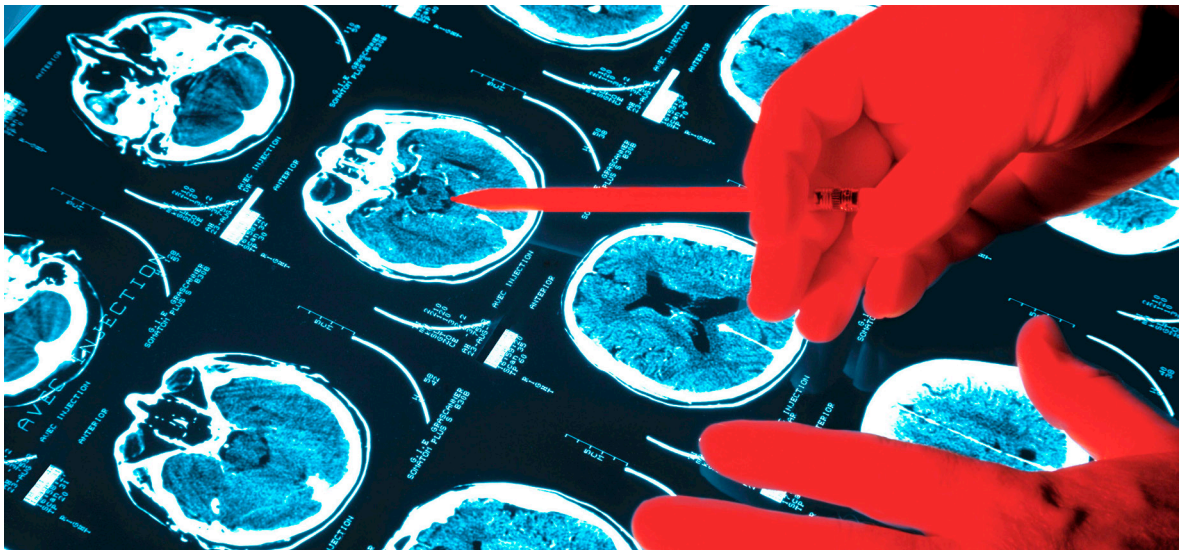


PETER BOWATER/SPL

"Incompetent" process recalls job offers

Radiology specialty training posts offered to resident doctors were retracted after an error in the application process

An error in ranking applicants for radiology specialty training programmes has led to job offers for some doctors being retracted.

Resident doctors were sent the outcomes of their applications on 24 March. They later received an update telling them the offers had been made in error, as only one component of the multistage selection process had been taken into account. Offers based on the correct rankings were reissued two days later.

Ahmed Mohamed had applied for radiology for the second time, having failed to secure a job offer last year. He told *The BMJ* he was "so happy and excited" when he got an email telling him he had succeeded this time. But after calling his family to celebrate he had to tell them hours later that his offer was in question.

He then spent two days constantly checking his emails. When the update came it advised him there was in fact no job offer for him.

He said, "If I'd got the bad news the first time round, I could have accepted that. But now, I feel like I've lost faith in the NHS. There was no real apology, no offer of support, and no information about how they will stop this happening to other people in the future."

Jasmine, a foundation year 2 doctor who asked *The BMJ* not to use her surname, said she was "pleasantly surprised" when she initially received an offer for her top choice of training programme. After spending two days "in limbo" after hearing of the errors, Jasmine had her original offer reinstated. But despite describing herself as one of the lucky ones she is frustrated by the "sheer incompetence" that caused the error.

Katharine Halliday, president of the Royal College of Radiologists, said, "This kind of error should be a 'never event' for NHS England. This will have been devastating for the doctors, especially in a year when there is such competition for training places. My heart goes out to everyone who was affected by this.

"We are in close contact with NHS England, asking for greater transparency on the process, asking for reassurance that this will never happen again, and ensuring that any affected candidates will be well supported."

An NHS England spokesperson said, "The NHS is extremely sorry for the distress caused to candidates and are liaising with applicants directly on next steps."

Ella Hubbard, *The BMJ*

Cite this as: *BMJ* 2025;388:r635

LATEST ONLINE

- "Abrasive culture" at Scotland's largest health board left doctors unable to raise concerns
- Patients with sensory impairment face higher safety risks, warns commissioner
- What is happening to the US National Institutes of Health?

MEDICAL NEWS

Assisted dying in England and Wales could be delayed as Isle of Man pushes on

CARL COURT/GETTY IMAGES

The timeline for the proposed introduction of assisted dying in England and Wales could be extended to four years, raising fears among supporters its introduction may be abandoned.

An amendment approved by the Commons committee scrutinising the bill came as the Isle of Man took its final step to legalise assisted dying, the first area of the British Isles to do so. The Isle of Man Assisted Dying Bill 2023 will now be sent for royal assent before an implementation period begins, with assisted dying potentially available to terminally ill residents from 2027.

The deferral in England and Wales was proposed by Kim Leadbeater (left), the Labour MP behind the private member's bill. She proposed the amendment to change the maximum implementation period from two to four years after consulting with civil servants, who advised that more time would be needed to set up training and systems for the new service.

The amendment was approved by the cross party committee overseeing the bill but will need to be voted on by MPs at the next stage of the process.

If the amendment is accepted the earliest an assisted dying service is expected to be operating is 2029, the year by which the next UK general election must take place.

Jacqui Wise, Kent Cite this as: *BMJ* 2025;388:r606

General practice

Reform in Scotland fails to ease pressure on GPs

A deal for GPs in Scotland that promised to transform their working lives has been a failure, said a damning report from Audit Scotland. A contract agreed with the Scottish government in 2018 sought to tackle the financial pressures and growing workloads facing GPs and to improve access to care. Instead, said the report, pressure had increased, investment as a proportion of overall NHS spending had fallen, as had the number of full time GPs, and patients reported finding it more difficult to get care.

Infectious diseases

Warning over rise in TB and measles in England

England saw rising cases of tuberculosis and measles and an intense season of flu and respiratory syncytial virus (RSV) in 2024-25, meaning "we cannot be complacent," said Jenny Harries (below), outgoing head of the UK Health Security Agency. The agency's first report on infectious diseases showed 600 new cases of TB in England in 2024, 13% more than in 2023. England also had a recent surge in measles, with 362 laboratory confirmed cases in 2023 and 2911 cases reported in 2024, mainly in children under 10.

Orthopaedics

Panel reviews 800 Addenbrooke's hip patients

A panel of expert clinicians will examine the treatment of around 800 patients by a now suspended, but unnamed, consultant paediatric orthopaedic surgeon at Addenbrooke's Hospital in Cambridge. The external retrospective review follows an initial review of complex hip surgery cases over the past two and a half years, which found nine children had received substandard care. Cambridge University Hospitals NHS Trust has also commissioned an independent investigation into any missed opportunities to identify concerns.

Pension tax

BMA calls for changes to "absurd" rules

A BMA survey of more than 5000 senior doctors found many had reduced work because of pension tax rules, to such a degree that if replicated it would equate to losing around 5400 full time consultants. The BMA said this was almost 10% of the capacity that could help the NHS in England to tackle waiting lists this year. It estimated that, for GP partners, the reduction in hours represented a potential loss of around four million appointments. The BMA has written to the Treasury to remove the tapered annual allowance on pension pots, to help stop doctors being disincentivised to work.

Smoking

Tobacco bill decreasing age of sale wins Commons vote

MPs voted in favour of the Tobacco and Vapes Bill by 366 votes to 41 during its third reading. The landmark bill would raise the minimum age for sale of tobacco by one year every year, meaning anyone aged 16 or younger would never be legally sold tobacco. The bill will now move to the Lords. Hazel Cheeseman, chief executive of Action on Smoking and Health, said, "Phasing out the sale of tobacco will protect future generations from the harms of smoking. Sooner or later, smoking will be just a footnote in history."

Prescribing

Prepayment certificates save money

The NHS Business Services Authority said 3.3 million patients used a prescription prepayment certificate (PPC) exemption in 2023-24. The authority's experimental estimates showed that these patients could have spent £817m in prescription charges had they not had a PPC exemption. The report noted that, although more PPCs were being issued every year, some patients had paid for 12 or more prescription items or for three or more PPC eligible HRT prescription items, which would cost more in prescription charges than the cost of an annual certificate.

HIV

Foreign aid cuts could undo decades of progress

Up to 10.8 million additional new HIV infections and around 770 000 to 2.9 million HIV related deaths in children and adults could occur worldwide in the next five years if funding cuts proposed by the top five donor countries, including the US and UK, are not mitigated, said a study. The modelling, published in the *Lancet HIV* journal, said populations in sub-Saharan Africa would be likely to be most affected.

IN BRIEF

H5N1

UK reports first case of avian flu in sheep

The UK confirmed a case of H5N1 influenza of avian origin in a sheep, a world first. The infection in the animal in Yorkshire was identified through routine and repeated milk testing, which was enforced after avian flu was confirmed in captive birds on the same premises. The sheep has now been destroyed, and no other cases of avian flu have been detected in the remaining sheep. This is the first time the virus has been reported in a sheep, but avian flu has been reported in dairy cattle in the US.

A sheep from Yorkshire is the first in the world to have H5N1 diagnosed

Targets

Think tank calls for rebalancing of funding

The King's Fund called on the government to rebalance spending towards primary and community care and to return hospital spending to below 50% of the NHS budget in the medium term. A new report from the think tank argued that the NHS was stuck in 1948 (below), with a model of care based on patients getting sick, being patched up, and going home. Instead, it argued, more

should be spent on helping people to stay healthy. It also called for an overhaul of existing hospital focused performance targets that were hindering progress towards a more sustainable NHS.

