this week

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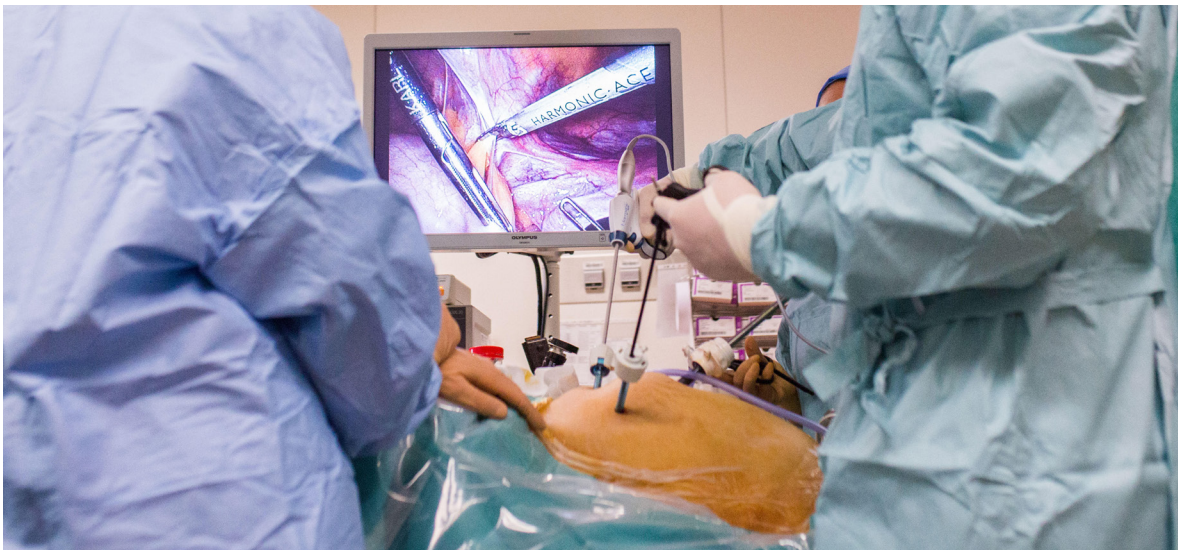


BURGER/PHANIE/SIPA/ALAMY

“Medical misogyny harms women”

Doctors are too often dismissive of women’s symptoms when they present for reproductive health conditions such as endometriosis, adenomyosis, and heavy menstrual bleeding, a parliamentary inquiry has found.

Some clinicians have an “ingrained belief” that women—particularly those from ethnic minority groups—exaggerate their symptoms, meaning conditions are left undiagnosed, said the inquiry by the Commons Women and Equalities Committee. “Such medical misogyny and racism is unacceptable,” the inquiry report said.

The MPs, who heard evidence from a range of witnesses, medical organisations, and charities, identified a “clear lack of awareness and understanding of women’s reproductive health conditions” among GPs.

Committee chair Sarah Owen said, “Women are finding their symptoms dismissed, are waiting years for life changing treatment, and in too many cases are being put through trauma inducing procedures. All the while, their conditions worsen and become more complicated to treat.

“The NHS must urgently implement a training programme to improve the experience of treatment and diagnosis of reproductive health conditions.”

Extra funding and protected time should be made available for GPs to undertake this training, the report said. The government should also consider how to incentivise more professionals to specialise in women’s health, including making obstetrics and gynaecology a mandatory rotation in training.

The 2022 Women’s Health Strategy for England should be updated to include targets to reduce waiting times for common conditions such as endometriosis, the report recommended. And protocols governing routine healthcare procedures that can cause severe pain to some women, such as hysteroscopy, IUD fitting, and cervical screening, should be enforced.

Rageshri Dhairyawan, an NHS consultant in sexual health and HIV medicine and author of a book about medical sexism, welcomed the report. She told *The BMJ*, “This report gives a wide reaching approach to address this crucial issue and will provide hope to thousands of women waiting for investigations and treatment.”

An NHS England spokesperson said it was taking action to improve services for women, including rolling out women’s health hubs to improve access to specialist support in the community and to train health professionals.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;387:q2780

MPs have called for doctors to receive more training on treating conditions such as endometriosis

LATEST ONLINE

- Malaria: drug resistance and fragile health systems are hindering progress, WHO warns
- Demand for private weight loss surgery declined last year
- US to begin testing unpasteurised milk for bird flu virus

SEVEN DAYS IN

Scottish NHS to get £2bn funding boost next year

The NHS in Scotland will get a "record" funding increase of £2bn to help reduce waiting lists, make it easier for people to see their GP, and advance plans for three new hospital buildings, the government has announced. The Scottish government's draft budget for 2025-26 proposes a health and social care budget increase to £21.7bn, up from £19.7bn in 2024-25.

If passed in February, the budget would allocate £16.2bn to deliver services and honour pay agreements, £200m to reduce waiting lists, £4m for the hospice sector, and £5m to support unpaid carers and people with disabilities. The money will also help to fund three hospital projects: replacing Belford and Monklands and building an eye hospital in Edinburgh.

BMA Scotland chair Iain Kennedy (left) urged the government to set out a "detailed plan" for the NHS that includes "fundamental reforms" and a "comprehensive workforce plan." A recent Audit Scotland report said the NHS in Scotland must consider reducing its range and level of services and focus on high priority care.

Commenting on a pledge that by 2026 no one will wait longer than a year for treatment, Conor Maguire, vice president of the Royal College of Physicians of Edinburgh, said, "If we are to match this ambitious target strong policies on recruitment and retention will be essential."

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2024;387:q2756

Climate

Call for action on global tourism emissions

An analysis of data from 175 countries from 2009 to 2020 showed that carbon emissions from tourism grew by 3.5% a year, more than twice the rate of the larger global economy, which grew 1.5% a year. This growth was driven by high demand and slow gains in technological efficiency. The 20 highest emitting countries, including the US, China, and India, contributed three quarters of the total carbon footprint. The study authors wrote in *Nature Communications* that the findings highlight the need for urgent action to curb emissions from tourism.

Obesity

TV junk food ads will be banned before 9 pm

TV advertisements for junk food products will be allowed only after the 9 pm watershed from October 2025 as part of plans to curb childhood obesity, the UK government announced. Paid online junk food advertisements will also be banned to help reduce children's exposure to foods high in fat, sugar, or salt. The health secretary, Wes Streeting, said, "Obesity robs our kids of the best possible start in life, sets them up for a lifetime of health problems, and costs the NHS billions."

Life expectancy

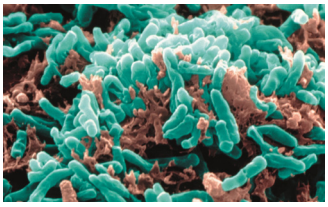
Data show up to 10 year geographical divide

Life expectancy in much of Great Britain is still below pre-pandemic levels, showed data from the Office for National Statistics. The gap between local areas' highest and lowest life expectancies is now 10.3 years in males and 7.6 years in females, both wider than in 2001-03. The 10 areas with the highest male life expectancies at birth were all located in the south of England, while the 10 lowest were in Scotland, the north of England, and Wales.

Dementia accounts for one in 10 deaths in the UK

Dementia continues to be the UK's leading cause of death and accounts for one in 10 deaths, ahead of conditions such as ischaemic heart disease and cerebrovascular disease, found an analysis by Alzheimer's Research UK. A total of 75 393 people died from dementia in 2023, up from 74 261 in 2022 and 69 178 in 2021. Hilary Evans-Newton, chief executive of Alzheimer's Research UK, said, "The 10 year health plan must be used as an opportunity to capitalise on the recent advances in research, future proof NHS dementia services, and ensure dementia doesn't remain a death sentence for everyone it touches."

Tuberculosis



Notifications in England rose 11% in a year

England had 4855 notifications of tuberculosis in 2023, up 11% from 4380 in 2022. The UK Health Security Agency reported that England remained a low incidence country for TB, with a rate of 8.5 notifications per 100 000 population. Reports of TB were lower in 2023 than their peak in 2011, which saw 15.6 per 100 000 population. Of all TB notifications, 80% were in people born outside the UK, but increases were seen in both this group and UK born populations.

