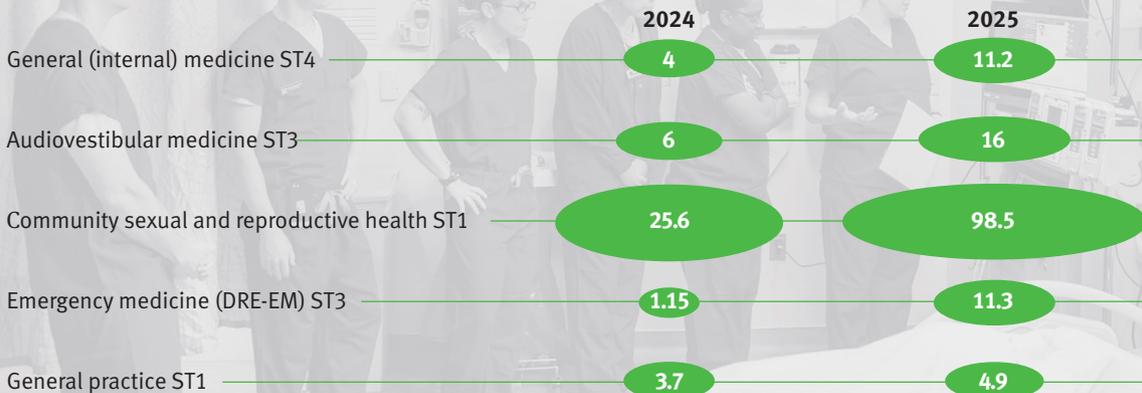


COMPETITION FOR SPECIALTY TRAINING PLACES

Number of applications per post (competition ratio) in England



“Scandal” of specialty training ratios

“Staggering” competition for NHS specialty training posts has laid bare a “crisis facing medical training” that is leaving many resident doctors “in limbo,” leaders warn.

Doctors said NHS statistics on 2025 competition rates, which show demand for some specialties has almost quadrupled, indicated a “broken application system.”

The data show that 91 999 applications were made in England for 12 833 specialty training posts, giving an overall competition ratio of 7. This means there were seven applications overall for every specialty training post in 2025, a rise from 4.7 last year and over three times the level in 2019.

But some specialties have faced far greater competition. For example, psychiatry saw 22 applications for every post, up from 10 per post last year.

The greatest competition was seen in applications for general practice and public health medicine, with 167 applications for every post. The second most competitive was community sexual and reproductive health, with almost 99 applications per post—nearly quadruple last year’s ratio.

Other specialty training posts have also gained a huge number of additional applications year on year. Demand for obstetrics and gynaecology posts more than doubled, jumping from a competition ratio of 7 in 2024 to nearly 17 this year.

The total applications is a jump of more than 30 000 in a single year. In contrast, the number of training posts has increased by only 90. GP specialty training year 1 had the most applications, with 20 995 for 4276 posts in 2025. This compared with 15 036 applications for 4096 posts in 2024.

Aadam Aziz, deputy chair of BMA North Thames, deemed the scale of the competition a “scandal,” adding, “The pathway to specialist training is being choked off, wasting talent [and] driving doctors out of the NHS.”

Shivam Sharma, a child and adolescent psychiatry specialist, said the “pathological competition is indicative of a broken application system. Enough talking—there needs to be bold action to prevent this becoming worse.”

Luke Craddock, a second year foundation trainee, said it was “an awful

(Continued on page 284)

“Pathological competition is indicative of a broken application system,” says Shivam Sharma

LATEST ONLINE

- Jess’s rule: GPs urged to use “three strikes and rethink” approach to prevent deaths of patients
- Low dose daily aspirin halves recurrence of colorectal cancer, study finds
- Garlic flavoured breast milk and eating plastic for weight loss win 2025 Ig Nobel awards



MEDICAL NEWS

Government names 14 NHS trusts at centre of rapid maternity care investigation



The government has named the 14 NHS hospital trusts whose maternity services will be investigated as part of a rapid national probe into systemic “failures.”

The investigation into maternity and neonatal care was announced in June after a series of scandals in recent years at trusts, including East Kent, Nottingham, Shrewsbury, and Telford. It will examine a range of services across England’s maternity system, how women’s voices are ignored, how safety concerns are overlooked, and poor leadership that leads to “toxic” cultures. It is being led by Valerie Amos (left), master of University College Oxford and a former government minister.

The 14 trusts, chosen on a range of factors, including Care Quality Commission survey data and perinatal mortality rates, are Barking, Havering and Redbridge University Hospitals, Blackpool Teaching Hospitals, Bradford Teaching Hospitals, East Kent Hospitals, Gloucestershire Hospitals, Leeds Teaching Hospitals, Oxford University Hospitals, Sandwell and West Birmingham Hospitals, Shrewsbury and Telford, Queen Elizabeth Hospital, King’s Lynn, University Hospitals of Leicester, University Hospitals of Morecambe Bay, University Hospitals Sussex, and Yeovil District Hospital.