Surgery

Updated guidance emphasises respect

The Royal College of Surgeons of England has published *Good Surgical Practice 2025*, setting the standards for delivering safe, compassionate, high quality surgical care. The revised document puts added emphasis on constructive working environments, expressing the college's commitment to eliminate discrimination, harassment,

sexual harassment, and victimisation, as well as advancing equality of opportunity. It also highlights evolving challenges in surgery, including the rise of new technologies such as robotic surgery, and the need for environmental sustainability.

Regulation

Nottingham maternity units still require improvement

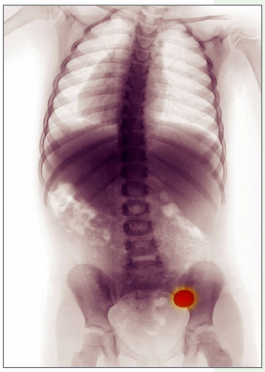
The Care Quality Commission inspected maternity services at Nottingham City Hospital and Queen's Medical Centre after receiving information of concern among staff at both services. Both were again rated as "requires improvement" overall and for being safe and well led. The rating for being effective improved from "requires improvement" to "good," and caring was re-rated as good. The inspectors identified breaches of regulation in safe care and treatment at both hospitals, relating to infection control procedures, equipment safety, and medicine storage.

Cite this as: *BMJ* 2025;389:r644

MENTAL HEALTH

The amount the NHS spends on mental health is forecast to fall from **8.8%** of its total funding in 2024-25 to **8.7%** in 2025-26, despite mental ill health accounting for about 20% of the UK's ill health

[Department of Health and Social Care]



SIXTY SECONDS ON . . . COIN SWALLOWING

THE LATEST YOUTUBE CRAZE?

Thankfully not. Instead, this is good news. Surgeons have linked moves to a cashless society to a dramatic drop in children needing operations for swallowing small items such as coins.

CASH ISN'T KING?

Researchers reviewed hospital episode statistics (HES) from 2000 to 2022 for procedures to remove foreign bodies from the alimentary tract, respiratory tract, and nasal cavity in 0-14 year olds. The study, published in the *Annals of the Royal College of Surgeons of England*, found the total number of procedures fell by 28% from 2405 in 2012 to 1716 in 2022.

THE PENNY DROPS

There are likely to be fewer lying around the house. Contactless payments were first introduced in the UK in 2007, and cash payments declined from 2012. The study found no statistically significant change in the number of removal procedures from 2000 to 2012 but a significant drop in the next 10 years. Surgeons performed 484 fewer procedures to remove something from a child's nose in 2022 than in 2012 (a 31% fall), 195 fewer from the digestive tract (28%), and 10 fewer involving the respiratory tract (8%).

COIN-CIDENCE?

A limitation of the study was that HES data do not specify the foreign body ingested or inhaled. Historically, coins accounted for more than three quarters of items swallowed by children under 6. But coins are rarely inserted into the nose—more common are beans, pins, teeth, screws, and food. Objects stuck in the airways are usually food items. Because there was a reduction in removal of foreign bodies across all three groups, the study authors concluded that the trend was "likely multifactorial." Other factors include better parental awareness, improved childproof packaging, changes in data collection, and shifting behaviours since the pandemic.

SO, NEW PARENTS CAN RELAX?

Not really. Ram Moorthy, a consultant ENT surgeon, warned, "We worry about other dangerous items, such as button batteries and magnets, that can really cause harm. We must continue to make sure small items are not within a child's reach."

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r633

LUCY LETBY: **Families' lawyers cast doubt on panel's findings that questioned convictions**

Lawyers for families whose babies the nurse Lucy Letby was convicted of killing or assaulting have cast doubt on the findings by an international panel of experts that seem to exonerate her.

The 14 strong panel revealed its conclusion that the deaths were attributable to natural causes or poor medical care at the Countess of Chester Hospital, where Letby worked, at a press conference organised by her barrister, Mark McDonald, in February.

Letby is serving 15 life terms after being convicted of murdering seven babies and attempting to murder seven others between June 2015 and June 2016. McDonald is asking the Criminal Cases Review Commission to send the case back to the Court of Appeal, after Letby's previous attempts to appeal were turned down.

In written submissions to the Thirlwall inquiry the legal team representing several babies' families, led by Richard Baker, noted that the panel, assembled by the retired Canadian neonatologist Shoo Lee, was asked to carry out case note reviews and decide whether the records revealed alternative causes of death. Each case was reviewed by two experts.

The experts are clear that the jury was misled on key evidence
Mark McDonald

"Obvious limitations"

The lawyers said, "It is not suggested that the panel saw transcripts of the evidence given at trial, that they necessarily saw all of the expert reports provided at trial, or that they saw other evidence, such as the witness statements provided by other witnesses or read transcripts of their evidence given at trial.

"The families will say that this creates an obvious limitation in the panel's approach. Firstly, in looking at cases in isolation the experts are vulnerable to the suggestion that they miss the bigger picture or that evidence that could be drawn from one case might influence their interpretation of another."

The legal team representing the families cited the cases of three children with siblings who also collapsed or died within a short time before or after they did. "The families would think it obvious that, when trying to consider evidence as a jury might have done, it is important to look at that evidence as a whole, not in silos. As there is nothing in the panel's report to suggest that Children A, F, and O had conditions that would also have harmed their siblings, why did their siblings collapse or die in quick succession following interactions with Letby? Another collection of unfortunate coincidences?"

In looking at the case of Child E, the medical records were misleading

"Sex and gender identity confusion in official data has dangerous implications"

A growing tendency in official data to ask a person for their gender identity rather than sex is having serious consequences in some areas of healthcare such as missed cancer screenings and mistakes in blood testing.

An independent, government commissioned report concluded that public bodies should collect distinct data on both sex and gender identity to ensure that data are accurate and clear.

Gender replacing sex

The report, published by the Department for Science, Innovation, and Technology, shows how the word "gender" started to replace "sex" in some data collection in the 1990s, and in some survey data gender was defined as "sex" while in others gender was defined as "identity."

The authors found that from around 2015 the word "gender" started to be understood in terms of the gender with which people identify, which can be different from their sex, which meant accurate data on biological sex were lost.

Currently, people of any age can request a change to their sex marker on their NHS medical record. One of the report's recommendations is for the NHS to stop the practice of giving out new numbers and changed gender markers. This is because data on sex are lost and can put individuals at risk regarding clinical care, screening, and safeguarding, said the report.

We've lost data on sex as people try to merge two things into one variable
Alice Sullivan

The NHS's failure to record sex on patients' records has led to trans patients not being called in for screening for conditions that might affect them, said the authors. This has potentially fatal consequences.

Alice Sullivan, head of research at University College London's social research institute, who led the review, said, "Government and other data owners should collect data on both sex and transgender and gender diverse identities. This will help develop a better understanding of the influence of both factors and the intersection between them, and this is crucial for research and policy making."

Speaking on the BBC's *Today* programme, she said, "We've lost data on sex, and not because somebody has made a decision to stop collecting data on sex but because there's been confusion between sex and transgender and gender diverse identities and people trying to merge these two things into one variable. There's no reason to see this as a trade-off between the two."

After the report was published Wes Streeting, the health and social care secretary, announced he was instructing the NHS to suspend applications for number changes for under 18s requested on the basis of gender change.

Adrian O'Dowd, London

Cite this as: *BMJ* 2025;388:r589

because Letby altered them, the lawyers representing the families said. In analysing Child G's case, the panel failed to mention a very large projectile vomit, far exceeding the very small amount of milk she had received, the families' lawyers added. Rather than being critically unwell at the time of vomiting, the child was doing well.

"No evidence of infection"

In the case of Child I, the panel postulated the colonisation of an endotracheal tube (ETT) with *Stenotrophomonas maltophilia*, causing thick secretions. But testing did not reveal evidence she developed such an infection and she had not had an ETT in place for some time before her death, the families' lawyers said.

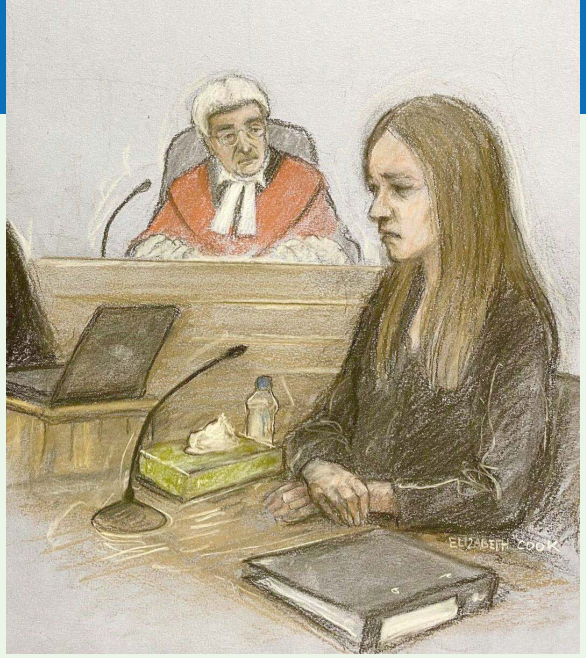
They added that the families were concerned that the panel experts were all neonatologists or paediatricians, with one expert in infectious diseases, and none seemed to possess any forensic experience.

The families' legal team suggested that the panel seemed to have adopted some lines of argument excluded during Letby's trial or by evidence given to the Thirlwall inquiry. For example, the panel surmised that the fact that Child A's mother had a blood clotting disorder might suggest that he was prone to develop blood clots. A haematologist at Great Ormond Street Hospital who reviewed A's blood samples told the inquiry, however, that he had not inherited his mother's clotting disorder.

The lawyers said Letby had experts available to her at trial, who had access to all the same material available to the prosecution experts and who provided multiple reports, yet she produced no evidence from expert witnesses at her trial.

"She understood that as clear as her experts were in their written reports, when faced with the full evidence, and when questioned by the prosecution, they would have effectively convicted her.

