment. A trust spokesperson said it accepted the report’s conclusions and had significantly improved processes and standards since the review was carried out, with a plan to address the issues highlighted in the review.

The review also recommended that NHS England produce evidence based guidance setting out national standards for high quality, safe care for people with complex psychosis and paranoid schizophrenia. Within three months of its publication every provider and commissioner must develop an action plan to achieve these standards, it said.

Jacqui Wise, Kent
Cite this as: *BMJ* 2024;386:q1796

PAs must be “supervised by a GP straight after seeing each patient”

Physician associates (PAs) working in general practice must have access to a named onsite GP supervisor at all times, says guidance from the BMA drawn up to support safe working in primary care.

Supervision means PAs must present the patient’s history and findings, where relevant, for the GP to review and oversee what action, if any, is to be taken. This should take place immediately after the consultation and before the patient leaves the practice. The advice also says that PAs should not undertake home visits or care home visits without a supervising GP present.

The BMA said the number of PAs working in general practice and hospital settings had increased while supervision and oversight had, in many instances, been relaxed. The latest guidance has been produced to help standardise PA working practice in the general practice setting, said the BMA, and it follows other guidance about safe working practices issued in March.

The BMA warned practices, “A lack of appropriate level supervision and support may result in increased exposure to regulatory risk and liabilities for employing practices and supervising GPs.” It added, “GPs providing supervision need to be appropriately indemnified for supervising PAs and should confirm this with their medical defence organisation.”

Zosia Kmietowicz, *The BMJ* Cite this as: *BMJ* 2024;386:q1763

Struggling doctors reduce hours to avoid burnout, finds GMC

Increasing numbers of doctors are looking to cut their hours or leave the NHS, the GMC has warned in its annual workplace report, which was completed by 4288 doctors—a 9% response rate, the highest since the survey began in 2019.

“The vicious cycle of unmanageable workloads, low satisfaction, burnout, and doctors leaving UK practice, which we have described previously, persists,” concluded the report.

An increasing number reported that they were “struggling”—regularly working more than their rostered hours and feeling unable to cope with their workload. Overall, 33% said they were struggling, with 48% of GPs reporting problems with workload.

More than one in five respondents (21%) were at high risk of burnout. Although this has decreased slightly since last year, it is more than double the proportion in 2020, during the height of the covid-19 pandemic. Among doctors in training 24% were at high risk of burnout, and 44% reported dissatisfaction.

“The survey exposes the enormous strain on overstretched NHS staff,” said Saffron Cordery, deputy chief executive of NHS Providers. “Trust leaders and their staff are working hard to deliver high quality patient care, but persistent pressure is sapping doctors’ morale and causing burnout. Stress, anxiety, and depression remain the top reasons for thousands of staff being off work sick.”

Some 19% of those surveyed reported reducing their hours to cope, compared with 8% in 2021. There has also been a huge increase in those saying they are more likely to refuse to take on additional work—41%, compared with 23% in 2021.

Latifa Patel, BMA representative body chair and workforce lead, said, “Reducing hours will be a last resort for many doctors who want to be working, looking after patients, and supporting their colleagues. Ultimately, however, a burnt out doctor is not a safe doctor.”

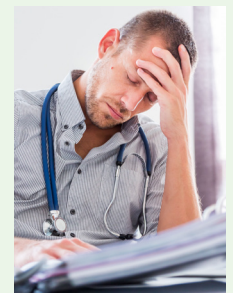
Some 16% of respondents said they had taken steps to leave the NHS. The GMC warned that if the trend continued, the capacity of the already stretched NHS would be reduced even more, putting patients at risk.

Patel said, “With near record waiting lists, it’s more important than ever that doctors can do their jobs with enough time, resources, and respect for their expertise, so they can deliver what they have trained uniquely hard to do: care for patients.”

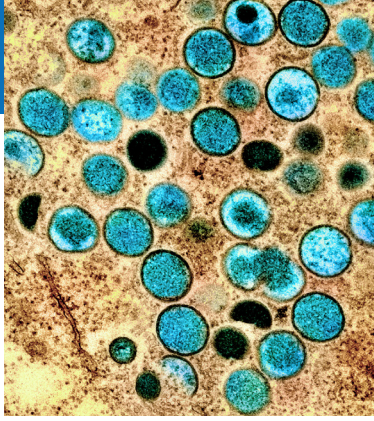
Katharine Lang, London Cite this as: *BMJ* 2024;386:q1764

Ultimately, a burnt out doctor is not a safe doctor

Latifa Patel



Among **DOCTORS** in training
24% were at high risk of burnout,
and **44%** reported dissatisfaction



WHO and African CDC declare mpox public health emergency

The reporting of a case in Sweden within hours of the declaration underlines the need for coordinated global action, argues **Luke Taylor**

The World Health Organization has declared mpox a public health emergency of international concern (PHEIC) for the second time, warning that the virus could spread quickly to new countries.

WHO's director general made the announcement on 14 August after an emergency committee of independent experts reviewed the rapidly rising number of infections in the Democratic Republic of the Congo (DRC) and the spread of the disease to new African nations where it had previously never been recorded. "It's clear that a coordinated international response is essential to stop these outbreaks and save lives," Tedros Adhanom Ghebreyesus said.

Ghebreyesus's announcement followed the declaration a day earlier by the Africa Centres for Disease Control and Prevention (CDC) that mpox had formally become a regional public health emergency. More than 15 000 cases and 400 deaths have been recorded in the region this year, the agency's figures showed.

