inside medicine

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MATT SAYWELL/BMA NEWS

GMC's PA definition faces legal challenge

Legal representatives of the BMA and the GMC have faced off in the High Court over the appropriate language that should be used when describing physician associates (PAs) and anaesthesia associates (AAs).

The BMA is accusing the medical regulator of abandoning its responsibilities to patient safety by "blurring the lines" between doctors and other health professionals. It is also challenging the GMC over its use of the term "medical professionals," which the BMA argues should be used to refer only to qualified doctors. The GMC, which took over the regulation of PAs and AAs in December, uses the term "medical professionals" in guidance to describe all those it now regulates.

During the hearing at the Royal Courts of Justice in London on 12 and 13 February, BMA lawyers claimed that the GMC's approach was unlawful, that it undermined its statutory functions and objectives, and that it contravened legal requirements.

They also argued that associates were neither doctors nor medically qualified and the distinction was important to patient safety as there was evidence of confusion among the public as to the roles of associates.

Speaking outside the High Court before the case began, Phil Banfield, the BMA council chair, said, "The GMC was set up to make sure that the public and patients understood who a qualified doctor was. Now the GMC, since December, is the regulator of non-doctors as well, and this has led to great confusion. We believe that the GMC has a statutory duty to make it clear what the distinction is between doctors and non-doctors."

Banfield said the GMC's Good Medical Practice guidance placed a duty on doctors to raise patient safety concerns and that the BMA was "quite surprised that the GMC is using public money to defend what we would say is a legitimate patient safety concern."

A GMC spokesperson said, "We have made it very clear we will recognise and regulate doctors, physician associates, and anaesthesia associates as three distinct professions. The registers on our website are clearly marked, to distinguish between the professions.

"From as early as 2021 we made the BMA and others aware of our intention to apply our core professional standards to doctors, PAs, and AAs and received no objections from them. The term 'medical professionals' is not a protected title, and it is an appropriate way to describe all the professional groups we now regulate."

A court ruling is expected in a few months.

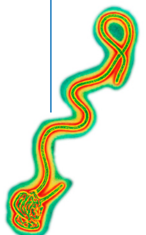
Adrian O'Dowd, London

Cite this as: *BMJ* 2025;388:r322

Phil Banfield, the BMA council chair, outside the High Court, said, "We believe the GMC has a statutory duty to make it clear the distinction between doctors and non-doctors"

LATEST ONLINE

- US health agencies are ordered to reinstate web pages removed after Trump's executive order
- Nordic alcohol restrictions are under threat despite proven success, WHO warns
- Ebola: Uganda launches vaccine trial as cases rise and nurse dies



MEDICAL NEWS

Wales plans to crack down on junk food promotion to tackle obesity

MATTHEW HORWOOD/GETTY

Larger retailers in Wales may be prevented from promoting junk food under government plans to boost healthier eating and reduce obesity levels. If the legislation is approved next month, restrictions will apply to businesses with at least 50 staff from next year.

The regulations, laid out on 11 February, will restrict promotions that can encourage overconsumption, such as multibuy offers and free refills of sugary drinks. They will also restrict the presentation of foods high in fat, sugar, and salt at prime selling locations in stores such as entrances and checkouts and on website homepages.

The Welsh government said restricting sites where unhealthy foods can be displayed can prevent impulse purchases and overconsumption. If approved, there will be a 12 month implementation period before the measures are introduced in March 2026.

The intention is to help reduce the prevalence of obesity in Wales, where around 60% of adults are now overweight or obese, with a quarter of those classified as obese, and nearly a quarter of children are obese or overweight by the time they start school.

Jeremy Miles (left), the Welsh health secretary, said, "We want to make the healthier choice the easier choice. We can do this by ensuring healthier food and drinks are more available, accessible, and visible to people in shops and stores."

Adrian O'Dowd, London **Cite this as: *BMJ* 2025;388:r316**

Mpox

Nine cases of infection confirmed in UK

As of 10 February the UK Health Security Agency had confirmed nine cases of clade 1b mpox in the UK. Mpox was detected in the UK for the first time in October 2024. The ninth case was reported on 4 February 2025 in a person with a history of travel to Uganda. The UKHSA has confirmed that the risk from mpox remains low. NHS England has opened 12 new mpox vaccination sites in England for people who may have an increased risk of getting the infection, such as men who have sex with men and have multiple partners.

Norovirus

Virus is still circulating at double season average

Data from the UK Health Security Agency showed that reports of norovirus from 20 January to 2 February were 17.4% higher than the previous two week period and more than double the five season average for the same two week period. Gauri Godbole (right), UKHSA deputy director, said, "Norovirus cases are still exceptionally high and continue to rise. School half term usually provides a bit of a firebreak, so hopefully we will see a fall in numbers in the next few weeks."

Hospital deaths

Police consider Sussex manslaughter charges

Police investigating more than 200 cases of serious harm and death at the Royal Sussex County Hospital in Brighton are considering possible charges of corporate manslaughter and individual gross negligence manslaughter. The police inquiry began looking into some 40 deaths in general surgery and neurosurgery from 2015 to 2020 but later expanded the investigation to include serious harm and extended the cut-off date to 2021. Cases being examined now total more than 200, and independent consultant surgeons have been asked to give expert opinions on individual cases.

Surgical mesh

Victims are still waiting for compensation

Henrietta Hughes, the patient safety commissioner, has said that women harmed by pelvic mesh implants are still waiting for financial compensation from

the government a year after her report called for redress. Some women were left in permanent pain, unable to walk, work, or have sex after mesh surgery to treat incontinence and pelvic organ prolapse. Hughes said that she was still waiting for a full response to her report, which also called on the government to help women who had taken sodium valproate during pregnancy.

Psychiatry

Lack of academic posts threatens new treatments

A critical shortage of senior academic posts in child and adolescent psychiatry is threatening the development of new mental health treatments, said researchers. A study published in the *British Journal of Psychiatry* showed that the UK and Ireland had only 24 professorships in child and adult psychiatry, which compares with 124 in neurology. This has knock-on effects on research, with only 30 active mental health trials in young people in the UK and four in Ireland. Ian Kelleher, study author, said, "Without this evidence, mental health services are firefighting with blindfolds on."

Medical devices

Shake-up of approval process is planned

NICE has proposed changes to how it evaluates medical devices, diagnostics, and digital and AI health technologies. The shake-up of its HealthTech programme would remove the requirement for medical devices to be cost saving in order to be recommended for use in the NHS. Instead, independent committees will assess all technologies on the basis of cost effectiveness and so will balance the cost of the technology with the benefits it brings to patients and the service, which may include savings or efficiencies. The programme director, Mark Chapman, said that the aim was "to deliver clearer, quicker, and more targeted guidance that fits NHS priorities."

IN BRIEF

Public health

Alcohol "should carry mandatory cancer warning"

All alcoholic drinks should carry prominent health warning labels to highlight the raised risk of cancer from drinking, experts advised. A report from WHO Europe said that mandatory, standardised labelling was needed to tackle a lack of awareness. Hans Henri Kluge, WHO's regional director for Europe, said, "Clear and prominent warning labels empower individuals with vital information to make informed choices about the harm alcoholic products can cause."

WHO has recommended that all alcohol products in Europe carry a health warning

Local authority services get £200m funding boost

The government has announced an extra £200m for local public health services in England for the next financial year. The public health grant, which funds health services and interventions by local authorities, such as sexual health clinics and smoking cessation programmes, will rise to £3.9bn—a 5.4% uplift from last year.

NICE endorses cytisinicline in final guidance

NICE has recommended cytisinicline (also known as cytisine) as a treatment option to help people stop smoking. In updated guidance the regulator said the pill should be considered as an alternative to varenicline, bupropion, nicotine replacement therapy, or nicotine e-cigarettes. Behavioural support should also be offered regardless of which option is chosen, it advised. Cytisinicline works in a similar way to varenicline, reducing the urge to smoke by attaching to some of the same neuronal receptors in the brain that nicotine targets.

Discharge delays

Surgeons demand action to meet targets

Steps are needed to tackle delayed discharges from hospitals to meet the 18 week treatment target, said the Royal College of Surgeons of England. After NHS performance figures showed only 58.9% of patients were seen within 18 weeks in December, the college vice president, Peter Friend, said, "The government must do everything it can to address discharge delays—sooner rather than later. Without decisive action, we risk sinking further into a crisis that leaves both patients and staff struggling to find solid ground."

US news

RFK is confirmed as health department chief

Robert F Kennedy Jr has been approved by the US Senate and sworn in by Donald Trump as head of the US Department of Health and Human Services. Kennedy won by a vote of 52 Republicans to 48 Democrats. Only one Republican, Mitch McConnell of Kentucky, who survived polio as a child and has strongly supported vaccines, voted against him. After being sworn in, Kennedy, who has previously opposed vaccines, said he endorsed measles and polio vaccines. During Senate hearings he said he would follow Trump's agenda and would follow the science regarding vaccines.

Cite this as: *BMJ* 2025;388:r342

NHS DEFICIT

NHS trusts in England had a

£1.2bn

collective overspend in 2023-24, putting healthcare reform plans at risk

[Nuffield Trust]

SIXTY SECONDS ON . . . GUM IN PREGNANCY

YET ANOTHER THING TO AVOID?

Not this time. A large clinical trial in Malawi has indicated that chewing gum containing xylitol during pregnancy can prevent periodontal disease and reduce the risk of premature birth and low birth weights.

AND KEEP BREATH MINTY FRESH?