"The key deception in Letby's approach in holding press conferences is that she can present evidence without the risk it will be analysed, challenged, or questioned. It permits her to control the narrative without having to explain why she chose not to call that evidence at trial," added the families' legal team.



In press conferences Letby can present evidence without the risk it will be analysed, challenged, or questioned
Family lawyers

McDonald said, "The experts are clear that the jury was misled on key evidence and this has led to a wrongful conviction. The summaries previously released were just that, and the full reports run to over 1000 pages.

"My heart goes out to the families, and we have offered to share the full reports with them, but their lawyers have not taken us up on this offer."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;388:r594

Doctors forced to "pick up the pieces" as 250 000 more people go into poverty

The government is facing a fierce backlash over welfare cuts that a new analysis says will push an additional 250 000 people—including 50 000 children—into relative poverty by 2030.

Under the policy 3.2 million people will lose around £1720 a year, said an impact assessment published by the Department for Work and Pensions (DWP) on 26 March.

Disability charities said the effect would be "catastrophic" for people who were unable to work and that those already the most vulnerable would be hit the hardest. The BMA said the cuts were short sighted and counterproductive and could "pile more pressure on health services as doctors and their colleagues are left to pick up the pieces."

The welfare reforms announced by the work and pensions secretary, Liz Kendall, are designed to save £4.8bn by the end of 2030. On 26 March the chancellor of the exchequer, Rachel Reeves, announced further adjustments in her spring financial statement to MPs, after the Office for Budget Responsibility found the initial plans would not raise that level of savings.

Personal independent payments

The biggest single cut will come from a rise in the eligibility threshold for personal independent payments (PIP) to save £4.5bn. Universal credit will also be cut, by £1.1bn.

Reeves told MPs that a more "sustainable" welfare system would protect the most vulnerable people, with an extra £1bn a year invested by 2029-30 to provide support to help people with disabilities or long term health conditions back into work. The DWP's analysis did not include the impact of that £1bn, which it said "we expect to mitigate the poverty impact among people it supports into work."

The analysis found 3.8 million families would gain from the package, with an average gain of £420 a year when compared with inflation. It estimated PIP changes would mean 800 000 people would lose entitlement—370 000 who receive it currently and 430 000 who would have done so in the future. The average loss is £4500 a year, the DWP said.

The Resolution Foundation said the combination of the UK's weak economic outlook and benefit cuts that fall "disproportionately"

UNDER the policy 3.2 million people will lose around £1720 a year

on lower income families meant living standards were on track to fall over the next five years for the poorest half of households, by £500 on average. "While the chancellor was right to balance the books, she was wrong to do so on the backs of low to middle income families, on whom two thirds of the welfare cuts will fall," said Ruth Curtice, the foundation's chief executive.

Matthew Limb London

Cite this as: *BMJ* 2025;388:r613

TRUMP WATCH

More cuts and White House briefings have fuelled fears over health and research in the US and beyond

South Africa, HIV/AIDS hit hard

HIV and AIDS researchers in South Africa are reeling from the termination or suspension of grants from the US National Institutes of Health (NIH). *Science* reported the cuts seem linked to a crackdown on grants with elements of diversity, equity, and inclusion. Researchers told *Science* that grants related to LGBTQ+ health in the US were also pulled. The Bhekisisa Centre for Health Journalism reported a leaked memo that instructed NIH staff to "hold all awards" to South Africa, listing it as a "country of concern" with China.

Fears for PEPFAR grants escalate

Congressional approval for the President's Emergency Plan for AIDS Relief (PEPFAR) expired on 25 March, leaving it with minimal funding for the rest of the financial year. Trump has terminated many PEPFAR grants and contracts. Health Policy Watch reported that clinics linked to PEPFAR are closing and prescriptions are not being refilled. WHO said that Burkina Faso, Haiti, Kenya, Lesotho, Nigeria, South Sudan, and Ukraine are likely to run out of antiretrovirals in weeks.

Hostility to mRNA vaccines

Trump is said to be reconsidering a $590m Biden era contract with Moderna to develop human vaccines against H5N1 avian flu, currently ravaging US farms. Experts said the virus could mutate into one capable of spreading among humans, triggering another pandemic. NIH staff have been ordered to compile a list of research grants involving mRNA vaccines.

Mun-Keat Looi, *The BMJ*
Owen Dyer, Montreal

Cite this as: *BMJ* 2025;388:r645

YURI GRIPAS/ ABACA PRESS/ALAMY

Sceptic named lead in vaccine and autism study, as 10 000 staff cut from US health agency

The head of the US Department of Health and Human Services (HHS), Robert F Kennedy Jr, announced on 27 March that he would cut 10 000 employees from department agencies as part of government restructuring by Elon Musk's Department of Government Efficiency. Another 10 000 HHS employees have left through early retirement and buyouts. President Donald Trump had previously told Kennedy to "go wild on health."

Major changes

Other major changes are also under way in the agencies that sit under HHS. The Centres for Disease Control and Prevention (CDC) will lose about 3500 employees and get a new head, Susan Monarez, current acting director. Trump's original choice, David Weldon, was withdrawn when it became clear he didn't have enough votes for approval.

The CDC will also conduct a large study to investigate a possible link between vaccines and autism, although many studies have debunked such a link. Researcher David Geier, who is not a doctor and who was disciplined by Maryland's Board of Physicians for practising medicine without a licence, has been reported to be heading the study. He and his physician father have many times claimed that vaccines cause autism.

David Geier is not a doctor and was disciplined by a state Board of Physicians for practising medicine without a licence

Peter Marks, the US vaccine regulator and a leader in the programme to develop a vaccine for covid-19, resigned from the CDC on 28 March instead of being fired. Marks, who headed the CDC's Center for Biologics Evaluation and Research, wrote in his resignation letter, "It has become clear truth and transparency are not desired by the secretary [Kennedy], but rather he wishes subservient confirmation of his misinformation and lies." In a *New York Times* interview he said, "This man doesn't care about the truth. He cares about what is making him followers."

As head of HHS Kennedy oversees the $8bn Vaccines for Children programme, which protects about 38 million children from low income families from childhood diseases. Kennedy has a history of linking childhood vaccines to autism and of advocating other treatments.

Vitamin A for measles

Faced with the current measles outbreak, which began in Texas and has now spread to at least 400 people in several states, Kennedy offered a lukewarm endorsement of vaccines and recommended cod liver oil for vitamin A. Doctors at a children's hospital in Lubbock, Texas, reported children with liver damage after receiving high doses of vitamin A.

HHS oversees the CDC, the Food and Drug Administration (FDA),the National Institutes of Health (NIH), and the Centers for Medicare and Medicaid Services (CMS).

HHS said that the cuts were part of a

restructuring that would save taxpayers $1.8 bn a year and would reduce the department's workforce by about 25%. Its 28 divisions would be consolidated into 15, including a new Administration for a Healthy America, which would improve coordination of services for people on low incomes.

FDA and NIH heads confirmed amid cuts

The FDA, which will lose about 3500 employees, will be headed by Marty Makary, chair of gastrointestinal surgery at Johns Hopkins School of Medicine in Baltimore and a former member of *The BMJ*'s editorial advisory board, after confirmation by the US Senate last week. He is known for criticising the medical establishment. He was the lead author of a surgical checklist that has been widely adopted and credited with improving safety in surgery.

The NIH will lose 1200 employees through centralising services in its 27 institutes and centres. Jay Bhattacharya, a health economist and professor of medicine at Stanford University in California, was confirmed by the US Senate last week to head the agency. He has a PhD in economics and heads Stanford's Center for Demography and Economics of Health and Aging. His research focuses on the economics of healthcare.

HHS said the cuts were part of a restructuring that would save taxpayers $1.8 bn a year and would reduce the department's workforce by about 25%

The CMS will lose about 300 employees. Mehmet Oz, a celebrity surgeon, is widely expected to be confirmed by the Senate to head the agency, which oversees medical care for about 160 million people through Medicare (the health insurance scheme for elderly and some disabled people), Medicaid (the scheme for people on low incomes, pregnant women, and children), and the Children's Health Insurance Program.

Janice Hopkins Tanne, New York

Cite this as: *BMJ* 2025;388:r642

Susan Monarez is the newly appointed head of the Centers for Disease Control and Prevention, which will lose around 3500 employees

GONORRHOEA: **Rise of antibiotic resistant cases prompts call for greater use of condoms and tests**

A rise in England of cases of antibiotic resistant gonorrhoea, including extensively drug resistant (XDR) strains, risks making the sexually transmitted infection "untreatable," health officials have warned.

While most gonorrhoea infections can be treated effectively, increased resistance to ceftriaxone, the most commonly used antibiotic, poses risks, the UK Health Security Agency said.

Katy Sinka, a consultant epidemiologist and head of the STI section at the UKHSA, said, "The best way to stop STIs is by using a condom. If you've had condomless sex with a new or casual partner, get tested."

Figures from the UKHSA show 17 cases of ceftriaxone resistant gonorrhoea were recorded between January 2024 and last month. This compares with 16 during the whole of 2022 and 2023. Nine cases were reported between 2015 (when ceftriaxone resistant gonorrhoea was first detected in England) and 2021.

Of the 42 resistant cases reported since 2015, 15 were XDR, meaning they were resistant to ceftriaxone and second line treatment options.

XDR cases are also rising. From January 2024 to March 2025 there were nine XDR cases (six in 2024 and three in 2025 so far), up from five in 2022 and 2023 combined.

The UKHSA said most cases were linked to travel to or from the Asia Pacific region, where ceftriaxone resistance is common. Transmission within England has been limited so far, but the agency warned that the rising number of cases increased the chance of wider spread and challenges in treating it.