The number of infections is 160% higher than in 2023, and the virus has spread to six new countries in 10 days, Jean Kaseya, director general of the African CDC, told a press conference on 8 August.

On 13 August, Kaseya said, "This declaration is not merely a formality; it is a clarion call to action. It is a recognition that we can no longer afford to be reactive. We must be proactive and aggressive in our efforts to contain and eliminate this threat. This declaration aims to enhance the global response, mitigate the impact of the health threat, and protect public health while minimising disruptions to travel and trade."

? **What is mpox?**
The monkeypox virus comes from the same family as the smallpox

virus and is believed to circulate in small mammals, such as monkeys and squirrels. In humans the infection commonly causes a skin rash or pus filled lesions, and sometimes flu-like symptoms such as fever and aches.

Humans had previously contracted the viral disease in central and West Africa after they had been in contact with infected animals, but that has changed in recent years. Human-to-human transmission is now a major driver of the virus's spread, worrying public health experts.

The growing transmission of the disease in Africa is thought to be linked to waning vaccine immunity. Mpox rates began increasing after smallpox was eradicated in 1980 and vaccinations against the disease, which also protects against mpox, were halted.

? Why has a PHEIC been declared for a second time?

WHO first declared mpox a PHEIC in July 2022 when the disease began to spread in several countries across Europe and North America through human-to-human transmission for the first time. More than 30 000 infections were recorded in the US and 20 000 in Europe, but public awareness campaigns, contact tracing, and the rollout of vaccines helped end outbreaks, and the PHEIC was declared over in May 2023.

WHO has activated the highest level of alert once more in the hope that it will spark an internationally coordinated response effort, more research into the disease, and scaled up vaccine production.



The case fatality rate in the DRC is around **2.4%** in people over 15 years of age, but in children, who account for **60%** of all cases, it is as high as **8.6%**. WHO data show



This declaration is not merely a formality; it is a clarion call to action

Jean Kaseya

WHO is particularly concerned with a surge in cases in the DRC and the rest of Africa, where its spread accelerated after the detection of a new variant in 2023. In the week to 4 August 2024, there were 887 new confirmed and suspected cases reported in Africa, bringing 2024's total so far to 15 132, the African CDC said, more than the 14 957 cases reported for the whole of 2023. So far, 461 deaths have been reported.

The DRC has recorded more than 14 000 of those cases, and humanitarian organisations are concerned that outbreaks are overburdening the country's fragile health system. "The health system is already collapsing under the strain of soaring rates of malnutrition, measles, and cholera coupled with the residual impacts of past Ebola and covid-19 outbreaks," said Greg Ramm, Save the Children's country director in the DRC. "In some health centres around Goma [the capital in North Kivu province], patient intake is 4000% higher than their capacity."

Some 354 000 children are also living in tents in refugee camps near Goma with little access to clean water, healthcare, and adequate nutrition, which is aiding the virus's spread through the vulnerable population, the organisation said. The case fatality rate in the DRC is around 2.4% in people over 15 years of age, but in children, who account for 60% of all cases, it is as high as 8.6%, WHO data show.

The virus has also been reported in another 16 other countries, the African CDC said. In four East African nations—Burundi, Kenya, Rwanda, and Uganda—it was the first detection of the virus. Dimie Ogoina, chair of the emergency committee convened by WHO to discuss the public health threat, said, "The current upsurge of mpox in parts of Africa, along with the spread of a new sexually transmissible strain of the monkeypox virus, is an

emergency, not only for Africa, but for the entire globe. Mpox, originating in Africa, was neglected there, and later caused a global outbreak in 2022. It is time to act decisively to prevent history from repeating itself.”

High infection rates have also been recorded in sex workers and men who have sex with men, both of whom are more likely to die from mpox because of high rates of HIV and thus immunosuppression. The outbreak in the DRC started with the spread of an endemic strain, clade I, but a new variant, clade Ib, which was discovered in sex workers in a mining town in North Kivu, seems to spread more easily through everyday close contact and is likely driving the outbreaks, the African CDC said. It is also harder to pick up in tests owing to its mutations.

Ghebreyesus said ahead of the emergency committee’s meeting, “We are dealing with several outbreaks of different clades in different countries with different modes of transmission and different levels of risk.”

? How is mpox spreading?

New outbreaks in the DRC have been strongly linked to sex workers and are thought to be spreading across borders by truck drivers, the African CDC said.

The virus can spread through physical contact with mpox lesions, kissing, or face-to-face interactions such as talking, which spreads droplets in the air. People can also contract mpox from touching contaminated objects such as clothing, bed sheets, or utensils.

The virus is probably more prevalent in children as they have more physical contact with others, have weaker immune systems, and because mpox symptoms also resemble other common childhood illnesses such as scabies and chickenpox, meaning late detection, Save the Children said.

? What can be done to contain mpox?

Vaccines, which proved useful in ending the previous outbreaks in Europe, would help control the current outbreaks, experts have said. Around 10 million doses are estimated to be needed, Kesaya said, but so far none have arrived in Africa, following delays in accessing supplies and hurdles getting local regulatory approval.



DRC is already collapsing under soaring rates of malnutrition, measles, and cholera

Greg Ramm



We will fail at killing the menace that is mpox without clean water and good hygiene

Irene Owusu-Poku

Last week the US pledged \$414m (£319m) for humanitarian help in the DRC, \$10m to support response efforts, and 50 000 mpox vaccine doses.

