OZEMPIC AND DEATHS page 229 • **MRCP EXAM ERROR** page 230 • **RACISM RIOTS** page 232

GPs agree £889m funding "starting point"

Katie Bramall-Stainer, GPCE chair, warned Wes Streeting, health secretary, that the deal was only the first step on the road to recovery for GPs

The BMA has agreed "in principle" to an £889m funding uplift to GPs' contracts in England this year, on the condition that the government commits to negotiating a completely new national contract within the current parliament.

The 2025-26 General Medical Services (GMS) deal includes a reduction in bureaucracy for GPs, greater flexibility for practices in employing different healthcare staff, and an increase in the fees paid for routine childhood vaccinations. Patients will also be able to book more appointments online and ask to see their usual doctor.

After the agreement in principle, which followed two months of intense negotiations with the government, the BMA's General Practitioners Committee for England said collective action by GPs was now over. GPCE has stipulated that the government must confirm its commitment to a new contract in writing by the middle of this month.

GPCE chair Katie Bramall-Stainer said, "This agreed uplift to our annual contract sees the first step on the road to recovery of rebuilding general practice across England.

"The government must now recognise the imperative to deliver a new contract within the current parliament for meaningful reform and vital investment. Only then can we keep the front door of our NHS open, provide timely patient care, and alleviate pressure across our entire health service."

As part of this year's deal, from 1 October general practices will be required to allow patients to submit routine, non-urgent appointment requests, medication queries, and administrative requests via online consultation tools during core hours. The government said this will free up phone services for patients who need them and help "end the 8 am scramble" for appointments.

The BMA and NHS England will work on the design and implementation of such tools over the coming months to make sure safeguards are in place to avoid urgent clinical requests being submitted online. GPs will also be given incentives to identify patients who would benefit most from seeing the same GP at every appointment, as part of the government's measures to bring back the "family doctor."

The new deal removes half the QOF targets (32 of 76), including indicators for reporting on staff wellbeing meetings or to explain how practices review staff access to IT systems.

The health and social care secretary, Wes Streeting, said, "Over the past decade, funding for GPs has been cut relative to the

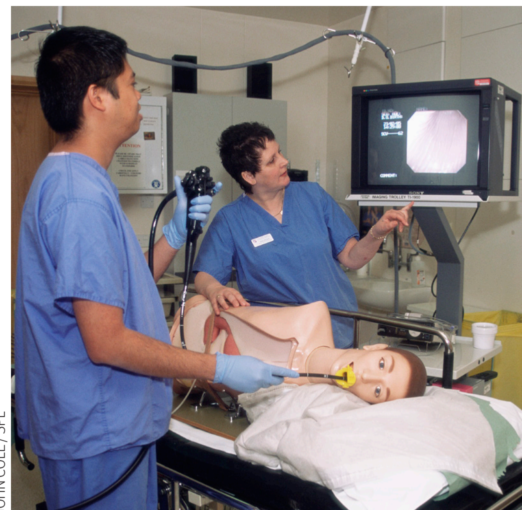
(Continued on page 228)

LATEST ONLINE

- General practices should be exempt from rise in national insurance, say peers
- Efforts to tackle antimicrobial resistance are having "limited impact," National Audit Office warns
- Lecanemab: EMA upholds decision to recommend drug for Alzheimer's disease

MEDICAL NEWS

Review of postgraduate training must tackle high competition ratios, say doctors


JOHN COLE / SPL

Doctors' leaders have warned that an NHS England review of postgraduate medical training must deliver "clear reform" and not be a token "listening exercise." England's chief medical officer, Chris Whitty, and national medical director, Stephen Powis, will oversee a "significant review" of postgraduate training, in response to resident doctors' concerns.

NHS England said the review will cover placement options, flexibility of training, rota problems, control and autonomy in training, and the balance between developing specialist knowledge and gaining a broad range of skills. But medical leaders said it must also tackle rising competition ratios in some specialty training places.

The Royal College of Physicians, which is calling for a long term commitment to expand training posts, welcomed the review but said it was just a first step. Anthony Martinelli, co-chair of the college's resident doctor committee, said, "This review cannot be another listening exercise—it must result in clear reform of the way our physicians are trained."

The BMA said that around 20 000 doctors were expected to miss out on a training place this year because of the mismatch in formal training places and applicants. Melissa Ryan and Ross Nieuwoudt, co-chairs of the BMA Resident Doctors Committee, said, "There is little benefit in rearranging the deck chairs while the ship is sinking; we need more training places for doctors and an increase in post-training jobs."

Matthew Limb, London Cite this as: *BMJ* 2025;388:r360

Medical students

Few students are from working class families

Research by the Sutton Trust showed that just 5% of medical students were from working class backgrounds, while 75% were from high socioeconomic groups. Data on nearly 94 000 applicants to UK medical schools between 2012 and 2022 showed that a very high number of medical students came from a relatively small number of secondary schools. Applicants from independent schools were 1.5 times as likely to receive an offer to study medicine as those from non-selective state schools, even after adjustment for exam grades, socioeconomic status, and other demographic factors.

NHS England

Amanda Pritchard steps down as chief executive

NHS England's chief executive, Amanda Pritchard (below), has announced she will step down at the end of March after three and a half years in the role. The surprise announcement followed recent strong criticism by two parliamentary committees that questioned NHS leaders' ability and "dynamism" to implement the government's desired health service changes. Pritchard, who has also been chief operating officer at NHS England since 2019, said now was the time for her to leave, with the NHS continuing to make progress in its recovery from the covid pandemic.

Cancer

Higher death rates linked to social deprivation

People living in the UK's most deprived areas are much more likely to die from cancer, with death rates almost 60% higher than in the most affluent areas, found an analysis by Cancer Research UK. Around 28 400 extra deaths from cancer a year were linked to socioeconomic inequality, said the report. It also found that patients in England's poorest areas were 33% more likely than those in the least deprived to wait more than 104 days for treatment after an urgent cancer referral.

Assisted dying

Bill passes final hurdle in Isle of Man

The Isle of Man is set to become the first place in the British Isles to legalise assisted dying, after a bill to allow terminally ill residents to end their life passed its final hurdle in the island's lower elected house. The law is now expected to pass, subject to final approval in the Isle of Man's Legislative Council, the higher chamber of the Tynwald (above). The bill will introduce the choice of assisted dying to residents who are mentally competent and have less than 12 months to live. Its proponents hope the service will be available from 2027 after royal assent and an implementation period.

Respiratory illness

Survey shows inadequate spirometry testing

The charity Asthma + Lung UK said that 600 000 people in England had undiagnosed chronic obstructive pulmonary disease because of backlogs in spirometry testing and geographical variation in access. Of the 27 integrated care systems that responded to the charity's survey, 16 said they did not have enough spirometry testing capacity to meet demand in their area, and only eight reported having enough to carry out all the tests needed. The review also showed worse outcomes among people with lung conditions who live in areas with higher levels of deprivation.

Multiple sclerosis

Inquiry into treatment switch is launched

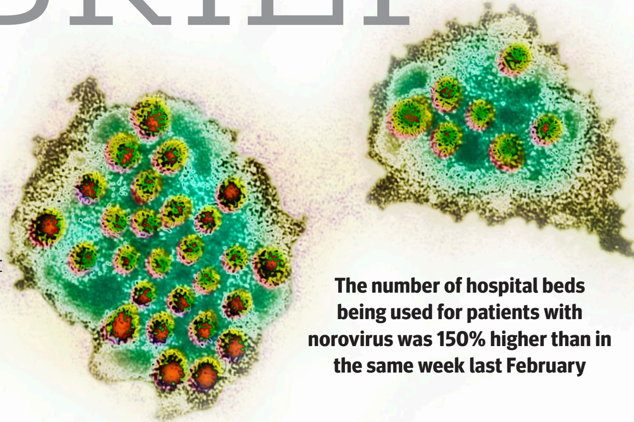
Imperial College Healthcare NHS Trust is to investigate why more than half of its patients with multiple sclerosis who switched from the disease modifying treatment Tysabri (natalizumab) to the biosimilar Tyruko have had to be switched back because of "significant and continuing side effects." The trust started switching patients last May after a request by NHS England. However, patients reported side effects, and after a clinical review the trust returned just over half to Tysabri. The trust's concerns have been reported to MHRA.

IN BRIEF

Norovirus

Number of patients in hospital remains high

The incidence of norovirus cases remains high, NHS England warned, with the number of beds taken nearly 150% higher than last year. On average 1134 patients a day were in hospital with norovirus in the week to 25 February, down slightly on the previous week (1160) but still nearly two and a half times the number in the same period last year (470).



The number of hospital beds being used for patients with norovirus was 150% higher than in the same week last February

New treatments

NICE recommends Altuvoct for haemophilia

NICE has recommended efanesoctocog alfa (Altuvoct) as an option for treating and preventing bleeding episodes in patients aged 2 years or over who have severe haemophilia A. The once weekly injection is an alternative to factor VIII injections, which are given every two to three days. Helen Knight, NICE's director of medicines evaluation, said, "Combined with its effective bleeding control, efanesoctocog A has the potential to have a significant positive impact for some people with severe haemophilia A."

Immunotherapy treatment approved for leukaemia

NICE has published final draft guidance recommending blinatumomab (Blincyto) with chemotherapy for adults with a specific type of acute lymphoblastic leukaemia. Current treatment involves intensive chemotherapy, but up to 50% of patients relapse and need a second line of therapy. Clinical trials showed using this treatment at the start of the "consolidation" phase—a crucial period focused on preventing cancer from returning—reduced the risk of relapse or death by 56% when compared with standard chemotherapy alone. Around 80 adults a year are likely to benefit from the treatment.

Personalised cancer therapy gets green light

NICE has approved the CAR T cell therapy lisocabtagene maraleucel (also called liso-cel or Breyanzi) for the treatment of large B cell lymphoma. The therapy involves collecting a patient's own T cells, which are then modified to specifically target and destroy cancer cells. These are then reinfused into the patient as a single treatment. NICE reversed its earlier negative recommendation, made in October, after Bristol Myers Squibb offered an improved commercial arrangement on the £297 000 list price per individual treatment.