End-of-life care

300 hospice beds are out of use, leaders warn

Around 300 hospice inpatient beds in England are currently closed or out of use because of funding and staff shortages, said Hospice UK. The charity said the income that hospices received from the NHS to supplement their charitable income had not kept pace with rising costs. It warned that the government's decision to increase employers' national insurance contributions would exacerbate pressures and force further cuts to staff and services.

Economic activity

Trial aims to help people back into work

NHS England has announced "health and growth accelerators" in South Yorkshire, North East and North Cumbria, and West Yorkshire—the areas most affected by economic inactivity resulting from ill health. The trial areas will work to prevent conditions that lead to people dropping out of work, including diabetes, heart attacks, and strokes. The trial will test digital tools to support therapy sessions for mental health and musculoskeletal pain and will potentially place employment advisers in clinical pathways and general practice settings.

MEDICINE

Pandemic preparedness

Peers warn about vaccine manufacturing capacity

Members of the Lords Science and Technology Committee have written to the government to say that experts had raised "troubling concerns" about the UK's capacity to manufacture vaccines for future biological threats. The committee chair, Julia King, said that a resilient domestic sector for vaccine research, development, and manufacturing was a "critically important sovereign capability for security" against the next pandemic. The letter called for a "peacetime vaccines taskforce" that would procure vaccines to tackle outbreaks around the world and maintain the UK's vaccine production capacity.

Experts are concerned over the UK's capacity to produce vaccines against the next pandemic

Mystery illness

WHO investigates as flu-like condition kills 71

The World Health Organization sent a team to study a mystery illness in the Democratic Republic of the Congo. The country's health ministry has confirmed 71 deaths from the illness, including 27 in hospitals and 44 in the community in Kwango province. Most of the fatalities have been recorded in people under 18. Patients typically experience flu-like symptoms, including fever, headaches, runny nose, coughing, breathing difficulties, and anaemia, the BBC reported.

International news

Australia bans youths from digital platforms

Under 16s will be banned from a range of social media platforms in Australia within a year, after the federal parliament passed a law to "deliver greater protections for young Australians during critical stages of their development." The bill will require social media platforms, including Facebook, Instagram, Reddit, Snapchat, TikTok, and X, to take reasonable steps to prevent anyone under 16 from setting up or holding an account on those platforms. The law exempts messaging services, online gaming, and platforms such as YouTube.

US Supreme Court considers care ban

The US Supreme Court last week heard spoken arguments on a 2023 Tennessee law that bans healthcare providers from providing puberty blockers, hormone therapy, or surgery to minors if the treatment aims to help the individual identify with or live as a person inconsistent with their sex at birth. The issue in the case is whether banning transgender care violates the 14th amendment of the US constitution, which guarantees all US citizens equal protection. Tennessee is one of 26 US states that have banned gender affirming care for people under 18 with gender dysphoria.

Cite this as: *BMJ* 2024;387:q2769

RESEARCH

The UK ranked **8th** in the world for the number of industry led phase 3 clinical trials initiated in 2023, up from 10th in 2022. UK trials increased from 182 to 212, up **16.5%**. The US came top, followed by China and Spain

[Association of the British Pharmaceutical Industry]

SIXTY SECONDS ON . . . CHRISTMAS No 1

PLEASE SAY IT'S LAST CHRISTMAS

You may be disappointed. The race for the Christmas No 1 has an unlikely new contender in the shape of Liberal Democrat leader Ed Davey.

IS HE SINGING ON A PADDLEBOARD?

Not as far as I know—but don't rule anything out when it comes to Dangerous Davey. He's teamed up with the Bath Philharmonia and its young carers' choir to release a charity single, "Love is Enough," to raise money for the Carers' Trust.

DO THEY KNOW HE'S THE LIB DEM LEADER?

I'm not sure—but Davey isn't a cynical politician jumping on a charity bandwagon. As a teenager he cared for his mother for two and a half years when she had terminal cancer. He said, "This time of year is tough for all carers, particularly young ones—let's put them in the spotlight."

ALL I WANT FOR CHRISTMAS IS ED?

He may have a fight on his hands. The Celebs—a group including former boxer Frank Bruno, Anne Hegerty ("the Governess" from *The Chase*), and assorted soap stars—have released a cover of the Beatles' "All You Need is Love" to raise money for Great Ormond Street Hospital.

ANYTHING ELSE TO GET ME ROCKING AROUND THE CHRISTMAS TREE?

Country and western singer Hank Wangford has penned a love song to the NHS, "Our Precious Thing," written while he was recovering from a five hour ablation for atrial fibrillation and tachycardia in Hammersmith Hospital in June. Wangford is the stage name of Sam Hutt, a retired reproductive health doctor.

COULD WANGFORD WING IT?

According to the official chart the shoo-in for Christmas No 1 is the grandaddy of them all, Band Aid's "Do They Know It's Christmas." The song features singers from the 1984 original as well as the 2004 and 2014 versions. Ed Sheeran said, however, that if the producers had asked permission to use his vocal from 2014 he would have refused, citing concerns raised by rapper Fuse ODG (left). The Ghanaian English artist said that such charity singles "perpetuate damaging stereotypes that stifle Africa's economic growth, tourism, and investment, destroying its dignity, pride, and identity."

Anne Gulland, *The BMJ*

Cite this as: *BMJ* 2024;387:q2740

GMC consultation leads to only small changes to PA and AA regulation

The General Medical Council has made only minor changes to how it will regulate physician associates and anaesthesia associates from 13 December, after a consultation that received more than 3000 responses.

The GMC said many of the responses were outside the consultation's scope or already settled in law. The main changes it has made were:

- Training providers must ensure student PAs and AAs inform patients when they are involved in their care
- Two case examiners will make decisions on fitness to practise cases, rather than a single GMC examiner, to prevent the risk of biased decision making, and
- The list of behaviours that indicate a high level of seriousness will include cases where a PA deliberately misled patients about their registration status.

Some 1909 doctors, 385 PAs and AAs, and 81 organisations responded to the consultation. A "significant number of comments" called for the GMC not to be the regulator of PAs and AAs or said PAs and AAs should not be professions or be regulated at all. The GMC replied that it was now legally required to start regulating PAs and AAs, after legislation was laid in the UK and Scottish parliaments in December 2023. It also deflected concerns about the role and deployment of PAs, saying it will share the feedback with other relevant bodies and with the independent review of PAs and AAs being led by Gillian Leng.

Scope of practice

Some respondents said that they couldn't respond to the consultation adequately without understanding the PAs' scope of practice, which the GMC has said it does not set.

Philip Banfield, the BMA's chair of council, was highly critical of the GMC's role, calling it a "cavalier" approach and a missed opportunity to show patients and doctors that it could carry out regulation responsibly.

He said, "A regulator should be able to set out what these associate roles can and cannot do. However, the GMC continues to believe that those decisions should be determined locally by each hospital trust. This will continue the postcode lottery of local variation that has already led to tragic patient safety incidents, including deaths."

He added, "In a week's time PAs and AAs will be under GMC regulation, but the GMC, NHS England, and royal colleges all continue to point to the other as the body to set what these associates can and cannot do at work. The buck must stop somewhere."

Jacqui Wise, Kent Cite this as: *BMJ* 2024;387:q2757

Tirzepatide's phased rollout "will protect GPs"

GPs' leaders have warned that the rollout of the weight loss drug tirzepatide (Eli Lilly's Mounjaro) will still have "significant practical and resource implications" for primary care even though it is being phased in gradually over an unprecedented 12 years.

NICE and NHS England have agreed a three year period to offer the weekly injection to 220 000 patients to avoid overwhelming primary care services.

Tirzepatide is recommended for people with a BMI of more than 35 and at least one related comorbidity, said final draft NICE guidance. Lower BMI thresholds are recommended for people of south Asian, Chinese, other Asian, Middle Eastern, black African, or African-Caribbean backgrounds.