In the meantime, foreign nations must provide funding to increase community access to water, sanitation, and hygiene, said Irene Owusu-Poku, a health policy analyst at the non-governmental organisation Wateraid. “We will fail at killing the menace that is mpox without clean water and good hygiene. While vaccines are important, they are not the only way out of this urgent and escalating health emergency,” Owusu-Poku said.

WHO released \$1.5m on 14 August and said that it planned to free up more funds later to support government response efforts, which would require an initial \$15m.

Congo’s leaders say that they are in talks with donors about possible vaccine donations and have obtained financial aid from Britain and the US.

? What about outside Africa?

The US CDC said that smaller households, better sanitation, and higher rates of vaccination mean the levels of close contact transmission within and between households seen in the DRC are highly unlikely in the US.

The risk in the UK is also considered “low,” the UK Health Security Agency said in response to the PHEIC declaration. “Planning is under way to prepare for any cases that we might

see in the UK,” said the agency in a statement. “This includes ensuring that clinicians are aware and able to recognise cases promptly, that rapid testing is available, and that protocols are developed for the safe clinical care of people who have the infection and the prevention of onward transmission.”

However, an mpox case caused by clade I has already been detected in Europe, with Sweden reporting a case just hours after WHO’s emergency declaration. Brian Ferguson, associate professor of immunology at Cambridge University, said, “It is not surprising, given the severity and spread of the outbreak in Africa, that travel has brought this case to Europe. There will likely be more here and in other parts of the world, as there are currently no mechanisms in place to stop imported cases of mpox happening.

“The timing of this case comes less than 24 hours after WHO’s PHEIC declaration and only 15 months after WHO ended the previous mpox PHEIC in May 2023. The lack of activity in the intervening period has resulted in what could now become a new global outbreak.”

Ferguson has called for “greater effort” to be made to produce and distribute vaccines to the affected areas. “It is possible to address these problems, but this requires rapid international cooperation,” he said.

Luke Taylor, Portsmouth
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INFECTIONS are **160%** higher than in 2023, and the virus has spread to six new countries in 10 days



A baby with mpox is checked at Goma hospital, DRC, on 15 August

ZANEWNETY ZAIDI/XINHUA

THE BIG PICTURE

Indian anger at doctor murder

Doctors across India took to the streets on 17 August to join marches and light candles in memory of a trainee doctor who was raped and murdered inside a Kolkata hospital eight days earlier.

The 31 year old was working a 36 hour shift. A week later, the hospital was attacked by a crowd of people who “destroyed various sections of the hospital including the area where the victim was found,” the Indian Medical Association (IMA) has said.

It is estimated around a million doctors joined the 24 hour strike in cities from Mumbai (main image) to Guwahati (below).

“Doctors across the country have withdrawn non-essential services today and are providing only emergency and casualty services,” the IMA said in a letter to prime minister Narendra Modi. “Doctors, especially women, are vulnerable to violence because of the nature of the profession. It is for the authorities to provide for the safety of doctors inside hospitals and campuses.”

According to the IMA, 60% of Indian doctors are women, along with 68% of dental staff, 75% of physiotherapists, and 85% of nursing staff.

Elisabeth Mahase, *The BMJ*

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ANUPAM NATH/AP/ALAMY



ASHISH VAISHNAV/SOPA/LIGHTROCKET/GETTY

US abortion laws are causing widespread harm

Policy makers must prioritise the lives and health of women and children

Evidence is mounting that, in the two years since the US Supreme Court removed constitutional protection for abortion in the ruling on *Dobbs v Jackson Women's Health Organization*, the harms to women, pregnant people, children, and their care providers continue to increase and are lethal.

A new study shows that SB8, Texas's post-*Dobbs* stringent abortion law, has resulted in a nearly 13% rise in infant deaths in the state.¹ Self-managed abortions, including unsafe methods, have increased by 40%, especially among people from Black or sexual and gender minority groups.² The *Dobbs* ruling targets people and providers already under attack from decades of disinvestment in sexual and reproductive health, failure to expand Medicaid, the chilling effect of the domestic gag rule, and targeted regulation on abortion provider laws.³

Restricting access to abortion has consistently been shown to cause serious harm, including increased maternal mortality⁴; intimate partner violence and homicide⁵; increased anxiety, chronic pain, pre-eclampsia, and postpartum haemorrhage; higher odds of poverty and unemployment⁶; and increased rates of children entering foster care.⁷ The *Dobbs* decision arrives in the context of alarming inequalities in maternal mortality ratios for Black and Indigenous women, with the ratio among Black women almost three times that in their white counterparts.⁸

Within the first 100 days after the *Dobbs* ruling, 66 clinics across 15 states stopped providing abortion care, forcing women to carry unwanted, non-viable, and high risk pregnancies to term, placing them in medical crisis, and threatening their lives and livelihoods.⁹ The effect of a total abortion ban has been estimated at 210 extra maternal deaths a year (24% rise overall, 39% among non-Hispanic Black women).¹⁰ The infant mortality



ANDREW CABALLERO-REYNOLDS/AFP/GETTY IMAGES

Dobbs's deleterious effects are compounding decades of policies eroding bodily autonomy and the right to health