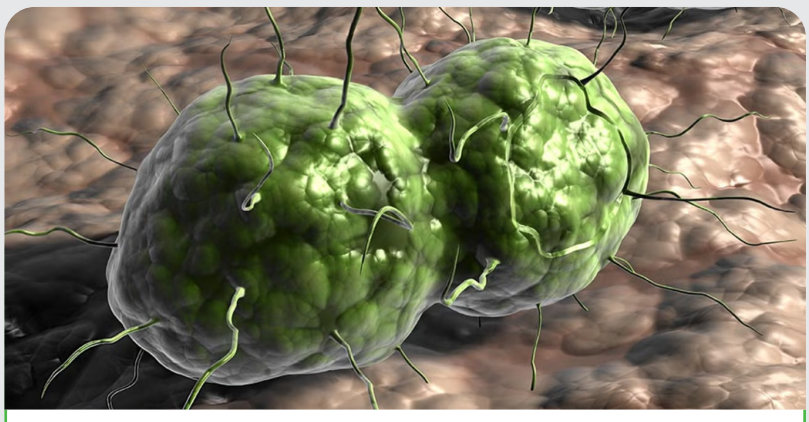
If you've had condomless sex with a new or casual partner, get tested Katy Sinka

Typical symptoms of gonorrhoea include a thick green or yellow discharge from the vagina or penis, pain when urinating, pain and discomfort in the rectum, lower abdominal pain, and bleeding between periods. But many infected people will have no symptoms, especially for infections in the throat, vagina, or rectum. The lack of symptoms makes it important to test regularly when having sex with new or casual partners, the UKHSA said.

Overall, the latest UKHSA data show around 54 965 gonorrhoea diagnoses at sexual health services in the first nine months of 2024. In the whole of 2023 85 000 were recorded.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;388:r622

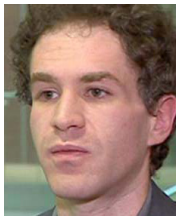


Figures from the UKHSA show that 17 cases of ceftriaxone resistant gonorrhoea were recorded between January 2024 and 20 March 2025 (13 in 2024 and 4 in 2025 so far). This compares with 16 during the whole of 2022 and 2023. Nine cases were reported between 2015 (when ceftriaxone resistant gonorrhoea was first detected in England) and 2021.

NEWS ANALYSIS

UK government is accused of unethical recruitment from "red list" nations

Since Brexit, ministers have flouted their own guidelines and initiatives by plugging NHS staffing gaps with staff from outside the EU. **Sally Howard** reports



Recruiting on this scale from countries WHO believes have troublingly few staff is difficult to justify ethically
Mark Dayan

The NHS is relying too much on recruiting doctors and nurses from countries that have their own significant healthcare workforce shortages instead of training and retaining enough domestic staff, a damning report has concluded.

By November 2024 around one in 11 NHS doctors in England (9%) held a nationality from a "red list" country—those listed by the World Health Organization (WHO) as having such a shortage of staff that other countries should not actively recruit from them—found the report from the Nuffield Trust think tank and academics from the University of Sheffield, Queen's University Belfast, and the University of Michigan.

The report, funded by the Health Foundation, found that since Brexit all UK countries had relied heavily on very high migration of healthcare staff from outside the EU.

Mark Dayan, Nuffield Trust policy analyst and Brexit programme lead, told *The BMJ*, "Yet again, British failure to train enough healthcare staff has been bailed out by those trained overseas. Recruiting on this scale from countries WHO believes have troublingly few staff is difficult to justify ethically for a still much wealthier country."

Dayan added that the strategy to plug gaps with migrant workers was also "risky" owing to shifting immigration policies and the unpredictable global labour market.

The figures prompted Wes Streeting, secretary of state for health and social care, to accuse the NHS of acting in an "immoral" way by depriving struggling nations of homegrown health professionals.

"Veneer" of ethical respectability

The UK government's own code of practice for international recruitment of health and social care staff in England, which was updated last September, states that one of its four objectives is to prevent "active recruitment to the UK" from countries on WHO's "amber" and "red" lists, "unless there is government to government agreement to support managed recruitment activities."

In 2023 the UK government gave £15m to Ghana, Kenya, and Nigeria to help boost their healthcare workforces. Last 6 September the Nigerian government approved the national health workforce migration policy, which used funds from the UK to "promote ethical recruitment practices, enhance data collection for better workforce planning, and invest in healthcare worker education and capacity building in Nigeria."

Last May Hampshire Hospitals NHS Foundation Trust announced an intake of 42 trained nurses from Nepal, another WHO red listed nation, in an ethical recruitment pilot scheme. Through the scheme Nepalese nurses gain NHS training in the UK as a means of boosting recruitment back home, as the NHS makes a per capita payment to the Nepalese government and benefits from an intake of nursing staff.

Jim Campbell, WHO director of workforce, said in response to the report that many of the red listed staff in question had applied directly for jobs in the UK and that therefore "unethical" recruitment by the NHS was much less common than the Nuffield Trust's overall numbers suggested.

But Howard Catton of the International Council of Nurses told the BBC that such deals were "trying to create a veneer of ethical respectability" rather than representing "a proper reflection of the true costs to the countries which are losing their nurses."

Post-Brexit reliance on non-EU staff

Since Brexit, the UK's reliance on healthcare staff from outside the EU has been particularly acute when it comes to nurses, the Nuffield Trust's report found.

Nurses trained in red list countries account for around a fifth of the total increase in NHS England nurses since the UK left the single market (at the end of 2020) up to September 2024. The number trained in red list countries rose by 15 151, of a total increase in nurses of 70 541. The number of registered nurses trained in red list countries also more than doubled in Wales, Scotland, and Northern Ireland respectively from 2021 to 2024.

Since 2018, 46% of the increase in red list nurses in the UK was from Nigeria, 21% from Ghana, and 16% from Zimbabwe. The number

MEDICINE SHORTAGES

In addition to its impact on recruitment, Brexit has led to "elevated and troubling levels of medicine shortages continuing," with no consistent sign of improvement in key indicators, the Nuffield Trust report found.

Medicine supply notifications issued to the Department of Health and Social Care by drug companies to alert the government to shortages were higher in 2024 than in 2022 or 2023. The report also found that the UK had the lowest import growth in medicines of any G7 country, driven by a reduction in EU imports.

IAN MILES / ALAMY

IN 2023 the UK government gave £15m to Ghana, Kenya, and Nigeria to help boost those countries boost their healthcare workforces

of Zimbabwean nurses in the UK is now more than a 10th of the number practising in Zimbabwe, the report found. Countries in the global south lose billions of dollars in the costs of training doctors and nurses who later migrate, as the receiving countries such as the UK save billions by recruiting healthcare workers who have been trained at the expense of poorer governments.

"Brain drain" in global south

WHO says that the drain of health professionals from the global south has had a crippling effect on public health systems and health outcomes. In 2021 life expectancy in Zimbabwe was 58.5 years, a two year drop from the already low 60.7 years in 2019, as its healthcare worker exodus mounted.

The mass migration of specialist nurses from Ghana has affected childhood immunisation rates and has led to higher mortality in hospital intensive care units.

Lynn Woolsey, chief nurse at the UK's Royal College of Nursing, told *The BMJ* that the college valued nursing colleagues "wherever they are from" but argued that it was "simply not sustainable nor ethical to ignore WHO guidelines and recruit from the most under-resourced healthcare systems in the world."

She added, "Aside from the disastrous impact on countries on the 'red list,' it is also a damning indictment of successive governments' unwillingness to properly fund and grow a domestic nursing workforce."

Perpetual Ofori-Ampofo, president of Ghana's Nurses and Midwives Association, told *The BMJ* that as wages in the UK were as much as seven times as high as in Ghana, nurses in her home nation desperately needed more incentives from their government to remain—particularly the highly trained nurses who commonly migrate, leaving hospitals staffed with trainee and auxiliary staff.

"You cannot blame individual nurses, as everyone has a right to migrate for better opportunities," she said.

Afiniki Akanet, a Nigerian GP working for the NHS in Oxfordshire, said that doctors from Nigeria migrated for better opportunities for themselves and their families, and she agreed with Ofori-Ampofo's sentiment that these workers should not remain in their home nations "out of a sense of guilt."

"Some of the most brilliant and hardworking healthcare professionals in the NHS are from Africa," Akanet told *The BMJ*. But she added, "In countries like Nigeria, basic healthcare is still a luxury for most of the population, and this does put an ethical duty on richer countries such as the UK to support staff retention there."

The Department of Health and Social Care's code of practice acknowledges a predicted global shortfall of 10 million health workers to achieve universal health coverage in low income and lower middle income countries by 2030. It states that the UK government "remains committed to be a force for good in the world and supports better health and care both within and beyond our shores."

The department was approached for comment but had not responded by the time of publication.

Sally Howard London

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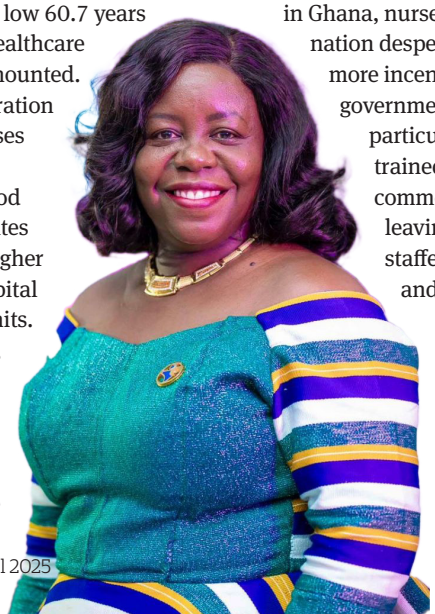
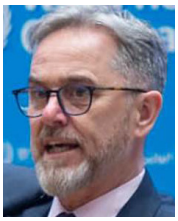


You cannot blame individual nurses, as everyone has a right to migrate for better opportunities Perpetual Ofori-Ampofo



Many of the red listed staff in question had applied directly for jobs in the UK
Jim Campbell

It is a damning indictment of an unwillingness to fund a domestic workforce
Lynn Woolsey

Some of the most brilliant and hardworking professionals in the NHS are from Africa
Afiniki Akanet

THE BIG PICTURE

Gaza: US doctor at bombed hospital says “the world doesn’t seem to care”

Doctors in Gaza have been "abandoned by the world" as they continue to struggle to provide basic healthcare amid renewed Israeli airstrikes, cope with a lack of staff and supplies, and come under threat of violence and death, a US doctor working at the recently bombed Nasser Hospital (pictured) has said.