That too. But more importantly, it is thought that oral infections during pregnancy can trigger systemic inflammation that could affect fetal development. Women with poor gum health are more likely to have pre-eclampsia, premature birth, and underweight babies.

TIME TO BRUSH UP DENTAL HYGIENE

Indeed. However, Malawi, a country with one of the world's highest preterm birth rates, has poor access to dentists and preventive care. Other strategies, such as dental scaling, have proved inconclusive, so researchers decided to look at a simpler, less invasive approach.

A TRIDENT TESTED FORMULA?

It depends on the type of gum. Sugar in chewing gum can cause tooth decay, but sugar-free gum can increase the production of saliva, which helps to wash away food particles and neutralise harmful plaque acids. Xylitol is a natural sugar alcohol that has shown promise in inhibiting harmful oral bacteria and reducing inflammation.

BY GUM! WHAT DID THE STUDY FIND?

The trial, published in the journal *Med*, involved 10 069 pregnant women at eight sites. The control group received routine prenatal and oral health education; the intervention group was also given gum containing xylitol to chew twice a day. The proportion of preterm births in the gum group was 12.6%, below the 16.5% in the control group. Only 8.9% of infants in the xylitol group had a birth weight below 2.5 kg, compared with 12.9% in the other.

IT'S AS EASY AS CHEWING GUM

. . . and cheap. The authors said that to prevent one occurrence of preterm and low birthweight delivery fewer than 26 pregnant women needed the gum.

SOMETHING TO CHEW OVER

The NHS emphasises the importance of good oral health in pregnancy, which is why free dental care is available during pregnancy and the year after the baby is born.

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r273

NHS must fix training for UK doctors before seeking applicants from abroad, says BMA

In my 40 years in the NHS I've never seen a credible workforce plan
Philip Banfield

EXCLUSIVE Doctors in training in the UK feel like a "number on a spreadsheet being shoved around," in a fragmented and "incredibly destructive" system, BMA chair of council Philip Banfield has said.

In an interview with *The BMJ* Banfield said the current training system "is a mess" and "bears no relationship to the workforce needs." He gave the example of there being just 400 anaesthetist training places for between 2000 and 3000 applicants, while the UK is 1900 anaesthetists short. "You have this complete contradiction," he said. "Why not train them now?"

Banfield said much of the problem came down to poor workforce planning and a lack of joined-up thinking, adding, "In my 40 years in the NHS I've never seen a credible workforce plan." He also said that the BMA was not consulted in relation to the latest NHS workforce plan.

The BMJ recently revealed that the total number of applications for specialty training posts had increased from just over 23 000 in 2019 to nearly 60 000 in 2024, while the number of training posts had barely changed, rising by less than 600 (12 175 to 12 743). The overall competition ratio in 2024 was 4.7, up from 3.3 in 2023 and 1.9 in 2019. Although there are no published figures on the number of applicants who do not get a place on any training programme, medical leaders have said that, given the workforce shortages, it should not be this difficult for applicants.

Turning to the recent controversy over training places and international medical graduates (IMGs), Banfield said that as BMA council chair he had encouraged members to have "difficult conversations."

"Prioritise UK graduates"

Last month the BMA apologised for any upset caused after its Resident Doctors Committee announced plans to lobby for UK graduates to be prioritised in applications for specialty training posts.

The BMA then released a clarifying statement saying that the position had not yet been finalised and citing the association's current and longstanding policy that "all doctors currently practising in the UK, regardless of nationality or place of primary medical qualification, should have access

Nottingham trust fined £1.6m for failings linked to three baby deaths

Nottingham University Hospitals NHS Trust has been fined £1.6m plus costs for failings relating to the deaths of three babies who died in its care shortly after their birth.

The trust had pleaded guilty at Nottingham Magistrates Court to six counts of failing to provide safe care and treatment to the babies and their mothers after a prosecution brought by the CQC.

"Significant risk"

Adele O'Sullivan, Kahlani Rawson, and Quinn Parker died within 14 weeks of each other in 2021, soon after their birth. The trust admitted causing a significant risk of avoidable harm to O'Sullivan, Rawson, and all three of the babies' mothers and of actual avoidable harm to Parker at Nottingham City Hospital.

The case was the second prosecution of the trust over maternity failings and marks the first time the CQC has prosecuted a trust more than once. In 2023 the trust was fined £800 000 after admitting mistakes in the care of Wynter Andrews, who died shortly after her birth in 2019.

The trust is at the centre of the largest maternity inquiry in NHS history, led by senior midwife Donna Ockenden, which is reviewing about 2500 cases.

O'Sullivan died 26 minutes after her birth in April 2021, Rawson died aged 4 days in June 2021, and Parker was 2 days old when he died in July 2021.

Families placed their trust in a system meant to protect expectant mothers and keep babies safe—and that trust was broken
Grace Leong

The fine was reduced from £5.5m because of the guilty pleas and the trust's financial position.

The failings in care included a lack of appropriate escalation of care, inadequate cardiotocography monitoring, and failure to deal properly with a placental abruption.

District judge Grace Leong said the "catalogue of failures" in the trust's maternity unit were "avoidable and should never have happened." She said the families had "placed their trust in a system meant to protect expectant mothers and keep babies safe—and that trust was broken."

Trust chief executive Anthony May said in a statement, "The mothers and families of these babies have had to endure things that no family should after the care provided by our hospitals failed them, and for that I am truly sorry.

"Today's judgment is against the trust, and I also apologise to staff who we let down when it came to providing the right environment and processes to enable them to do their jobs safely."

May added that the trust had implemented changes to improve maternity services, which had made the working environment safer and more effective than in 2021.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;388:r308

NHS PHOTO LIBRARY

BANFIELD: The current training system "is a mess" and "bears no relationship to the workforce needs" . . . The UK is short of 1900 anaesthetists

to training opportunities, prior to recruitment from abroad."

Banfield said, "That is one of those conversations resident doctors have had about how we deal with the ridiculous bottlenecks in training that see our own foundation doctors unable to progress into specialty training. That then becomes difficult. Who should fill those places?"

Banfield's comments came days before the Royal College of Physicians released a position statement calling for the UK nations to review postgraduate medical training because early career doctors were "worried about their future" and whether they will be able to secure an NHS training post.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2025;388:r328

Judge temporarily blocks Trump's NIH research cuts as 22 states sue

A federal judge in Massachusetts has temporarily blocked Donald Trump's proposed cuts to National Institutes of Health research funding after 22 US states filed a temporary restraining order.

The states involved include Massachusetts, New York, California, and North Carolina—all of which are top recipients of NIH funding. The court application came after the Trump administration announced on 7 February it would cut funds for medical research, as part of plans to reduce government costs and to end "diversity, equity, inclusion" schemes.

The issue is now likely to play out in the courts and may reach the Supreme Court before it is resolved. Trump has said he would abide by court rulings he agreed with and would appeal those he disagreed with.

The NIH is the world's largest public funder of biomedical research. It has a budget of nearly $48bn (£38.7bn), used for research at its own centre and distributed through grants and contracts to researchers at universities.

Trump aims to cut government costs and said he would reduce the amount of overhead costs in NIH grants to 15% to save about $4bn. Grant funds include the overhead support that researchers need to keep the lights on, provide laboratory supplies, and employ support staff. Support funds can amount to as much as 30% of funding.

The NIH said that last year about 20% of the funds institutions received went to indirect costs, although that may be as high as 50% in some places. Opponents said universities with large endowments could easily cover the costs.

Speaking to PBS NewsHour, David Skorton, head of the Association of American Medical Colleges, said the costs were crucial to enabling research. He said, "Not paying these reimbursable costs will cause research operations to stop. The lights will go out, the people will be let go, and these advances will not occur, and people will not get the lifesaving benefits of medical research."

Janice Hopkins Tanne, New York

Cite this as: *BMJ* 2025;388:r303

Doctor who ran Letby trust wins tribunal

A doctor who was chief executive of the NHS trust that employed the nurse Lucy Letby is expected to be awarded a seven figure sum in compensation after an employment tribunal ruled she was forced out of her job for blowing the whistle on bullying by the trust's chair.

Susan Gilby became acting chief executive of the Countess of Chester Hospital NHS Foundation Trust in August 2018, during the police investigation into Letby, who was later convicted of killing seven babies and attempting to murder seven others. Gilby was appointed to the substantive post in April 2019.

A former consultant in anaesthesia and intensive care, Gilby initially alleged that finances at the cash strapped trust were being put ahead of patient safety. She complained to the trust that Ian Haythornthwaite, an accountant who became chair in 2021, subjected her to intimidating, aggressive, and undermining behaviour, and that he bullied other, more junior, employees.

Project Countess

The trust did not investigate his behaviour, but instead Haythornthwaite, human resources director Nicola Price, and two non-executive directors, Ken Gill and Ros Fallon, colluded to engineer Gilby's exit, in an operation called Project Countess, the tribunal found.

Although Gilby had received positive appraisals, and there was no evidence of gross misconduct or poor performance, in December 2022 she was prevented from accessing the documents and emails necessary to build a defence. This also gave the trust "time to permanently delete and destroy documents," including "excellent" appraisals, said employment judge Dawn Shotter.

It was incredibly low behaviour, designed to frighten me off
Susan Gilby

Haythornthwaite had a deliberate intention to hide documents that would have thrown light on the true part he played in the termination of Gilby's employment, said the judge. She added that Price, Fallon, and Gill were also "inaccurate historians and did not give credible evidence on a number of key matters."