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rate in Texas has also climbed, with congenital anomalies, the leading cause of infant death, increasing by 22.9% in Texas compared with 3.1% fall in the rest of the US.¹

Effect on healthcare providers

Dobbs is harming healthcare providers. Physicians working in states with abortion bans report that broad and unclear legal language on medical exemptions and potential criminal charges, on top of policies requiring waiting periods and onerous counselling, have driven them to leave their practices, creating reproductive care deserts.¹¹

In 2022, states with restrictive abortion laws had a 32% lower ratio of obstetricians and gynaecologists to live births and a 59% lower ratio of nurse midwives to live births compared with more permissive states.¹² This loss is expected to worsen: in a 2022 survey of more than 2000 medical providers and trainees, 76% reported they would not work in states where providing abortion care had legal consequences.¹⁴

Dobbs also opened the floodgates to attacks on access to reproductive healthcare beyond abortion. Obstetricians and gynaecologists have said the decision has hindered their ability to provide safe and legal reproductive and sexual healthcare.¹⁵ In a 2024 wrongful death case brought against an in vitro fertilisation (IVF) clinic that inadvertently destroyed patients' embryos, the Alabama State Supreme Court quoted *Dobbs*: "as far back as the 18th century, the unborn were widely recognised as living

persons with rights and interests."¹⁶ Following the ruling, three fertilisation clinics paused IVF treatments.¹⁷

Extremist groups also challenged the Food and Drug Administration's approval and disbursement of mifepristone, one of the two drugs for abortions that are safe, effective, and widely used, accounting for 63% of all abortions performed in formal healthcare systems. The Supreme Court dismissed the case only on procedural grounds. It also sent a case in Idaho back to the lower court challenging whether the Emergency Medical Treatment and Labour Act, which mandates provision of emergency care, pre-empts an Idaho law criminalising most abortions, leaving open the possibility of future challenges.¹⁸

The post-*Dobbs* frenzy to restrict abortion access has illuminated the hypocrisy of many banning states that fail to advance policies that support families such as parental leave and cash assistance.¹⁹ Idaho and Texas refuse to expand Medicaid, a programme linked to reduced maternal mortality. In Texas, burdensome tactics like checking the eligibility of children on Medicaid every four months have led to increased rates of uninsured children.²⁰ Half of all states with abortion bans are ranked in the bottom 10% for child poverty.²¹

Dobbs has accelerated and compounded harm to many, but it has not reduced the number of abortions. In 2023 the number of abortions performed in US was the highest in a decade, with the greatest rises in states that border the 14 states with bans.²²

The deleterious effects of *Dobbs* are compounding decades of policies eroding bodily autonomy and the right to health. We need investment in programmes and policies that prioritise the lives and health of women and children, not repressive policies that cause serious harm to many, and fail their stated aim to reduce abortion.

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AMR: action must shift towards prevention

Better water and sanitation are preventive and come with important co-benefits

Antimicrobial resistance (AMR) is a global health problem undermining our ability to treat bacterial infections.

Each year, five million deaths are associated with AMR, more than from HIV, TB, and malaria combined.¹

As with many communicable diseases, the emergence, transmission, and burden of AMR disproportionately affects the most socially and clinically vulnerable in society; in 2019, children aged under 5 years accounted for one in five deaths because of AMR.² Moreover, rates of morbidity and mortality associated with AMR are highest in some low and middle income countries, making it a particularly serious concern in the world's already poorest nations.¹

The scale of the problem has led the UN general assembly to convene a high level meeting during its 79th session next month.³ The aim is to draft, and then agree on, a political declaration on AMR, possibly linked to high level targets that can be used globally. In the run-up to this meeting, many international organisations, including the World Bank,⁴ have put forward their preferred AMR policy options.⁵⁻⁷

The World Bank has chosen to emphasise classic, evidence based, and cost effective interventions such as infection prevention and control; improved infrastructure for water and sanitation; strengthened surveillance; increased oversight of antimicrobial use by veterinarians; and increased access to diagnostics and vaccination for human health and agriculture.

These commitments take a One Health approach—spanning human health, agriculture and food, water, and the environment—and are largely focused on prevention. The World Bank report states that “investments are aimed at strengthening and developing agricultural, health and water and sanitation systems, which are critical to preventing the emergence and spread of resistance.”⁴ Such preventive measures are especially vital in low and



TEK IMAGE/SPL/ALAMY

Local data, especially from low and middle income countries, are essential for tailoring prevention efforts

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middle income countries, where the burden of AMR is highest and resources are limited.

Political landscape

The World Bank report differs from the others because, as well as its “top 20” interventions, it acknowledges the broader political landscape of military conflicts, displaced peoples, and climate change. The report states that “taking action on climate change will decrease the likelihood of extreme weather events and the associated spread of resistance,”⁴ and outlines feasible and responsive strategies, such as building water and sewerage infrastructure. However, global leaders will need to go further and tackle the root causes of climate change; otherwise they risk perpetuating the notion that mitigation is the best we can do, whereas it is imperative to champion effective solutions.

The report also states that indigenous communities face “multiple challenges in health care access,” which may hinder effective management of resistant infections. This consideration of the vulnerabilities of indigenous societies, which have historically been affected by colonisation, displacement, and extreme weather events, is welcome. However, there is also potential to learn from indigenous knowledge systems, especially those in which the wellbeing of an individual is inherently connected to the wellbeing of the land.⁸ These historical, philosophical, and spiritual approaches lend themselves to sustainable models

for community and environmental renewal⁹; in other words, such models are the original One Health strategy.