The investigation will make interim recommendations in December.

Adrian O’Dowd, Kent [Cite this as: BMJ 2025;390:r1941](#)

Infectious disease

Cholera deaths rise again despite prevention efforts

Cholera killed more than 6000 people in 2024, up 50% on 2023, despite availability of vaccines and treatment, said the World Health Organization. It added that the figures were likely to be an underestimate and that conflict, climate change, and poor sanitation were fuelling the crisis. Outbreaks were reported in 60 countries, up from 45 in 2023—with Africa, the Middle East, and Asia bearing 98% of the burden. WHO called for stronger surveillance, wider vaccine access, and investment in safe water.



regions with more than 45% forest cover and indigenous territories saw fewer fire related and zoonotic diseases. Where forests were fragmented the protective effect was weaker or reversed. The authors emphasised the need for indigenous land rights policies, not only to protect the populations but to “generate positive outcomes for human health.”

C auris

Drug resistant fungus is now endemic in Europe

A drug resistant fungus has spread so quickly through European hospitals in the past decade that it is becoming difficult to control and has established itself as endemic in at least three countries, said the European Centre for Disease Prevention and Control. *Candidozyma auris*, formerly known as *Candida auris*, is a pathogenic yeast usually resistant to at least one antifungal treatment and can be deadly when it infects people with weakened immune systems. It was detected more than 4000 times in European Economic Area countries from 2013 to 2023.

General practice

England’s GPs enter dispute with government

GPs in England have voted to re-enter a dispute with the

government from 1 October over plans to allow patients unlimited requests for online consultations. Rules set to come into effect next month could become a “critical patient safety issue,” the BMA’s GP Committee said, as the volume of inquiries could mean serious problems being missed. The committee was also considering legal action to challenge the change. Health secretary Wes Streeting recently branded GPs “laggards” over the issue.

Medical training

Urgent reforms needed to prioritise UK graduates

Ministers need to act quickly on introducing reforms that prioritise UK medical graduates over overseas ones for training places, said the BMA’s chair. In an interview with *The BMJ* Tom Dolphin (below) said that “the reforms need to come in as soon as possible.” He made the comments after the health secretary, Wes Streeting, told a BMA special representative meeting on the NHS 10 year plan that he could not promise such changes would be in place by the next specialty training recruitment cycle this autumn.



Regulation

GP convicted of attempted murder is struck off

A GP who was convicted of attempted murder after posing as a community nurse to inject his mother’s partner with a toxin has been struck off the medical register. Thomas Kwan sent Patrick O’Hara false NHS letters pretending to set up an appointment for a covid booster, a medical practitioners tribunal heard. Kwan feared O’Hara could stand in the way of him inheriting his mother’s home. Sentencing Kwan, Mr Justice Lambert described him as a “dangerous offender.”

Maternity care

Systemic failures “worsen outcomes” for black women

Racism in NHS maternity care is an ongoing problem responsible for poorer outcomes among black women in England, a report by the Health and Social Care Committee has concluded. The MPs found that black women in England continued to face disproportionately poor outcomes, owing to systemic failings in leadership, training, data collection, and accountability. These failings had contributed to £27.4bn in negligence claim payouts since 2019, they added.

Amazon’s indigenous lands are linked to better health



Protecting indigenous territories in the Amazon may reduce cases of malaria and respiratory disease in surrounding areas, a study in the *Nature journal Communications Earth & Environment* found. Researchers analysed 21 diseases across nine Amazonian countries from 2000 to 2019, finding that

IN BRIEF

Sexual health

University freshers receive STI warning

University students are being urged to use condoms, as sexually transmitted infections remain widespread, said the UK Health Security Agency. Despite small declines from last October to March—gonorrhoea cases fell from around 18 250 to 15 920 and syphilis from 2320 to 2030 cases—rates are still high. Young people aged 15-24 remain the most at risk, with more than 350 diagnoses a day last year. Hamish Mohammed, UKHSA consultant epidemiologist, urged students to use condoms and sexual health services, adding, “Starting university is an exciting time—don’t let an STI ruin the fun.”

Contraception

Confusion over \$10m of “incinerated” US aid

Contradictory statements suggesting that the US had incinerated \$9.7m (£7.2m) worth of contraceptives intended mostly for low income countries in Africa sparked anger and confusion. The *New York Times* reported on 11 September that a spokesperson for the US Agency for International Development, Rachel Cauley, had confirmed that contraceptive pills, intrauterine devices, and hormonal implants had been destroyed. But when Belgian authorities searched the warehouse in Geel on 12 September they found that the supplies remained untouched.

US vaccinations

Florida is first state to end mandatory childhood jabs

Florida intends to end all mandates



Students just starting university have been warned to protect themselves from STIs

requiring vaccines for children and adults, said its governor, Ron DeSantis, and the surgeon general, Joseph Ladapo. It is the first US state to make such a move. DeSantis also announced that he was creating a state commission to “make America healthy again,” like that proposed by the US health secretary, Robert Kennedy. All 50 US states and the District of Columbia have vaccine requirements for children in school but allow exemptions on medical grounds. Most allow exemptions on religious grounds and some on personal grounds.