Polio

Mass vaccination campaign is planned for Gaza

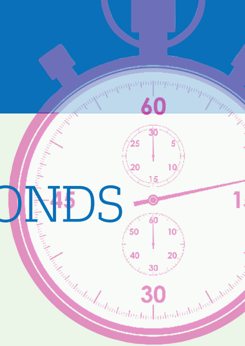
The novel oral polio vaccine type 2 was administered to more than 591 000 children aged under 10 years in the Gaza strip in February. The campaign followed the detection of poliovirus in wastewater samples. Two previous vaccination rounds were held in September and October, reaching over 95% of the target population. WHO said the campaign was needed to close immunity gaps.

Cite this as: *BMJ* 2025;388:r428

OBESITY

Around 60% of the world's adults (3.8 billion) and a third (31%) of all children and adolescents (746 million) will be overweight or obese by 2050, without urgent action

[Source: Lancet]



SIXTY SECONDS ON . . . COMEDY

ISN'T LAUGHTER THE BEST MEDICINE

Apparently. And trials are under way to put this old cliché to the test.

AM I MISSING THE PUNCHLINE?

It's no joke. A pilot study has been launched to see whether comedy on prescription, as an alternative to antidepressants for patients with mild to moderate symptoms, can help improve people's mental health and reduce costs to the NHS.

DAVID BRENT'S MOTIVATIONAL TALKS?

This is a different vibe. The company Craic Health has secured a grant from the social prescription charity One Westminster to test a scheme to provide standup comedy shows and workshops to people who are isolated, lonely, and vulnerable.

WILL THEY USE A LAUGH-O-METER?

Not exactly. Participants are given forms before and after they attend the events and asked to rate their mood at each stage.

THE WISDOM OF MANY AND THE WIT OF ONE?

It's a collective effort. Louisa Jackson, the founder of Craic Health, is overseeing the scheme, while Simon Opher (below), the MP for Stroud and a GP who has espoused other forms of social prescribing in his Gloucestershire practice, is a big advocate.

YES, MINISTER?

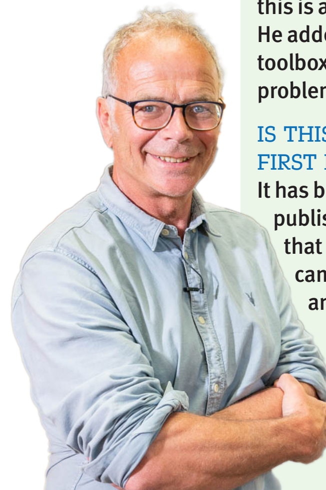
Opher believes the UK has an over-reliance on antidepressants and says "comedy is one of the ways we can address that." He explains that in his practice he is trying to get a "really broad width" of things to which patients can be referred. "Comedy is quite a wacky one, but it has sparked people's imagination," he told *The BMJ*.

GOOD COMIC TIMING?

It could be, given the pressures on the NHS, but Opher emphasises, "We're not saying this is a panacea to all unhappiness." He added, "But it's another tool in the toolbox, particularly for mild to moderate problems."

IS THIS THE MEDICAL PROFESSION'S FIRST FORAY INTO COMEDY?

It has been known to dabble. Research published in *The BMJ* in 2020 showed that the presence of hospital clowns can help alleviate symptoms such as anxiety, fatigue, and pain.



Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;388:r415

(Continued from page 225)

rest of the NHS, while the number of targets for GPs has soared. That's why patients are struggling to get an appointment.

"This government is cutting the red tape that ties up GPs' time and backing them with an extra £889m next year. In return, more patients will be able to request appointments online and see their regular doctor for each appointment."

In addition to the £889m, there will be £80m for an enhanced service to compensate GPs for advice and guidance (A&G) requests—the correspondence that GPs send to hospital consultants to ensure patients get the best care in the most appropriate setting. GPs will be paid a £20 item-of-service fee per request.

GPs will be paid a £20 item-of-service fee for each A&G request

The government said the 7.2% boost to the GP contract was higher than the 5.8% growth to the NHS budget as a whole, which will help to reverse the trend of general practices receiving an ever smaller proportion of NHS funding and support the shift from hospital to community care.

Under the deal, GPs and practice nurses will be permanently added to the main additional roles reimbursement (AARS) scheme, and GPs employed under it will now be paid in line with the BMA's recommended salary range. The cap on the number of GPs that can be employed through the scheme will also be removed, which the government hopes will help reduce unemployment among GPs in the short term. However, the BMA said a practice level employment solution will still be needed in the long term.

The new contract will also see locum reimbursement payments rise by between 15.9% and 17.1% and fees for childhood vaccinations increased by £2 to £12.06.

HELEN SALISBURY, p 251

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r426

Coroner warns about role of PAs after woman's death

A coroner in Surrey has raised concern about the role of physician associates in the NHS in response to the death of a woman with abdominal pain whose condition was wrongly diagnosed as nosebleed.

Coroner Karen Henderson published a report asking agencies such as the General Medical Council and NHS England to act to prevent future deaths, warning that the safety of patients was at risk unless greater clarity was provided about the role and scope of practice of PAs.

Pamela Marking, 77, died in February 2024 from complications of a strangulated femoral hernia. Four days before her death, she presented to the emergency department at East Surrey Hospital with abdominal pain and having vomited bloodstained fluid. She was reviewed by a PA who diagnosed epistaxis (nosebleed) and discharged her without a review by a doctor.

Marking returned to the hospital two days later and was found to have a grossly dilated small bowel obstruction. She was taken for emergency surgery but later died from respiratory failure and sepsis after vomiting faeculent bowel contents during the induction of anaesthesia. The coroner concluded that the clinical management of Marking on both attendances "materially contributed" to her death.

The coroner found that the PA had reached the epistaxis diagnosis "without appreciating the relevance" of Marking's vomiting and abdominal pain or understanding the need to palpate the groins as part of an abdominal examination. She warned that PAs' "limited" training "gives rise to concern that they are working outside of their capabilities."

The report listed eight concerns that should be acted on to prevent future deaths. Of these, three related to a lack of up-to-date guidelines on the risk of aspiration during rapid sequence induction of anaesthesia. Five related to PAs, including concerns about a lack of public understanding of the role, PAs working outside their capabilities, and the lack of local or

PAs' limited training gives rise to concern that they are working outside of their capabilities Karen Henderson

Moorfields consultants warn of "culture of fear" and leadership crisis

Consultants at London's Moorfields Eye Hospital, a world leading ophthalmology centre, have voiced serious concerns over the NHS trust's leadership, alleging a "culture of fear" and loss of institutional confidence in the board.

In a letter to the trust's oversight body, seen by *The BMJ*, the chair of the Moorfields consultants' committee, backed by more than 80 senior clinicians, warned of coercive leadership, financial instability, and fractured relations with key research partners. The letter, which has been shared with NHS England's London region and the local integrated care board (ICB), raises questions about the trust's governance and future direction.

The consultants accuse trust chair Laura Wade-Gery of presiding over an atmosphere of suppression and intimidation. They cite an "inexplicable" turnover of senior executives and a breakdown in relations with the National Institute for Health and Care Research and University College London. "This poses a serious and very real threat to the future of Moorfields," the letter said.

Asked to respond, the trust said it was "actively listening to concerns, beginning an open and transparent dialogue, and agreeing and commencing a plan to move forward."

Hari Jayaram, chair of the consultants' committee and a consultant ophthalmic surgeon, wrote to Moorfields' membership council on 26 February, warning that consultants had lost confidence in the trust's policy on freedom to speak up. "The morale of the consultant body is at a significant nadir which most colleagues do not ever recall experiencing in their consultant careers," Jayaram wrote.

The allegations centre on Wade-Gery, a former chair of NHS Digital, with claims of a "culture of fear and suppression

national guidelines on supervisory arrangements or scope of practice.

Marking's son had mistakenly believed that the clinician who saw his mother was a doctor, and the coroner found that neither the PA nor the hospital had taken steps to explain that PAs were not medically qualified practitioners. The coroner warned that this "raises issues of informed consent."

Blurring of roles

The report also raised broader concerns regarding the "blurring" of the roles of doctors and PAs, saying that witnesses from the Surrey and Sussex Healthcare NHS Foundation Trust, which runs the hospital, had told the inquest that PAs were "clinically equivalent to a tier 2 resident doctor without evidence to support this belief."

A trust spokesperson said that it would ensure lessons were learnt from the case and that all PAs at the trust "follow a nationally recognised programme of training and work within a very specific scope of practice under the direct supervision of a consultant, as was the case here."

An NHS spokesperson said, "The NHS has always been clear that PAs are not replacements for doctors and should only practise with appropriate medical supervision. There remain legitimate concerns about the roles, and the Leng review will gather insight from across the NHS to ensure PAs are being used appropriately to deliver safe care for patients."

Ella Hubbard, *The BMJ*

Cite this as: *BMJ* 2025;388:r425

The morale of the consultant body is at a significant nadir Hari Jayaram

of information." The letter said senior clinicians had cited examples of "pressure to conform to an unhealthy corporate agenda." It also accused leaders of fostering a "bullying" culture, with instances of "patronising, demeaning, and disrespectful" treatment.

A North Central London ICB spokesperson said, "We will be working, along with NHS England, to support the trust in addressing the concerns."

• As *The BMJ* went to press, Moorfields announced Wade-Gery's resignation. In a statement she said a new chair will be "best placed to lead the board in addressing the areas where improvement is needed."

Rebecca Coombes, *The BMJ*

Cite this as: *BMJ* 2025;388:r424

GLP-1 AGONISTS: **82 UK deaths are linked to adverse reactions**

Data from the UK yellow card scheme for reporting adverse events to the Medicines and Healthcare Products Regulatory Agency (MHRA) show a total of 82 deaths related to glucagon-like peptide-1 receptor agonists up to 31 January 2025.