Feroze Sidhwa, a US trauma surgeon who is volunteering in Gaza with the medical aid charity MedGlobal, told a press conference on 26 March that the horrors he had witnessed since entering the Gaza Strip on 6 March far exceeded anything he had seen during his humanitarian career, including during his three stints in Ukraine since the Russian invasion.

"Doctors feel alone. They feel abandoned by the world, and I think rightly so. When Russia bombs a children's hospital in Kiev everybody loses their mind, and rightly so," Sidhwa said. "But what's going on here is far more severe, and they see that the world, and especially the West, just doesn't seem to care and, actually, more so than the attack, that's what's hurting."

Sidhwa said many medical staff were being denied entry to Gaza and that three of the five doctors on his mission were not allowed in at the last minute.

Elisabeth Mahase, *The BMJ*

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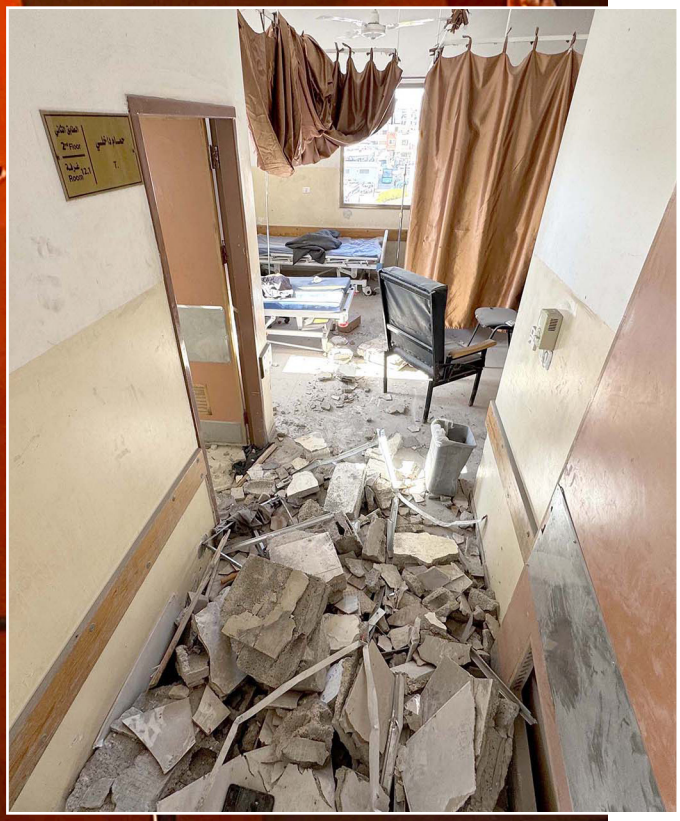

AFP/GETTY; ABDALLAH F.S. ALATTAR/ANADOLU/GETTY

EDITORIAL

UK welfare reforms threaten to harm health

Cuts to disability benefits will worsen health and the economy

The chancellor of the exchequer, Rachel Reeves, set out the UK government's spending plans in her spring statement on 26 March.[1] The consultative green paper, *Pathways to Work*,[2] outlined plans to cut several billion from the welfare budget, with the aim of saving £5bn by 2029-30.[3] The plans include stricter criteria for personal independence payments (PIPs) for people with disabilities; halving incapacity benefit payments under Universal Credit for new claimants; and restriction of incapacity benefit top-ups to those aged 23 and older.

Ministers have argued there is a "moral case" for these cuts, and that "people that can work [should be] able to work."[3] However, the chancellor's approach is unlikely to achieve this goal for two key reasons. First, high rates of economic inactivity in the UK reflect its almost unique failure among industrialised countries to recover population health after the pandemic,[4-6] which came on top of over a decade of declining health linked to austerity,[7] as well as long term structural weaknesses of precarious employment in a low pay economy.[8] Second, health outcomes and economic policy are inseparably intertwined—even if the government chooses to focus solely on the economy, it cannot expect growth without a healthy population.[5 6]

Evidence from austerity

The experience of the past 14 years of austerity is a warning. From 1945 to 2012, life expectancy in the UK rose steadily. But after 2012 it flatlined, and for those in the most disadvantaged areas, it declined,[9] caused by deep cuts to social security and local government spending.[7-11] The list of consequences is shameful, including increased infant mortality, deterioration of mental health, particularly in young adults,[12] and record numbers of children being taken into care in England.[13 14]

Policies to improve health are more likely to achieve economic gains

Policies justified on the grounds of austerity—including real term reductions in the value of benefits, stricter eligibility requirements, and harsher sanctions—have harmed health and pushed millions of people, especially children, further into poverty.[15-17] The cost of living has risen sharply in recent years,[18 19] leaving prices far higher than they were just five years ago. The combined result is that, since 2010, more people in Britain are experiencing destitution and many in full-time work live in poverty.[20]

Since 2012 the UK has seen the largest rise in child poverty among countries in the Organisation for Economic Cooperation and Development, according to Unicef.[21] Child poverty adversely affects child mental health, creating a cascade of mental health challenges into young adulthood,[22] which in turn creates difficulties transitioning into the labour market, and higher social security spending in the long term.[23]

A key proposal in the green paper is to tighten access to PIP—a benefit covering the extra costs of disability or long term health conditions—by raising the eligibility threshold. The Fraser of Allander Institute, an independent economic research centre, estimates that saving £1bn a year could mean about 250 000 fewer people receiving PIP.[24] Existing evidence suggests this is unlikely to increase employment rates.[25 26] Previous governments have sought to restrict eligibility to, and levels of, these benefits. Most notably, just over one million existing recipients had their eligibility re-assessed between 2010 and 2013, with benefits removed if the assessor thought they were fit for work. This led to an increase of 290 000 people with mental health problems, increased antidepressant prescribing, and an estimated 600 suicides.[27 28] It did not increase employment, but rather shifted people, particularly those with mental health problems, onto unemployment benefits, many of whom later moved back onto disability benefits.

When people become too sick to work, or when people with disabilities lose the support they need to enable them to live and work independently, there are costs to the state as well as to society, notably in terms of health and social care. Instead, enhancing social security and public services to improve population health, and creating high quality, better paid, and accessible jobs, is better evidenced as the key means to support people into work, and to reduce the costs of social security for those who are experiencing in-work poverty.[6] Policies and interventions to improve health are more likely to achieve the economic gains the government is pursuing.

Solving this austerity fuelled health crisis will take political will and commitment to recreate a society with high quality public services and rebuild a social security system that lifts people securely out of poverty. If the government is serious about supporting people with disabilities and long term health conditions to work, it needs to collaborate with people, with relevant lived experience, employers, and researchers to develop and implement effective, evidence based policies and interventions.[25]

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EDITORIAL

Clinical care for psychosis-related violence

Valdo Calocane case shows the importance of continuity of care

An NHS review into the clinical care of Valdo Calocane, who killed three people during a psychotic episode, found serious failings that contributed to his relapse and the tragic events that unfolded.[1 2] Nottinghamshire Healthcare NHS Foundation Trust reported that Calocane, who had been admitted to psychiatric hospitals four times because of psychotic episodes linked to schizophrenia,[2] was under the care of the early intervention psychosis (EIP) service, which provides standalone community support for people after their first psychotic episodes, including for those unwilling to engage with services.

EIP services were designed to have low ratios of clinicians to patients (roughly 1:15), with an emphasis on continuity of care.[4] However, the current reality is that care coordinator:patient ratios can be up to 1:35, which are insufficient to provide the intended assertive outreach approach whereby clinicians actively seek out people in their home settings when they are unwilling to engage with services.[5] At the time when they would most benefit from continuity of care, patients are transferred to crisis services or out-of-area private providers. In Calocane's case, this had direct repercussions—the EIP team requested that antipsychotic medications be started and that a community treatment order was put in place while he was in hospital, but inpatient teams did not institute either.

How to do better

A key lesson from the Calocane case is that people with severe mental illness and histories of violence should have a structured risk assessment to support clinical decision making.[6] Currently,

JONATHAN BRADY/PA/ALAMY

Lack of care coordination led to missed antipsychotic treatment

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assessments are insufficient and based on simplistic binary categorisations of "elevated risk" or "no risk." A structured risk assessment would allow consideration of factors such as previous violence or non-compliance with antipsychotic medications, as well as ensuring that clinicians consider all relevant variables rather than relying on recent, readily available information such as inpatient improvement.[7]

The case also shows the importance of strengthening multiagency working and information sharing, in particular with the police. This would also apply to risks of other adverse outcomes in schizophrenia, including suicide, self-neglect, and victimisation.[8] Calocane's first admission to hospital was triggered by a serious violent incident that would typically result in criminal charges but did not because it was connected to a psychotic episode. Pursuing charges is crucial to reinforce the importance of treatment and underscores that violence—regardless of its roots in mental illness—has serious consequences and must be factored into future risk assessments.