Drummond Rennie

Tributes are paid to “prophet of peer review”

Drummond Rennie, a British-American nephrologist turned legendary medical editor who devoted his career to championing scientific literature and peer review, died in Oregon aged 89. Known as the “prophet of peer review,” Rennie was deputy editor of the *New England Journal of Medicine* from 1977 to 1981 and became deputy editor of *JAMA* in 1988. In 1986 he founded the International Congress on Peer Review and Scientific Publication, a forum for evidence and scientific scrutiny still held every four years.

Cite this as: *BMJ* 2025;390:r1986

ADHD

Prescriptions of central nervous system stimulants and other drugs for ADHD rose by

6% in the first quarter of 2025-26, from 910 217 to 964 837

[*NHS Business Services Authority*]



SIXTY SECONDS ON... BURNING ARMPITS

A NEW PUNK/METAL BAND?

Not this time. Mitchum, the self-proclaimed heavy duty deodorant, is under fire after scores of users have reported that some of the roll-on products left them red, raw, and in some cases scarred. Social media sites have been awash with photos and videos of blistering armpits, rashes, and burns.

ROLL ON THE EXCUSES?

The company insisted the formula for its 48 hour roll-on hasn't changed but admitted a manufacturing tweak to a raw ingredient altered how it behaved on the skin. Mitchum has urged customers to stop using affected products “until irritation subsides” and to contact its customer care team “so we can make it right.”

CORPORATE ODOUR CONTROL

Mitchum apologised and pulled affected batches from shelves. A full recall was not issued, although users were urged to check batch codes. The company is also offering compensation to affected consumers.

UNDERARMAGEDDON

Some comments on Mitchum's Instagram posts argue that describing the injuries as “temporary irritation” is deodorising the truth. Influencers and ordinary shoppers have posted furious videos online, saying they can smell the PR spin.

FORMULA FOR DISASTER?

Experts have warned that, although antiperspirants can cause mild contact dermatitis, the pain reported by some patients might indicate more than just run-of-the-mill deodorant drama. Patients with infections could require antibiotics or antifungal cream, Penny Ward, professor of pharmaceutical medicine at King's College London, told *Women's Health*.

SHOULD WE SWITCH TO SPRAY?

Not necessarily—this issue was limited to a few products. But a spokesperson for the British Association of Dermatologists told *The BMJ*, “The key if irritation occurs is to identify and remove the source of the problem. Consult your pharmacist about emollient products to soothe the skin—particularly if you are worried that infection is present.”

WILL THE STINK CLEAR?

Mitchum says it is “deeply sorry for the inconvenience and concern this has caused.” But the burning sense of anger may last a while for affected consumers.

Kate Bowie, *The BMJ*

Cite this as: *BMJ* 2025;390:r1987

(Continued from page 281)

day to be a doctor out of training or a medical student.” He added, “Frozen progression is a further nail in the coffin of a career in medicine in the UK.” This comes amid reports of doctors leaving the UK or changing careers entirely while struggling to find employment.

Doctors’ leaders echoed resident doctors’ concerns. “These new competition ratios lay bare the crisis facing medical training and resident doctors and send a deeply worrying message to the next generation of doctors,” said Mumtaz Patel, president of the Royal College of Physicians.

“Increasingly grim”

Stephen Joseph (below), co-chair of the Royal College of Physicians’ resident doctor committee, commented, “Our career prospects feel increasingly grim. Year on year we have seen competition for training posts rise, leaving more and more early career doctors without a clear path forward.

“These chronic bottlenecks in the training pathway leave many doctors extremely worried about their future in medicine. Many have been working in a high pressure NHS environment for years already and find the door slammed shut on training progression.”

The BMA’s Resident Doctors Committee co-chairs, Melissa Ryan and Ross Nieuwoudt, said, “This has been a disaster long in the making as successive governments have failed to deliver enough training places to keep up with demand.” They warned that the “staggering” figures, which showed that 10 000 doctors applied this year to become psychiatrists while fewer than 500 could get a place, would mean an “ever larger cohort of doctors unemployed, stuck, or looking for the exits.”

“Good news for patients”

The Department of Health and Social Care said it was “good news for patients that the highest ever number of highly trained, skilled, and compassionate doctors are in post across the country.” It added, “However, the training bottlenecks we inherited are unfair to doctors, which is why this government is ensuring current first years will emerge from their foundation training into a transformed landscape.”

The government said it had committed to tackling training bottlenecks in its 10 year plan for the NHS, pledging to prioritise UK medical graduates for foundation and specialty training and to create 1000 new specialty training posts.

Kate Bowie, *The BMJ*

Cite this as: *BMJ* 2025;390:r1981

Experts warn of vaccine and cancer misinformation as Malhotra and Reform row goes mainstream

Fallout from comments at the Reform UK conference linking covid vaccines to cancers in the royal family continued with the prime minister wading into the controversy.