The past decade of global AMR policy has largely focused on technological or market based solutions, many of which failed to materialise or have not delivered equitable gains.¹⁰ This World Bank report, along with others,⁵⁻¹¹ shifts the focus towards prevention and the key tenets of public health, which aligns better with the needs identified by experts working in relevant contexts. For example, One Health Trust's Ramanan Laxminarayan wrote: “We can prevent infection, so we don't have to have antibiotics, and we don't have to worry about AMR in the first place.”¹²

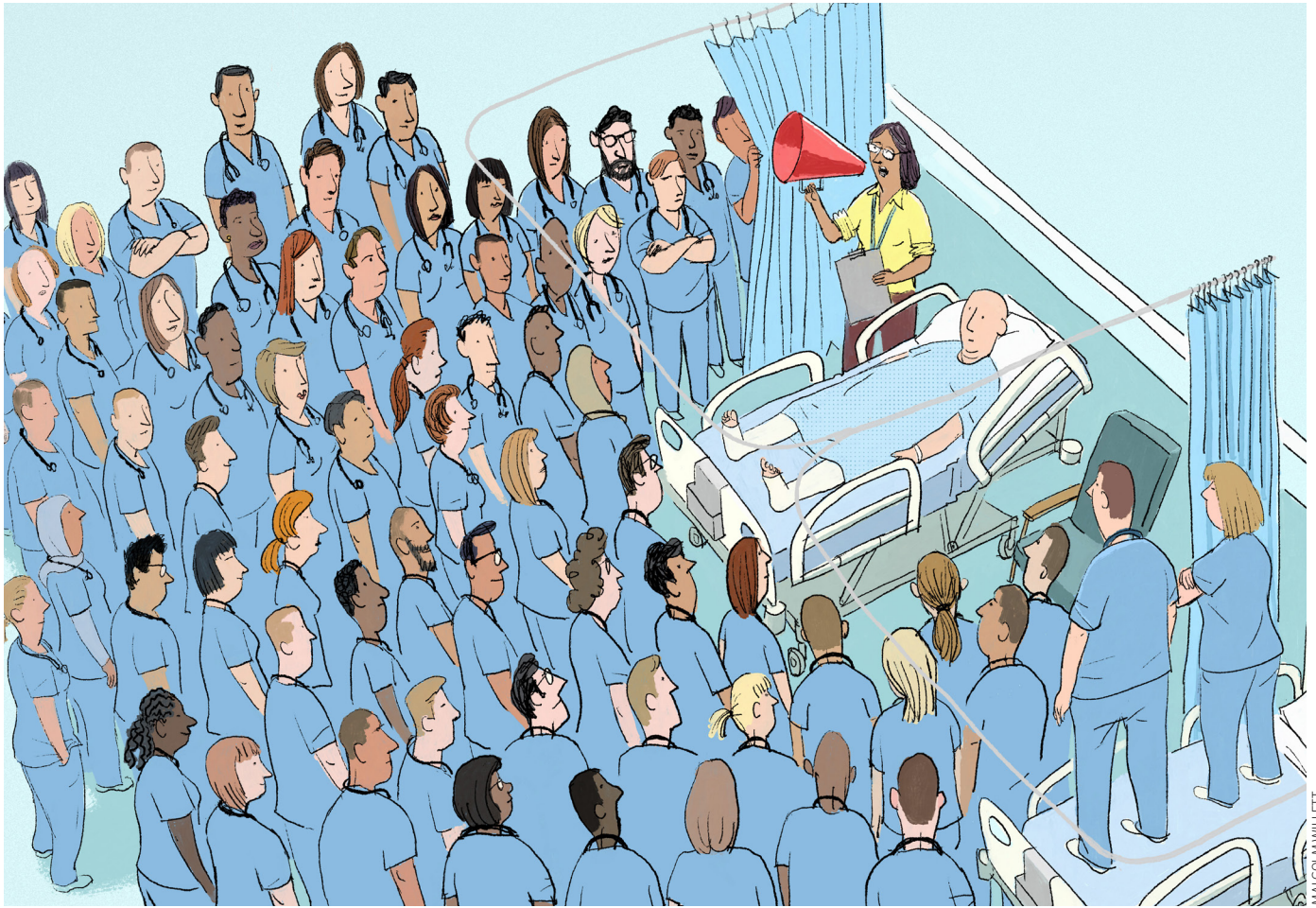
Infection prevention and control, vaccination, and better sanitation and water infrastructure are incontrovertibly effective and come with numerous benefits beyond AMR. Any AMR mission that focuses on the foundations of global public health, such as those in this report, is likely to gain broad support at the UN general assembly.

The pervasive lack of comprehensive local data on interventions is a key challenge that will hinder the ability to set appropriate targets at the UN and assess progress towards them. Local data, especially from low and middle income countries, is essential for tailoring prevention efforts and supporting sustainable AMR surveillance. Investing in data to support effective prevention strategies must therefore be a priority.

How can coordination and collaboration be agreed across the UN to develop measures that will reduce AMR morbidity and mortality globally? By prioritising prevention, supported by comprehensive data and sustainable surveillance, and not shying away from terminous crises such as climate change, we can and must make meaningful progress against AMR to safeguard global health.