Of these reported deaths, 22 were linked to adverse reactions associated with use of GLP-1 agonists for weight loss and 60 were linked to use of the drugs for treating type 2 diabetes.

Commenting on the figures, Alison Cave, MHRA chief safety officer, said, "The decision to start, continue, or stop treatments should be made jointly by patients and their doctor, based on full consideration of benefits and risks."

The MHRA had previously warned people not to buy prefilled pens online that claim to contain prescription only GLP-1 receptor agonists, amid reports of a "very small number of people" being admitted to hospital after using fake Ozempic pens.

Earlier this month online pharmacies in England, Wales, and Scotland were issued with new regulatory guidelines instructing them to carry out stricter checks on people who are buying weight loss drugs, in response to concerns about unsafe online prescribing.

The data showed 18 deaths linked to tirzepatide (Mounjaro), of which 10 were linked to its use relating to weight loss and eight to its indication for type 2 diabetes. A total of 29 reported deaths were related to semaglutide (Ozempic, Rybelsus, Wegovy)—four to its use for weight loss and 25 to type 2 diabetes. A further 35 deaths were reported linked to liraglutide (Saxenda, Victoza)—eight to weight loss and 27 to type 2 diabetes.

Calls for tougher regulation

The Society for Acute Medicine has previously expressed concern over the rising number of patients being seen in hospitals after the use of weight loss drugs.

Commenting on the MHRA data, Vicky Price, the society's president elect, said, "We are deeply concerned about the latest figures published with respect to mortality in patients using these medicines, particularly as colleagues across the UK continue to report that increasing numbers of patients are attending hospitals with complications as a result of inappropriate use.

"There are two concerns here. One is that patients are taking these medications without properly understanding the potential risks involved or the importance of using these as part of supported weight loss programmes.

"Another concern is that patients are obtaining these drugs from non-reputable sources and they are not actually a weight loss drug. Patients could then be injecting anything into themselves, including life threatening substances."

More analysis needed

The MHRA has noted that, as the use of GLP-1 agonists has increased, so has the number of reports to the yellow card scheme associated with them. However, the MHRA's data don't specify whether a death related to medication was obtained on the NHS or privately or whether it was prescribed by a doctor or purchased online.

The MHRA pointed out that deaths reported through the yellow card scheme do not necessarily mean they were caused by the drug in question, only that the person or agency reporting the death suspected that it may have been. Underlying or previously undiagnosed illness unrelated to the drug can also be factors.

Lily UK, which manufactures Mounjaro, and Novo Nordisk, which manufactures Wegovy, Ozempic, and Rybelsus, said they were committed to patient safety and to collecting and evaluating safety data.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;388:r390

Decisions to start, continue, or stop treatments should be made jointly by patients and doctor Alison Cave

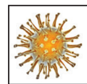
OVERSEAS NEWS

Foreign aid cut leads to resignation

Anneliese Dodds, the minister for international development, resigned after the UK government said it would cut overseas aid by £6bn so as to boost defence spending. "Ultimately, these cuts will remove food and healthcare from desperate people," Dodds wrote in a letter to the prime minister. Aid organisations called the cuts "disgraceful" and a "betrayal of the world's most vulnerable."

Cite this as: *BMJ* 2025;388:r410

Two hospital cases of H5NI in US



Two people in the US have been admitted to hospital with H5N1 avian flu, adding to concerns over the rising number of cases worldwide. There have been 70 cases of the disease in humans in the US, all of which, including the two patients recently admitted—one of whom has been discharged—involved people who work with infected cattle or poultry. There is no evidence of human-to-human transmission.

Cite this as: *BMJ* 2025;388:r396

Mystery disease in DRC kills 60 people

An outbreak of an "unknown" disease in the Democratic Republic of Congo has caused 60 deaths and 1096 cases in two separate areas. The outbreak began in Boloko village, where three children died after eating a dead bat. Symptoms include fever, vomiting, diarrhoea, and muscle aches, and some patients display haemorrhagic fever symptoms. Experts are suggesting a possible link to malaria and malnutrition. It is uncertain whether it is the same threat in both locations.

Cite this as: *BMJ* 2025;388:r417

Candidates to become Royal College of Physicians members were given the wrong results in the part 2 exam

HISTORIC ENGLAND ARCHIVE/HERITAGE IMAGES/ALAMY

Doctors affected by MRCP exam error face unemployment

Doctors who were incorrectly told they passed a crucial medical exam only to be told 18 months later that they had failed have now been told that their applications to higher specialty training this year will be withdrawn.

One of the doctors affected, who asked to remain anonymous, told *The BMJ* that they were concerned they will be left unemployed in August when their current contract ends. They are the sole breadwinner for their spouse and small child. "It's devastating," they told *The BMJ*. "This has ruined our careers and turned our lives upside down."

The error affected nearly 300 candidates who in September 2023 sat part 2 of the membership of the Royal College of Physicians (MRCP) exam, which is needed for higher training in some subspecialties.

The Federation of the Royal Colleges of Physicians of the UK, which administers the exam, has said the problem was caused by

Researchers could soon access GP patient data—how will it work?

Nearly 18 months after NHS England announced its intention to allow scientists to analyse general practice data for research, the scheme finally looks set to go ahead, reports **Elisabeth Mahase**

What has been announced?

NHS England has said it is actively working with GP leaders to prepare for sharing of general practice patient data with select researchers through the OpenSAFELY system. This could potentially happen within months.

Do researchers currently have access to GP patient data?

Deidentified patient data from general practices in Scotland and Wales are available for research, but this is largely not the case in England. However, an exception has been made in recent years in relation to covid-19. Early in the pandemic the government issued a "control of patient information" (COPI) notice, which gave researchers access to deidentified patient data, but only for research relating to covid-19.

What is OpenSAFELY?

OpenSAFELY is a software platform that enables researchers to analyse electronic health record data in England, including GP patient records for the whole population of 58 million—but currently only for covid related work. Developed in the early months of the pandemic, it is a collaboration between the University of Oxford's Bennett Institute for Applied Data Science, the London School of Hygiene and Tropical Medicine, NHS England, and GP system suppliers such as EMIS Health and TPP.

Speaking at a media briefing on 19 February, Ben Goldacre, director of the Bennett Institute, said, "OpenSAFELY began during the pandemic, motivated by the need for enormous population level data that we had to have flowing at unprecedented scale but also unprecedented speed." He said the

It's open source free. It's free for security review. It's free for scientific review, and it's free for reuse
Ben Goldacre

"human error" in data processing that saw temporary values accidentally left in the software used to process results.

A total of 61 doctors who were originally told they failed the exam were belatedly informed they passed, and 222 candidates who were originally told they had passed have been told they actually failed and must resit the exam.

In an email to doctors from NHS England, seen by *The BMJ*, those who have now been told they have failed have been informed that, because the error has left them unable to complete the MRCP by a deadline of 15 April 2025, they are no longer eligible to apply for higher specialty training in the current recruitment round and their applications will be withdrawn, a decision taken "in the interests of fairness to all candidates."

The federation said it was "disappointed." The resident doctors' committees of the three royal colleges of physicians have written a letter to the NHS bodies responsible, saying the event "has caused distress among the medical community that extends beyond the individuals affected."

The letter said, "While 'fairness' has been cited as the main reason behind the decision to withdraw applicants, we would question how the decision for 'fairness' has been assessed and whether the views of resident doctors have been considered."

The letter added that the April deadline was "unnecessarily punitive" in not giving affected doctors the opportunity to obtain the necessary qualifications before the start of their higher specialty training programmes in August.

A BMA spokesperson said it was advising the affected doctors not to withdraw their applications and to retain evidence of any attempt to prevent them applying. The spokesperson added, "We are making an urgent legal intervention to attempt to mitigate this harmful course of action and the associated stress and detriment to doctors who have already had too much of both."

Ella Hubbard, *The BMJ*

Cite this as: *BMJ* 2025;388:r422

THE ERROR affected nearly 300 candidates who in September 2023 sat part 2 of the membership of the MRCP exam, which is needed for higher training in some subspecialties

DOCTORS LEFT "DEVASTATED" BY ERROR

Doctors affected by the MRCP exam error told *The BMJ* that receiving the news felt "devastating." Katherine, an internal medicine trainee who asked for her surname not to be used, said she had planned her career around the timing of the exam, electing to sit it while she was not in a training programme to ensure she had adequate time to prepare for and resit the exam if required. On the offer to resit she said, "The first time round I spent three or four months revising. I was turning down events with family and friends so I could dedicate time to revision. It's undermining to suggest you can prepare for an exam like this in only a month."

Another affected doctor told *The BMJ* they had delayed getting married and had a baby only after passing the MRCP. "I have applied for two higher specialty training programmes and been longlisted for both of them, based on having full MRCP. I now have a baby, and resitting the exam is almost impossible for me in my current circumstances."

platform had since supported 181 projects across 31 organisations.

How does it work?

Goldacre said OpenSAFELY was designed to combat some of the past challenges around data privacy and security that had dominated discussions on sharing GP patient data. He highlighted two major challenges: making sure patients cannot be identified, and enabling people to find out exactly what has been done with their records. To tackle these concerns, OpenSAFELY developed a system whereby the records never leave the GP system, and GPs and NHS England stay in control.

Goldacre added that what makes OpenSAFELY unique is that "researchers don't get to log into an environment and tinker directly with the raw data." Instead, the platform generates random "dummy data" the researchers can use to write and test all their code. Once they have it working, they can then "press a button, and their code gets sent off into the machine to run at arm's length against the real records and then they get their results back."

In addition, he said, steps have been taken to ensure the system is transparent. "All of the code for the platform itself is openly shared on GitHub. It's open source free. It's free for security review. It's free for scientific review, and it's free for reuse."

I'm optimistic a way can be found to see this service expand carefully to non-covid-19 purposes
Mark Coley

When will the data be made available for non-covid work?