Tirzepatide can be used in all healthcare settings, including primary care, and should be prescribed alongside diet and exercise support, NICE has advised. Trials have shown that patients taking tirzepatide lost on average 21% of their body weight in 36 weeks, more than those using diet and exercise support or semaglutide.

"Profound" effect on GPs

An estimated 3.4 million people in England would be eligible for treatment, said NICE. In response to draft recommendations published in October, NHS England said it would need 12 years to fully implement the guidance and warned of a "profound" effect on general practice, taking up around 18% of all GP appointments.

NICE accepted the 12 year implementation period because of the large number of people who would potentially be eligible for treatment and because the "resources needed for its delivery, such as diet and exercise support, are not available equitably across the country." But it added there was "likely to be scope to complete implementation within a significantly shorter period" and it would review the

PM's pledge to end backlog is big challenge, health leaders warn

The government's renewed pledge to end the NHS hospital treatment backlog in England by 2029 will require a "monumental increase in activity," healthcare leaders have said.

In a speech setting out his government's core objectives, Keir Starmer said meeting the target for 92% of patients in England to wait no longer than 18 weeks for elective care was one of six "ambitious and credible" milestones to deliver by 2029. The pledge was first set out in Labour's manifesto earlier this year.

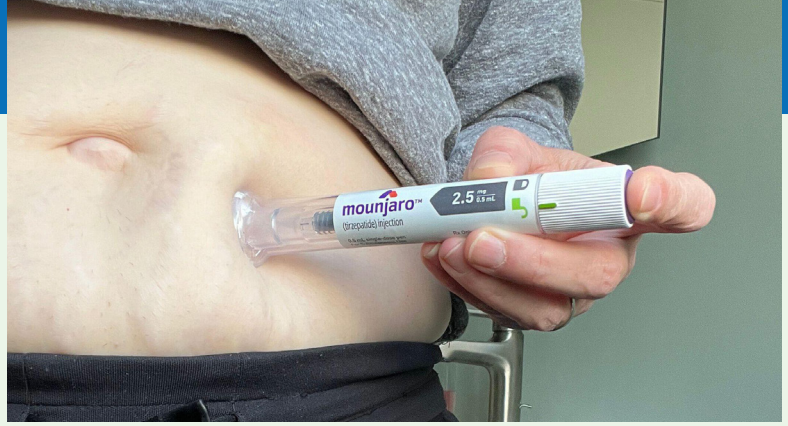
Healthcare leaders welcomed the NHS being a priority but warned that meeting the target for the first time since 2016 would be a tall order, with the waiting list in England now standing at 7.57 million patients.

Matthew Taylor, NHS Confederation chief executive, said, "Health leaders are ready to take forward the government's ambition . . . supported by the funding increase announced in the budget. However, delivering it will require a monumental increase in activity."

Taylor said the NHS Confederation looked forward to seeing further detail of how NHS England planned to meet the target in its new elective recovery plan, due later this month.

In his speech Starmer acknowledged the scale of the task, saying, "Some people may say: 'That's pretty brave . . . you know how hard that NHS milestone is.' I'll be honest. They're right. We face an almighty challenge: we are starting from ground zero." But he said the target was part of the "most ambitious and credible programme for government in a generation."

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2024;387:q2754



situation again within three years.

Jonathan Benger, NICE's chief medical officer, acknowledged the long rollout would mean "many people will have to wait," but he added, "The world will look very different in three years, which is why we've taken the unprecedented decision to review the way this medicine is delivered then."

Tirzepatide will at first be available to people already receiving care from specialist weight management services within 90 days of NICE's final guidance, expected on 23 December.

Commissioning guidance

NHS England will publish interim commissioning guidance early next year and will detail which patients outside specialist weight management services will be offered the drug.

General practices are likely to be in charge of referring patients, but questions remain over who will provide the ongoing support involving diet, exercise, and monitoring.

NHS England has proposed that in the first phase people would be eligible if they have a BMI >40 and at least three of four weight related health conditions: hypertension, dyslipidaemia, obstructive sleep apnoea, and cardiovascular disease. It would then be offered to patients with fewer conditions.

Kamila Hawthorne, chair of the Royal College of General Practitioners, warned, "It's right that the proposals prioritise those patients most in need of weight loss medication—but as more patients become eligible, serious consideration will need to be given to the impact this will have on general practice. It's vital that general practice is resourced appropriately and that GPs have the necessary training to safely take on any additional responsibility that comes their way."

Simon Cork, senior lecturer in physiology at Anglia Ruskin University, said evidence showed that "primary care physicians often do not feel qualified to provide this level of wraparound care, which may limit the effectiveness of these medications. Access to dietitians and physiotherapists will be key to maximising the health benefits that these medications have to offer."

He also warned that targeting people with the greatest clinical need would lead to frustration among the millions who struggle with their weight. "We have seen with semaglutide how this demand has led many to purchase this medication either privately or through the black market, with potentially dangerous consequences," said Cork.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;387:q2744

The world will look very different in three years, and we'll review the delivery to patients then Jonathan Benger

CLINICAL TRIALS have shown that patients taking tirzepatide lost on average 21% of their body weight in 36 weeks

LETBY INQUIRY: **Former trust chair admits to failures**

The chair of the Countess of Chester Hospital trust board failed to realise when he read a report on unexpected baby deaths that it did not exonerate the nurse Lucy Letby, he has told a public inquiry into how she managed to kill and attack babies on the neonatal unit from June 2015 to June 2016.

Duncan Nichol, who led the trust at the time the nurse Beverley Allitt carried out a series of killings in the 1990s, told the Thirlwall inquiry he "didn't pick up" that a report commissioned by the trust from the Royal College of Paediatrics and Child Health did not exclude Letby as a possibility for causing harm and death to babies. Nichol said it was a "big failure on my part" that the paediatric consultants, present at the first extraordinary board meeting in July 2016 to discuss the babies' deaths, were not invited to the second meeting in January 2017, when the board was considering Letby's return to the unit.

Grievance

Letby went on two weeks' leave at the beginning of July 2016 and on her return was taken off the unit and assigned to administrative duties after pressure from the consultants. She brought a grievance alleging victimisation, which was upheld, and managers were supporting her return to the unit.

In the event she never returned, but police were not called in until May 2017. Letby was arrested in July 2018 and is serving 15 whole life terms in prison after being convicted of murdering seven babies and attempting to kill seven others.

Nichol described an "emotional conversation" with Ravi Jayaram, one of the consultants, in May 2017, after police had begun investigating. At the July 2016 meeting Jayaram had said the consultants' suspicions about Letby were the "elephant in the room." Nichol sent an email to Jayaram saying, "I want you and your consultant colleagues to know how deeply sorry I am for the personal distress that you have and are all suffering and for my part in not intervening sooner."

WE DIDN'T EXERCISE APPROPRIATE DUTY OF CANDOUR TOWARDS THE FAMILIES Duncan Nichol

Nichol told the inquiry, "It's clear from what I know now from the evidence that I have read that a huge amount of sympathetic support was being given [by] senior managers to Lucy Letby during the course of these events. The board I don't think was sufficiently sighted on these matters.

"The families were not in the big picture. We didn't exercise appropriate duty of candour towards the families, and that was a failure—a serious failure."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2024;387:q2720

NEWS ANALYSIS

How would the new assisted dying law work for doctors?

Clare Dyer examines what effects the historic vote would have on the medical profession

STEPHEN CHUNG / ALAMY

It should be a specialist service—it's vital it's done well
Sam Everington

Terminally ill patients in England and Wales look likely to join more than 300 million citizens worldwide who have the right to a doctor's help in dying at a time of their choosing, after members of the UK parliament voted to give the Terminally Ill Adults (End of Life) Bill a second reading. MPs supported the private member's bill, introduced by Kim Leadbeater, Labour MP for Spen Valley, by an unexpectedly large majority of 330 to 275. The bill is thought to have a reasonably good chance of becoming law.