Gilby was offered a settlement on condition she withdrew her allegations, but she refused, stating in an email it was an "absolute red line for me . . . If this means there can be no settlement agreement then so be it."

The trust contacted the GMC to ask whether the regulator wanted to take action against Gilby, a "veiled threat aimed at stopping her in her tracks," said Shotter. Gilby told *The BMJ* she had been "outraged" by the move, which she described as "incredibly low behaviour," adding, "It was designed to frighten me off."

A compensation hearing will be held in May. The trust will thoroughly review the judgment, a spokesperson said.

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2025;388:r339

Warning of “significant” impact on GPs of online pharmacy weight loss drug checks

New restrictions and safety checks on online pharmacies that prescribe high risk drugs such as the weight loss drugs semaglutide and tirzepatide could have a “significant” effect on GPs’ workload, primary care leaders have warned.

Under new guidance from the General Pharmaceutical Council (GPhC), online pharmacies can no longer dispense weight loss drugs to patients purely on the basis of an online questionnaire or photos. As part of stricter checks, pharmacies will now have to independently verify the information provided by the patient, including by checking with their GP.

Workload concerns

Although the restrictions have been welcomed by GPs’ leaders, who are concerned about inappropriate use of these drugs, they have also raised concerns about workload.

According to the Medical Defence Union, GPs have been increasingly asking for advice on disclosing patient information to online pharmacies in relation to weight loss drugs. The MDU said GPs were being put in a difficult position, because they were concerned about having to rely on the pharmacy’s reassurance that a patient had consented to their information being shared. GPs also risked encountering discrepancies between what the patient had told the pharmacy and their own records, especially in relation to the patient’s BMI or medical history, the MDU said.

MDU medicolegal adviser Ellie Mein said, “Our advice is that, if it becomes clear there may be a risk to the patient in receiving the medication, GPs will need to discuss this with the patient and check if they agree to this being shared with the pharmacy. If the patient objects, GPs will need to explain this to the pharmacy, and it will then be for the pharmacy to consider whether the prescription is appropriate.”

If it becomes clear there may be a risk to the patient in receiving the medication, GPs will need to discuss this with the patient
Ellie Mein

Mein noted that investigating these requests will place an “additional burden on GP practices at a time when they are already under strain.” Despite this, she said that “if there isn’t a robust system in place to gather relevant information before a prescription is provided, patients could be at risk and prescribers vulnerable to criticism and medicolegal investigations.”

The MDU has also advised GPs to “make it clear to pharmacies that a general review of the patient’s notes may not capture every relevant consideration the prescriber may need to know” and that the prescriber would “need to go through the patient’s online records with them so they can satisfy themselves they are prescribing in line with the guidance from their regulator.”

Last year the European Medicines Agency said people were increasingly using GLP-1 RAs for cosmetic use, and the UK regulator, MHRA, has also warned people against obtaining pre-filled pens online that claim to contain the prescription only weight loss drugs after a small number of people were admitted to hospital after using fake pens.

Responding to the GPhC’s guidance, Kamila Hawthorne, chair of the Royal College of General Practitioners, said, “It is encouraging to see the GPhC strengthening its safeguards for patients, making it harder to access weight loss medications inappropriately.

“While these drugs can be beneficial for some patients, the college has been concerned about reports of patients acquiring weight loss medication without appropriate checks and balances or proper medical oversight, which comes with the risk of serious side effects.”

However, Hawthorne said the extra steps posed “ethical considerations for GPs” and were likely to have a “significant impact on their time.” She warned, “An influx of requests for information will only intensify unmanageable workloads.”

Hawthorne has argued that the responsibility to ensure a patient has given consent for their GP to share information should fall on the private provider, as should the responsibility for “interpreting any information they have access to or that the GP shares, for example the summary care record, and communicating this, including the risks associated with taking weight loss medication based on their circumstances, with the patient.”

In October Londonwide LMCs, the body that represents the capital’s GPs, issued a template letter to help them respond to, and reject, requests from private providers such as online pharmacies. It said its review of the many requests received by members suggested that a “failure to respond could essentially be deemed as ‘tacit confirmation’ that the patient has no contraindications to the treatment.”

LAST YEAR the EMA said people were increasingly using GLP-1 RAs for cosmetic use

The statement said, “Given the majority of patients have full online access to their health records, it is fair to state that the practice/GP is unable to confirm if the patient has any contraindications to the medication and suggest the private provider review the patient’s medical records with them (with the patient’s consent) to determine if the medication is appropriate for them to prescribe.”

The organisation had also suggested that practices could “contact the provider directly to politely explain the difficulties that such requests present and try to agree a shared understanding as to how the matter may be resolved.”

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2025;388:r295

RACISM IN MEDICAL SCHOOLS
Are things improving for students?

EXCLUSIVE Five years ago a BMJ investigation revealed poor monitoring and responses to complaints of racism within university medical departments. **Gareth Iacobucci** repeated the exercise to see whether any progress has been made

When *The BMJ* asked UK medical schools in 2020 whether they recorded students' complaints about racism and racial harassment, half of the schools said they did and that between them they'd counted 11 such complaints in 10 years. Students from ethnic minority groups told *The BMJ* the depressingly familiar reason for such a low figure. "What's the point of reporting?" was their conclusion, as nothing is done about it.

Five years on, the landscape is very different. A global pandemic highlighted the possible links between discriminatory practices in the NHS and the higher proportion of deaths among ethnic minority doctors, nurses, and patients than among white staff and service users. A BMA charter, launched with the 2020 investigation and now widely adopted, aims to help medical schools "prevent and effectively deal with racial harassment." The Black Lives Matter movement, which started in 2013 but gained global prominence in 2020 after the murder of George Floyd by a Minneapolis police officer, has also raised awareness of the wider societal problem of racism.

Another round of freedom of information requests by *The BMJ* to the UK's 46 medical schools has now found that four fifths are collecting data on complaints about racism: of 41 schools that responded, 34 (83%) said they did. And the number of complaints logged has risen to at least 138 in five years.

It's hard to say whether this rise is significant as there are no comparable data about racial incidents reported among ethnic minority undergraduates generally. But the number of 138 seems small, given that almost half (49%) of the UK's 50 000 or so medical undergraduates are from ethnic minority groups. The number of reports has risen from one a year before 2020 to an average of at least 28 a year.

The increase in complaints could indicate that people feel more confident to report issues
Olamide Oguntimehin

But even still, it is a sign of progress, said Olamide Oguntimehin, a resident doctor working in Kent and the founder of Melanin Medics, a group that supports students and doctors from the Afro-Caribbean community. It could reflect a growing willingness among students to speak out, she said.

"I think under-reporting has always been an issue," she told *The BMJ*. "While the increase in complaints may seem concerning at first glance, it could also indicate that people feel more confident to report it, because they trust or hope that there'll be action taken or support provided as a result."

Ria Bansal, the BMA Medical Students Committee's co-deputy chair for student welfare and in her fourth year at the University of Nottingham, told *The BMJ* she believed that since 2020 racial harassment and racism had become less of a "taboo topic" and that grassroots activism by ethnic minority students and doctors was holding medical schools more accountable.

The committee's other co-deputy chair for student welfare, Akshata Valsangkar, a fourth year medical student in Bristol who is currently intercalating, agreed but said she hoped that in the future universities would be more proactive in leading on change. "Hopefully, it will be more that universities reflect on policies and data and make changes themselves rather than needing the victims to speak out," she said.

Although collecting data was a "really important first step," the way data are used is crucial, she added.

Lois Haruna-Cooper, associate professor at UCL Medical School, who sits on the school's equality, diversity, and inclusion (EDI) committee, said that under-reporting was definitely still an issue, particularly among those on clinical placements, despite efforts to support students who wish to make complaints.

"Students are always reluctant,"

Black Lives Matter protesters outside the US Embassy in London in September 2020

TOLGA AKMEN/AFP/GETTY

There's always fear, especially if it pertains to part of their identity, where they feel very visible Lois Haruna-Cooper

she said. "There's always fear, especially if it pertains to part of their identity, where they feel very visible. Even if it is an anonymous report, if it's to do with racism and they are the only student of colour in a placement, then they feel like no matter how anonymous it is it will come back to them."

She said that officers who handle complaints can try to mitigate concerns about anonymity, such as by waiting until the end of a clinical rotation or placement to take it further. But "there are still ongoing challenges that we continue to try and address."

Clare Owen, director of the Medical Schools Council, said the council was pleased to see that the number of schools reporting that they collect data on complaints has increased. "This is something that we encourage, and we are aware that schools are working hard to implement the BMA charter on racial harassment.

"We would encourage students to report any experience of racism, harassment, or discrimination of any kind from staff or patients while on placement, as this allows schools to offer support and action on the issue as well as develop a picture about the training environment and culture."

Clinical placements

The issue of how medical schools support students who experience racism or harassment while on clinical placements is a longstanding one.

The BMJ's 2020 investigation found that responsibility for handling complaints during students' clinical placements was not always clear. The latest figures suggest that this issue has not gone away. Although most schools have published protocols for dealing with students' complaints about racism or harassment within university grounds, these typically don't cover students working on placements in hospitals or general practices. When asked to give details of their specific agreements with placement providers on how complaints are handled, some schools sent links to generic documents such the NHS's national "tri-partite agreement" for undergraduate medical education.

Something that needs a bit more attention is the reporting outcomes Ria Bansal

SIMON DACK NEWS / ALAMY

Medical schools that sign the BMA charter commit themselves to improving their complaint reporting and handling processes. They also agree to set clear expectations for how those who run placements deal with racial harassment on placements, provide more support to medical students who want to speak out, and ensure that students have an individual to whom they can speak confidentially.