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MALCOLM WILLET

NHS WORKFORCE

Medical training at breaking point: will an increase in learners push the system over the edge?

Medical education is already under extreme pressure, and there are fears the planned expansion of trainee places will cause the system to collapse.

Adele Waters reports

There have always been tensions between service delivery and training in the NHS. But trainers, trainees, and policy makers alike are warning that medical education now requires urgent attention to stop the future workforce pipeline failing altogether. This is particularly true in England, where actions from its long term workforce plan are already under way and placing increasing

demands on teaching capacity.

Last June, the long term workforce plan set out an ambition to double the number of medical school training places, taking the total number of places up to 15 000 a year by 2031-32 (table, right) It also announced pilots for medical apprenticeships—this academic year will see 200 join the workforce. The goal is that, by 2031, some 13% of medical students will be apprentices. On top of that, there is

How are we going to ensure that we have the education capacity?
Sheona MacCleod



a plan to increase training places for physician associates to over 1500 in that same timeframe.

But new staff need training—and this requires NHS organisations and trainers to have capacity. It seems that too little focus has been paid to this crucial matter. Speaking at the NHS ConfedExpo conference in Manchester on 12 June, Sheona MacCleod, director of education and training at NHS England, said that NHS England wanted to work with NHS employers on how to manage the expansion of doctors in training and deliver the placements they would need.

“If we are looking at significantly increasing foundation and specialty training, how are we going to ensure that we have the education capacity?” she said. “That’s something we really want to work with employers on. How do we support you to make sure that the learners you have want to come back and stay as permanent members of staff or continue on a training pathway as a member of staff in your organisation?”

Matching education capacity to expansion

“Delivering medical education feels like one of the biggest challenges in the NHS right now,” says Simon Frazer, chief executive officer of DoctorsTraining, which employs 70 medical trainers to deliver training programmes and workshops for senior doctors and consultants across the NHS. Frazer, who has been involved in medical training for over 20 years, says, “I think most doctors are very passionate about supporting training, but I think they are finding that harder and harder to do.

“They’re worried about how they will keep up that extra effort without more training capacity and protected time. I think they are feeling a bit overwhelmed about the expansion in the workforce needing their support. They’re worried about the longer term demands as the number of staff needing training increases.”

Billy Palmer, senior fellow at Nuffield Trust, says that the capacity to train doctors is one of the most pressing challenges for the health

The planned expansion of medical school places and medical apprenticeships

Placements	Year					
	2024	2025	2026	2027	2028	2031
Medical school places	7500	8200	8700	9350	10 000	15 000
Medical apprenticeships	200	200	400	tbc	850 (9% of medical school places delivered as apprenticeships)	2000 (13% of medical school places delivered as apprenticeships)

Source: NHS England

service. “It has become a real problem and has to be addressed urgently to have any success for the long term workforce plan being delivered,” he warns. The previous government stayed silent on how the NHS can create enough trainers, he says. “The workforce plan does not explain how sufficient numbers of academic and clinical educators and supervisors can be found from the current NHS clinical workforce that is often already under too much pressure. We have been concerned about that from the outset.

“The ratio of supervisors to people needing education has suddenly shifted very rapidly, and the health service is going to struggle to keep up with that,” he warns. “Not only are we having the expansion of medical school training places, but we’ve also got the expansion of physician associates, advanced clinical practitioners, and, in some cases, they are drawing on the same supervision capacity—so sometimes looking at the same consultant to provide their education.

“We are seeing things getting worse in that medical training pipeline over time. We have a real leaky pipeline, and I would question whether the current system is working.” Retention rates support that view. Only a third of doctors completing their foundation training continue to the next stage straightaway, according to data analysed by the Nuffield Trust. Many decide to take a break, and not all return

Doctors are passionate about supporting training, but are finding it harder and harder to do
Simon Frazer



to work for the NHS. “We think we lose about one in eight—every year we see a higher proportion opting to take a break,” says Palmer.

As for doctors in core training, around 40% have left the NHS within eight years. “That points to a problem. They might go on and pass their exams, but, from a public taxpayer perspective, you also want them to join and remain in the NHS. By providing people an inadequate and stressful education, there’s a real risk they’re less likely to join,” Palmer says.

There are other quantitative indications that medical training is under pressure. The General Medical Council (GMC) conducts an annual UK-wide survey to ask trainees about the quality of their training and trainers about their experience as clinical or educational supervisors.

The 2024 survey found that while most trainers (90%) said they enjoyed their role as medical educators, 27% said they didn’t think their job plan had enough designated time for their role as a trainer. Less than half (48%) said they were always able to use the time allocated for training specifically for that purpose.

The percentage of trainers reporting burnout has remained broadly similar since 2022, with 50% measured to be at high or moderate risk of burnout and a third (32%) saying their work frustrated them to

We are seeing things getting worse. We have a real leaky trainee pipeline
Billy Palmer



Physician associates “prioritised”

Mohammad Ahmad, a core surgical trainee year 2 based in Wigan, is part of a rotational training scheme in Health Education North West but says that he has become disillusioned after permanent staff such as physician associates and medical associate professionals have been given training opportunities ahead of him.

Having raised this with his consultant on a previous placement and presenting proof that he had done statistically more service provision, he was accused of “not being a team player.” “It is quite clear to see that the primary objective for most managers and trusts is service provision,” Ahmad says. “The majority of this I have done as a goodwill gesture, in the hope of training opportunities. This goodwill has been exploited to the extent that many junior doctors, including myself, are now disillusioned with the junior doctor role.”

a high or very high degree.