Speaking on 10 September, Keir Starmer said, “The man who wrote Reform’s health policy has made shocking and baseless claims that vaccines are linked to cancer. These dangerous conspiracies cost lives, and it shows that Reform can’t be trusted with our NHS.”

Starmer was referring to a speech by UK cardiologist Aseem Malhotra (right)—an adviser to the US health secretary, Robert F Kennedy Jr—at the conference in Birmingham on 6 September.

Malhotra said, “One of Britain’s most eminent oncologists, Professor Angus Dalglish, said to me to share with you today that he thinks it’s highly likely that the covid vaccines have been a significant factor in the cancer of members of the royal family.”

The comments provoked a widespread backlash, with the medical regulator the

THESE NEW COMPETITION RATIOS SEND A DEEPLY WORRYING MESSAGE TO THE NEXT GENERATION OF DOCTORS

Mumtaz Patel

New residents’ deal “will ensure pay for additional hours”

The BMA and government have agreed a deal to ensure resident doctors in England are paid for the additional hours they work.

Changes to the “exception reporting” process will make it easier for doctors to report their working hours and unsafe staffing levels and will guarantee they are paid for extra hours they work, the BMA said.

There will be rolling fines for employers who fail to provide appropriate systems for reporting, and hospital administrators will be allowed to sign off exception reports, which the BMA said will free up senior doctors’ time. The changes will also allow doctors to choose either payment or time off in lieu for all the time they work above contracted hours.

The changes will be rolled out across NHS hospitals by February. The reforms were promised as a non-pay element in the 2024 pay deal, but it has taken over a year to agree. The BMA’s Resident Doctors Committee (RDC) entered into a dispute with the government over slow progress on the issue this February.

Commenting on the deal, Melissa Ryan and Ross Nieuwoudt, RDC co-chairs, said, “At the moment,

too many doctors are not reporting additional hours, not pointing out where they are missing out on training, not raising the alarm over staff shortages because they don’t trust the system. We’re putting in place a system that gives them that confidence.

“That doesn’t only mean doctors will now get paid the money they have fairly earned. It also means hospitals will be able to see the flaws in rotas, patient safety concerns, and inefficiencies that are weighing down our NHS.”

Talks continue over pay

The RDC and government remain in talks over pay after five days of strike action by resident doctors in July, with further action possible.

Health secretary Wes Streeting said, “This shows that when there’s constructive dialogue between the government, the BMA, and the NHS, real progress can be made to improve resident doctors’ working lives, without the need for strike action.

“I am determined to continue this momentum to avoid further needless disruption to patients.”

Kate Bowie, *The BMJ*

Cite this as: *BMJ* 2025;390:r1993



General Medical Council confirming it was now considering whether to take action.

Posting a response on X to Starmer's comments, Malhotra said he did not state that vaccines were linked to cancer and that he was presenting information from US Health and Human Services department data and quoting Dalgleish.

Malhotra added, "Conflating legitimate safety concerns of a novel mRNA technology with all vaccines is preposterous and dangerous."

What does the evidence show?

Numerous virologists and cancer experts told *The BMJ* there is no evidence to support claims that mRNA vaccines are linked to cancer.

Lawrence Young, a virologist and professor of molecular oncology at the University of Warwick, said, "This idea that somehow aggressive and fast developing cancers have been seen post-vaccination . . . There is absolutely no medical evidence to support that."

Ian Jones, professor of virology at the University of Reading, added that



epidemiological data showed no spike in cancer cases after use of the covid vaccine. "For me, that's the bottom line. You can speculate all you like—you can come up with bits of individually plausible information and conflate them all together to give some story.

"But the actual data of people who are being diagnosed with cancer has not changed since the delivery of the mRNA vaccine into millions of individuals."

How has the myth gone mainstream?

Asked why the issue has gained traction in the media, Jones said it was "largely Trumpian derived" and part of a "general backlash against vaccines" fuelled by RFK, who has cancelled \$500m (£375m) in funding for mRNA vaccines.

Stephen Griffin, professor of cancer virology at the University of Leeds, concurred, adding, "This is exactly the same strategy that RFK is doing. They call it an honest discussion. They call it a debate, but actually what they're doing is pointing fingers and fuelling the whole 'there's no smoke without fire' type thing . . . designed to increase hesitancy and doubt."

Griffin added, "All of this is having a huge ripple effect. They're focusing on the mRNA vaccines, but it's fuelling vaccine hesitancy as a whole, and it's causing harm."

Reform UK said Malhotra was a guest speaker with his own opinions and that the party "does not endorse what he said but does believe in free speech."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;390:r1934

AUTISM: Trump links condition to Tylenol in pregnancy and touts leucovorin as "first" US therapeutic

US president Donald Trump has linked use of the painkiller Tylenol (acetaminophen; paracetamol in the UK) to autism and urged pregnant women to avoid it.