An example of action taken in this area is the University of Bristol's "speak-up guardian" project (see box), which Valsangkar said had made a "massive difference."

But despite signs that medical schools are increasingly engaged with the issues, Haruna-Cooper said that the "buy-in and the support that people receive can vary quite a lot."

She told *The BMJ*, "Sometimes, unfortunately, this is just down to resourcing. How many staff members you have, how available they are, how many other duties they have, and how much time they can afford to support them with it can sometimes be a challenge."

Bansal said students' experience "varies massively" by trust, institution, and medical school. "Students might say that some medical schools deal with racism, harassment, and complaints better than others. I think something that needs a bit more attention is the reporting outcomes. When a report is made, what actually happens at the end?"

Not a one-off exercise

Medical leaders also said that emboldening students to speak up in the face of abuse was not just a one-off action. Haruna-Cooper said, "One of the things I'm always cognisant of is, although we've done a lot of work and we think we've done a great job publicising it, every year there's a whole new cohort of students and this needs to be an ongoing cycle.

"It's something that we've embedded in our introductory weeks, and even though they receive it in year 1, they receive the information again at repeated points during their degree, because we know that students forget, or sometimes it's not relevant to them when they enter a new environment. For example, going from the university into clinical settings, they might encounter more challenges."

Bansal said that in the context of recent societal incidents such as the 2024 riots led by far right groups, ethnic minority medical students needed more support than ever from their medical school. "I know the riots really affected ethnic minority students and how they felt like going

A counterprotest against a far right march in Brighton last August

into placements," she said. "I myself felt a lot more worried than usual about going into placement and what I might face."

Overall, Haruna-Cooper said she has mixed feelings about how much improvement there has been in tackling racism and racial harassment. "There's definitely a sense of accountability from organisations, but also from students, and I think that is a huge, huge pull," she said.

"Students are expecting more in terms of things being done to tackle racial discrimination and harassment, and it's helpful to push medical schools to take this on board and make sure it's embedded properly throughout what they're doing."

But she said success won't come from medical schools taking action in isolation. "We hold medical students for a relatively short proportion of their time. They go into the NHS—and that's lagging behind quite significantly.

"If a student experiences racial harassment from a doctor or nurse or someone within the clinical environment . . . we can hold them accountable and have conversations, but we don't have the same level of authority to steer that disciplinary process as we do if it was a lecturer within the medical school," she said.

"Unfortunately, it's not within our power to do everything that needs to be done. Do I think things are moving in the right direction? Yes. But the movement is still relatively slow."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;388:r312

The issue of how medical schools support students who experience racism or harassment is longstanding

HOW MEDICAL SCHOOLS ARE TACKLING RACISM

Some 80% of UK medical schools (34 of 41 that responded) told *The BMJ* they had adopted the BMA's charter and guidance for students to prevent and effectively deal with racial harassment. The seven that hadn't said that they were aware of its contents and were following principles as part of their own policies on equality, diversity, and inclusion. Among those that had acted were the following.

UCL

In 2021 University College London Medical School added "racial discrimination" as a coding option on its reporting form to allow students to indicate this type of complaint. Students also have the option of describing their experience in writing.

Lois Haruna-Cooper, associate professor, explains, "It's not up to the staff member who's receiving [the complaint] to say, 'I think this is something that's racist.' The student can say, 'This is what my experience was.' Then, when we're collecting the data, it's not subjective, there's no uncertainty about it." Collecting this information helps identify patterns or trends in certain departments or clinical sites, Haruna-Cooper added.

Leicester

In March 2020 staff and students set up the MedRACE group in response to the BMA's charter. Mashuda Khandokar (left), a foundation year 3 doctor and former Leicester student still involved in the group, told *The BMJ* that it offers to act as an intermediary to ensure complaints are acted on. "Students can either put in a feedback form or come to the team at MedRACE, and we can channel it through the right people to make sure those behaviours don't happen again," she said, adding that the group has also helped redesign complaint forms, introduced active bystander training, and pushed for a more racially inclusive curriculum.

Bristol

Bristol University has appointed speak-up guardians to guide students on how to report incidents when working on NHS placements. Its scheme provides bystander training for staff and students on how to intervene in situations of racial harassment or discrimination. It also provides bias training for NHS staff, communication skills training for students, and webinars led by students that focus on issues faced by staff and students and that advise on how to tackle them.

WHAT STUDENTS TOLD US

Yaseen Yousaf, third year medical student, Warwick

"I was the only ethnic minority student in the teaching group. The patient was excited to see the other two students and said, 'Finally, I get to see two white doctors.' It was my go to do the patient history. The patient was reluctant to answer my questions and was talking to me about how they haven't seen any white doctors.

"I didn't report it. I didn't think it was a big issue at the time, and I thought that if I reported it nothing would be actioned. The medical school is quite open about reporting things and raising issues and concerns. I just think it's such a deep ingrained thing within the NHS where if you're an ethnic minority healthcare worker . . you're expected to just ignore things and carry on.

"I think that's what led to staff members telling me that these things happen all the time. Generally, the culture is not to report things like that unless it's really, really serious."

Akshata Valsangkar, fourth year medical student, Bristol

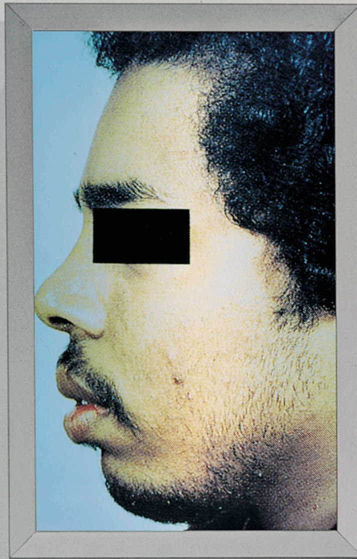
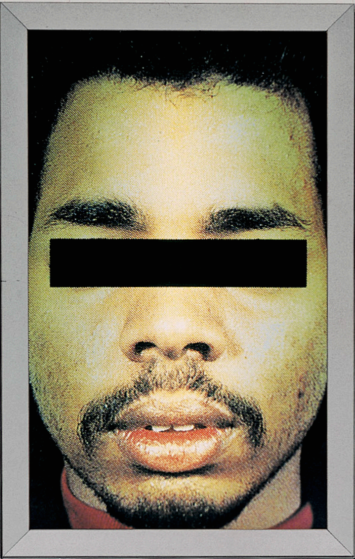
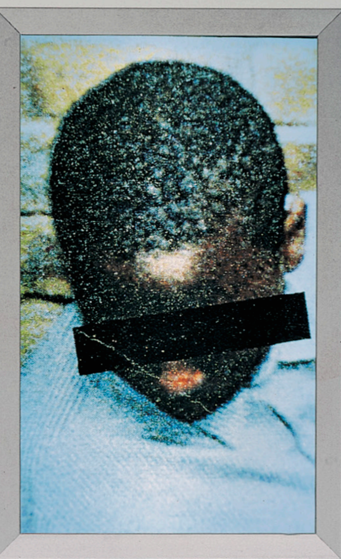
"I experienced a microaggression. Previously, in other workplaces, I would have just let this slide, I would have just said, 'There is no evidence, there's no point in talking about it.' But before we started our placement our tutors made it really clear that this is unacceptable and mentioned that they are doing work to support this with the university.

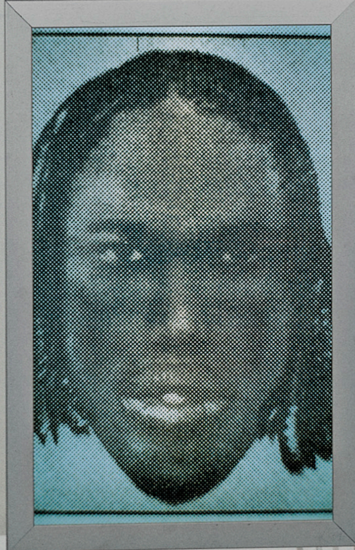
"So even in an NHS trust I felt really comfortable going to my tutor. But I don't know if this is the case for every hospital. I think this needs to be the experience for everyone."

Anonymous medical student

"In my first year of medical school I was watching a lecture on the evolution and mechanism of gait. The lecturer had a slide that used images of bonobos next to images of people of various indigenous African tribes, to draw a parallel. I emailed them explaining why it was inappropriate. They emailed me back a very long, condescending email talking about anthropology and science of evolution and not once apologising. Afterwards, I pushed for a formal complaint, but the medical school closed it, as the lecturer had 'apologised.'

"I did not feel supported. I felt I was being actively targeted for speaking out and making a 'fuss.' The slide was removed but nothing else came of it. I would likely never attempt to submit a complaint or speak to faculty again about this."



1

THE BIG PICTURE

Visceral art reflects pain of disease and racism

A major London gallery has launched an exhibition of the late artist Donald Rodney's multimedia work, much of which was informed by his experience of living with sickle cell anaemia.

Rodney, who was a founding member of the pioneering BLK Art Group, died in 1997 at the age of 36 from complications of the illness, one of the fastest growing genetic diseases in the UK.

The show details Rodney's use of his own x ray pictures, fake blood, and the motif of a canker sore as a metaphor for the illnesses and injustices of society at large.