The bill would allow terminally ill adults whose death "can reasonably be expected" within six months to have help in ending their lives, with the agreement of two doctors and the approval of a High Court judge. Doctors would provide the drugs that would end the patients' lives, but patients would have to administer the substances themselves.

The Labour MP Kim Leadbeater introduced the bill, which won a majority of 55 Commons votes

How would the process work?

People seeking assisted death would have to be at least 18 years old, resident in England and Wales, and registered with a GP for at least 12 months. They must have the mental capacity to take the decision and be deemed to have expressed a clear, settled, and informed choice, free from coercion or pressure. They must be terminally ill and expected to die within six months and must make two separate declarations, signed and witnessed.

Two doctors must be satisfied that the patient is eligible: the "coordinating doctor" and a second, independent doctor who is not a partner or colleague in the same practice or clinical team. A High Court judge must hear from at least one of the doctors—which can be done by live video link—and may also question the dying person and anyone else considered appropriate.

There must be at least seven days between the assessments by the two doctors, and a further 14 days must pass after the judge's ruling, although the 14 day period could be reduced to 48 hours if death is expected within a month. The coordinating doctor must either give the patient the approved substance for self-administration or prepare a medical device that would enable the patient to administer it themselves. There is currently no information on how much the system would cost or who would pay.

Where is assisted dying legal and which model does the bill follow?

Canada, Australia, New Zealand, Switzerland, the Netherlands, Belgium, Luxembourg, Spain, Austria, and 10 US states and the District of Columbia have all legalised assisted dying. The bill for England and Wales is unusual in requiring the approval of a judge. A separate bill is under discussion in Scotland, and politicians in Jersey and the Isle of Man have backed plans to introduce assisted dying.

Would the bill create an opt-in or opt-out model for doctors?

Effectively it is an opt-in model, although the BMA pointed out in a briefing that this was not made explicit in the bill. However, the association notes that no doctor would be under any duty to participate and that "it is our understanding that it would only be the doctors who actively choose to do the training who would in effect be opting in to provide the service." The BMA's briefing adds, "If the bill progresses, we would want it to be made explicit that this is an opt-in arrangement for doctors."
The bill provides that any doctor can refuse to carry out activities related to assisted dying, for any reason, not just conscientious objection.

Would doctors be allowed to raise assisted dying with patients?

Doctors would not be under a duty to raise assisted dying but would not be prohibited from raising it. It would be a matter of professional judgment.

What are the training needs, and where would NHS services occur?

Much of this detail would need to be worked out. As in other parts of the world where assisted dying is legal, GPs would probably provide most of the services. The BMA has suggested a separate specialist service that uses a network of specially trained doctors, with GPs able to assist their own patients provided that they had received the training. Sam Everington, a London GP and member of the BMA council and the Royal College of General Practitioners' council, agrees. "It should be a specialist service—it's vital it's done well," he said.

What would be the effect on GPs' workload?

Cases of assisted dying would require extra work for GPs. An Australian doctor has estimated that a consultation involving assisted dying took three times as long as a usual consultation. But the number of patients requesting the procedure is not expected to be large.

What drugs would be used?

This is not specified in the bill and, like many details about

the process, would be dealt with by regulations.

What would be the effect on the availability of palliative care?

The Commons Health and Social Care Committee, which took evidence from several jurisdictions that allow assisted dying, commented in its report in February, "In the evidence we received we did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD/AS [assisted dying/assisted suicide], indeed the introduction of AD/AS has been linked with an improvement in palliative care in several jurisdictions."

What protections does the bill provide for doctors?

No doctor or other health professional would be under any duty to participate in providing assisted dying, and the bill specifies that no employer must subject an employee to any detriment for either participating or not participating. The bill also rules out criminal or civil liability for assistance provided in accordance with its provisions.

What happens next with the bill?

The bill will go to a committee of MPs—yet to be selected—who will scrutinise it and propose amendments. The committee, which is expected to include supporters and opponents, will be able to take evidence from witnesses, and the government is likely to table amendments. The report stage will happen on or after 25 April 2025.

If the bill receives a third reading after the report stage it will go through similar stages in the House of Lords. If it passes the Lords it will be sent for royal assent and will come into force two years after the king gives his assent or at an earlier date specified by the health secretary. This is likely to be 2027 at the earliest if it proceeds without challenges.

If the bill passes, the health secretary will have to take a number of decisions, including the identification that patients must provide, the substances to be used, the records to be kept by doctors, and the codes of practice governing the process.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2024;387:q2755

RCGP will consult members over changing stance on assisted dying

The Royal College of General Practitioners has voted to go back to its members to poll them on whether it should shift from its current stance of opposing a change in the law on assisted dying.

At the RCGP's UK council meeting on 30 November 39% of council members voted to move immediately to a position of neither opposing nor supporting a change in the law to legalise assisted dying, but 61% voted to undertake a new survey of members to determine the college's stance on the legalisation. No members abstained. The UK council has 64 members, but the RCGP was not able to say how many voted.

A ballot is a serious risk. We should be discussing with the legislators how to implement the law
Aneez Esmail (right)

The decision came after MPs voted for a bill that could change the law on assisted dying in England and Wales if voted into law. A separate bill to legalise assisted dying in Scotland remains at first stage as MSPs consider the general principles of the legislation.

The RCGP adopted its current position of opposing a change in the law on assisted dying in 2020. At the time the college was subject to a legal challenge over its handling of the member survey.

Aneez Esmail, an RCGP council member who was involved in mounting the legal challenge in 2020 and supports a change in the law, said he was frustrated at the outcome, warning that polling members again created a "serious risk" that the RCGP would miss the chance to be involved in discussions on how to implement the new law.

"Any evidence taken to advise on implementation will happen in the early part of next year. And the RCGP will still be having its ballot," he said. "At the council at the debate it was very much people rehashing the arguments that were debated in parliament the day before.

"But parliament passed the bill, and council members should have been saying, 'OK, this is what the public wants and what the legislators want, and as a professional body which may potentially be involved with this in a big way we should be discussing with the legislators how to implement it.'"

The RCGP chair, Kamila Hawthorne, said that assisted dying was "one of the most contentious and sensitive issues" in society and that the council thought that RCGP members should be consulted on reviewing the college's stance.

Whatever the outcome of the consultation, Hawthorne said, the college "will have a clear role in advocating for our members, regardless of their views on assisted dying, as to how potential changes in the law will impact on their daily practice and the care they deliver for patients. We will also continue to push to ensure that palliative and end-of-life care, much of which is delivered by GPs and our teams, is the best it possibly can be."

No timeline for the consultation has yet been agreed, but the college said it was likely it would report at some point next year. Until then the college's position remains opposition to a change in the law.

Sam Everington, an RCGP council member and a GP in Bromley by Bow, east London, who was also among the claimants in the 2020 legal challenge, said it was vital that the college engaged with the legislation and informed its members of the relevant facts. "To me it is not just about finding out what their views are," he said. "We are now in a scenario where it's very likely that it's going to happen, so there's a need to inform."

Everington, who supports a change in the law, urged the college to produce an advice sheet for members setting out exactly what the legislation entails and what the expected involvement of GPs will be and emphasising the safeguards in place.

"This is probably the tightest legislation in the world in terms of assisted dying," he said. "That's important for people to understand."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;387:q2742

AT THE RCGP's UK council meeting **39%** of council members voted to move immediately to a position of neither opposing nor supporting a change in the law to legalise assisted dying

THE BIG PICTURE

Taliban bans women from nursing and midwifery

Health and human rights organisations have condemned the Taliban's ban on women from attending nursing and midwifery training in Afghanistan.

Human Rights Watch reported that the edict from supreme leader Haibatullah Akhundzada has not been formally announced, but students were told by schools, such as Kabul's Omid Institute (main image and below), on 3 December they would no longer be able to study.

The move is the latest restriction placed on women's education and access to healthcare since the Taliban returned to power in 2021. The theocratic regime banned women from attending secondary schools in March 2022 and from attending universities, including medical schools, and working for NGOs nine months later.