The BMJ understands that data could be made available for other uses through OpenSAFELY in the next few months. The process involves the health secretary issuing a legal direction to NHS England.

Speaking at the press briefing, Michael Chapman, NHS England's director of data access and partnerships, said the infrastructure for data sharing was "set up in a hurry for the pandemic" and so NHS England has been working with the OpenSAFELY team, as well as GPs and other stakeholders, to "take that brilliant work done during the pandemic and [see] how we extend that so that we can use that for all diseases."

What do doctors, patients, and campaigners think?

Goldacre said that, because of the amount of work that OpenSAFELY had put into ensuring its system was transparent and protected privacy, the team was able to get "support from all of the organisations that historically objected to work on GP data," including the campaigning group medConfidential, the RCGP, the BMA, and the BMA and RCGP's joint GP IT committee. He said the system had also been "evaluated in a citizens' jury during the pandemic" and was the "most strongly supported of all the covid era data platforms."

Mark Coley, IT policy lead for the BMA's General Practitioners Committee, said it was "optimistic a way can be found to see this service expand carefully to non-covid-19 purposes for the common good" and that it looked forward to working with NHS England "to see what can be achieved."

Elisabeth Mahase, *The BMJ*

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NEWS ANALYSIS

"I received verbal abuse walking to work in my scrubs"—how the racist riots of 2024 affected NHS staff

Doctors were left feeling angry and unsupported after health service leaders failed to take the threat of racism and Islamophobia seriously. **Annabel Sowemimo** and **Zosia Kmietowicz** report

Last summer an estimated 29 Islamophobic and xenophobic riots occurred in towns and cities in the UK. Several of these targeted mosques and hotels housing asylum seekers and were attended by far right activist groups.

Healthcare workers were also targeted by threatening posts on social media, verbal abuse, and intimidation by patients and the public.

The violence followed false news about the perpetrator of a July 2024 knife attack on a dance class in Southport, in which three girls died. Posts on social media claimed that the man, who was later jailed for 52 years for the murders, had recently arrived in the UK by boat and was a Muslim, when in fact he was born in Cardiff to Christian parents.

One of the first reported incidents involving healthcare workers was an attack in Sunderland on two Filipino nurses, who were making their way to work in a taxi when it was pelted with rocks. Some general practices closed their doors early, and hospitals cancelled appointments to keep their staff safe from racist abuse. Doctors and other healthcare workers reported rising concern for their safety, when travelling to work as well as when seeing patients.

One doctor told a survey by the British Islamic Medical Association (BIMA) that the police were called after a patient was racially abusive. "I was trapped in my car after hours and unable to leave the site as the patient refused to leave the premises. My husband had to come and get me away from him," she said.

When I go somewhere outside of London I don't want to arrive after sunset
Indranil Chakravorty

Indranil Chakravorty, a consultant physician at St George's Hospital in London, told *The BMJ* that on 12 August he had to change his travel plans for the first time in his 30 years working for the NHS, as he travelled to Middlesbrough as an examiner for the Royal College of Physicians.

"I was due to arrive in Middlesbrough at 10 pm and was advised not to get off the train in the city but at a stop before and to get a taxi," he says. "Two days later when I was returning home there was still unrest, and the only safe way to get to the train was to get a taxi to a remote station outside the city.

"I could see the nervousness of people. Now when I go somewhere outside of London I don't want to arrive after sunset."

Feeling unsafe at work

Salman Waqar, a GP and past president of the BIMA, told *The BMJ* that "during the riots people were emboldened to express their hatred for foreigners and Islamophobia," as they were goaded by social media.

Over a third of the 295 respondents to the BIMA's online survey reported having experienced or witnessed Islamophobic or racist incidents among colleagues or patients at work in the three weeks after the riots.

Two thirds of respondents said that they felt unsafe travelling to work, and a fifth felt "very unsafe." One respondent described "a middle aged white man riding a bike" who "shouted [a racial slur] at me whilst I was walking to work in my scrubs (this happened in front of the hospital early in the morning)."

Almost a third of respondents also reported feeling unsafe while at work or study, and over half didn't feel safe working alone. Eight in 10 said that they had changed their lifestyle for safety reasons, including avoiding public transport and public spaces and "being less visibly Muslim."

A week after the riots started, doctors' leaders called for NHS Employers to "urgently support migrant and ethnic minority staff" as the riots spread. The health secretary, Wes Streeting, later called for patients who abused NHS staff to be turned away, and several organisations, including the Nursing and Midwifery Council and the GMC, issued statements of support and clearer guidance on how staff should manage racism in the workplace.

Yet the lack of follow-up from NHS England since the riots has made its stated desire to tackle racism appear hollow. Waqar says, "Very few institutions really understood what was going on. Many struggled to call it racist. There was a lot of sanitised language, such as calling it 'civil unrest' and 'thuggery,' with

OVER a third of 295 survey respondents reported having experienced or witnessed Islamophobic or racist incidents among colleagues or patients at work in the three weeks after the riots

CHRISTOPHER FURLONG/GETTY

An asylum hotel in Rotherham is attacked during last August's riots

many refusing to name Islamophobia. NHS England only mentioned that in passing many days later."

Weak stance

Half of the doctors who responded to the BIMA survey didn't believe their employer had taken an appropriate stance against last summer's violence. Two thirds thought that the government didn't treat all forms of discrimination equally, and slightly fewer also levelled this accusation at professional regulators and national NHS leadership.

Aisha Malik, a GP in Manchester with a special interest in the health of asylum seekers, runs a complex case management service in a hotel for asylum seekers in Blackpool. She said that people living in the hotel were left traumatised by masked individuals banging on windows in the middle of the night or waiting outside the hotel to verbally abuse anyone who walked out.

She told *The BMJ*, "For children who have come from war zones and been displaced by conflict, that was really terrifying and triggering in terms of their mental health." She and a member of staff had to pick up medicines for her patients, as it was deemed too risky for them to leave the hotel.

Although the threat of violence during the riots was acknowledged towards all staff, there was no recognition of the additional impact on Muslim staff and their families. "While I was at work I was worried about my child walking home alone from school," Malik tells *The BMJ*.

A respondent to the BIMA survey also noted the lack of support: "I am visibly Muslim. During the riots, no one—neither my colleagues nor my immediate managers—approached me or asked me if I am OK going home, etc. In fact, it was a topic not discussed at all."

There is a reluctance or just wilful neglect on this to address it head on as racism and Islamophobia
Salman Waqar

What next?

After the riots, the Race Equality Foundation published a report—*Racist Riots and the NHS: What Next?*—which examined the NHS's response to the riots and how racism could best be rooted out.

The report's author, Roger Kline, is a research fellow at Middlesex University and a longtime researcher of racism in the NHS, who was motivated to write the report because the NHS's response "places the responsibility on the people being distressed and attacked, not on their employer."

Kline is clear that the riots are "part of a wider problem" and that there is a lack of leadership on the issue of racism generally. He asked, "What are you going to do about the everyday racism that was there before the riots, and continues, and will continue afterwards, unless you get your act together?"

Waqar said that when a general practice in London was vandalised and daubed with Islamophobic graffiti last month neither the police nor the integrated care board referred to the incident as Islamophobic, preferring to call it a "hate crime."

"I don't even think they called it racist," Waqar told *The BMJ*. "They just said that hate speech is not tolerated. So, it suggests that at the very top there is a reluctance, squeamishness or just wilful neglect on this to address it head on as racism and Islamophobia."

Waqar wants clearer thinking from the top. "These deep rooted issues of racism, Islamophobia, and xenophobia are crucially important for us to address in the health sector," he said. "I think we should be talking very clearly about it, given the fact that so many of the health and social care workforce come from ethnic minority backgrounds and are Muslim."

He said that he wasn't sure whether NHS leaders had understood what happened last summer or how to respond to such racist incidents. "They need to be upfront, call it for what it is, give people practical support, and make sure that zero tolerance means zero tolerance," he said.

In the wider NHS, Kline calls for any NHS leaders who fail to act on racism to lose their jobs. He concluded, "Those few leaders who have recently had to step down on such grounds [of not responding adequately to issues of racism] have done so as a result of external pressure, not through any formal process. That has to change."

Malik told *The BMJ*, "There needs to be an absolute compulsory drive to understand racism, Islamophobia, and any kind of hatred based on faith and how that influences the NHS, because we're not immune to those prejudices and those discriminations."

A spokesperson for NHS England defended the agency's response to the riots, saying that it had told senior leaders that the riots were racist and Islamophobic and had reminded them about national guidance and their right to refuse treatment.

The spokesperson added, "The NHS provides care and treatment for everyone regardless of race, faith, or background, while staff should be able to speak out about any concerns in the knowledge they will be listened to."

Annabel Sowemimo, London
Zosia Kmietowicz, *The BMJ*

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FIVE RECOMMENDATIONS FROM THE KLINE REPORT

- NHS leaders must step up and "own" the problem of racism
- Leaders must also deliver an NHS that's proactive and preventive, rather than one that responds only to individual racist incidents
- HR departments must improve their game "to recognise racism, understand the standard of proof needed, refuse to accept the ways in which managers tend to 'skirt around the topic,' and improve how investigations are conducted"
- Whistleblowers must not face retaliation
- Trusts must have robust policies in place to refuse requests by patients wanting to see a white doctor or nurse

THOMAS PADILLA/AP/ALAMY

THE BIG PICTURE

Anger as French surgeon faces third child sex abuse trial

Protesters gather outside the court in Vannes, Brittany, where the trial of French surgeon Joël Le Scouarnec opened last week. In what is thought to be France's biggest ever paedophilia case, the 74 year old is accused of sexually abusing 299 children over 30 years in hospitals in western France.

In 2005 Le Scouarnec was given a suspended sentence of four months for possessing indecent images of children but was allowed to continue working. Since 2020 he has been serving a 15 year prison term, after being found guilty of rape and sexual abuse of four minors, including two nieces.