Donald Rodney: Visceral Canker runs at the Whitechapel Gallery in London until 4 May

Alison Shepherd, *The BMJ* Cite this as: *BMJ* 2025;388:r347

2

3

1 ***Self Portrait: Black Men Public Enemy*** **(1990), from the Arts Council Collection, Southbank Centre, London**

2 ***Psalms*** **(1997) and** ***Cataract*** **(1991), an installation view from** ***Donald Rodney: Visceral Canker*****, Spike Island, Bristol,**

3 ***The House that Jack Built*** **(1987), from Sheffield Museums**

DONALD RODNEY ESTATE; LISA WHITING

EDITORIAL

Surgical hubs to reduce waiting lists

Ringfenced surgery comes with funding, staffing, and ethical considerations

With long NHS waiting lists, the UK needs innovation to tackle a backlog of surgical cases.[1] One solution is surgical hubs[2]—networks of protected beds and staff to provide high volume, low complexity elective surgery.

Surgical hubs are a key component of the government's pledge to reduce waiting lists in 2025.[3] Ninety hubs already exist across NHS England, and a further 40 are planned over the next three years.[2] To qualify as a surgical hub a centre must perform planned surgery exclusively, ringfence staff and facilities, and operate 48 weeks of the year, six days a week, and at 85% theatre utilisation.[2]

Using hubs separates workstreams, in theory enabling scheduled care to continue unimpeded by unscheduled demands such as increased emergency admissions because of seasonal viruses or extreme weather.[5] The impact of hubs in an overwhelmed healthcare system is, however, unclear. Their potential is limited by availability of staffing and resources, the need for better organisation of preoperative pathways, and ethical considerations.

Between April 2021 and March 2022, trusts with established hubs carried out 51 000 (11.2%) more procedures than predicted had they not had a hub.[6] But evidence is lacking that hubs are more economical per procedure than a main hospital, especially given the capital investments needed to set them up. Moreover, trusts able to implement hubs immediately after the pandemic had more resources available, including staff and intensive care beds, limiting extrapolation.

Requirements for success

To unlock their potential, surgical hubs will need substantial capital and investment in infrastructure, equipment, and people. In 2024 the Treasury pledged £1.5bn for hubs and scanners,[7] which could support 40 000 elective appointments a week.[7] However, hubs will also need the promised investment in primary care to support management of chronic health conditions and preoperative pathways.[8]

MARK THOMAS

Selecting and preparing patients for the hub pathway is a resource intensive process

The BMA reports 7768 medical vacancies[4] in secondary care and the Nursing and Midwifery Council declares around 48 000,[9] representing 10-12% of the workforce. Ringfencing staff for new work streams such as hubs may increase the workload for others. This may contribute to burnout,[10] particularly if hubs are implemented without collaboration between management and frontline staff. Requiring people to work six days a week—especially without a Saturday premium—could damage goodwill.

Ramping up surgery will mean greater need for effective preoperative assessment to determine which patients are suitable for hub treatment. Surgical hubs generally have limited access to inpatient beds—especially critical care—so it is important to identify which patients are appropriate to follow this pathway and then optimise them for elective surgery. Such assessments also help to avoid some of the tens of thousands of last minute cancellations to elective operations that occur every year[7,11] by ensuring patients are fit for surgery and identifying problems early.

Selecting and preparing patients for the hub pathway is a resource intensive process, with more patients needing blood tests, heart scans, face-to-face consultations, medication amendments, and often iron transfusions for anaemia. This will mean greater pressure on primary care,[12,13] where the resources to manage this extra workload are limited.[14] NHS England proposes improved information sharing between primary and secondary care to enable early screening and identification of perioperative risk.

Sharing patient health records, test results, consultations, and lifestyle factors (eg, smoking) will give clinicians a full picture of the patient's health and highlight risk factors such as uncontrolled hypertension, diabetes, and obesity. This enables early intervention and patient education and could reduce complications and improve patient outcomes. Furthermore, sharing information in this way would reduce health inequalities by ensuring that all patients, regardless of socioeconomic background, have equal access to presurgical optimisation and resources.[15]

Hubs remove patients who need low complexity surgery from waiting lists and might enable more complex cases to be managed within existing services. However, high volume, low complexity operations are generally day case procedures that favour younger, fitter patients. Hubs might therefore represent a barrier to healthcare in some populations and areas with higher socioeconomic deprivation.[17]

Innovation is welcome in an era of expanding waiting lists, but evidence to support the widespread implementation of surgical hubs remains to be collected. More research on its long term viability and effectiveness is needed before it is confidently expanded.

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EDITORIAL

Labour's 10 year plan for the English NHS

Government must provide hope, clarity, and investment

The NHS is in crisis after a decade of austerity, covid-19, and political failures since 2010 that weakened the health service and constrained what it could deliver.[1] Patients are suffering—for instance, as they wait too long for hospital care.[2 3] The new government has promised to recover services and transform the NHS, and is producing a 10 year plan for how this will be done.[4] The plan, due this spring, will set out reforms to achieve three "shifts" in services: more community based care, prevention, and use of digital technology.

The NHS has a long history of producing long term plans, with mixed results. The NHS plan in 2000,[5] for instance, formed part of a broader programme of investment and reform that contributed to big improvements under Labour governments over a decade.[6] The five year view in 2014,[7] meanwhile, focused on developing "new care models" but was crowded out by growing pressures on services amid a decade of austerity.[8]

What should the latest plan do? First, government must provide hope. The health secretary, Wes Streeting, has declared the NHS "broken."[9] Labour's political story now needs to turn to the strengths of the NHS and clear direction for change. Any vision for the future must be combined with the confidence it can be realised. Government's public engagement on the plan may help.[11] But Streeting's "targets and terror" approach, such as threats of sacking managers, risks undermining the support needed in the service to make the plan happen.[12]

CHRISTOPHER FURLONG/GETTY IMAGES

Improving care and productivity is hard in crumbling buildings

Making limited funding count

Second, the plan must prioritise. NHS plans tend to suggest everything will get better, everywhere, all at once. But if everything is a priority then nothing is. And there's not enough money anyway. Health spending is rising but growing pressures—for instance, from pay increases—will eat up a chunk of extra spending.[13] The broader outlook for public finances is gloomy.[14]

Improving primary care should be high on the list. People are struggling to get appointments, and continuity of care is declining.[15] Priorities include recruiting and retaining more general practitioners, better integrating GPs and other primary care staff, and fixing pervasive operational failures.[16] This will take investment. Successive governments have pledged to shift resources from hospitals to the community. Yet the flow of NHS resources since 2000 has gone in the other direction.[17]

Hospitals risk remaining the overriding priority. The prime minister has pledged that by the end of parliament 92% of patients will wait no longer than 18 weeks for routine hospital treatment.[18] Making it happen will require substantial resources.

Third, policy makers should focus on how change will happen. Recent plans have been weak on how care will improve.[19] Streeting's focus on league tables[20] and rewarding higher performing trusts[21] sits oddly with the new NHS structure based on organisational collaboration.[22]

A mix of policy levers can be pulled to guide the system in a new direction. For example, NHS targets shape what gets done but are skewed towards hospitals. The NHS payment system is a complex mess of conflicting incentives and is ripe for reform. But none of this will make much difference unless policy makers strengthen the NHS's capacity to innovate and improve in response—for instance, by developing the capabilities to identify, implement, test, and spread promising service changes.[23] This includes time and resources, skilled managers, and data analytics.

A stronger national approach is also needed to shape the development of new technology to benefit the NHS—rather than just shift towards adopting it. As a national system with a single payer structure, the NHS should fund and evaluate totemic innovations in a coordinated way. One priority should be technology that could free up clinicians' time—for instance, by automating administrative tasks.[25]

Fourth, the plan needs cash. Labour has emphasised policy change—"reform"—over investment.[26] But increased spending is often a major driver of NHS improvement. Labour's NHS reforms in the 2000s were backed by real terms funding growth of almost 7% a year.[27] Policy change—like targets and performance management—helped make use of extra spending.[28] Capital investment—in buildings, equipment, and IT—will be essential this time around. Improving care and productivity is hard in crumbling buildings and with outdated equipment.[30 31] Yet the NHS's maintenance backlog—including urgent repairs to avoid serious injury—stands at £13.8bn.[32]

Finally, the plan needs to go with broader policy change to improve health. The social care system in England is a threadbare safety net failing too many people and adding pressure on hospitals.[29 33] Government has promised a plan reform after an independent review,[34] but this may mean reform is ducked or delayed (again).[35] A cross-government strategy for reducing England's vast health inequalities is also needed. A plan for the NHS will not be enough on its own.

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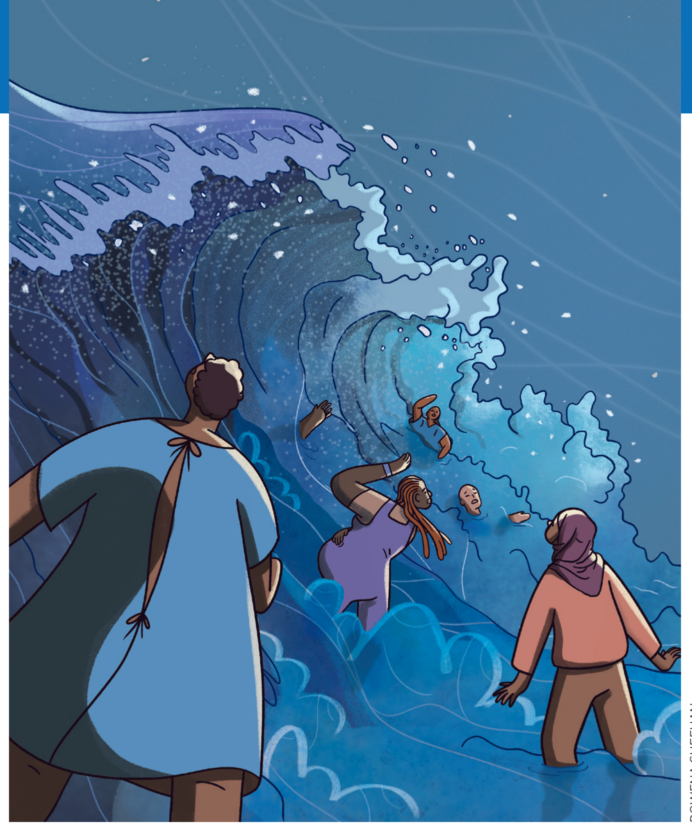
HEAD TO HEAD

Has racism in medicine improved since 2020?