The case also highlights difficulties in how community treatment of severe mental illness is managed. A clinical staging model,[9] in line with other areas of medicine, has been proposed. Calocane's high likelihood of relapse and the associated level of risk to others would equate to a stage 4 illness, requiring the most intensive and assertive treatment. Calocane missed 11 of 15 appointments to collect medication after his last hospital discharge, and the clinical team were unable to contact him, leading to his eventual discharge to his general practitioner on 22 September 2022. There were no further healthcare contacts until his arrest in June 2023. Discharge to GPs because of non-engagement has become routine in mental health services and was rightly criticised in the NHS England review.[2] If his illness was recognised as being at the most severe stage (stage 4), discharge to a GP should not have been considered; instead Calocane's ongoing treatment would remain the responsibility of specialised mental health services.

Continuity of care is fundamental to high quality mental health treatment, and while transitions between services may be necessary, preventing tragic outcomes hinges on three key factors: collaborative decision making between inpatient and outpatient clinical teams, communication between specialist services and primary care, and consistent family involvement throughout these transitions. What changes can services make? First, EIP services need to be ringfenced and adequately resourced so that they can provide the more assertive care required in the early stages of illness. Second, mental health services should adapt their risk assessment processes to include more structured approaches that incorporate the new evidence of risk prediction and consider how to involve families further. Finally, continuity of care should remain the norm rather than the exception.

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REFUGEE CARE

Migrants in limbo and the doctors struggling to provide care

Caring for people in immigration removal centres can present GPs with complex practical and ethical difficulties, reports **Sally Howard**

MARK KERRISON/IN PICTURES/GETTYIMAGES

A United Families & Friends Campaign banner from last October lists immigrants who've died in detention

Several cases haunt Alan Mitchell from his 14 years as a general practitioner at Dungavel House immigration removal centre in Scotland (box). One man was deported to eastern Asia with a large bowel tumour that a prison GP had failed to find under examination, despite a textbook anal protrusion. The discovery of the tumour did not prevent the man's deportation.

Then there was the detainee with advanced multiple sclerosis whose symptoms had gone untreated for years owing to fear that GPs would report him to the Home Office. There were also avoidable deaths, Mitchell says, from cancers and communicable diseases—the result of late presentation. These losses, he says, "are all part of providing care to this highly vulnerable population."

Mitchell retired from his role at Dungavel House last June but remains the immigration removal centres lead for the Royal College of General Practitioners' secure environments group.

It's a year and a half since the publication of the Brook House Inquiry report, which was commissioned to investigate the mistreatment of detainees at Brook House immigration removal centre near Gatwick Airport in Sussex between 1 April and 31 August 2017. And there are concerns that guidance set out by the report on a range of matters, including the use of force, has not been implemented across centres.

I cannot prescribe medicines that will require follow-up or blood tests
Alan Mitchell

WHAT IS AN IMMIGRATION REMOVAL CENTRE?

Around 20 000 people are held in the UK under immigration powers every year. In the year ending June 2024, 18 918 people entered immigration detention. Most detained people are in immigration removal centres, short term holding facilities, or pre-departure accommodation; a small proportion are held in prison.

The typical reasons for detaining a person in an immigration removal centre are to effect their removal from the country, to establish their identity or the basis of their claim to live in the UK, or because there is reason to believe that they will fail to comply with the conditions attached to a grant of immigration bail.

Immigration removal centres in the UK are currently managed on behalf of the Home Office by private firms. The Home Office retains ultimate responsibility for the welfare of detained people.

NHS England is responsible for commissioning health services for people who are detained in England's six immigration removal centres. This includes primary care, dental, mental health and substance misuse services.

Healthcare services at Dungavel House, Scotland's only immigration removal centre, are commissioned by the Home Office. There are no centres in Wales. Northern Ireland has a short term holding facility at Larne in County Antrim where detainees are held for a maximum of seven days before being released, transferred to an immigration removal centre in Scotland or England, or removed from the UK. There are three additional short term holding facilities in England.

Challenging setting for GPs

Immigration removal centres are one of the most challenging settings for GPs to practise in, presenting ethical quandaries for clinicians navigating between vulnerable patients' best interests and Home Office pressures that can conflict with clinical independence.

The health of people in immigration removal centres is often poor. A 2021 review of the clinical literature found that three quarters of people in immigration detention in the UK experienced depression, more than half experienced anxiety, and almost half experienced post-traumatic stress disorder. Detainees may have the physical symptoms of torture and rough transits including dislocations and wounding. These can be compounded by social determinants that drive health inequalities, such as homelessness, unemployment, financial insecurity and debt, social isolation, and poor access to or reluctance to engage with health services appropriate to their needs.

Mitchell says the work is necessarily "ultra cautious medicine. I cannot prescribe medicines that will require follow-up or blood tests; in some cases, I don't know if we will see terminally ill patients ever again. Immigration removal centre GPs have to think on their feet," he says.

MARK KERRISON/IN PICTURES/GETTY IMAGES

Banners outside the Royal Courts of Justice in 2018 ahead of hearing for an independent public inquiry

Guarding against medical complicity in human rights abuses is more urgent than ever
Rachel Bingham

Brook House failures: a year on

The Brook House Inquiry was established in November 2019 after a 2017 BBC *Panorama* programme reported the mistreatment of detainees at the centre. In the period covered by the report, healthcare services at Brook House were contracted separately by G4S Health Services, with GP services subcontracted to another provider, Doctor PA.

The inquiry found that doctors had sanctioned staff to use force against unwell patients and that former detainees felt that doctors and nurses at Brook House were "dismissive and exhibited a lack of care or empathy." It found that 19 incidents of mistreatment took place at the detention centre in five months. It rejected the Home Office's "bad apple" narrative—that events at Brook House were primarily the result of the behaviour of a small minority of staff.

Rachel Bingham is a clinical adviser at Medical Justice, a UK charity that sends volunteer clinicians to visit people held in immigration removal centres and compiles case studies. She told *The BMJ* that she was concerned that the guidance set out in the Brook House Inquiry report on a range of topics, including the use of force, had not been implemented across centres. She thinks that clinicians "continue to be drawn into facilitating custodial management at the expense of safeguarding vulnerable patients."

Jonathan McAllister is a specialist in general practice in immigration removal centres and medical director for such centres at Practice Plus Group, the healthcare company commissioned to provide healthcare at the centres in Gatwick, Heathrow, and Derwentside. Practice Plus Group took over the contract for the provision of healthcare services at Brook House in September 2021.

The Brook House Inquiry report said that, although the company had made improvements, such as focusing on the management of mental ill health in detention, it had not tackled "significant concerns about the lack of priority given to the safeguards for vulnerable people in detention and the deficiencies that remain in that system."

McAllister says that working as a GP in immigration removal centres is clinically challenging owing to the needs of the population, and he compares it to general practice in prisons. "Both populations have high levels of unmet need, but there is an increased level of trauma with patients [in immigration removal centres]," he tells *The BMJ*. "This might be because patients have been victims of slavery, torture, or trafficking. But then, of course, you have a lot of people that have travelled across the channel, who have got significant physical injuries from making that journey."

This is a highly rewarding field for GPs
Jonathan McAllister

Improving care

McAllister is saddened that reports of mistreatment in immigration removal centres often obscure the efforts of many hardworking GPs in the sector. "This is a highly rewarding field for GPs, and it's sad that a sector with recruitment challenges has received such bad press," he says.

Mitchell says that he would like to see improvements in a few key areas, including more engagement of GPs in the community when detainees are released to their care with short notice. "I often have to remind them of their duties," he says. He would also like to see the introduction of secure treatment rooms in hospitals so that handcuffed patients from immigration removal centres are not treated and discharged too quickly and for a medical adviser to be established in the Home Office.

Calls for more support for clinicians working in secure settings also note the risk of clinicians' traumatisation. A 2017 BMA report, for example, said that clinicians reported a feeling of powerlessness in being able to help or reassure people who talk about their fears of death or torture on returning to their home countries. There are also demands for better networking for clinicians working in the sector and a recognition of the higher toll of the specialism.

Bingham says that, with the populations of immigration removal centres increasing, guarding against "medical complicity in human rights abuses" in immigration detention is "more urgent than ever." "GPs working in these centres must begin by insisting on the implementation of the Brook House Inquiry recommendations," she adds. A government spokesperson said, "The abuse that took place at Brook House in 2017 was unacceptable, and we are committed to ensuring it will never happen again."

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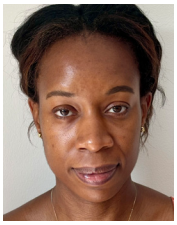
Antiracism in medicine: what is it?

Aisha Majid reports on the efforts being made to go beyond EDI initiatives and confront racism head on



Antiracist is identifying with me and showing support Desire Onwochei

If by 2030 we've made no progress, we're going to look daft Anton Emmanuel

"I don't think he realised how offensive it was," says Desire Onwochei, recounting an exchange with a fellow anaesthetist at a conference. He had decided to share his opinion that black people don't enjoy cycling.

Also present during the exchange between the white anaesthetist and Onwochei, who is a black consultant at Guy's and St Thomas' NHS Foundation Trust, was one of her white female colleagues. "Later on that evening my colleague told me how uncomfortable she had felt in that conversation," says Onwochei. "She said she felt bad that she hadn't said anything but that she didn't know what to say."

Data and lived experiences unequivocally show that staff from ethnic minority backgrounds have a poorer experience of working in the NHS, from being more likely to be referred to the regulator than their white counterparts to being less likely to be appointed to a post after shortlisting. The NHS has long had strategies aiming for equality, diversity, and inclusion (EDI), but since the tragic murder of George Floyd in 2020 and the subsequent boost in the Black Lives Matter movement, more organisations are talking about being "antiracist."

For Onwochei, her white colleague's reaction was an example of being antiracist. Even though her colleague didn't know what to say, she still "wanted to let me know that she didn't think that what happened was right." She adds, "It made me feel like she actually understands, and, for me, that was being antiracist—her identifying with me and showing her support to me."

But what does antiracism mean, and what makes it more than just an elevated term for EDI?