France's medical regulator, the Conseil National de l'Ordre de Médecins (CNOM), declined to comment on the case while the trial is in progress.

Among the placards carried by the protesters were those reading, "Rape by prescription: how many more?" "20 years of silence = dissolution of CNOM," and "Shame changes sides."

The court is expected to deliver its verdict on 6 June.

Barbara Casassus, Paris

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Switch to public health and social measures

It's time to move away from talking about "non-pharmaceutical interventions"

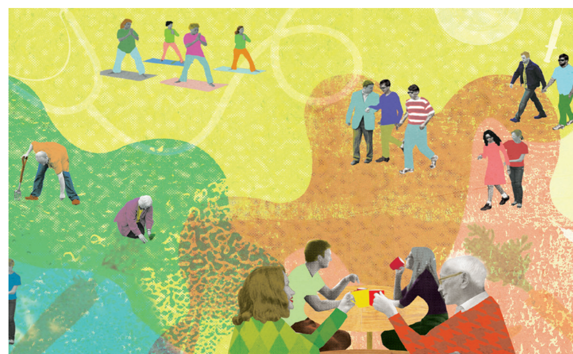
The covid-19 pandemic highlighted the importance of public health interventions such as contact tracing. The expression "non-pharmaceutical interventions" (NPIs) became common, appearing in academic articles, public health guidance, and media reports as a convenient way of describing these interventions and to separate them from pharmaceutical treatments.[1] However, in line with World Health Organization recommendations, it is time to replace non-pharmaceutical intervention with the more accurate and comprehensive descriptor, "public health and social measures."[2]

A key limitation of the term non-pharmaceutical intervention lies in its definition by negation. It describes interventions by what they are not—pharmaceutical products such as drugs and vaccines—rather than by what they are. Framing them as simply "not drugs or vaccines" diminishes the complexity of these interventions and undermines their scientific legitimacy. No one would describe surgery, for example, as a non-drug intervention.

The same applies to public health and social measures. These are not merely placeholder interventions until a drug or vaccine arrives; they are powerful tools in their own right, and often the only tools available in the early stages of a health crisis. They also often remain essential even as pharmaceutical treatments become available.[3]

Problem of perception

The "non-pharmaceutical" label implies a secondary or inferior status to pharmaceutical interventions, which is a misconception. Many public health measures, such as sanitation, contact tracing, and quarantine, are based on robust scientific principles and are highly effective. The implication that they are second best control measures reinforces a hierarchy where pharmaceutical solutions are prioritised, potentially leading to underinvestment, less rigorous evaluation, and a lack of use of other public health strategies.[4]



PRIYA SUNDRUM

Framing interventions as simply "not drugs or vaccines" diminishes their legitimacy

Using the label "non-pharmaceutical" also fails to capture the crucial social and behavioural dimensions of these interventions. Many public health interventions, such as hand hygiene, rely on both individual and collective behaviour change. Understanding the social context, cultural norms, and psychological factors that influence these behaviours is essential for their successful implementation.

Calling these interventions "non-pharmaceutical" overlooks this complexity and the evidence underlying their effectiveness. Furthermore, it encourages a technology focused approach that fails to address the social determinants of health—such as poverty, education, and housing—and may have fewer benefits for populations at greater risk of health inequalities.

Public communication

Another limitation of the use of the expression non-pharmaceutical interventions is that lack of clarity about the definition can hinder public understanding and acceptance of these measures, particularly during a public health crisis when clear communication is essential.[5] By contrast, "public health and social measures" is more transparent and self-explanatory. It communicates that these interventions are aimed at protecting public health and that they often involve collective action and changes in behaviour.

Using "public health and social measures" provides a more accurate and comprehensive description of these interventions, acknowledging their diversity and complexity. It also highlights the crucial social and behavioural aspects of these measures, emphasising the need for interdisciplinary approaches to their implementation.

By consistently using the term public health and social measures, medical journals can set a new standard for public health communication. The term also aligns with the need for a more holistic understanding of health. It reflects a shift away from a purely biomedical model towards an approach that considers the complex interplay between individual, social, and environmental factors. This change will not only improve public communication and understanding but also elevate the status of these interventions, ensuring that they receive the attention and resources they deserve.

To support this change in terminology, *The BMJ* will now aim to use the term "public health and social measures" in all its content. We call on editors in other journals to also make this change, for peer reviewers to advocate for accurate language, and for public health professionals to use this term in their own practice. This change will put public health interventions in their rightful place and help ensure that we have the necessary research and resources to protect population health, both now and in future health emergencies.

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EDITORIAL

Organ donation after assisted dying

International experience could inform UK law, regulation, and clinical practice

Organ donation after physician assisted dying has the potential to increase the availability of lifesaving organs while respecting the wishes of dying patients and their families. However, legal, regulatory, clinical, and ethical challenges need to be carefully navigated.

Belgium, the Netherlands, Canada, and Spain permit voluntary euthanasia through intravenous drugs administered by professionals. In Quebec, organ donation after assisted death increased from 4.9% of deaths to 14% between 2018 and 2022.[1]

In jurisdictions that allow donations after voluntary euthanasia, good medical outcomes have been reported for kidney,[2] liver,[3] lung,[4] and, in one case, heart transplantation.[5] Organ retrieval must occur in a controlled hospital environment, such as intensive care, within minutes of death being confirmed. Voluntary euthanasia usually occurs nearby in the hospital, although initial sedation at home before transfer to hospital is possible.[6]

The patient's underlying condition may be terminal but cannot be malignant; in almost 30% of Dutch cases of organ donation after euthanasia it was psychiatric.[7] As is standard for organ donation after death, clinical teams responsible for voluntary euthanasia and organ retrieval are separate to ensure the prospect of donation does not influence patient care.

Need for legal clarity

Four jurisdictions in the British Isles are currently considering proposals to legalise assisted dying. Although Jersey's proposal offers some legal clarity on organ donation after assisted dying,[8] it is not mentioned in the bills in England and Wales,[9] Scotland,[10] or the Isle of Man.[11] If a bill passes, clinicians may encounter patients who wish to donate organs after assisted dying.

PRIYA SUNDRUM

Patients, families, and clinicians must understand the necessity of timely organ retrieval

Bonnie Venter, law lecturer, University of Bristol Law School
Frank J M F Dor, consultant transplant and retrieval surgeon, Erasmus MC University Medical Center, Rotterdam
Mary Ryan, patient representative, Royal College of Psychiatrists, London
Avi Sewpaul, consultant transplant and retrieval surgeon
Stephen Potts, consultant transplant psychiatrist, Royal Infirmary of Edinburgh
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The four bills provide for conscientious objection, so that clinicians could opt out of participating in assisted dying, but it is unclear whether this right would extend to institutions or to members of organ retrieval teams.

Given these constraints, rates of organ donation are likely to be low, at least initially. However, requests would inevitably arise, and legislators, regulators, and clinicians must be prepared. The UK has a robust legal and regulatory framework governing deceased and living organ donation, with the Human Tissue Authority (HTA) as regulator in England and Wales and Scotland, and NHS Blood and Transplant (NHSBT) coordinating clinical processes in all four jurisdictions. Unless assisted dying bills explicitly prohibit donation after assisted dying, it will fall to these bodies to develop regulation and professional guidance. Jersey's proposals serve as a starting point, alongside well developed guidance and practice elsewhere.

As well as providing general guidance, the HTA and NHSBT should consider two possible but likely rare types of donation associated with assisted dying: deceased donation directed to a specified recipient and living donation soon before assisted dying.

Proposed law in Jersey and the Isle of Man explicitly permits voluntary euthanasia, with professionals administering intravenous drugs. Under the bills for England and Wales and Scotland, eligible patients must self-administer the drugs, though self-controlled intravenous administration is provided for in the England and Wales bill and not specifically excluded in the Scottish bill. However, jurisdictions supporting organ donation after assisted dying use professional administered intravenous drugs to bring about death rather than self-administered oral or intravenous agents.[13]

Uncertainty remains about potential organotoxic effects of assisted dying drugs before and after death and potential differences between routes of administration.[3,12] Research will be needed to examine the effects on organ quality.

If assisted dying is legalised, public clarity on organ donation will be essential.[14] Patients, families, and clinicians must understand its implications for the dying process, including the necessity of timely organ retrieval. Clinicians must also remain mindful of possible motivations underlying patient requests. Some patients may wish to benefit recipients as they face inevitable death; others may seek assisted death when otherwise they would not because donation afterwards offers consolation for psychiatric problems.

The bills under consideration in the British Isles exclude assisted dying for mental disorders alone but do not preclude coexisting mental illness if the person retains capacity. Treatable depression is known to be common in terminally ill people, and associated feelings of burdensome worthlessness might drive people to seek assisted dying instead of treatment for mood disorder. This has been recognised in debates around the bills, but the additional possible influence of organ donation has not.