Five years on from The BMJ's special issue on racism in medicine—and after a global pandemic—has anything changed in the NHS and UK medicine? **Mala Rao** sees shoots of hope, but **Victor Adebowale** argues that any progress still has a long way to go



ROWENA SHEEHAN

We're seeing small steps in the run-up to a jump

Mala Rao, director, Ethnicity and Health Unit, Imperial College London
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The BMJ's special issue in February 2020 marked a turning point in race equality in the NHS and changed the face of equality, diversity, and inclusion (EDI) in UK healthcare.

Ethnic minority staff have gained voice and feel sufficiently emboldened to demand to be heard. Tista Chakravarty-Gannon, head of outreach, strategic delivery, and national engagement at the General Medical Council (GMC), says that this is a transformational change because "you can't fix what you can't say." Talking about EDI has become normalised, she says, and there can't be a more powerful and effective place to start this journey.

Contrasting sharply with past decades of indifference, we've seen demonstrable progress since 2020. For the first time in NHS history, the need to welcome and value international medical graduates (IMGs)—a beleaguered group who have nevertheless played a key role in delivering NHS healthcare—has been acknowledged. In 2022 a comprehensive induction programme aimed at integrating IMGs into life in the UK and the NHS was introduced, which also helps ensure greater patient safety.

Racism is the most common form of discrimination against specialist, associate specialist, and specialty (SAS) doctors and locally employed doctors in the NHS. This sizable and increasing proportion of the workforce (most of whom are IMGs) has a history of being underappreciated "gap fillers," with few entitlements for career enhancement or recognition of the experience and value they bring to healthcare. But Robert Fleming, a founding member of a group of SAS doctors who launched a roadmap for improvement, says that changes under way since 2021 are offering this highly deserving group greater autonomy, better terms of work, and opportunities and flexibility for career advancement.

The NHS landscape has changed beyond recognition

Greater fairness towards ethnic minority staff has translated into consistent improvements in employer complaints and GMC referrals. Importantly, data show that this trend could continue to a point where there's no significant disproportionality in referrals.

There are also promising signs that differential attainment in specialty training is narrowing, according to data on specialty trainees' performance at annual reviews of competence progression and exams. These improvements are testimony to the commitment, enthusiasm, and work of senior staff in educational roles, who have felt more encouraged to tackle these variations in the past five years.

Antiracism for healthcare equity

Change is evident on several healthcare fronts, with students, postgraduate trainees, and senior staff joining forces to challenge conventional practice and relegating to history the many clinical norms and guidelines that have undermined diagnoses and care of ethnic minority people.

Successes to date include greater racial diversity in resources for diagnosing skin conditions and the removal of ethnicity adjustments to kidney function testing from the NICE guidelines on diagnosing and managing chronic kidney disease. These unvalidated adjustments had undermined the accuracy of kidney function estimates in black people for many decades.

These successes may be linked to steps being taken to tackle racism and exclusion in medical schools. An EDI Alliance has been launched by the Medical Schools Council, bringing all UK medical schools together with the GMC to implement bold proposals, ranging from recruitment and selection to the learning environment, and working with students who have been clamouring to diversify curriculums.

Trends in publications highlight a notable and steep increase in research papers

on racism and health in the high impact UK medical journals since 2020. Trust and confidence among ethnic minority communities in health research and healthcare delivery are being gained by innovative research teams and at last being recognised as a significant contributor in breaking structural barriers to tackle racism.

Encouragingly, the National Institute for Health and Care Research—the UK's main funder of health research—has acknowledged the historical neglect of ethnic minority communities in health research and, in a landmark move, made inclusion a key condition of research funding.

Better leadership

After *The BMJ*'s 2020 special issue there could have been no better display of empathetic leadership than that shown by the then chief executive of NHS England who, in response, announced funding to establish a Race and Health Observatory.

Simon Stevens's lead has inspired an upsurge of activism and leadership at the front line of healthcare, with medical staff taking the initiative to lead antiracist action through their many spheres of influence—as senior clinicians, educators and mentors, members of policy committees, or simply as doctors, with large networks of allies minded to drive positive change.

Further, there's been a modest increase in ethnic minority representation in medical leaders on the NHS board, in NHS trusts, and at some medical royal colleges.

True equity across ethnic groups will take many years to achieve. But the NHS landscape has changed beyond recognition, and action to root out racism and discrimination is stronger than ever.

Five years on there has been change, but it's not enough

Victor Adebowale, chair, NHS Confederation
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In the five years since 2020, has racism in medicine improved? The answer is yes and no.

The response from Simon Stevens, then NHS chief executive, to *The BMJ*'s special issue was to support the Race Health Observatory (RHO) set up by me, Yvonne Coghill, Mala Rao, and others.

This had been an idea long before the special *BMJ* issue, but it was through those pages that Stevens was alerted to it and subsequently committed funding. Launched during the covid pandemic, this was a notable act of systemic and value driven leadership, given that no other body responded to my original proposal to establish the RHO in 2017.

The RHO has gone on to move the needle on several issues relating to racial equity in the NHS and healthcare, starting with its first piece of work on pulse oximetry and going on to reveal the shocking inequality in maternal mortality outcomes among black women. This is certainly progress, along with the work of the Medical Workforce Race Equality Standard and other interventions. It's also true that ethnic minority staff and students have been empowered to speak out more against racism because of *The BMJ*'s coverage.

However, I remain frustrated at the lack of systemic progress. I can't say, hand on heart, that raising the discursive temperature alone has led to the kind of shift across the system that I'd like to see. This article doesn't afford me the space to go into the challenges faced by the RHO in its operational environment, but when I tell you that abolishing the RHO featured in a political party's manifesto during last year's general election, I think that you'll get my drift.

The NHS and healthcare don't exist in a vacuum, and recent events in the US—and indeed the mood in Europe—risk reversing the small gains made in healthcare and in society in general, with many pushing back on equality, diversity, and inclusion (EDI) programmes and a rise in general "anti-woke" sentiment. This must not be ignored in any assessment of how far we've come in the five years since the special *BMJ* issue or the launch of the RHO.

Glacial progress

Failures to tackle racism in medicine, healthcare, and the NHS are still too prevalent for me to say that we're making anything like enough progress, which I would describe as glacial in its speed. This "progress" is at risk of being undermined by the demise of EDI programmes, while attention to antiracism risks being seen as either political, a waste of precious resources, or simply no longer fashionable in leadership circles which, for too many people from ethnic minorities in medicine, remain hard to reach or to communicate with meaningfully.

I remain frustrated at the lack of systemic progress

As far as racial equity and equality are concerned, we live in dangerous times. There are leaders who recruit EDI leaders, sanctioning antiracist programmes as a way of avoiding the direct responsibility they hold for creating and upholding a culture in which people can thrive regardless of race. Such leaders will dump such programmes and change antiracism statements in the light of budget constraints and shifts in the political weather, which shows how committed they were to these principles and actions in the first place.

In the anti-woke paradigm, the importance of leadership is only highlighted more, as the work of the Harvard professor David Williams shows. It's not the existence of EDI programmes, antiracist statements, or bias training that makes the difference (if it did, this article and *The BMJ*'s special issues would have been unnecessary). Williams showed that it's what leaders do and say, whom they say it to, and when and how, that make the difference in creating the conditions for racial equity and equality.

To be clear: expertise in how leaders apply their authority in organisations, and the help leaders may need to understand their workforce and the systems in which their healthcare organisations operate, is still necessary—hence the RHO. But these resources are meant to help leaders respond to their accountabilities, not replace them.

As I look around the health and care landscape, I still see a lack of accountability from those at the top to lead everyone everywhere all the time, as opposed to leading some of the people somewhere some of the time—with the resulting racial inequity and inequality ranging from cancer outcomes to mental healthcare. While I can see small signs of improvement, the needle isn't moving quickly enough, and it may start going backwards as leaders respond to the prevailing societal and political winds.

If we're to build on *The BMJ*'s 2020 work and the RHO, we must see racial equity and equality as a core competence for leaders. Put simply, if you can't or won't lead everyone, you can't call yourself a leader in any healthcare organisation or system worthy of the name.

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RACISM IN MEDICINE

Tackling the root causes of maternal deaths in black women

Samara Linton explores why more women from ethnic minorities than their white peers don't survive pregnancy—and what's being done to improve outcomes

Maternal mortality is the tip of the iceberg
Marian Knight

The UK has one of the lowest maternal mortality rates in the world, but black women are still twice as likely as white women to die from pregnancy related causes. Historically, this disparity has been as high as fivefold, kickstarting initiatives such as Five X More to push for improved maternal outcomes in black women. Despite improvements in recent years, racial inequalities stubbornly persist.