IRA L. BLACK/GETTY IMAGES

A New York Black Lives Matter rally in June 2020

Putting plans into action

Anton Emmanuel led NHS England's Workforce Race Equality Standard (WRES) programme until 2023. He says that antiracism is about moving beyond just celebrating events such as black history month or South East Asian heritage month, which he says can be "tokenistic and non-challenging."

Instead, he says, antiracism is about being truly disruptive when it comes to recruitment, advertising, fitness-to-practise processes, or deciding on promotion to boards. "You can't take a quality improvement approach to our [current] processes, because the data tell us that in England and in Wales our processes are so fundamentally wrong," he says, reflecting that data show a level of discrimination that can't be tackled just through tweaks.

The WRES is a key priority in the Antiracist Wales Action Plan, which has been a programme for government commitment for Welsh ministers since 2022, aiming to ensure that Wales is an antiracist nation by 2030. In Wales, the WRES aims to collect detailed workforce data to pinpoint the actions needed by each organisation as a precursor to ensuring accountability in the health and social care sectors.

In the first stage, work has focused on gathering data from each of NHS Wales's health boards, trusts, and special health authorities on how they perform on indicators related to race and then comparing this nationally. Emmanuel says, "The aspiration is that we use data as a central point to give local organisations the targets for what they should be focusing on," adding that each NHS Wales organisation has now identified specific actions to take in response to the data. While he acknowledges that Wales's relatively small size helps in making antiracism a national commitment, high level governmental support has been key to enabling people like him—with "lived experience"—to challenge systemic racism.

The WRES in Wales reflects on learning drawn from Emmanuel's work in NHS England—an approach supported by the Welsh government's key commitment to the Antiracist Wales Action Plan to try to do things better. "If it doesn't work and we see that actually people have found a workaround, that's where the accountability framework comes in," says Emmanuel. "That's why I'm really trying to reinforce that point to organisational leadership that you're on the hook here: if by 2030 we've made no progress, you're going to look daft."

Asked what accountability will look like in practice, he says, "We've refreshed the Antiracist Wales Action Plan 2024-26 to provide a clear mandate for all NHS Wales board members to demonstrate antiracist leadership within their inclusion objectives, and for all NHS bodies in Wales to demonstrate and report progress in driving antiracism at all levels. This is the big ambition we're working towards—the idea of providing strategic accountability that delivers real cultural change."

A demonstration in Middlesbrough to show support for George Floyd in June 2020

IAN FORSYTH/GETTYIMAGES

Organisational change

While NHS England doesn't have a central antiracism strategy, several organisations have made their own commitments. This includes NHS Providers—a membership organisation for NHS acute, ambulance, community, and mental health services, which stated its aim to become an antiracist organisation with the launch of its race equality programme in 2021.

"It was about becoming an actively antiracist organisation and making sure we had an organisational culture where our staff feel safe, valued, and able to achieve their full potential," says Isabel Lawicka, NHS Providers' director of policy and strategy. "We also wanted to lead by example. We've always been really mindful that we've got a responsibility and a role for the staff in our organisation of about 100 people. But we've also, as a membership organisation, got an important role in helping our members make progress on race equality in the broader NHS."

Through events and peer learning, the organisation is supporting trust boards in tackling race inequalities that affect their staff, patients, and service users. Lawicka says that engagement has been high, with over 90% of trusts joining at least one of NHS Providers' specific race equality events since 2022. While NHS Providers already had a focus on inclusive leadership and diversity at different levels in the NHS before its antiracism statement, she says, this programme has for the first time made being antiracist a clear priority for the organisation.

It's about a culture where our staff feel safe, valued
Isabel Lawicka

If you've got a doctor who is aware and empowered, it's positive for the workforce
Deepak Kumar

However, while NHS Providers can be actively accountable for its own progress—for example, through planned personal objectives for its senior management team—it can't formally hold its members to account. Softer mechanisms, such as asking trusts about their race equality efforts in NHS Providers' annual sector survey, can be useful. "It's self-reported by trusts, but it's an important measure and a prompt for them," says Lawicka.

The NHS Confederation—the membership organisation for the whole healthcare system in England, Wales, and Northern Ireland (which included NHS Providers until 2011)—has its own antiracism strategy. Joan Saddler, the confederation's director of partnerships and equality, says that its members work to tackle discrimination in all forms, including racism, as part of their responsibilities under the public sector equality duty.

She acknowledges, however, that more could be done. Not all state funded health and social care providers are required to meet the public sector equality duty, but Saddler believes that a worthwhile step would be consulting with racially minoritised communities on whether a national antiracism action plan for health and social care would improve outcomes to tackle racism.

She says, "The deadly impact of racism will continue unless we learn lessons of the past and present and stop enabling racism and inequality by using the same solutions that haven't stamped out racism."

Teaching doctors to be antiracist

For some organisations, an antiracist NHS starts when doctors and medical professionals are in training. Deepak Kumar is the undergraduate GP lead at Anglia Ruskin University's School of Medicine and heads up work on the medical school's antiracism agenda. Its antiracism work is organised around four key areas set out by the BMA's racial harassment charter for medical schools: supporting individuals in speaking out, robust processes for reporting and handling complaints, mainstreaming EDI in the learning environment, and tackling racial harassment in work placements.

Anglia Ruskin's antiracism commitment involves signposting students to where they can get help and advising on what they should do if they're racially harassed. It aims to ensure that complaints are raised to the appropriate level, and it reviews the curriculum to ensure that EDI is embedded in every single session and not just an "add-on." Kumar points to the school's dermatology teaching as an example: "Previously we had one lecture that was focused on dermatological conditions in different skin tones, but now, for

example, we're showing what eczema looks like on different skin tones within the eczema session."

One of the most thought provoking sessions, says Kumar, is the bystander intervention training, which aims to empower students to become "active bystanders." One scenario involves someone who witnesses a colleague being racially harassed by a member of staff, to encourage students to think about what they could do in such a situation.

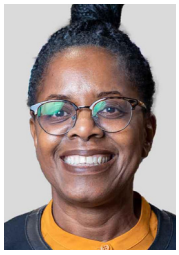
In another scenario the students witness a doctor being harassed by a patient, to help them understand how to set boundaries and challenge a patient who may be racially harassing them while maintaining the doctor-patient rapport. Kumar says that Anglia Ruskin's internal survey data show that after the session around 95% of students said that they would feel empowered to speak out if they witnessed a colleague being racially harassed, up from 60% before the session.

Despite Anglia Ruskin's relatively small medical student population—the medical school was set up five years ago and enrols only 100 students a year—Kumar hopes that its antiracism work will have a positive impact. "There's something around cultural humility, cultural awareness, and producing a group of doctors who are aware and empowered. If you've got a doctor who is aware and empowered, it's positive for the workforce and positive for patients," he says.

Partha Kar, coauthor of a five point NHS action antiracism plan published in 2023 as part of NHS England's Medical Workforce Race Equality Standard (MWRES), believes that since late 2022 the political climate in UK government has shifted further right and that, as a result, national level efforts on antiracism in England have faltered. In his view there's been a return to the lens of EDI, which he thinks is less effective than antiracism. Kar says, "If you put it all in one box as with EDI, you deal with nothing," he says. "It actually opens you up to the critics on the far right who say, 'Well, it's a waste of time and money.'"

A healthcare worker at a protest outside Downing Street in June 2020

WIKTOR SZYMANOWICZ/NURPHOTO/PA/ALAMY



The deadly impact of racism will continue unless we learn lessons
Joan Saddler

Antiracism hasn't really progressed much beyond soundbites
Partha Kar

Setting boundaries

So far, race equality indicators show a mixed picture. Data on referrals to the GMC, for example, show that the difference in referral rates has fallen by 54% in recent years, from 0.58% among ethnic minority doctors and 0.3% among white doctors in 2016-20, to 0.31% among ethnic minority doctors and 0.18% among white doctors in 2020-23. In the same period the difference in referral rates between UK trained and international medical graduate doctors fell by 62%, from a difference of 0.42 percentage points to 0.16.

In England, the WRES shows that the percentage of ethnic minority board members has increased year on year at the national level, although the percentage of board members recording their ethnicity as BME (black and minority ethnic) hasn't kept up with the increasing percentage of BME staff in the NHS workforce overall. Other indicators, however, continue to reveal a lack of progress—or backsliding in some cases. At 76% of NHS trusts, white applicants were "significantly more likely" than ethnic minority applicants to be appointed from shortlisting in 2023, up from 71% in 2022.

One problem, says Kar, is that few people are willing to raise their voices publicly on the subject. He says that those in positions of power would rather not change things, meaning that "antiracism hasn't really progressed much beyond soundbites, apart from certain areas."

Several surveys have shown that doctors avoid speaking out about racism for fear that calling out seniors and colleagues could negatively affect them. Onwochei acknowledges that the nature of medicine as a profession makes it hard for individuals to speak out. For example, doctors find it difficult to refuse to treat a patient who displays racist behaviour, as they believe that they have a duty of care to the patient.

Onwochei says that she's learnt to set better boundaries for herself as she's progressed though her career. "When I was a junior doctor, I'd just try to brush it off and rise above it," she says. "But the older I've become and the more progression I've made in my career, the less I tolerate it, unless that patient is in a compromised state where if I walk away they're going to suffer. But if that's not the case, I will walk away from that situation."

She would like health trusts to back up doctors who walk away from such situations by making it clear that patients who racially abuse staff won't be treated, rather than placing that patient in the hands of a white doctor. "But I think it will take a very bold trust to state that they are antiracist to the point where, if a patient is racist to a staff member, we as a trust are not going to treat that patient," she adds.

For Kar, establishing a national lead on antiracism would be a big step forward for the NHS in England, while establishing clear markers of accountability. Otherwise, he warns, "it always falls to other people to do."