The survey also found that 31% of secondary care trainers said that their trainees’ education and training were adversely affected because rota gaps weren’t always dealt with appropriately.

The regulator said that for England’s workforce plan—alongside those in Northern Ireland, Scotland, and Wales—to succeed, additional capacity needed to be created with the expansion of the educator workforce.

The GMC’s medical director, Colin Melville, said, “Plans to increase medical school places are much needed and welcomed. However, to ensure these places produce the skilled doctors of tomorrow, we also need to increase the number of educators and provide them with the necessary time and support.” In January the Royal College of Surgeons of England published results of its annual census of members. Findings also indicated a workforce under huge strain due to excessive workloads, a factor that had a knock-on effect on education. Up to 52% of surgical trainees said that they did not have sufficient training time, and 61% said that they lacked access to theatres. “The pressures of service provision prevent them from attending training sessions both in the clinical environment and in educational settings,” the report noted.

Extra workload on consultants

David Oliver, consultant in geriatrics and acute general medicine at Royal Berkshire

NHS Foundation Trust, says that as more groups of staff require postgraduate training, more work is falling on consultants to provide it. “We train all levels of doctors, from medical students up to specialty registrars, and then we’re adding on medically associated professionals on top, and it all falls on the same consultants to do that training. On top of that, there’s also big pressure on consultants to focus on things like waiting list initiatives, urgent care waiting times, and improving patient flow in hospitals.”

He adds, “Meanwhile, of course, consultants have big gaps in their own workforce and rotas and a lot of competing demands on their time.”

Partha Kar, consultant in diabetes and endocrinology at Portsmouth Hospitals NHS Trust as well as the national lead in diabetes for NHS England, agrees that demands on trainers have grown exponentially. “In my job plan, I have time to properly supervise four doctors, but I currently have seven. I’m a supervisor to seven trainees

The system relies on a huge amount of goodwill

Partha Kar



across all different levels. This is a pretty typical picture, so it means the system relies on a huge amount of goodwill to get things like annual appraisals done,” Kar says.

Acknowledging that the workforce plan has recently been somewhat discredited as “overly optimistic” by the spending watchdog, Kar says that confidence in NHS England’s Workforce, Training and Education Directorate is now low. “I have lost confidence, and you would struggle to find anyone or any organisation right now that would give it their unequivocal support. We have a workforce plan that is clearly not working, and it’s impossible to deliver it on the budget given.”

The BMA took its concerns to the electorate, by making training part of its manifesto ahead of the general election. The government must tackle these bottlenecks with additional funding, it says.

David Strain, BMA medical academic staff committee chair, says, “The long term workforce plan promises that any expansion in medical school places is going to be matched with a sufficient number of specialty training places. We made clear in the BMA’s election manifesto that any new government will need to properly fund these promises.

“That means ensuring sufficient clinical educationalists to ensure the quality of trainees’ education does not suffer and support for educational development. Without that resourcing, the kind of training bottlenecks we have already seen are only going to get worse.”

It all falls on the same consultants to do the training

David Oliver





Sometimes trainees have to fight to get study leave, to go to courses, to get the training opportunities they need
Nicola Cooper



Impact on teaching

Meanwhile, the burden of ensuring that training happens often falls on trainees themselves. “Being on a training contract doesn’t necessarily mean doctors get trained,” says Shonnely Novintan, a core surgical trainee at Colchester Hospital and a representative of the Doctors’ Association UK.

“I was fortunate to have a good six month placement in breast surgery recently. I had good trainers who would discuss each case and give me feedback, and then because I was in theatre the week after, I could practise what I’d just learnt,” says Novintan. “In previous jobs, I’d go to theatre once a month. You can’t consolidate skills in that time. In my current job, I had to take on the voluntary job of being a rota coordinator—managing all the duty rotas—to ensure I get to theatre once or twice a week.”

Foundation doctors report the same problem with taking up learning opportunities. Penelope Sucharitkul, a foundation year 1 doctor based in Bristol and training under Severn Postgraduate Medical Education, says that if there are staff shortages, trainees are often unable to get to their training. “Deaneries put on simulations, which are good, but it’s four hours off the ward, which is impossible for most doctors. I’ve struggled to get my annual leave, let alone take any study leave.”

Nicola Cooper, consultant physician, former training programme director, and a clinical supervisor and teacher, says that doctors should be able to expect that someone has looked at their



Being on a training contract doesn’t necessarily mean doctors get trained
Shonnely Novintan

curriculum, understands the requirements, and is delivering it. But this is not the case. “It’s turned into a situation where doctors in training and locally employed doctors are regarded solely as employees who have to fight to get their training along the way,” she says.

“It is now difficult for doctors in training to leave the wards to attend classroom teaching or other learning opportunities. And quality teaching and learning on the shop floor is often lacking, in part, due to the clinical pressures everyone is under,” Cooper adds. “This means they

I’ve struggled to get my annual leave, let alone take study leave
Penelope Sucharitkul



sometimes have to fight to get study leave, to go to courses, to get the training opportunities they need. Often, junior doctors have to escalate issues to get their training arrangements sorted.”

The result is that specialty training is very patchy and varies by specialty. “Over time, we seem to have arrived at a situation where we are aiming for competence rather than excellence in our medical workforce,” Cooper says.