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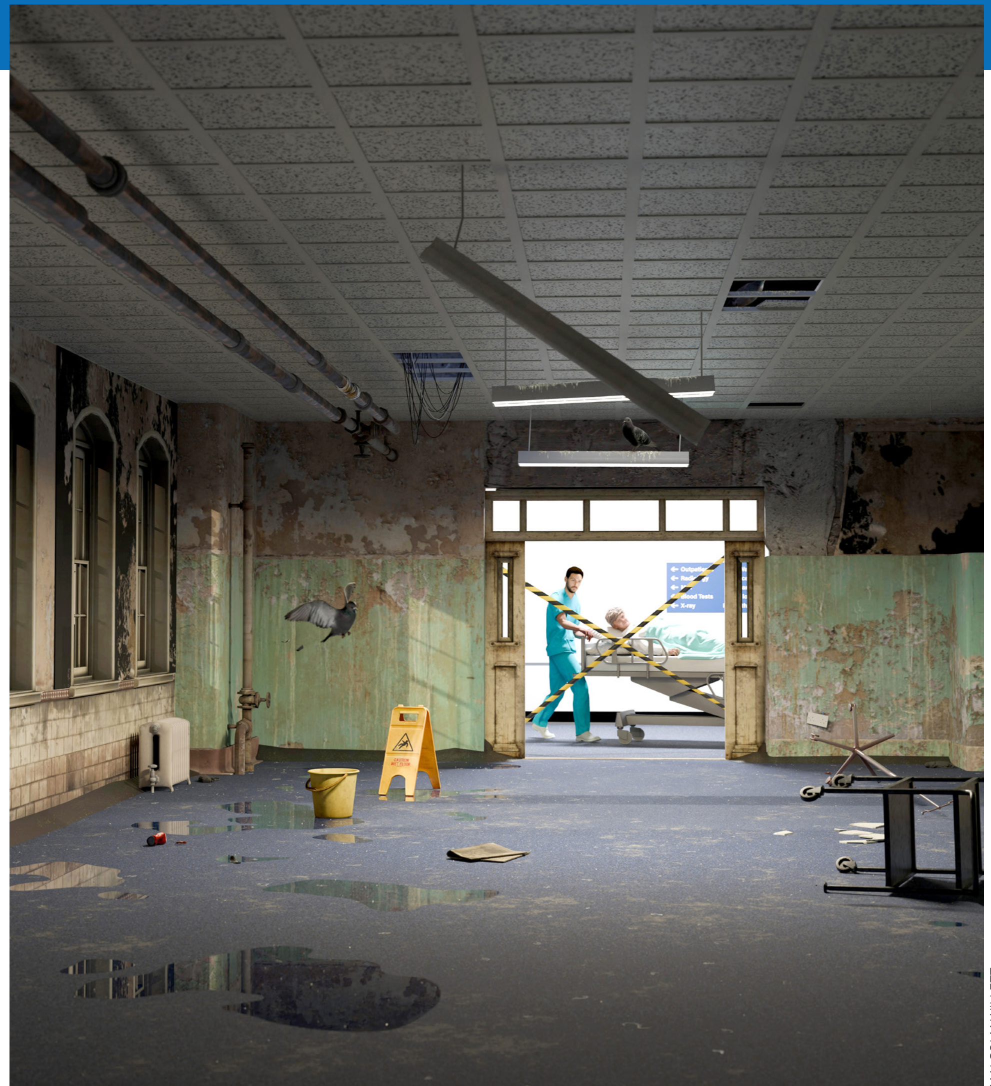
NHS ESTATE

"Sewage, roaches, pigeons"—working in decrepit NHS buildings

The Darzi review revealed billions of pounds' worth of unmet maintenance needs and the estate in a poor state. **Kathy Oxtoby** speaks to doctors across the UK about their experiences



MALCOLM WILLETT

"We've had several patients faint, be unable to keep their appointments, or have to leave. The nurses keep sick bowls and glasses of water for them."

These consequences of extreme heat on patients, and other similar examples, are the reality for many doctors working in NHS buildings in the UK. Doctors may be delivering 21st century care, but in many cases it is being provided in crumbling 19th century buildings.

In January it was revealed that the New Hospital Programme—first announced by Boris Johnson's government in 2020—would not be completed until at least a decade after the original deadline. The scheme aimed to deliver 40 "new" hospitals—some of which were refurbishments or extensions rather than new buildings—by 2030.

After the 2024 general election the Labour government conducted a review of the programme and found that it was unfunded beyond 2025. This resulted in an announcement that it would not be completed until at least a decade after the original deadline.

In a foreword to the review the health and social care secretary, Wes Streeting, said, "If I was shocked by the state of this programme, patients ought to be furious. Not only because the promises made to them were never going to be kept; they also desperately need new buildings and new hospitals.

"The NHS is quite literally crumbling. I have visited hospitals where the roof has fallen in and pipes regularly leak and even freeze over in winter."

Streeting's statement came after Ara Darzi published his independent investigation of the NHS in England. He found that much of the NHS estate was "crumbling, notably in primary care, with a backlog of maintenance that amounted to £11.6bn in 2022."

The NHS is quite literally crumbling
Wes Streeting

The BMJ spoke to doctors across the UK about their experiences.

England: "Victorian buildings that are not fit for purpose"

Bob Klaber is a consultant paediatrician and director of strategy, research, and innovation at Imperial College Healthcare NHS Trust in London.

"We have significant problems and a huge maintenance backlog at St Mary's, Charing Cross, and Hammersmith hospitals," he says. "This isn't just about grotty paintwork and slightly old fashioned windows. We're seeing patients in Victorian buildings that are not fit for purpose."

Some of the hospital buildings are around 150 years old. Wastewater and rainwater have come through the ceilings. Some ward ceilings have caved in, and parts of hospital buildings have crumbled and fallen, he says.

"Gradual loss of space" in mental health services

In October last year the Health Services Safety Investigations Body published a report of an investigation into mental health inpatient settings. It found that "built environments for mental health inpatient care contributed to patient harm and didn't always support therapeutic engagement and care."

Pavan Srireddy, vice chair of the Royal College of Psychiatrists in Scotland, says a "range of problems" exist in buildings and infrastructure in mental health services in Scotland.

These include "old buildings with poor fabric," but there are also challenges with newer mental health units, because some were placed within a general hospital setting rather than designed specifically, he says. This often means a lack of private spaces to interview and treat patients.

Day to day, psychiatrists are having to apologise to patients for leaks on wards, poor heating and ventilation, and a lack of spaces that feel safe for patients, Srireddy says. "We already have a workforce crisis in mental health services, and having to work in environments that aren't suitable or supportive is likely to make it worse," he says. Problems with infrastructure "contribute to burnout and poor retention and make it harder to recruit the staff that we desperately need."

One consultant psychiatrist in Scotland who asked to remain anonymous told *The BMJ* that a 19th century building he works in has problems with leaks, and there have been times when parts of it have been closed to deal with environmental problems. "One room is condemned because of dampness, which worsens clinic space problems. My internal office wall is intermittently damp when it rains heavily."

At a time of long waiting lists and staff shortages, "we struggle to have enough rooms to see patients," he says, because of problems with the building.

Although he finds the problems with the building frustrating, he says they can also increase patients' distress. Having treatment in small dark rooms "is not recovery focused."

He says, "For patients who are often experiencing the worst period in their lives and feeling very vulnerable, this is not an environment that's welcoming or healing."

Staff try to keep areas clean while working in "old and crumbling infrastructure," and there are times when there are not enough cubicles to isolate patients who are infectious or at risk of infection. "We know that every day our staff are spending time trying to manage estate problems—time they could spend caring for patients."

Persistent inaction

Klaber—who has worked at St Mary's since 2006 and is part of the executive leadership team at the trust—is frustrated that these problems have been known about "for a very long time, and persistent inaction has continued to compound things."

"We're apologising to patients all the time," he says. In summer, "we see babies in cubicles where we can't control the heat very well—there's no air conditioning," he says. "You're trying to work out whether their fever is related to the environmental temperature or whether they've got meningitis, or anything in between. Hour to hour, day to day, these problems get in the way of care."

There has been much debate about the word "broken" with reference to the NHS, but when it comes to its infrastructure "that is probably a fair use of the word," Klaber says. "There's been a systematic lack of investment for a very long time.

"As an advanced society and a country that aspires to be focused on the life sciences and having world leading care, we're too often delivering that care in the most appalling infrastructure."

All three of the trust's main sites were included in the New Hospital Programme. This included a full rebuild of St Mary's, along with major refurbishment and some new building at Charing Cross and Hammersmith.

Tim Orchard, chief executive of the trust, said that the news that the programme would be delayed was "devastating" for staff and patients. "We understand that the programme must be affordable, but the truth is that St Mary's, in particular, will not last until the 2040s," he says.

He says that the trust would need to find ways to advance its redevelopment plans more quickly. "This includes exploring alternative funding approaches—such as leveraging the value of any of our land that will be surplus to requirements and the significant contribution of our life science partnerships to local and national economic growth."

In an earlier comment, Orchard noted that it was increasingly difficult to manage the effects of the trust's crumbling estate, "parts of which are over 180 years old and are not configured for modern healthcare."

"Despite spending up to £30m a year on essential maintenance across our sites, building failures are increasingly common, especially at St Mary's," he said. "For instance, we recently had to close clinical areas in one of our oldest buildings for urgent structural maintenance. Just before that, one of our operating theatres was out of action because of flooding caused by roof problems.

"Our staff are working hard to find workarounds and continuing to provide high quality care, but it comes at a cost."

Plug sockets are hanging off the walls

Jessica Walker is a specialty doctor in emergency medicine who has worked at North Tees Hospital in Stockton for just over two years. She describes the 1960s building as "dreadful" and "very knocked about." Inside the building "plug sockets are hanging off the walls," and in the resus bay there is "what looks like a dinner plate sized manhole cover," she says.

When Walker was admitted to the hospital as a patient in 2023 she saw cockroaches in the toilet on the medical unit, and "the gastro ward ceiling was held together by big bits of tape." She says constant heating means temperatures on the wards and in the emergency

Hour to hour, day to day, these problems get in the way of care
Bob Klaber

Our estates team do their best in awful circumstances
Jessica Walker

When the environment you're working in isn't up to scratch it's depressing
Oba Babs-Osibodu

department are "scorching," while her department's staff room has air conditioning permanently on and is "freezing."

"Our estates team do their best in awful circumstances," she says. "Our domestic team does their best to keep the place as clean as possible."

She agrees with Streeting that the NHS is broken. "I am a leukaemia survivor, and I really do owe my continued existence to the NHS," Walker adds. "It's a jarring juxtaposition that I've received such advanced, world leading care for my leukaemia in the NHS, and yet some days at the hospital it's difficult to find a working plug socket."

A spokesperson for University Hospital of North Tees said the buildings were almost 60 years old, which presented maintenance challenges. "We have an annual maintenance budget of more than £4m, not including capital projects, to manage both large scale projects and smaller problems which are tackled as they are reported.