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ROLE MODEL

Raja Badrakalimuthu

The consultant old age liaison psychiatrist speaks to **Kathy Oxtoby** about why making a difference to a person with dementia or their family makes his day

RICHARD H SMITH

A love of people and their life stories inspired Raja Badrakalimuthu to specialise in old age psychiatry.

"Working with older people, you get to have conversations about their lives," says Badrakalimuthu, a consultant old age liaison psychiatrist at Royal Surrey County Hospital in Guildford. "Their generation built our society, and we've inherited the legacy of their hard work. I find it satisfying to be able to do something for them—to thank them, and show my gratitude."

Old age psychiatry is "the perfect blend of medicine and mental health," he says. "Older people can have multiple physical conditions and you have to take this into account when diagnosing dementia."

As new dementia drugs are incorporated into clinical practice, and new cognitive assessments and scans become available, "it's an exciting time to be doing old age psychiatry," Badrakalimuthu says. The need to be aware of any support available in the community, such as respite care, also adds variety to his role, he says. "You're not just intervening at an illness level, you're also trying to make life as good as possible for the person and their family."

Growing up, he was more interested in languages and history than medicine. Both his parents were doctors who ran a general practice in Tamil Nadu in southern India. "There was a huge assumption that as their son I would take up medicine. But I was contemplating a career as a historian or writer," he recalls.

Good at science, and with huge respect for his parents' work, in 1996, he chose to go to Coimbatore Medical College—just as they had done in the 1970s. While doing house officer jobs he became interested in the workings of the brain and psychology, and chose psychiatry as his specialty.

He spent a year as a senior resident at the Institute for Mental Health in Chenai, southern India. Encouraged by a retired professor he was assisting in research, he came to the UK in 2003 to work at the Maudsley Hospital as a senior house officer in old age psychiatry. "Working with older people made me feel fulfilled. I felt warmth and respect for them. I decided it was what I wanted to do."

After working in various training posts he qualified as a consultant old age psychiatrist in 2012. In the next few years he encountered two significant role models. In Norwich he met Daphne Rumball, a now retired consultant in drug and alcohol services, "who had an ability to move between clinical psychiatry and research," which he learnt from. "She became a close friend and godmother to my son," he says.

The second mentor was Tracey Eddy, a senior old age psychiatry consultant, now retired, whom he met while working in Basingstoke. She "gave me the opportunity to act on my ideas to make services better for people," he says.

Badrakalimuthu spent three years as an associate medical director for older adult services in Surrey before taking up his current post as an old age liaison psychiatrist in 2022. Shortlisted for awards for improving old age psychiatric services, he continues to develop ways to make services better. "When I go home after work and can tell myself I've made a difference to a person with dementia or their family, that makes my day," he says.

As academic secretary for the south eastern division of the Royal College of Psychiatrists, he is involved in providing teaching, training, and education to psychiatrists of all grades. And whether it's medical students, junior doctors, nurses, or allied healthcare professionals, he says senior clinicians need to "take every opportunity to teach them."

"If I hadn't had such good role models I wouldn't be where I am now. And if I'm not a good role model, then I'm failing the next generation," he says.

A specialist trustee of the charity Dementia Carers Count he believes we all need to take responsibility for the care and support of people with dementia and their families—"the NHS and social care cannot do this alone."

Outside of work, Badrakalimuthu uses running and trekking as a way of raising money for dementia charities, which has taken him to Everest base camp and Kilimanjaro.

While he may have chosen to follow in his parents' professional footsteps, "I didn't give up on my writing." His book *A Way With the Fairies* gives the perspective of an 8 year old boy whose father is diagnosed with dementia.

If he was telling his 8 year old self about his life now, he says, "I wouldn't change anything. The successes, disappointments, highs, lows—they've all led to amazing moments where I've been able to make myself useful to people. What more could I want?"

Kathy Oxtoby, *The BMJ*

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NOMINATED BY NIRJA BEEHUSPOTEEA

"I first came across Dr Raja in 2016 during my foundation year placement on a dementia unit where he was a consultant.

"He involves trainees and members of the multidisciplinary team in making the unit efficient in the management of the behavioural and psychological symptoms of dementia. Importantly, he brings families on board, along with local hospice services, with the aim of making the ward suitable for end-of-life care provision.

"While working with him, I was most struck by how he always involves families and carers in discussions, and he ensures that everyone understands the process. He has an ability to bring clarity to the most complex discussions and he inspires confidence as a leader. He has a rare skill of being very hardworking and disciplined, while equally showing compassion to patients and their carers."

Nirja Beehuspoteea is a consultant old age and liaison psychiatrist

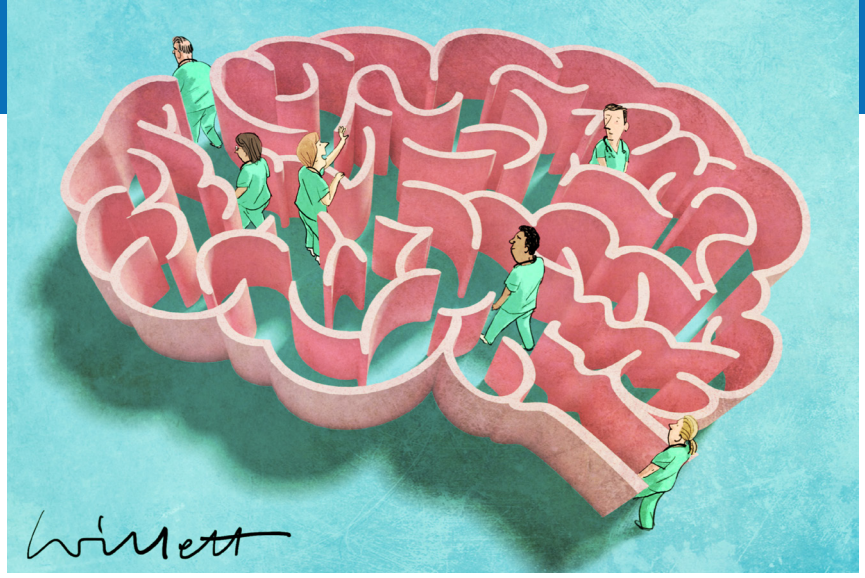
NOMINATE A ROLE MODEL

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 emahase@bmj.com

CAREERS CLINIC

How can I support a neurodivergent colleague?

There are many ways that you can help make workplaces feel more inclusive, hears **Abi Rimmer**



Make them feel safe

Catriona McVey, final year medical student

"Neurodivergent colleagues often bring unique strengths—such as attention to detail and deep focus in specialised areas—but they can also face additional challenges and barriers to success.

"Work with them to identify what they personally find difficult, and explore what accommodations can be made at work. Neurodiversity is a spectrum and something that helps an autistic colleague may not be useful for a colleague with attention deficit/hyperactivity disorder (ADHD). Likewise, some people with ADHD might prefer to work alone when they need to concentrate, whereas others find they're more productive when they can 'body double' by working alongside colleagues.

"Culture is an important part of supporting neurodivergent colleagues. Neurodivergent problem solving can be unconventional, but still effective. As long as professional standards are met, focus on outcomes rather than rigid processes by being open to different approaches and communication styles. Lack of eye contact or a monotone voice doesn't necessarily indicate disinterest, a lack of engagement, or rudeness. Being clear and precise, and avoiding ambiguity when communicating, can also be helpful.

"Our colleagues need to feel safe to disclose their neurodivergence and ask for support without fear of judgment or exclusion. Many will mask their neurodivergent traits and are unlikely to feel safe to unmask and be themselves at work if they are fearful of discrimination, stigma, and a lack of support."

Educate yourself

Rosie Baruah, consultant in intensive care medicine, University of Edinburgh

"Every doctor is an individual and will have individual support needs—and so there is no one way to support a neurodivergent colleague. I'd recommend listening to your neurodivergent colleague as a first step toward providing effective support.

"I would also advocate a three pronged approach of belief, education, and support. Many neurodivergent colleagues will be reluctant to be open about their identity in the workplace because of a fear of the stigma that still surrounds neurodivergent identities. This may be magnified for doctors, who may worry that their livelihood would be at risk as a result of disclosure. If a colleague is open about their neurodivergence with you, believe them.

"Educate yourself about neurodivergence and how this relates to doctors. This is especially important if you have educational supervisory or line managerial responsibilities. Many deaneries have online education materials you can access, and national societies set up to support neurodivergent people have websites containing a wealth of useful information.

"As doctors we may think we understand the nature and impact of neurodivergence, but in reality we may have many learning needs that we are unaware of.

"Finally, supporting neurodivergent colleagues could involve pointing them toward professional support networks such as Autistic Doctors International, deanery support, or practitioner health programmes.

"Doctors should be able to access the support they need when they need it."

Get to know them as an individual

Emily Starling, Acas senior research officer

"About 15-20% of UK adults have some form of neurodivergence, so this is likely to come up in your working life. We've just published a research report on practice and policy around neurodiversity at work, which includes lots of suggestions and case studies of organisations providing good support to neurodivergent colleagues.

"Easy access to reasonable adjustments is key, ideally without requiring formal diagnosis. A lot of these are easy to implement and low cost or free (like accessibility software).

"As a colleague, it's important to recognise a person's individual experience, rather than relying on their medical diagnosis (if they have one). Their neurodivergence can intersect with other identities (like their gender or caregiving responsibilities) and pose additional challenges.

"Leaders can support neurodivergent friendly workplaces with things like neurodiversity awareness campaigns and training (especially for line managers), supporting employee networks, and sharing their own experiences with neurodivergence, if applicable.

"Leaders can also provide support through specialist career pathways.

"Finally, take the time to get to know your colleague and their needs as a unique individual, not just as a neurodivergent person. Try asking everyone how they prefer to work or communicate—normalise the differences between people and try to work with people's strengths."

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