Marian Knight, professor of maternal and child population health at the National Perinatal Epidemiology Unit, leads MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) which investigates the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK. She tells *The BMJ*, "Women from different ethnic groups are dying from the same causes but at disproportionately greater numbers.

"Maternal mortality is the tip of the iceberg: we know that these disparities exist for morbidity as well as mortality. We actually need to be looking at morbidity to see progress and see how changes in services or different interventions can actually make a difference."

Box 1 | Maternal mortality in numbers

In 2021-23, 254 women in the UK died during pregnancy or within six weeks of its end from pregnancy related causes—an estimated 12.67 deaths per 100 000, down slightly from 13.56 per 100 000 in 2020-22, although the decrease was not statistically significant. Maternal death rates in 2021-23 also remain non-significantly higher than in 2018-20, even when excluding deaths caused by covid-19.

The leading causes of maternal mortality were venous thromboembolism, cardiac disease, and covid-19. The leading causes of late maternal deaths (six weeks to one year after the end of pregnancy) in 2021-23 were mental health related.

"In England, the maternal mortality rate in black women was 2.31 times as high as in white women. Data also suggest that maternal mortality for Asian women and women from mixed ethnic backgrounds may be higher than for white women, though offical UK data for 2021-23 did not show a statistically significant difference in mortality rates for these groups.

Why do these gaps persist?

In the UK, Asian women and those from mixed ethnic backgrounds may also face a higher risk of maternal death than their white counterparts (box 1). Similar inequalities are seen in the US, where black women die from pregnancy related causes at nearly twice the rate of white women.

"There are clinical factors, there are social determinants, and there is racism: structural, cultural, and interpersonal," says Ranee Thakar, president of the UK's Royal College of Obstetrics and Gynaecology. "I think it's difficult to quantify which one has more of a role to play, but we have to acknowledge the intersectionality," she adds, acknowledging how various forms of inequality—such as gender, ethnicity, or socioeconomic status—can interact and exacerbate each other to create unique experiences of discrimination.

Women living in the UK's most deprived areas are almost twice as likely to die from pregnancy related causes as those in the least deprived areas. Black and Asian people are disproportionately represented in deprived areas, exposing them to additional environmental risk factors. As an example, Thakar says that pollution "can predispose women to have smaller babies, pre-eclampsia, and high blood pressure during pregnancy."

The leading causes of maternal deaths in the UK are venous thromboembolism and cardiac disease, which partly reflect rising risk factors such as obesity in the maternity population, with almost twice the levels of medical comorbidity seen among maternal deaths in 2020-22 as in 2014-16.

Black and South Asian women are more likely to have comorbidities than their peers, but even after accounting for socioeconomic status, smoking, and body mass index, racial inequalities in maternal outcomes persist. Similarly, when excluding deaths from covid-19—which disproportionately affected black and Asian people—the maternal mortality gap remained significant.

Racism and colonial legacies

Black women in the UK have reported discriminatory treatment when using maternity services, including dismissive attitudes,

Box 2 | Annabel's story

Annabel Sowemimo, a community sexual and reproductive consultant and founder of the Reproductive Justice Initiative, never imagined that she would join the ranks of black women traumatised by negative birth experiences, despite dedicating her career to empowering others to make informed choices about their bodies.

"I felt like a failure," she tells *The BMJ*. "How had I allowed this to happen to me with all the tools and knowledge I have at my disposal?"

Her antenatal care was inconsistent, with different staff at each visit and only one scan at 20 weeks. Although her pregnancy was considered low risk, she was advised that a consultant should handle her epidural because of prior surgery for scoliosis.

Sowemimo went into labour and, after several hours of steady contractions at three-in-10 intervals, she contacted the hospital but was told to stay at home. As she was in severe pain, she and her partner decided to go in, but she was found to be only 1-2 cm dilated. "I asked if I could be admitted for pain relief. I have quite a high pain threshold, and something felt off," she says. Still, she was sent home.

Poor communication

Later that night, her waters broke. Although she was advised again to remain at home, Sowemimo returned to the hospital with increasing pain, only to face scepticism. She says, "I'm a senior medic. I tell others when their waters have broken. When does my credibility matter?" After an examination her partner noticed that she was bleeding, triggering alarm among staff.

She was admitted with hyperstimulation—when the uterus contracts too frequently or contractions last too long—but things worsened. She endured three failed epidurals before receiving a patient controlled analgesia device, which staff struggled to manage. "I ended up labouring without adequate analgesia and in lots of pain," she recalls.

Ultimately, she opted for a caesarean section, which was delayed by communication problems. By the time she arrived in the operating theatre she was 9 cm dilated, and the baby was obstructed.

Sowemimo ended up delivering a healthy baby but lost 1.2 L of blood. "They try to tell you that everything has been fine because your baby is fine. But I'm not fine. My partner is not fine," she explains. "The whole thing was just a car crash of multiple errors and issues."

She continues to experience birth flashbacks. "I keep ruminating on what I could have done differently," she says. "It's something I'm still managing and seeking help for."

In addition to describing some healthcare professionals as having been "forceful" and "pushy," Sowemimo recalls a lack of candour when things went wrong. She says, "It's such a cliché, but a lot of this experience could have been improved through better communication and treating me with kindness and compassion."

a poor understanding of clinical presentations in black people, and assumptions about their pain tolerance, anatomy, education level, and relationship status.

"Midwifery curriculums have been mainly European based for many years," says Gill Walton, chief executive of the Royal College of Midwives. In 2023 the college worked with stakeholders to publish its "decolonising midwifery education toolkit," designed to help educators challenge the implicit and explicit legacies of colonial perspectives in all aspects of midwifery education. For instance, it includes guidance on diagnosing conditions such as jaundice and cyanosis in people with darker skin tones. Several NHS trusts are also working to improve cultural competence and reduce racial bias among maternity staff, but racist and prejudiced beliefs persist.

Thakar says, "Asian women are sometimes called princesses because it is assumed that they are not tolerant to pain, just as black women are considered to be very strong and to have a higher pain threshold." Such biases can have tangible effects on care. For example, black women are less likely to receive spinal and epidural anaesthesia or to have interventions during vaginal births.

"I'm hoping that with increased awareness these biases are reducing, but they certainly do exist," Thakar adds. "Some of these are unconscious biases, and that's why it's so important to have healthcare professionals who reflect [people in] their community.

"But it's not just on the front line. It's the leadership in the NHS, in the hospitals. We need to have leaders who represent the population."

We need leaders who represent the population
Ranee Thakar

Trust and advocacy

Trust between healthcare providers and black and Asian women is essential for improving maternal outcomes. Positive maternity interactions are characterised by shared decision making, empathy, compassion, and women's confidence in their abilities to advocate for themselves. In contrast, poor interactions can lead to physical and emotional trauma (box 2).

"If healthcare professionals would own up more when they make mistakes, it would help to build trust," says Elizabeth Idowu, a midwife and founder of an antenatal programme, Mama's Classes. While staff can view potential complications as being normal, such as a perineal tear, these occurrences can be incredibly distressing for patients and their families. Idowu says, "These women who have gone through trauma just need to know that they're not crazy in the way that they're feeling."

Idowu is known as Mamadinya on TikTok, where her humorous but educational videos about maternity care have racked up millions of views and gained her more than 300 000 followers. "When women come to me in sheer desperation, it's kind of sad that the only person they think they can trust is someone they've only met online," she says.

Her experiences of working in labour wards highlighted the need for accessible educational content to help women prepare for labour. She has since expanded her videos to include postnatal and other content, finding that her videos resonate with black women in particular: "I speak like them, I look like them, so it was easy for them to take me in."

A national survey in 2024 found

Women who have gone through trauma need to know they're not crazy
Elizabeth Idowu

Migrant mothers face barriers

Recently arrived migrants in the UK, including refugees and asylum seekers, often face significant barriers to healthcare, ranging from language difficulties to a lack of understanding of NHS systems.

The "hostile environment"—policies designed to create a hostile environment for people living in the UK without official immigration status—exacerbates these challenges. "Some people are worried about [NHS] charging, and they're frightened," says Gill Walton, chief executive of the Royal College of Midwives. "They hear lots of negative stories about how they might be treated, so they don't come forward, and then they get ill, or something happens to their baby. We've got a lot of work to do to create that confidence."

The college's maternity disadvantage assessment tool aims to support midwives in appropriately assessing and documenting women's social needs as soon as they present antenatally. Midwives can develop a personalised care and support plan to facilitate smooth communication with the multidisciplinary team.

"It's not just the midwives' responsibility for supporting that mother," Walton adds. "It's also about how they then get all the agencies around the mum and the family so that they get the very best care during their pregnancy and birth and afterwards."

One obstacle to migrant women's antenatal care is the UK government's practice of frequently relocating people seeking asylum to different accommodation while processing their applications. These relocations, which can occur multiple times and at short notice, contribute to delays in booking antenatal care and can disrupt the continuity of care. The Royal College of Obstetrics and Gynaecology and the Royal College of Midwives are among the organisations calling for the government to review these practices and suspend charging regulations for maternity care.

that black people in the UK were considerably more concerned about safety in maternity services than those from other demographic backgrounds.

Idowu says, "The number one question I get from black women is, 'How do I advocate for myself?' A lot of black women don't know that they can say no. That's the most dangerous thing, especially in a society that isn't necessarily structured to look after them."

By working to educate and rebuild trust with women, Idowu hopes to help reach those most vulnerable to misinformation and poor advice from unsafe practitioners. She has also created an accredited course for doulas (birthing partners), better equipping them with the knowledge to advocate for women with different health and accessibility needs.