Health organisations told *The BMJ* the ban on all female medical training would make it even harder for women to receive essential healthcare services and lead to more women dying in childbirth.

Afghanistan has one of the worst rates of maternal death in the world, with a 2023 report citing mortality of 620 deaths per 100 000 live births (compared with an average high income country maternal mortality rate of 11). It also has one of the highest rates of infant mortality, with 43 deaths per 1000 live births in 2021.

Sally Howard, London

Cite this as: *BMJ* 2024;387:q2761

WAKIL KOHSAR/AFP /GETTY

EDITORIAL

Infrastructure is key to unifying UK health data

Technical, rather than bureaucratic, solutions are needed

Reforming the NHS by shifting from analogue to digital, from treating sickness to prevention of disease, and from hospital to community care is a priority for the UK government.[1]

Better use of data will be central to achieving these shifts—revealing who is likely to become unwell, enabling predictive modelling, and simulating the effects of changing the location of care. The November publication of the Sudlow review of the UK's health data systems[2] is therefore timely.

Commissioned by the chief medical officer for England, the review makes recommendations for overcoming barriers to linking and sharing data by streamlining control; standardising mechanisms, governance policies, and public engagement activities for data access; and broadening access to imaging and free text data.

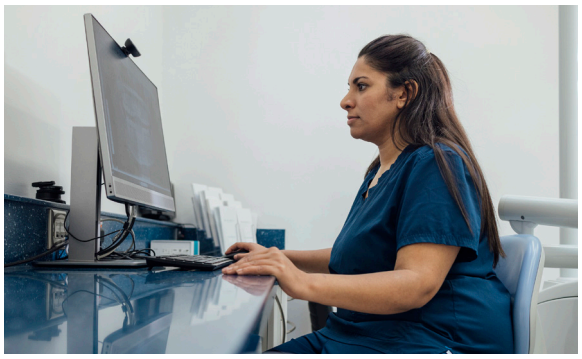
The UK's health data infrastructure is outdated[3] and fragmented, with datasets siloed across many locations[4] and controlled by different entities making inconsistent access decisions.[5] This slows research and undermines trust.

Three tensions

Infrastructure needs to be consistent and better coordinated. Yet the Sudlow recommendations for creating "critical national infrastructure" over-rely on bureaucratic solutions (rather than technical ones) and fail to resolve key tensions around privacy, public benefit, data security, and trust.

First, a narrative runs through the review that privacy "overprotection" prevents the realisation of public benefit from data use.[2] But privacy or public benefit is a false dichotomy. It is possible to build scalable infrastructure that protects privacy and delivers public benefit. Other countries, such as Finland, have delivered infrastructure as capable as the UK's but with better accountability and patient participation.[6]

Undermining the need for privacy protection directly harms public benefit. The care.data and GPDPR schemes, which proposed a centralised GP record database with limited privacy safeguards, triggered a public backlash and increased the number of opt outs beyond direct care.[7-9] High opt-out rates can reduce the utility of NHS data, undermining representativeness and introducing biases.[10]



The Sudlow review's vision is compelling, but its implementation strategy is misguided

A second tension stems from contradictions on how researchers should access NHS data. Since 2022, the NHS's position has been that organisations should move away from sharing de-identified datasets and establish secure data environments as the preferred mechanism for access.[11] Although the review acknowledges and supports this direction, it also advocates maintaining transfers of de-identified data, stating this "remains highly relevant and necessary."[2] Techniques to de-identify data have serious limitations,[12] particularly for imaging and free text data that cannot be anonymised without undermining their utility.[13 14]

De-identified datasets take time to produce and (once distributed) are difficult to track and control—especially when accessed by private companies. Advocating for their use contradicts Sudlow's intentions to create a system that supports streamlined, trustworthy, and coordinated access. Building flexible, traceable infrastructure is feasible, and it can provide better insight, in a way that releasing limited de-identified datasets does not. Developing such infrastructure requires investment but would offer long term benefits for both security and utility.

The third tension lies between bureaucratic oversight and efficient access. The review acknowledges access is hindered by many, inconsistently interpreted governance frameworks. Yet these mechanisms were introduced to mitigate risks inherent when data controllers have limited oversight over downstream use.

When sharing de-identified datasets, controllers rely on paperwork, personal relationships, and lengthy review procedures. However, modern technical infrastructure such as secure data environments can provide verifiable guarantees, reducing reliance on paper based bureaucracy that can cause delays.[5] By stating it is "not realistic" to expect NHS infrastructure to support diverse research needs, the review defaults to recommendations that will increase bureaucratic complexity.[2]

The review's vision is compelling, but its implementation strategy is misguided. It assumes current limitations to the scale and capability of privacy preserving, high utility infrastructure are permanent, rather than asking why these limitations exist. Understanding these root causes is essential for developing evidence based solutions that enable the system to "lower barriers to data sharing for public benefit whilst keeping it secure."[2]

Adding bureaucratic requirements, while perpetuating ideas about NHS technical limitations will slow progress. This risks leaving the NHS vulnerable to exploitation by private companies whose offers to "assist" could result in loss of control over valuable public assets.[15] Instead, the NHS needs investment in teams capable of developing privacy preserving platforms at scale with robust security measures that go beyond criminalising re-identification. This can deliver the "critical national infrastructure" the review supports.

Jessica Morley, postdoctoral research associate, Digital Ethics Center, Yale University, New Haven, Connecticut, jessica.morley@yale.edu

Luc Rocher, lecturer, Oxford Internet Institute, Oxford

Cite this as: *BMJ* 2024;387:q2735

Find the full version with references at http://dx.doi.org/10.1136/bmj.q2735

EDITORIAL

Time for a revolution in academic medicine?

A *BMJ* Commission will redefine the role of academia in healthcare

Academic medicine remains under scrutiny. Despite various attempts to tackle its problems, including a global initiative in 2003, *The BMJ*'s editor in chief recently concluded it is "broken."[1 2]

At the centre of the "crisis" are historical power imbalances that have led to broken career structures, perverse incentives for academic reward and research funding, and a widening rift within medical institutions between research and education.[1]

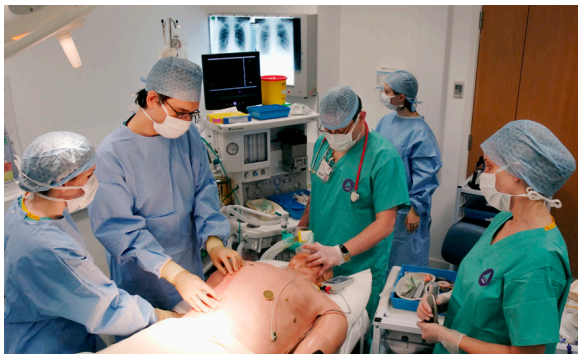
A crisis in evidence based medicine is also part of the problem.[3] In addition, workforce shortages and growing health service demands are putting strain on health system budgets, leaving little room for governments to direct public funds into research rather than service delivery.

To respond to the growing crisis, *The BMJ* has launched a Commission on the Future of Academic Medicine, which aims to revive academic medicine and redefine its role for the rest of the century. It seeks to trigger a global conversation to build on what is working, to fix what is not, and to realign the role and function of academic medicine to ensure its relevance for the future.

Fundamental principles

What is meant by academic medicine? Broadly, we mean "academia" and "healthcare." Its overarching goal should be to train medical professionals and advance knowledge, with the central aim of improving health and wellbeing of the population and planet in an equitable manner. Fundamental principles of academic medicine are that it should serve both academia and medicine, combining science, ethics, and humanities, and promote lifelong learning.

Without the rudder of science and ethical thinking, ignorance or misinformation can dominate, making societies vulnerable to populism, poor decision making, and power play. Recent history has shown us how this can exacerbate conflicts, mismanagement of pandemics, and poverty.



BRIAN BELL/SPL

A deep reflection on what we are doing and achieving is long overdue

Academic medicine has many stakeholders, including the academic community, health organisations, policy makers, the medical workforce, and medical students, with different perspectives. All these groups need to have their say and take responsibility for creating a better future.