Speaking on 22 September, he advised women to avoid the drug while pregnant or use it sparingly, "if you can't tough it out."

Acetaminophen is considered the standard option in the US and UK for treating fever and pain in pregnancy as it has the most favourable safety profile among commonly used painkillers.

The US medical community reacted to Trump's announcement with scepticism. Steven Fleischman, president of the American College of Obstetrics and Gynecologists, said, "The claim is not backed by the full body of scientific evidence and dangerously simplifies the many and complex causes of neurologic challenges in children."

The US administration also endorsed the drug leucovorin, often used by patients with cancer, for treating cerebral folate deficiency (CFD), a rare condition that can include autistic features.

A White House statement labelled the drug—also called folinic acid, which increases the amount of folate in the brain, supporting processes such as neurotransmitter production and brain development—as "the first Food and Drug Administration (FDA) recognised therapeutic" for children with CFD and for "autism symptoms."

Trump, speaking alongside health secretary Robert Kennedy, said a range of measures aimed to tackle what he called an "epidemic" in autism spectrum disorder (ASD). Kennedy's Department of Health and Human Services (HHS) said rates of autism have surged nearly

400% since 2000, with the condition now affecting 1 in 31 children. This has been disputed, with a US CDC report confirming that while diagnosis rates were rising the increase was because of better screening.

"For too long, families have been left without answers or options as autism rates have soared," Kennedy said. "Today we are taking bold action—opening the door to the first FDA recognised treatment pathway. We will follow the science, restore trust, and deliver hope to millions of families."

The announcement included



the first recipients of National Institutes of Health (NIH) grants from the Autism Data Science Initiative, the programme to gather information on the causes of the condition, with more than \$50m in funding to 13 projects.

In its statement, HHS said on Tylenol and autism: "The FDA is responding to prior clinical and laboratory studies that suggest a potential association between acetaminophen use during pregnancy and adverse neurodevelopmental outcomes," citing a 2020 study published in *JAMA Psychiatry*.

Mun-Keat Looi, Kate Bowie, *The BMJ*
Cite this as: *BMJ* 2025;390:r2004



UK REACTION

British health officials were quick to come out against Trump's announcement.

"There is no evidence that taking paracetamol during pregnancy causes autism in children," Alison Cave, chief safety officer at the UK drug regulator MHRA, said. "Untreated pain and fever can pose risks to the unborn baby, so it is important to manage these symptoms with the recommended treatment."

Speaking on the *Lorraine* show, health secretary Wes Streeting said, "Don't pay any attention whatsoever to what Donald Trump says about medicine, don't even take my word for it as a politician. Listen to British doctors, British scientists, the NHS."

British scientists also denounced Trump's claims. Steven Kapp, senior lecturer in psychology at Portsmouth University and a member of the Coalition of Autism Scientists, said, "Rigorous research found paracetamol does not cause autism." He added, "research claiming to find a link does not separate out correlation from causation."

Senior surgeon who sexually assaulted female colleagues is jailed for six years

The former head of cardiovascular surgery at Blackpool Victoria Hospital—who was accused of creating a “toxic and sexualised culture”—has been given a six year jail sentence for sexually assaulting five female staff members.

Amal Bose, who denied that some of the incidents happened and described his conduct as “flirting” or “workplace banter,” was convicted in June of 12 counts of assault against the five women, which took place between August 2017 and December 2022.

He targeted mainly younger women, who were reluctant to report him because of his powerful position in the hospital.

Preston Crown Court heard that the women endured lasting effects, including panic attacks and anxiety. One said she self-harmed as a coping measure, and two left their jobs.

The court was told that Bose, 55, touched women on their breasts,

groin, and waist. One said he pulled down her top to expose her chest and bra. Another told how he groped her breast as he took a pen from her pocket.

The women told the court that Bose’s behaviour went unchallenged because of his seniority in the department, although one said that his misconduct

was a “well known fact” and that new employees were warned about him.

Judge Ian Unsworth KC said he believed that Bose lacked “any genuine remorse to victims or survivors.”

Maggie Oldham, chief executive at Blackpool Teaching Hospitals NHS Foundation Trust, said, “As a trust, we have cooperated with the police throughout their investigation into Mr Bose, who has not worked at the trust since December 2022.

“We have been truly shocked and saddened by the experiences of the victims, and we will now be supporting all colleagues as we move forward together.”

Bose qualified at the University of London in 1994 and joined the trust in 2012, becoming head of the department in 2020. He will serve at least half of his six year sentence in prison and will be on the sex offender register for life.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;390:r1967

We do not tolerate inappropriate sexual behaviour, misogyny or sexism

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NEWS ANALYSIS

“DANGEROUSLY UNSAFE” Victims and researchers condemn tribunal’s handling of sexual misconduct cases

The process for dealing with accusations of abuse and harassment against doctors is “deeply flawed” and requires radical reform, the authors of an analysis of a year of MPTS records tell **Adele Waters**

A team of academics and clinicians from six organisations have reviewed how the Medical Practitioners Tribunal Service (MPTS) manages sexual abuse cases and found the guidance that underpins sanctioning of doctors is “wildly inadequate.”