"The maintenance team work hard to respond to estate repairs as they arise, and their work is widely appreciated by our colleagues and patients. Our high levels of performance continue to demonstrate our dedication amid a backdrop of an ageing estate."

The spokesperson added, "We are developing a long term strategy to improve our estates to ensure they provide the modern healthcare services our communities deserve."

Wales: "There are pigeons nesting inside the building"

Oba Babs-Osibodu is chair of the BMA's Welsh resident doctors committee and a radiology registrar at University Hospital of Wales, Cardiff.

"My fear is that the hospital is not fit for purpose any more—it's falling apart," he says. "Tiles are coming off the ceilings. Pipes are bursting and leaking unknown brown substances through the walls, and you regularly see buckets in corridors collecting fluids from various leaks.

"There are pigeons nesting inside the building. We hear them through the walls of the radiology registrars' room. This is a space we are expected to work and rest in every day. It's not good enough."

Babs-Osibodu adds, "You're trying your hardest and working in conditions that are already extremely difficult. That the environment you're working in isn't up to scratch makes it way harder. At times it's depressing.

"Sometimes when I'm scanning patients there's a leak in the room or the air conditioning is broken and it's too warm or too hot. I apologise to patients. They are the ones who end up suffering."

The state of the hospital has been reported by local media, including concerns about leaks and a report of "multiple buckets being used to collect rainwater on maternity ward and in theatres."

Other hospitals in Wales also have problems. In October rainwater entered the Princess of Wales Hospital in Bridgend, resulting in the declaration of a critical incident.

Babs-Osibodu has also heard concerns from other doctors working across Wales that hospital buildings are "old, run down, and broken."

A spokesperson for Cardiff and Vale University Health Board said, "The increasing financial challenge and inability to be able to plan for long term capital improvements in estates means we are consistently managing the risk with a long backlog of repairs and ongoing maintenance.

"We accept this does not always deliver the best or a clinically appropriate environment for colleagues to work in or patients to be treated. We apologise that, like other NHS organisations, we are not in a position to be able to do more at the present time."

Responses of the four UK governments

A Department of Health and Social Care spokesperson said of services in England, "We inherited a broken NHS, and it is unacceptable that patients are suffering in crumbling hospitals or missing treatment because wards are closed for repair.

"Repairing and rebuilding our hospital estate is a vital part of our ambition to create an NHS that is fit for the future through our 10 year health plan.

"We will provide the investment and reform needed to get patients the care they deserve."

A Scottish government spokesperson said, "Because of large increases in construction costs because of inflation, and a lower than expected capital grant from the UK government, a capital review is currently under way. We plan to publish a revised Scottish government infrastructure investment pipeline alongside the 2025-26 budget."

A Welsh government spokesperson said, "We continue to invest significant sums into the Welsh NHS, with over £400m capital funding being provided to organisations this current financial year. As part of the capital funding provided, organisations receive a share of over £83m as discretionary capital for them to direct towards priority areas."

In Northern Ireland the department of health said that because of "longstanding funding challenges, the healthcare estate now has an estimated maintenance backlog of £1.4bn." The amount given to health and social care trusts for backlog maintenance in the financial year 2024-25 is £25m, the department said.

It said that the department works closely with trusts to maintain and keep the Northern Ireland healthcare estate up to standard. "It is important to acknowledge the challenging job of trusts' estates departments and the tireless efforts they make in maintaining the estate."

Water and ventilation systems have been contaminated
Clodagh Corrigan

Patients and staff deserve buildings that are fit for a safe, modern health service
Latifa Patel

Northern Ireland: "Sewage pipes burst, faeces rained down"

Clodagh Corrigan is a specialty doctor in emergency medicine who works at the Southern Health and Social Care Trust in Northern Ireland. She is a disability advocate for staff at the trust and also deputy chair of BMA's Northern Ireland Council and co-deputy chair of the BMA's Northern Ireland specialist, associate specialist, and specialty doctor committee.

Corrigan is based at Daisy Hill Hospital in Newry, County Down, which was built around 50 years ago. She says that twice in the past five years sewage pipes have burst "and faeces rained down."

There are buckets at various spots in the hospital to catch leaks when

it rains, she says. "There's also been contamination of water systems and ventilation systems, and they have needed upgrading works," she says.

Corrigan has multiple sclerosis and is a wheelchair user. She is unable to access some areas of the hospital because there is insufficient room for a wheelchair. "I don't feel I can deliver the care I want to deliver," she says. "It feels at times that what I'm doing is pointless."

Other hospitals in Northern Ireland are also struggling with maintenance, and some have had to use Portakabins to make additional wards, Corrigan says. "We practise evidence based medicine, but our estates aren't keeping up with the evidence."

A spokesperson for the trust recognises that its facilities needed investment and says it is working with the health department to secure capital investment for major developments across the trust.

"The challenge of maintaining and improving a large, diverse, and ageing estate across the trust area is considerable," the spokesperson says. "Daisy Hill Hospital was built around 50 years ago.

"Despite the best planning and prioritisation of works, it is normal that damage to our facilities, unplanned leaks, or failures in our services occur—these are prioritised by our maintenance teams. On occasion it may require the affected areas to be decanted for a short period to enable the works to be completed safely. Works are completed as soon as possible to avoid impact on services.

"We are not aware of areas that have been closed because of time taken to make repairs on the estate. The trust currently has no ward accommodation located in Portakabins."

Scotland: "We've had several patients faint—the nurses keep sick bowls for them"

One doctor who asked to remain anonymous told *The BMJ* that Glasgow Royal Infirmary has problems by virtue of the building's age—more than a century old. These include poor ventilation, many windows in non-patient areas being glued shut, and old Nightingale ward layouts—creating covid and flu transmission problems.

The old building connects to the newer buildings through a corridor on stilts, "which leaks at the slightest rain and is hazardous as a result." During the summer, clinic areas in the new building can reach up to 30°C because of a lack of ventilation. "We've had several patients faint, be unable to keep their appointments, or have to leave. The nurses keep sick bowls and glasses of water for them," the doctor says.

Elsewhere in Scotland, a public inquiry is looking at ventilation and other key building systems matters at the Queen Elizabeth University Hospital campus in Glasgow and the Royal Hospital for Children and Young People and Department of Clinical Neurosciences in Edinburgh.

A spokesperson for NHS Greater Glasgow and Clyde said, "We would like to reassure all our patients, and our staff, that all our hospitals are safe. Glasgow Royal Infirmary is the oldest hospital in our estate, and that can present additional challenges in comparison to a more modern facility.

"We have a rolling programme of maintenance for all buildings, including the Glasgow Royal Infirmary, and we will continue to make significant investments in the site to make sure it provides a high quality environment for modern hospital care.

"We are aware of specific problems in some areas of the hospital, and work is ongoing to tackle them."

Saint Mary's in central London was one of the hospitals earmarked for a rebuild in the Tories' undelivered 2020 programme

What now?

Speaking to *The BMJ*, Latifa Patel, chair of the BMA's representative body and its lead on workforce, says, "The Darzi review is clear that the health service has been starved of capital investment and that inadequate hospital infrastructure is holding the NHS back.

"We urgently need investment to clear maintenance backlogs and to fund improvements to estates. Patients and staff deserve buildings that are fit for a safe, modern health service."

"We need a clear plan to sort out healthcare infrastructure," says Klaber. "If short term policy makers continue to kick this into the long grass, our infrastructure will get worse, and the citizens of this country will suffer more and more."

And doctors need to urge politicians and leaders to make "clear, thoughtful decisions" on investment in long term infrastructure, he says.

The consequences if nothing changes are already being seen in doctors' NHS recruitment and retention rates, says Babs-Osibodu. "People are going to stop working for the NHS. There are other industries where they will be treated far better and not constantly have to apologise on behalf of the system they work in."

Without massive investment by government, "we're going to lose more staff overseas," says Walker. "Part of the push factors for somebody leaving the NHS is this constantly being worn down by poor infrastructure—it makes each shift so much more hard work than it needs to be.

"As much as I love the NHS, things are dire at the moment."

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MALCOLM WILLETT

CRITICAL THINKING Matt Morgan

Marginal gains and major fails

I'm often amazed by the slim margins that separate success and failure. At the 2024 Summer Olympics, Noah Lyles won the men's 100 m sprint by just 0.005 seconds, with the top seven athletes all finishing within 0.09 seconds of each other.

Marginal gains—an economics term popularised by a former performance director of British Cycling, Dave Brailsford—play an important part in training and winning. Even an athlete's hairstyle can mean the difference between winning and losing these races. Long curly hair or loose fitting clothing can add 0.07 seconds to a finish time, which would be enough for Lyles to have missed out on a gold medal.

It's no wonder that this science of success has been applied to healthcare. To prevent us being blinded by the obvious, however, we must recognise the huge difference between elite sport and public health systems. This week's *BMJ* investigative feature (p238-241) details the abysmal, crumbling state of UK hospitals, including those in Wales, where I work.

Against this backdrop of constant sewage leaks, broken sinks, and a lack of isolation facilities, people are doubling down on marginal gains to save the day. The posters telling us to "roll up our sleeves," "take off our watches," and "only wear wedding rings" have become bigger and brighter, in bold block capital letters.

Rather than being used in combination with long term, sustainable fixes, marginal gains alone are being used to tackle the major failings that affect patient care. Often, these marginal gains lack evidence and are little more than a loin cloth used to cover the embarrassing state of NHS infrastructure, which isn't being fixed owing to a lack of funding. It's a bit like me shaving my legs to improve my 50 m swimming time while using doggy paddle rather than swapping to freestyle.

For those of us working in healthcare, this is more than just an irritation. It can drive a wedge between the clinical staff affected by such meaningless policies and those who are enforcing them. The term "moral injury" is increasingly used to describe the psychological, emotional, and spiritual distress that arises when someone perpetrates, witnesses, or fails to prevent actions that conflict with their deeply held moral or ethical beliefs. I would like to suggest a new term: "logic injury." This describes the psychological, emotional, and organisational distress that arises when someone perpetrates, witnesses, or fails to prevent actions that are entirely illogical or are out of proportion with other interventions that are far more meaningful but not done.