Other important voices are those supporting medical research, including funders from public and private sectors and industry, and the world's scientific and medical societies and journals.

Misalignment of goals

As a first step, we as co-chairs have identified misalignments in goals and drivers of scientific agendas, and gaps in academic capacity that need fixing in academic medicine (box, see bmj.com).

These include a fundamental and widening rift between universities and health systems; disengagement between teaching, clinical, and research activities among academics in medical faculties; and lack of incentives and rewards to pursue an academic career. This broad non-prioritised list is intended to encourage global discussion, including the active participation of *The BMJ*'s regional advisory boards.

The BMJ will advance the work by commissioning articles on cross-cutting themes deemed relevant globally, assuring broad and inclusive representation. In addition, each regional advisory board will be invited to reflect on priorities and future perspectives for academic medicine, providing concrete actions within their own realities.

Key questions

We hope to obtain innovative proposals to reshape the current situation and re-establish academic medicine on a firm footing. The key questions include: what is the vision for academic medicine in an era of rapid change? How healthy is academic medicine currently, and is it getting better or worse? Which challenges do we need to tackle first? What strategies, policies, or other actions are needed for urgent or progressive reform?

We also seek your submissions and contributions for publication, which will be considered by *The BMJ* in the usual way.

This reflective process is not only timely but crucial in a world that is dominated by immediacy, superficial exchange of ideas, and increasing acceptance of incomplete or bluntly false information. A deep reflection on what we are doing and achieving in academic medicine is long overdue.

Our ambition for this commission is that it leads to root and branch reform of academic medicine so that it is fit to meet the challenges of a world facing polycrises, including the existential threats from climate change. We aim for no less than academic medicine becoming one of the forces for the good of human and planetary health.

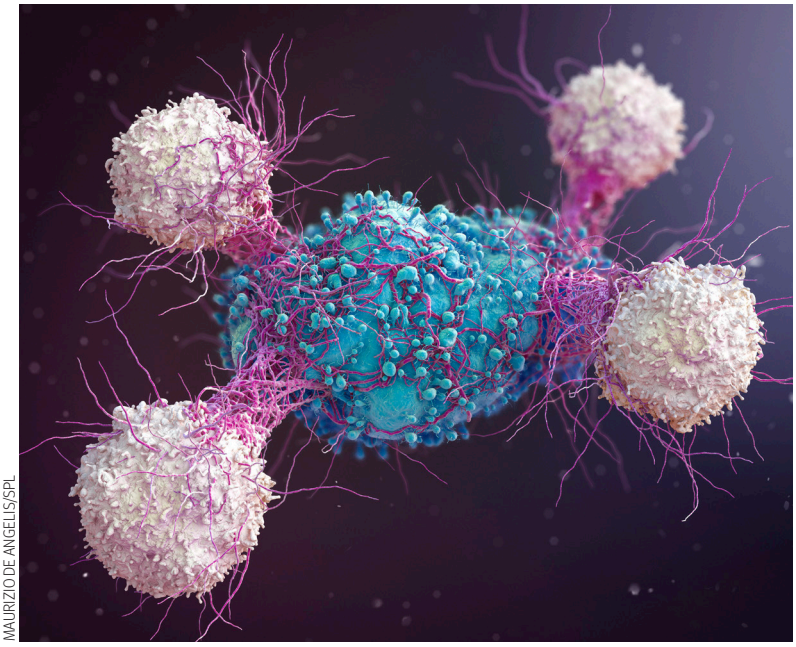
Miguel Luis O'Ryan, dean, Faculty of Medicine, University of Chile, Santiago
moryan@uchile.cl

Sonia Saxena, professor of medicine, Imperial College London

Fran Baum, director, Stretton Health Equity, University of Adelaide, Australia

Cite this as: *BMJ* 2024;387:q2508

Find the full version with references at http://dx.doi.org/10.1136/bmj.q2508



MAURIZIO DE ANGELIS/SPL

BIONTECH

VACCINES

The rapid rise of the UK's cancer vaccine trials

The UK is making progress in developing cancer vaccines, but there are still challenges ahead, **Chris Baraniuk** reports

The UK is on its way to becoming a hotbed of cancer vaccine trials. In May this year, it emerged that 30 British hospitals had signed up to be part of the Cancer Vaccine Launch Pad, a scheme to enrol NHS patients in messenger RNA (mRNA) cancer vaccine trials. Just three months later, in August, a 67 year old man named Janusz Racz became the first person in the country to receive a new mRNA vaccine, as part of a clinical trial, for non-small cell lung cancer.

The vaccine, which was developed by the German biotechnology company BioNTech, is designed to present tumour markers to the patient's immune system and thereby trigger an immune response that will target cancer cells specifically. In principle this reduces the risk of toxicity to healthy, non-cancerous cells. Chemotherapy, in contrast, often affects both cancerous and healthy cells.

Vaccine trials for melanoma and bowel cancer using BioNTech jabs are also currently active in the UK. Future trials could target a growing range of cancers, including breast cancer and head and neck cancers, among others.

mRNA technology

Excitement over the prospect of a new era of cancer vaccine research has been building for some time, driven in part by the rise of mRNA technology, which was used with stunning success in various covid vaccines.

The first mRNA vaccine ever approved for use in humans was actually a cancer vaccine: Provenge, for treating prostate cancer. Until 2020, however, mRNA vaccines were rare. Most vaccines didn't use mRNA molecules but rather inactivated viruses, or parts of viruses, that could trigger an immune response.

Using an mRNA molecule is different. It's like a code that initially prompts the body to replicate part of a target virus or tumour: the part in question is called an antigen. After the target's antigens are replicated, a person's immune system can then learn how to fight off the virus or cancerous cells. If the same virus or cancerous cell later raises its head the immune system will know how to respond.

Patients would say, "I don't want to be a guinea pig." We get that a lot less now
Sarah Danson

One potential advantage of mRNA is in allowing vaccine makers to quickly develop personalised jabs, which are designed to target the specific tumours affecting individual patients. It's possible to do this much more quickly with mRNA than with previous vaccine technology.

Separately, a Cancer Research UK funded project at the University of Oxford, announced in September, will target a small group of cancers associated with Lynch syndrome. The exact type of vaccine that will be used in the trial is yet to be determined. However, the idea is to analyse abnormal changes in precancerous cells in patients and eventually develop a vaccine that can train their immune systems to eliminate those cells. If this proves successful the vaccine could in future prevent cancer from occurring in people with Lynch syndrome, rather than requiring doctors to treat it once the cancer has already taken hold.

Separate, non-mRNA research for a lung cancer vaccine based

AARON CHOWN/PA/ALAMY

What is a cancer vaccine?

Personalised cancer vaccines using messenger RNA (mRNA) are a form of immunotherapy treatment. Tailored to each person's cancer, they work by training the immune system to recognise, destroy, and prevent the spread of cancer cells.

The reason they're called "vaccines" is because they teach the immune system to fight cancer, in the same way that existing vaccines teach the immune system to protect itself from viruses or bacteria.

Currently, personalised cancer vaccines aren't designed to prevent cancer from developing in the first place, although they could prevent the return of cancer after successful treatment.

Who can take part in a cancer vaccine clinical trial?

NHS England says that cancer vaccine trials are for people who have had cancer diagnosed for the first time or for those who are undergoing treatment for a returning cancer.

For either kind of recipient, cancer vaccines may reduce the risk of the cancer coming back, although this is still the subject of study. Not everybody who has a cancer diagnosis or is having treatment for cancer is eligible for a trial.

on technology developed by the University of Oxford and AstraZeneca has started. In October it was announced that scientists at the University of Oxford had been awarded funding to create the world's first vaccine to prevent ovarian cancer.