Their article, published this week in *The BMJ* (p 314), concludes that tribunal panels are too reliant on subjective evidence when it comes to issuing sanctions and, as a result, that decision making is inconsistent and, sometimes, too lenient.

At the same time, *The BMJ* has spoken to a patient in a recent case in which a doctor was suspended after forming an intimate relationship with her (they engaged in sexual activity when she was 17, which led to sexual intercourse between them in the days after she turned 18). The patient told *The BMJ* that the current MPTS process is “dangerously unsafe” and needs major reform to genuinely support victims (see box, right).

In their article, the academics recommend a package of reforms to not only encourage reporting of sexual misconduct incidents but deter such behaviour in the first place.

They examined all publicly available MPTS case records over the year to August 2024. Of 55 sexual misconduct cases, nine were not proved, so researchers analysed the remaining 46 to identify themes and the relationships between offences and sanctions given. Misconduct ranged from inappropriate comments and sexual touching to rape, and victims included colleagues, patients, and children.

Frances Dixon, one of the authors of the report and a general surgery registrar in the Thames Valley deanery, said that the research team found that, while most sanctions handed out by the MPTS “were in keeping with their own guidance,” the guidance itself “was wildly inadequate and gave the possibility for inconsistency in its application.”

The guidance, which helps tribunal panels determine sanctions, directs members to balance aggravating factors such as abuse of

A **BMJ** investigation in 2023 found NHS trusts had recorded more than **35000** incidents of rape, sexual assault, harassment, stalking, and abusive remarks between 2017 and 2022

a doctor's position against mitigating ones, such as "insight" into their behaviour. But, because the mitigating factors are not clearly defined, they are open to variability in their interpretation by panel members, say the researchers. As a result, these factors can skew outcomes.

Unable to cope with nuances

Mei Nortley, senior author of the *BMJ* article and a consultant surgeon at Oxford University Hospitals NHS Foundation Trust, said that, as it stands, "the guidance is simply not able to cope with the nuances and complexity of sexual misconduct."

To find a doctor guilty of sexual misconduct, Nortley said, tribunal panel members are asked to identify sexual motivation for their behaviour. "But there's widespread recognition that sexual harassment, and even rape, is not sexually motivated," she said. "It's about power, humiliation—and it's about suppressing people downwards in a hierarchy."

Nortley added that "time elapsed since incident" was a particularly flawed mitigation, since reporting sexual misconduct is commonly delayed because victims fear retaliation, blame, or disbelief.

The sanctions guidance, which was updated in February 2024, applies to all types of misconduct, but this is also problematic, said Dixon. "It's not written explicitly for sexual misconduct. But sexual misconduct is different to prescribing fraud or a speeding ticket, and it requires specialist handling."

In their *BMJ* article the authors also

highlight that the MPTS panels are not directed to consider aggravating factors usually considered material to sexual misconduct cases, such as grooming, coercion, manipulation, and persistent patterns of behaviour.

Interviews that the research team conducted with victim witnesses in MPTS hearings also revealed a lack of fair treatment, leading to a risk of secondary harm.

Endemic problem

In 2023 a joint investigation by *The BMJ* and the *Guardian* found that NHS trusts had recorded more than 35 000 incidents of rape, sexual assault, harassment, stalking, and abusive remarks between 2017 and 2022.

In 2019 a review of 232 proven sexual misconduct cases by the Professional Standards Authority, which oversees the regulation of all UK health professions, found that doctors are treated more leniently and erased from the register less often than other UK healthcare professionals.

The MPTS is expected to issue updated sanctions guidance this autumn. A spokesperson for the service said the update would reflect the development of recent case law and build on good practice. They said, "We recognise the impact of our work and decisions on the lives of the doctors referred to a hearing as well as on the lives of the witnesses and complainants involved."

"It is paramount that our decisions are fair and proportionate, and are seen to be so,



Sexual misconduct is a special area, so tribunal panels need specialist training

Frances Dixon

and that we are open to informed scrutiny in this regard."

A GMC spokesperson said it took a zero tolerance and proactive approach to all forms of sexual misconduct, and at the heart of its efforts was the support it provided to victims and survivors.

They added, "We've strengthened our guidance for doctors in the GMC's Good Medical Practice, ensuring that the definition of sexual misconduct is clear—along with the duty of doctors to address this unacceptable behaviour."

So, what needs to change? First, MPTS panels need to be upskilled,

advised Dixon. "Sexual misconduct is a special area, so tribunal panels need specialist training. They also need improved sanctions guidance so that they don't add too much weight to those mitigating factors and they need to add in the missing aggravating factors."

"Second, we also need to see victim support," she added. "That means improving their access to both legal advice and support which recognises they are already vulnerable and at risk of secondary harm."

Lastly, she said the system needs to recognise "that any inconsistency and leniency of sanctions have knock-on effects—on individuals and on the (reduced) likelihood of others reporting sexual misconduct incidents."