I don't pretend that the challenges involved in tackling a creaking healthcare estate are simple to solve. But neither are the complications that arise from not doing so. Simply berating the people most affected by the illogical policies that act as a shadow to cover the underlying poor state of buildings will only result in more gold "wedding" rings being worn, rather than gold medals being given for patient care.

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These marginal gains are little more than a loin cloth used to cover the embarrassing state of NHS infrastructure

ROLE MODEL

John Mulinga

The consultant psychiatrist talks to **Erin Dean** about how the kindness of a senior colleague inspired him to support doctors in training throughout his career

John Mulinga started working in mental health after meeting the first consultant in his career who was truly welcoming. "This consultant wanted to know a bit about me before we started the training, which was quite different to the other roles I'd had," says Mulinga, who works as a consultant psychiatrist for Lancashire and South Cumbria NHS Foundation Trust.

"I'd never had a time before that when the consultant said, 'Sit here and let's just have a chat about who you are, what you want, or how we can best help you.' But that's exactly what happened when I started with that psychiatric consultant. At the end of my three month placement my mind was made up to stay."

Mulinga had wanted to be a doctor ever since being rushed to hospital as a child after drinking from a bottle of what he thought was water—but which turned out to be paraffin. Watching the medical staff as a 5 year old motivated him to pursue medicine as a career throughout his school years in Malawi.

He was one of three students from the southern African country who secured a British Council scholarship to study medicine at Manchester University, arriving in 1979. While it was a big change for a young man who had never left his home country before, he and the other two students supported each other, he recalls. "One of the good things was that there were already a number of Malawians studying in Manchester, so they looked after and supported us as well."

He has stayed in the north west of England ever since and after four decades in the NHS, two of those as a consultant, he has recently dropped down to a part time role.

During his career Mulinga has specialised in psychiatry for older people and those with substance misuse problems. Caring for older people with mental illnesses, with the opportunity to understand and unpick the impact of their comorbidities and medications, is an area he has found rewarding and stimulating.

Another area of interest has been the misuse of alcohol and benzodiazepines in older people, which can be much harder to pick up than in younger people. "While in younger people you may see problems at work, road traffic accidents, or fights, as older people tend not to be working they are more likely to be drinking at home and may present more with falls, bleeding, or depression," he says.

"Another important area of work has been with the memory clinic, as alcohol can be an important factor in memory problems for older people."

Alongside his clinical work, Mulinga has been dedicated to supporting junior members of staff throughout his career. This includes preparing resident doctors for their membership of the Royal College of Psychiatrists exams, and, once a consultant, becoming an educational and clinical supervisor.

"Only when we understand our strengths and weaknesses can we help each other"

Supporting international medical graduates who have joined the NHS has also been a focus for Mulinga, and he served as a tutor for specialist, associate specialist, and specialty doctors for three years.

Throughout he has set out to replicate the welcome that he received when he joined psychiatry. "The experience I had with my first consultant in psychiatry stayed with me," he says. "I try to see if I can make trainees feel welcome—feel that we're actually interested in supporting them and interested in them. We are all different, but we all have something to contribute. It's only when we understand our strengths and weaknesses that we can help each other."

Mulinga spends time talking to new recruits, sharing information about himself and inviting them to do the same. "I ask them what they've done, what their aims and goals are, and how they like to do things."

He says it can be challenging when young doctors rotate into psychiatry and make it clear that they are only there because they have to be, and don't want to engage. A deeper understanding of mental health can benefit doctors who want to specialise in any area, he says.

Flattening the hierarchy so that less experienced doctors can speak up is also important. "I want us to treat each other as equals," he says. "I'll say to them, 'If you see me do something that you're not sure about, don't shy away from asking me why I'm doing it.' I want to create an atmosphere where people can bring out their best."

Erin Dean, *The BMJ*

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NOMINATED BY RADWA EL-ATTAR

"Two years ago Dr Mulinga welcomed me to his team as a doctor new to the country, the NHS, and to older adult psychiatry.

"He was gentle and patient with my lack of knowledge about the culture of the NHS and England.

"The most impressive thing about Dr Mulinga is his compassionate leadership style and dedication to serving vulnerable patients.

"I have never encountered a mentor with such wisdom, passion, and resilience. And, above all, kindness. Working with him was a lifechanging experience."

Radwa El-Attar, specialist psychiatrist, Devon

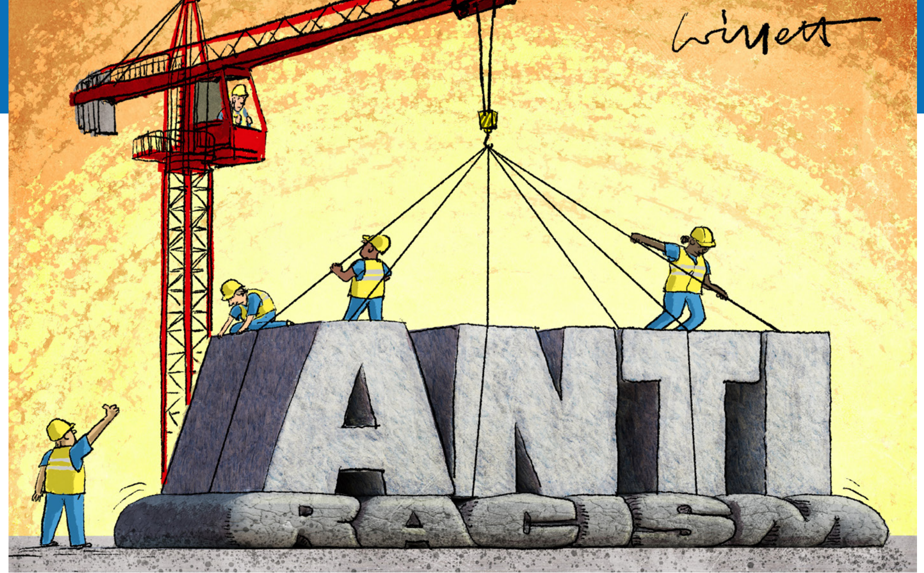
NOMINATE A ROLE MODEL

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

How can I be antiracist?

Actively challenging racism takes courage, **Abi Rimmer** hears



It requires work and considerable effort

Aaliya Goyal, GP with special interest in occupational health and wellbeing

"Racism, in all forms, has no place in healthcare. However, it does exist, and it leaves a devastating impact on colleagues and patients and has consequences for patient safety.

"Being antiracist means recognising that we're part of a racist system. This can be challenging, as it requires introspection, humility, and an acknowledgment of privilege, which can lead to an uncomfortable epiphany: we're all part of a system that wasn't built for everyone.

"Being antiracist is a call to action: a commitment to learn, understand, and actively participate to eliminate racism. It requires work and considerable effort and goes beyond simply not being individually racist or discriminatory. Changing ingrained structures can cause fear, due to a perceived loss of the status quo. We need to move past that and actively target, challenge, and remove the systemic barriers that enable racism.

"I strive to be antiracist by sponsoring and advocating relentlessly for colleagues. I notice barriers in application processes, absences in leadership teams, and gaps in healthcare that contribute to health inequalities. I speak up and do my best to overcome these challenges and to embed change. Once you start looking through an antiracist lens, you notice things that are difficult to unsee. The current systems were built by a demographic that doesn't reflect the current population and workforce. We have the power to change that.

"Being antiracist is everyone's responsibility. We must all feel accountable."

Challenge your own biases

Partha Kar, consultant in diabetes and endocrinology

"We all have biases, and among them stands our bias about race. The question is how we challenge that, how we become better, and how we act when we see something happening in front of us that's racist in nature.

"When I talk about challenging one's own bias, I'm talking about racism being more than a white versus non-white issue. Colourism, for example, continues to be an issue in my own South Asian community, and antiblackness isn't a concept confined to people of white ethnicity. How we challenge ourselves on that and how much we stand up to those issues is very important for our own development. It certainly is for me.

"As regards understanding or pushing oneself to be antiracist, I quote the great John Amaechi [psychologist and former NBA basketball player]: 'There's a big difference between being not racist and being antiracist.' To put it simply, a non-racist person can look at a racist incident and decide to keep quiet and not rock the boat. They understand that the incident is wrong, but they do nothing about it. An antiracist person makes sure that they push back against a racist incident—respectfully yet firmly, in public—making it clear to all around that the incident they witnessed was racist.

"It may feel as though you can't change the bigger picture, but this shouldn't stop you speaking up when you see something offensive or racist. Be a vocal ally: that's what antiracism is fundamentally about."

Say it. See it. Sort it

Evelyn Mensah, consultant ophthalmic surgeon

"Say it. See it. Sort it. These three steps are my framework for antiracism, providing a clear pathway to move from acknowledgment to recognition and then to action.

"Racism is a problem we can't solve unless we name it. Yet many people struggle to say the word racism, skirting around the issue with euphemisms. 'Say it' means acknowledging that racism exists and understanding that antiracism is not about labelling individuals as racist but about tackling the systemic policies, practices, and procedures that uphold racial inequities.

"'See it' requires looking at the data. NHS England publishes the Workforce Race Equality Standard, highlighting the disadvantages faced by Black and minority ethnic staff. The same structural inequities affect patient outcomes, as seen in disparities in maternal mortality and survival rates in prostate and breast cancer, for example. Recognising these patterns moves us from personal discomfort to systemic accountability.

"Antiracism is not passive but is a continuous process. 'Sort it' demands action. It requires dismantling systemically racist structures within institutions. Essential to this journey is self-education but reading alone is insufficient, so individuals and organisations must actively develop and implement action plans to challenge inequity.

"Antiracism requires courage, so please join me on this journey of 'Say it. See it. Sort it.' Anything less is complicity, and that's unacceptable in 2025."

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