Role of the NHS

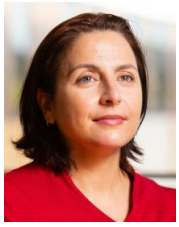
The high visibility—and success—of covid vaccine research has helped encourage UK patients to consider signing up for cancer vaccine trials, suggests Sarah Danson, professor of medical oncology at the University of Sheffield.

Danson is also co-clinical lead for cancer at the Vaccine Innovation Pathway, a clinical trial delivery accelerator. "Patients would say quite often, 'I don't want to be a guinea pig,'" she says. "We get that a lot less now."

Maria Koufali, head of the Vaccine Innovation Pathway, says that the challenge in the UK is to bring trials to healthcare sites around the country, not just at the big university hospitals. "We are lining up the infrastructure," she says. "I would say that we are very close to becoming a globally competitive destination for these vaccine trials." She expects the UK's "cancer vaccine portfolio"—the list of trials and cancers targeted by vaccine candidates—to double by early 2026.

Both Koufali and Danson say that the NHS is an obvious platform through which to enrol participants—a sentiment echoed by Alan Melcher, professor of translational immunotherapy at the Institute of Cancer Research. He points to the clinical benefits: "Where you can include a lot of centres, you can treat a lot of people."

Above from left: computer image of white blood cells attacking a cancerous cell; a BioNTech technician working on mRNA cancer vaccine production; a patient takes part in the first clinical trial for lung cancer immunotherapy in the UK in August



We are close to becoming a globally competitive destination
Maria Koufali

Where you can include a lot of centres, you can treat a lot of people
Alan Melcher

However, he adds that many challenges are still afoot. For one thing, the personalised jabs that aim to target cancer antigens specific to individual patients are expensive. BioNTech has said that it can get the cost of such jabs down to less than $100 000 (£77 000) per dose. While an entire course of immunotherapy with more traditional methods can cost around the same or more, participants in the BioNTech colorectal cancer vaccine trial, for example, will receive as many as 15 doses of the vaccine candidate.

There are also different approaches for different cancers. The UK lung cancer vaccine trial doesn't use personalised vaccines, whereas the bowel cancer and melanoma trials do, and uncertainty remains over which kind of treatment will turn out best for each specific cancer. "The truth is, we still don't know which antigens are most effective," says Melcher.

Cancer vaccines could also prove important in helping to prevent cancer from recurring, he adds—or for reducing the risk to patients whose genes make them more susceptible to certain cancers. And these vaccines could one day reduce the need for toxic treatments such as chemotherapy and radiotherapy.

Melcher concludes, "In these sorts of trials, it's a constant theme of 'excitement is justified,' in my view—but overexcitement is a risk."

Chris Baraniuk, Belfast
chrisbaraniuk@gmail.com

Cite this as: *BMJ* 2024;387:q2294

FEATURE

How did the RCP get into a mess over physician associates?

The Royal College of Physicians has been at the centre of the UK row over PAs. **Adele Waters** explores what happened and where it leaves the college now

In March 2024 the Royal College of Physicians was forced to hold an extraordinary general meeting, only the third in its more than 500 year history. The issue that prompted it was physician associates (PAs), specifically their regulation, scope of practice, and expansion across the health service.

The meeting was ill tempered and fraught, with participants describing it later as "really aggressive" and an "unmitigated disaster." Such was the concern about the meeting's conduct and the level of hostility in the room that the RCP was forced to admit it had failed its membership and ordered an independent review to establish what had gone wrong.

That review, carried out by the King's Fund and published in September, found a "pervasive lack of trust and confidence" in the RCP's governance and that its governing council had been operating ineffectively.

After the EGM the college saw several high level resignations: its former president Sarah Clarke, registrar Cathryn Edwards, former deputy registrar Jamie Read, and, after the King's Fund review, the chair of the board of trustees, David Croisdale-Appleby.

In 2015 the college had established the Faculty of Physician Associates (FPA), in conjunction with Health Education England (as it was then called) and other medical royal colleges (box). Several members of the FPA's board also resigned en masse after the EGM, including its president and vice president. The FPA will close at the end of this year, although the RCP will continue to oversee the annual PA exam.

How and why did such a historic institution end up in this position? According to college documents and the testimony of members who have served on its council or committees, several factors played a part: precarious finances, an ambitious modernisation strategy, and an unhealthy culture with opacity and resistance to challenge at its heart.

"The issue around PAs perhaps exposed a lot of underlying issues with the way the college works," says Partha Kar, a council member since 2023. "Frustrations were building, and they coalesced into this whole issue around PAs. Today it was PAs, but tomorrow it would have been something else. It would have come to this point either way."

Financial pressure

Available accounts show that in 2014 the college was in a healthy financial position, with its annual report for the year stating, "Once again…a strong year financially." Consolidated total income was £40.7m, £2.7m higher than in 2013 (table 1). Louella Vaughan, who has sat on the RCP council since 2020, describes the college in that period as "completely flush" with funds.

Table 1 | RCP's annual income and expenditure (£m), 2013-23*

	Income	Expenditure	Operating loss or profit	Funds carried forward at 31 Dec
2013	38.0	36.3	1.7	46.4
2014	39.7	37.9	1.8	47.6
2015	40.7	40.5	0.2	49.9
2016	40.7	42.5	−1.8	50.8
2017	41.8	45.5	−3.7	49.8
2018	43.2	45.3	−2.1	46.8
2019	42.7	43.9	−1.2	47.5
2020	31.0	34.3	−3.3	45.0
2021	34.8	33.9	0.9	51.9
2022	38.4	38.9	−0.5	46.9
2023†	42.5	43.3	−0.8	46.5

*Restated figures taken from consolidated accounts in RCP annual reports.
†Figures taken from 2023 annual report as 2024 report (containing restated figures) not yet published.

The issue around PAs perhaps exposed a lot of underlying issues with the way the college works
Partha Kar

In 2014 the college worked on plans to develop itself. It launched a new five year strategy (2015-20), underpinned by a series of planning documents, to expand substantially its regional work and educational offering, among other initiatives. The strategy was ambitious and expensive, but it put in place a five year, forward looking financial plan to mitigate any financial risk, aiming to bring it back to a break even position by 2020. The RCP refused *The BMJ*'s request to share the planning documents linked to its strategy.

Vaughan says the RCP leadership

TIMELINE—RCP AND PAS

2003 First physician assistants begin working in UK

2011 Managed voluntary register for PAs is launched

2013 PAs included in NHS workforce plans for first time

2014 Government announces big increase in number of training places for PAs

2015 RCP establishes Faculty of Physician Associates, in conjunction with UK Association of Physician Associates and Health Education England

RCP begins new five year strategy (2015-20)

2020 First covid-19 lockdown begins in UK in March, affecting RCP revenue

2021 RCP focuses on financial recovery, including staffing cuts and reducing running costs

2024 RCP holds emergency meeting (March)

agreed to a permissive deficit of £1m for each of the five years of the strategy (2015-20), but the actual deficit by the end of that period was around £12m. "It overspent every single year and never fiscally tightened up the following year," says Vaughan. "And then, at the same time, it took on The Spine."

Vaughan refers to the college's commitment to establish an "RCP North" base, new premises for its members in the north of England, with an education and assessment centre. Dubbed "The Spine," the new seven floor development in Liverpool's "Knowledge Quarter" cost the RCP £14m over the first three years in fitting out and rental. The RCP confirmed in an email to *The BMJ* that the 25 year leasehold for The Spine costs the organisation £1.1m a year, and in 2020 the then president, Andrew Goddard, said that the RCP took a £6.75m bank loan to help pay for the project.

Phil Smith, an honorary consultant gastroenterologist in Liverpool who sat on the college's trainee committee from 2012 to 2016, remembers early concern about "what was coming down the road." He says, "They knew it was going to be an expensive project."

At the same time, financial liabilities linked to the college's defined benefit pension scheme was an enduring problem. From 2015 to 2020 the scheme swallowed up a £3.8m extra deficit repair, and it required a further £1m of additional support in 2021.

From 2014 to 2015 the RCP's costs rose by 7% (expenditure increased by £2.6m), while its income saw only a modest rise of 2.5%. Against this financial backdrop the college established the FPA. Then covid-19 hit.