Improving outcomes

Improving maternity outcomes requires systemic changes. Walton highlights an urgent need for increased investment in specialist midwife roles and maternity services, to deal with staffing shortages and enhance the quality of care.

A review of England's maternity services rated nearly half as requiring improvement or inadequate, with researchers warning that serious harm was at risk of becoming normalised. Walton asks, "How do you build relationships with women so that they trust you enough to talk to you so you can listen? You have to have the time and the staff to do that."

We've got a lot of work to do to create confidence
Gill Walton

In 2023 NHS England launched a three year plan to make maternity and neonatal services safer and more equitable, with commitments to tackle staffing problems, personalise women's care and support plans, and reduce inequalities in experiences and outcomes. Measuring the success of such efforts depends on reliable data collection. But how trusts collect and use demographic data varies considerably, undermining the success of large scale improvement programmes.

Knight emphasises the need for real time data tools such as the perinatal monitoring system, developed for MBRRACE-UK by the University of Leicester, which monitors perinatal deaths in real time at a local level. She hopes for funding to create a similar tool for monitoring maternal deaths. "I'm cautiously positive about the new developments around data for research and development," says Knight.

For example, the National Institute for Health and Care Research's newly formed Maternity Disparities Consortium, backed by £50m in funding, is working to tackle inequalities through collaborative research. Thakar also emphasises the need for a collaborative approach, highlighting the Royal College of Obstetrics and Gynaecology's involvement in the 200 member Inequalities in Health Alliance, which calls for a cross government strategy to reduce inequality.

Walton adds, "We work alongside our NHS colleagues at every level. We work with neonatal teams, ultrasonographers, anaesthetists, and the Royal College of Obstetrics and Gynaecology, so we all have a shared agenda. We call it a One Voice agenda, and hopefully that will make a difference."

Achieving equity in maternity care requires tackling the root causes of disparities, including structural racism, social inequalities, and systemic underfunding. "If we get it right in maternity care, we have opportunities to impact the future health of women and their families," says Walton. "And if we can get that right, could that go some way towards inclusivity and changing the culture in the UK?"

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ROLE MODEL

Azeem Majeed

The professor of primary care and public health talks to **Carla Delgado** about his passion for tackling health inequalities through data

IMPERIAL COLLEGE

As a medical student, Azeem Majeed didn't think he would end up becoming a professor. "That would never have occurred to me at that time," he says.

Now he is a professor and the head of the department of primary care and public health at Imperial College London. He says he found a desire to tackle the wider social determinants of health early on in his clinical career, after seeing health problems that were rooted in deprivation and occupational hazards.

"That made me realise that, while medicine is important, there are important things beyond medicine—such as poverty, housing, and occupation," he says. "That drove my interest in public health."

Not using data is like driving a car with a blindfold on. You're not really sure where you're going

Majeed developed his research skills during an outbreak of hepatitis A in Gloucester where he worked in the community doing contract tracing and outbreak control. This then led to the publication of his first articles and a lecturing role.

Most doctoral students focus on clinical trials or studies for their thesis. Majeed decided to work with primary care data—a move that was uncommon at the time, he recalled. This piqued his interest in what were considered to be routine data sources and how they shed light on the problems communities face.

As a researcher, he drew on data from the census and health authorities as well as primary and secondary care to study the link between socioeconomic factors and healthcare. He strives to use these data to measure inequalities between population groups, look into health outcomes, and analyse how best to tackle disparities.

"We need to guide the NHS and our public health system and that's best done by using data," he says. "Otherwise, it's like driving a car with a blindfold on. You're not really sure where you're going."

Getting data ready for a research project is more straightforward than it was in the past—Majeed recalls going through paper based records and having to clean and code data before analysis. But there are still gaps in today's primary care datasets. Information about people's occupation, education, and housing is not often linked to their medical data or recorded in any logistic data system, Majeed says, making it more challenging to study their impact on health outcomes.

What makes Majeed most proud of his work is seeing his team members grow from junior researchers, doctoral students, and clinical fellows into professors. "Since I've been a professor, I've aimed to develop my team members," he says. "I'm proud that I've mentored and supported and advised a lot of people who've gone on to become professors in their own right."

Medicine can be an unstable career option at times, but he offers three pieces of advice to those doubting the path they are on. "Firstly, medicine remains a good career," he says. "It's a rewarding career both professionally and personally. Secondly, don't worry if you haven't got a plan, because I had no plan and I'm doing quite well. And thirdly, don't obsess too much about doing well at a young age."

Although today's fast paced world may come with pressure to reach certain benchmarks of success early on, Majeed advises young doctors to go easier on themselves. "Don't worry," he says. "Just pursue your career. Things will often work out for you."

Carla Delgado, Manchester

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NOMINATED BY MALA RAO

"Azeem Majeed researched ethnic inequalities in primary care long before anyone was interested in it. Ethnic inequality is only one of a huge portfolio of research that Azeem leads.

"Health academia is fiercely competitive and Azeem is likely to have encountered challenges along the way to become the head of the department of primary care and public health at Imperial College London and one of the most distinguished medical academics in the UK.

"Most importantly, he has encouraged and supported a team that is highly diverse in terms of ethnicity, gender, and other dimensions to decolonise curriculums, explore reverse innovation, and to pursue their special interests in ethnic variations but also other aspects of health inequalities. As a consequence, people in his department feel good and do well."

Mala Rao is a senior clinical fellow and director of the ethnicity and health unit at the Department of Primary Care and Public Health, Imperial College London; clinical adviser to the GMC on international medical graduates; and former medical adviser to NHS England on workforce race equality

NOMINATE A ROLE MODEL

To nominate someone who has been a role model during your medical career, send their name, job title, and the reason for your nomination to arimmer@bmj.com

CAREERS CLINIC

Am I more likely to be referred to the GMC?

Statistically, black doctors are more likely to be referred by their employer, **Abi Rimmer** hears

MALCOLM WILLETT

Referrals are more likely

Udvitha Nandasoma, MDU head of advisory services

"As a doctor from an ethnic minority you are twice as likely to be referred to the GMC by your employer as a white colleague. And doctors who graduated outside the UK are three times more likely to be referred to a fitness to practise process by their employer than UK graduates.

"Despite this disparity it's important to remember that the overall risk of being referred to the GMC remains relatively low. The latest figures show that between 2018 and 2022 0.22% of white doctors were referred to the GMC by their employer compared with 0.41% of doctors from an ethnic minority. The GMC has pledged to eliminate this disparity by 2026.

"Changes at the GMC are only part of the solution. Employers must also improve their support for doctors, especially those new to UK practice, with better induction and supportive interventions when things go wrong.

"For MDU members involved in GMC provisional inquiries, the proportion of cases discontinued without any sanction being imposed on the doctor was similar for both UK graduates and international medical graduates at 82%. Being referred to the GMC is stressful, regardless of the outcome, and not all doctors benefit from medical defence organisation membership.

"Work must continue to ensure the process by which employers consider whether to refer, and how the GMC considers those referrals, is fair and transparent. The MDU website has an information hub for international medical graduates."

Seek out support

Patricia Ogunmakin, anaesthetics core trainee and education and training officer at Melanin Medics

"The possibility of a GMC referral can be daunting for any doctor, but for black doctors this concern is amplified by the evidence. As a black doctor, I am acutely aware of the challenges I might face.

"To mitigate this, it is crucial to familiarise yourself with your work environment. Attend inductions, engage with and complete mandatory training, and seek shadowing opportunities. Don't hesitate to ask for support from clinical supervisors and colleagues. Organisations like Melanin Medics can be an invaluable source of peer support, offering a safe space to discuss concerns and develop strategies to thrive. Having a support system of peers, buddies, or mentors not only aids personal development but is also vital for your wellbeing.

"Complaints are an inevitable part of medical practice and can arise long after an event has occurred. Keeping accurate, thorough, and timely documentation is essential. It's a safeguard for both you and your patients. Joining a medical defence organisation early in your career is also vital—they can provide expert advice and support if you're ever referred.

"For those working with black doctors, particularly those who are new to the NHS, advocacy is essential. I encourage colleagues to offer guidance during their transition, and employers to ensure transparency and inclusivity in their systems. A welcoming and supportive environment can make a profound difference. By taking proactive steps, we can collectively work to reduce the disparity in referrals of black doctors to the GMC."

We have robust checks in place

Sondra Roberto, assistant director of outreach at the GMC

"The GMC receives over 7000 complaints a year, but the vast majority do not meet the threshold for investigation and are closed with no action being taken.

"Doctors from ethnic minorities are, however, disproportionately referred to us by their employer, as are doctors who trained outside the UK. Racism and prejudice remain part of the reality of our health system, and this is just one example of where some doctors from ethnic minorities are treated differently from their white colleagues.

"In 2021 we set an ambition to eliminate this disproportionality by 2026 and we are on track to meet that target. One area of focus has been the training delivered to responsible officers and employers to help them build supportive and inclusive cultures.

"Responsible officers must now answer more questions before they make a referral to us. They must tell us how they've considered systemic problems, and any action they've taken locally to tackle them. They must also confirm they've undertaken impartial checks to ensure the referral is fair.

"But knowing that there is progress may not allay fears you have now. It's important to understand that if you're ever the subject of an employer referral we have robust checks and balances in place to make sure you're treated fairly in the GMC process. The decision making principles that we published last year help our decision makers to be aware of bias, to challenge assumptions, and to avoid taking evidence at face value."

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