Educator workforce strategy

Hardly a ringing endorsement for Navina Evans, chief workforce officer at NHS England, or the civil servants that helped put together plans for a sustainable workforce for the NHS. *The BMJ* asked her and her team several questions. In response, NHS England issued a statement saying, “The NHS is taking action to improve working conditions and retention as part of the NHS long term workforce plan, including increasing choice and flexibility in rotas and reducing duplicative inductions and training.

“We know there have been concerns about sufficient educator capacity, and that is why we are implementing our educator workforce strategy. This includes introducing guidance and metrics for integrated care boards, developing a career framework for educators, and collating and sharing best practice. Together, all these measures will improve the quality of education, training, and patient care.”

Adele Waters, freelance journalist, London
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INTERVIEW

“If general practice is the bedrock of the NHS, then the NHS is collapsing”

The BMA England GP Committee’s chair tells **Gareth Iacobucci** why the profession is taking a stand against underfunding

Earlier this month GP partners in England voted overwhelmingly to take collective action in response to an imposed contract. *The BMJ* spoke to Katie Bramall-Stainer, chair of the BMA’s General Practitioners Committee for England (GPC), to discuss the concerns.

What has led GPs to this vote?

General practice in England has been in “dire straits for an extremely long time,” Bramall-Stainer says, with 1300 practices lost in the past decade and 2000 fewer full time equivalent GPs since 2010. Also, the proportion of GP trainees who take up an NHS job within a year of completing training has fallen from just under half to just over a third.

“The profession is collapsing. And if general practice is the bedrock of the NHS, then the NHS is collapsing with it as well,” she warns.

The 2024-25 contract imposed under the previous government offered practices an uplift of just 1.9%, which Bramall-Stainer says has already forced some to close. The financial pressure facing practices means many GPs now struggle to find work, despite huge demand and workload pressures. “We never wanted to be where we find ourselves

now,” she says. “I’ve been consistent in wanting safety and stability immediately to stop practice closures and to stop GPs being haemorrhaged from the workforce.”

She also highlights the “moral injury” that GP partners and staff face from having to close. “One in four GPs know another GP who has taken their own life,” she says.

Will patients be at risk from the action?

Bramall-Stainer says the action, which amounts to GPs not carrying out work outside their contractual terms, has been coordinated with the aid of BMA safe working guidance and is designed not to harm patients. Referring to media headlines suggesting that stopping non-contractual work could bring the NHS to a standstill, Bramall-Stainer says, “It perhaps suggests we deserve to be resourced for all that additional work we do, that we deliver to the NHS, that keeps it going.”

Ultimately, taking action is about improving patient care, she says. “This is the professional permission to draw your line in the sand . . . because otherwise we are not going to get any more investment in our practices to fund services to get better patient care. That’s what it’s all about. This is not pounds in doctors’ pockets.”

Could anything halt the action?

Bramall-Stainer says her door is “always open” for talks with the government but says this “needs to be a negotiation, not an imposition or a cursory consultation.” But if the government made a “really sensible offer” the GPC would recommend it to the profession, she adds. In terms of what this might look like, she cites the need to invest in the core practice contract, which “has reached the point where it’s not credible.”

The government said it will honour the review body’s recommended 6% pay rise. What kind of figure is the GPC seeking?

“If the DDRB awarded 10.7%, that would



have brought us back to where we were five years ago,” Bramall-Stainer says. “Anything less is a retrograde position for our practices that are still closing and GPs who are still leaving the workforce.”

Bramall-Stainer says that the proportion of the NHS budget spent on general practice must rise to “at least 15%.” But she suggests this could see general practice incorporating other areas, such as district nursing, ambulatory care, and health visiting services, co-located in general practices.

Is that likely when the Treasury and NHS say there is no money?

Although Bramall-Stainer recognises that it is “very difficult to unlock resources from Goliath to pass them down to David,” she is hopeful of change. Having met Wes Streeting, the new health secretary, she believes that there are opportunities for “immense public health gain” with the right investment in primary care.

“We have presented suggestions [see box], and Wes Streeting said, ‘None of this looks unreasonable,’” she adds. “Great. So let’s progress.”

What’s the long term vision?

“For us in GPC and for the conference of local medical committees (LMCs) it’s very much embedding the expert generalist. We can’t afford not to,” says Bramall-Stainer. She says that continuity of care and a “cradle to grave” focus on preventing ill health should underpin what GPs do, referring back to the Marmot review.

Beyond this, she says that if it were given the right resources general practice could help solve some of the NHS’s biggest problems, such as the huge backlog in waiting times.

“We’re always painted as the problem,” she says. “But actually we’re really pragmatic and we’ve got lots of solutions. We just want the opportunity to be heard.”

Gareth Iacobucci, *The BMJ*

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GPC ENGLAND’S PROPOSALS TO THE GOVERNMENT

- A new reimbursement scheme for GPs to prevent unemployment—this could be done through the existing retainer scheme as an emergency amendment, or the existing newly qualified fellows scheme could be extended.
- Uplift item-of-service fees for vaccinations, which have stayed at £10.06 since 2019, to match inflationary costs.
- Uplift payments set out in the statements of financial entitlements that reimburse practices for things such as long term sick leave and parental leave, unchanged since 2017.
- Invest in a new national safeguarding directed enhanced service (DES) to support practices that care for the most vulnerable people in society.