● ANALYSIS, p 314

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2025;390:r1935

MPTS PROCESS IS "DANGEROUSLY UNSAFE"



In June this year Cian Hughes (left), a doctor who formed a relationship with a teenage

patient he met in hospital, was suspended from the UK medical register for 12 months.

Hughes met the patient, named only as Patient A, in March 2011 when she was 13 and Hughes was a fourth year medical student. The pair maintained regular correspondence for years, and the relationship became intimate after they met again in person years later, culminating in sexual intercourse soon after Patient A turned 18. Their

last contact was a 2018 message from Patient A asking to meet, to which Hughes did not reply.

In 2020 Patient A reported the relationship to the police, who interviewed Hughes but took no further action.

The BMJ spoke to Patient A in the case against Hughes, and she described her experience of the MPTS tribunal:

"I spent eight months preparing for the MPTS hearing, meticulously revisiting thousands of text messages and emails, ready and willing to finally share my experiences in person. But at the last minute Cian Hughes admitted most of the charges against him and decided he didn't want to question me. Just like that, he stole my voice,

much like he did with my virginity and innocence.

"The system is so flawed: unless a party disputes a witness's evidence, victims of sexual misconduct are often blocked from testifying beyond written statements, even if they desperately want to. His lawyer then dared to present this as an act of kindness by Hughes, to spare me trauma. In reality he was silencing me. The time for Hughes to protect me was over 10 years ago when I was a child, not now. I needed to say that our relationship was manipulative, deeply damaging, and gave me PTSD [post-traumatic stress disorder].

"The process felt victim hostile and utterly unfair. As a 'member of the public,' I only received

redacted hearing outputs and had to get exemptions to attend private sessions, even though they were meant to protect my own identity. I wasn't allowed to know what allegations he admitted until the hearing started, making it impossible to ensure my witness statement fully covered all points.

"Conversely, Hughes was able to submit multiple glowing references saying he's a brilliant doctor; this isn't about his technical ability, but whether his conduct towards me makes him unfit for the profession.

"The tribunal focused on protecting Hughes's career, not the profound impact of his actions on me."

The BMJ contacted Hughes, but he did not wish to comment.

NEWS ANALYSIS

Is big pharma falling out of love with the UK?

Amid a string of cancelled projects and investments, **Jacqui Wise** looks into why global drug companies seem to be turning their back on Britain and asks how it will affect the NHS and the life science sector

The government was dealt a major blow earlier this month when US pharmaceutical giant Merck announced it has halted construction on its £1bn London research centre.

This was the latest in a series of setbacks that have thrown the UK's life science sector—described by the government as “one of the crown jewels” of the country's economy—into disarray.

Merck, known as MSD in Europe, has also cancelled ongoing projects at the Francis Crick Institute in London and will move its life science research to the US. The company accused successive UK governments of not investing enough in the sector and of paying too little for innovative drugs and vaccines.

Days after Merck's announcement, AstraZeneca said it was putting a new £200m laboratory in Cambridge on hold, having in January already cancelled a £450m investment in its vaccine site at Speke, Liverpool.

Eli Lilly also recently paused a planned investment in a biotech innovation accelerator hub in London while it waits for more clarity on the UK sector. Last year the French company Sanofi closed laboratories in Cambridge it had acquired and transferred the work to Boston, Massachusetts.

Commenting after Merck's announcement, Paul Naish, Sanofi's UK head of market access, told the *Guardian* that the UK was at a critical point. “It's an expensive place to operate, and it's a terrible place to sell medicines,” he said.

Role of US tariffs

Donald Trump has threatened tariffs of up to 250% on pharmaceuticals imported to the US. He is putting pressure on drug companies to invest in the US and to lower drug prices for US customers.



We need to make sure we get rapid uptake of the best new medicines and equitable access

Patrick Vallance

Decisions to pause or withdraw investment are unlikely to be isolated reactions to UK specific factors

Huseyin Naci



Assessing the current landscape, Huseyin Naci, associate professor of health policy at the London School of Economics and Political Science, told *The BMJ*, “Companies are likely reassessing their global investment portfolios in response to mounting pressure from the US administration to lower domestic drug prices and increase investment within the US.”

He added, “The recent decisions to pause or withdraw investment in the UK are unlikely to be isolated reactions to UK specific factors.”

MPs held an emergency session of the science, innovation, and technology committee on 16 September in response to Merck's decision. Ben Lucas, MSD's managing director for UK and Ireland, told the committee there were several reasons behind the decision, not just US tariffs. “The UK commercial operating environment does need to be addressed, and we find that difficult—that is, end to end from development all the way through to commercialisation of our medicines,” he said.

NHS spending on drugs in decline

The science minister Patrick Vallance, a former GSK executive, told the committee, “The crunch issue is appropriate uptake, access, and payment on medicines, which is causing an environment that the industry is finding difficult in the UK.”