Effect of pandemic

As was the case for many organisations, the RCP's income took a significant hit from the covid pandemic and the subsequent lockdowns, which had a severe effect on its exams, events, and education activities.

In 2020 the college lost £11.7m (table 1), a third of its income, which

MALCOLM WILLETT

it attributed to covid (in an email to *The BMJ*). It even considered selling off millions of pounds of rare books from its library collection to plug the deficit. The *Times* reported that the college was forced to sell valuable bottles of wine from its cellar, although the RCP would not confirm this. "I looked through the accounts and I remember I was very unhappy about the state of the finances," says Vaughan. At that point, it was clear the college was in significant financial difficulty, she adds.

In the end the RCP managed to avert a crisis by cutting 28 whole time equivalent staff, but it remained focused on financial recovery in subsequent years. The RCP's accounts show it trying to rein in expenditure but facing further cost pressures resulting from inflationary energy prices (in 2022).

"The college has faced some very significant challenges over the last few years in terms of its finances," Simon Bowman, the college's current treasurer, told the March EGM. But he also explained why backing out or even slowing the college's commitment to PAs did not make financial sense.

He explained, "PAs have to pass a national exam, which, at the moment, the RCP is responsible for. We have a whole bunch of legal contracts that if we . . . are forced to renege on those contracts . . . we know there are going to be very significant legal fees for the college."

Yet although the PA debacle has become emblematic of the RCP's problems, insiders agree it is not the sole or root cause.

PAs were seen as an opportunity Louella Vaughan

What is the RCP for?

The root problem for Vaughan is confusion over the college's identity and purpose: whether it is a membership organisation for doctors as a profession that is mainly about doctoring (which is what she believes) or whether it should be a "thoroughly modern charity," in Vaughan's words, needing to deliver public benefit.

Previous senior leadership teams saw it as the second, Vaughan says, leading them to focus on "justifying its charitable status"—that is, satisfying the UK Charity Commission that it was delivering public good. Setting out the college's public benefits is all well and good, Vaughan says, "but you can't do that at the expense of the membership."

Kar adds that there was a lack of openness and accountability in the way the college council ran affairs. "When I first joined [the council], I noticed that meetings would be completely closed, and nobody could observe them," he tells *The BMJ*. "Why [weren't] the meetings even open to members and fellows? If they paid for the organisation, surely they should know what their elected councillors were talking about?" Kar asked his fellow councillors why and was told, "That's the way it's always been."

Such customs led to an impression of secrecy, identified by the King's Fund review as among its "significant cultural issues." Effective functioning of the council had broken down, the King's Fund found, with meetings where participants thought their contributions were not always welcome. Vaughan says it seemed as though "anyone who dissented, myself included, was told to 'be kind'—which was shorthand for 'sit down and be quiet.'"

How much income did the FPA bring?

The FPA promised a new, regular income stream for the RCP. Figures from the college's accounts show that annual revenue from all PA activity has grown year on year, from just over £1.3m in 2021 to nearly £1.9m in 2023 (table 2).

"PAs were seen as an opportunity," says Vaughan. "They were a way of making money from membership and exams . . . If you start to think about the potential for money to be generated, it's a very substantial amount . . . 1000 people a year taking an exam that costs £500, that's half a million pounds a year, plus annual membership fees for the whole group . . . a substantial sum that is guaranteed annually, with the potential to grow."

Continuing professional development activities were another possible offering for PAs. And Vaughan says that the addition of PAs to the membership justified the RCP's purchase of The Spine in Liverpool as a physical space to sit exams.

An RCP spokesperson says that PA income accounts for less than 5% of the total annual income of the RCP. When asked whether the RCP had regarded PA related activity as, in part, an income stream, the spokesperson said, "The FPA is a faculty managed by the RCP, not a separate legal entity, and therefore does not have its own accounts. Since hosting the FPA in 2015, the financial impact on the RCP has been assessed as broadly cost neutral, with the early years making a small deficit which has been recouped by modest surpluses in more recent years."

The college provided *The BMJ* with figures for recent expenditure on PA related activities (£1 288 206 in 2021, £1 453 210 in 2022, and £1 716 634 in 2023) but would not provide a breakdown of costs. The spokesperson said that "revenue generated via the FPA is used to fund the faculty's operations, including the delivery of the PA national exam. As a registered charity the RCP publishes its accounts, which are available via the Charity Commission."

Table 2 | Income generated by the FPA (£)

	2023	2022	2021
Income			
Membership fees	810 200	640 303	516 030
Conference sales	166 182	111 700	106 875
Exam fees	875 433	750 320	639 570
Grants from HEE	-	-	59 747
Total	1 851 815	1 502 323	1 322 222
Expenditure	1 716 634	1 453 210	1 288 206
Indicative net profit*	135 181	49 113	34 016

*As the RCP does not publish full accounts for the FPA and would not provide a detailed breakdown of costs, this table has been created by *The BMJ* to provide an indication of profits.
Source: RCP

Things came to a head over the PA issue, she says. "When there are legitimate patient safety concerns about the expansion of PAs in the NHS, and even evidence of some patients dying as a result—as the high profile case of Emily Chesterton shows—what do you expect those of us on council to do? Say nothing?"

Chesterton died in November 2022, aged 30, after two appointments at a general practice in north London with a PA who failed to diagnose a deep vein thrombosis. She died from a pulmonary embolism.

The college's internal processes worked against concerns over PAs being taken seriously by senior leadership, says Smith. No forum was available for doctors on the trainee committee to voice an opinion or concern openly, he says. "You had to present your concerns to the hierarchy of the RCP—the president or the registrar—and it would then get filtered, so those concerns may or may not ever get aired," he says. "We weren't even able to produce a statement that could be independently released."

We are working hard to regain the trust and confidence of our physicians
Mumtaz Patel

This situation made the trainees believe that their committee was just a "tick box exercise for the college hierarchy to say they had discussed the issue with the trainees," Smith says.

What now?

Kar says that the college's senior leadership was caught on the hop over the EGM and "how to deal with that level of crisis." But he says that ultimately it has been "cathartic," because it has made the senior leadership "look inwards and reflect."

Conceding that its reputation has been damaged, the RCP has said that it is committed to a "fresh start." On the day the King's Fund review was published, the college accepted its recommendations in full. Acting president Mumtaz Patel said the review showed the college had been "neither listening, nor responding quickly enough, to the questions and concerns being raised by its fellows and members." She said the review called for a "more honest and open relationship with our membership, and one that welcomes constructive challenge rather than avoiding it."

The same day (10 September), at the RCP's most recent annual general meeting, Patel reinforced that message by setting out a new vision for the college's future. "The RCP must become more inclusive, modern, and transparent in how it works with, and for, our members," she said. "We are working hard to regain the trust and confidence of our physicians."

Patel told members she was determined to re-establish the RCP as the voice of medicine, and promised it would deliver constitutional and governance modernisation over the coming months. *The BMJ* approached Patel for comment but was told she was not available.

A spokesperson said the college's financial position is most clearly summarised by its operating position (loss or profit) as shown in its annual accounts. These accounts reported a surplus of £750 000 in 2001, a £483 000 deficit in 2022, and a £784 000 deficit in 2023. "The difference between the net movement in funds and the net operating loss/profit is any movement in the value of investment and pension assets. The value of these assets fluctuates with global markets, some years making an unrealised gain and other years making an unrealised loss." However, the spokesperson added that the college's operating position could "not be wholly explained by the value of investment and pension assets."

The RCP is likely to remember 2024 as its annus horribilis. But with the election process for the next college president under way (for appointment next April), there is an opportunity for it to rebuild trust and its brand as a college that serves doctors.

Kar is quietly optimistic. "The RCP is going through the throes of a much needed modernisation. The last four months, it has been a completely different place—a world apart from where I began—and that is a very important start."

Adele Waters, freelance journalist, London
awaters@bmj.com

Cite this as: *BMJ* 2024;387:q2729