He said the share of the NHS budget spent on drugs has been falling since 2015. The NHS's outlay on medicines has fallen to 9% of total healthcare spending, which compares with 14% in Germany, 15% in the US, and 17% in Italy and Spain.

But Vallance said the issue was not just about paying more for drugs in the UK. “We need to make sure we get rapid uptake of the best new medicines and equitable access right across the UK,” he said.

Vallance added that

the government was “determined to solve” the standoff with the industry and to reverse a decade of declining investment.

Richard Torbett, chief executive of the Association of the British Pharmaceutical Industry (ABPI), told MPs on the committee that since 2014 the NHS budget had increased in real terms by 44% but that spending on branded innovative drugs had declined by 10%.

“We need a concerted effort to turn this around,” Torbett said.

Talks over drug pricing in collapse

The industry has been pushing for the price thresholds set by NICE to be raised in line with inflation. Drug companies point out that quality adjusted life year (QALY) cost effectiveness thresholds have not moved since 1999.

The industry also wants the clawback rate—the amount drug companies pay back to the NHS under the voluntary scheme for branded medicines pricing, access, and growth (VPAG)—reduced to single digits. The tax unexpectedly soared this year, forcing companies to pay back 23% of their UK sales—above the 15% that was expected.

Last month the health and social care secretary, Wes Streeting, walked away from talks on changes to the VPAG scheme, saying that drug companies were being “shortsighted” and that he would not let them rip off UK patients and taxpayers.

Commenting on the situation, Mark Dayan, policy analyst for the Nuffield Trust, told *The BMJ*, “This is a difficult position for the NHS, which is at its financial limit and under great pressure to deliver waiting times and new digital options for patients. Adoption and spending on new medicines has risen very quickly: if the health service has to pick up the bill from

Patients using black market to obtain weight loss drugs still in clinical trials, experts warn

More needs to be done to crack down on the black market for weight loss drugs, with patients ordering counterfeit versions of drugs that are still in clinical trials, experts have warned.

Doctors, pharmacists, and online providers told the London Assembly's health committee that poor access to the drugs on the NHS—as uncovered in *The BMJ*'s recent investigation (*BMJ* 2025;390:r1855)—and the recent Mounjaro price hike were pushing patients to seek the jabs through the black market.

Sokratis Papafloratos, founder of Numan, an online provider of weight loss drugs, said, “In terms of illicit access, I think we really underestimate the problem and misunderstand it. “The other day I was sent a link to the Chinese website where you can buy retatrutide, a drug that is in development by Lilly and could be the next generation of antiobesity medication.

“You can buy the active ingredients as somebody that does research. However, people are finding these companies and buying and importing ingredients that are designed for clinical research and are injecting them into their bodies, which I find mind blowing.”

Next generation of drugs

Retatrutide, currently in phase 3 trials, is similar to other weight loss drugs such as tirzepatide and semaglutide in that it is a GLP-1 RA. However, it is also an agonist for glucagon receptors and gastric inhibitory polypeptide. As such it's referred to as a triple agonist and is thought to represent the next generation of weight loss jabs.

Sukhi Basra, vice chair of the National Pharmacy Association, also speaking to the committee, said she had recently had a patient show her the counterfeit drugs they had been offered. Basra added that patients had told her they'd been offered counterfeit weight loss drugs in hair salons and beauty shops and by personal trainers and sellers on social media sites.

An Eli Lilly spokesperson said, “Retatrutide has not been reviewed or approved by the FDA, EMA, or any regulatory agency anywhere in the world, and therefore at this time no one can sell retatrutide for human use.

“Any product falsely representing itself as a Lilly investigational product not yet approved by the FDA, like retatrutide, may expose patients to potentially serious health risks.”

Elisabeth Mahase, *The BMJ*
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Companies such as Sanofi, Eli Lilly, and AstraZeneca have paused projects in the UK

THE NHS's outlay on medicines has fallen to 9% of total healthcare spending, which compares with 14% in Germany, 15% in the US, and 17% in Italy and Spain



This is a difficult position for the NHS
Mark Dayan

a lower clawback, it will be paying more while getting the same, eating into what can be spent on staff or purchasing services.”

Increasing global competition

The UK's pharmaceutical industry is under pressure from different directions. It's not just the threat of US tariffs: China is also becoming a far bigger player. Brexit may also play a part, with companies choosing to base their factories in mainland Europe rather than the UK.

Dayan commented, “Investment and other competitiveness indicators broadly worsened in the UK immediately before and after the covid-19 pandemic, before today's intense struggles over pricing. That is consistent with Brexit playing a role, through issues such as the UK not being part of EU reforms to smooth the approval of clinical trials across member states.”

Pivotal moment

Vallance told MPs there would be an increase in the 9% spent on medicines in the NHS. He added that among the recommendations of the government's life sciences sector plan, published in July, was that regulation needed to be faster. The MHRA was already rising to that challenge, he said.

He told the committee that, although the government had not formally restarted talks with the ABPI over VPAG, ministers were holding “lots of discussions around the commercial environment in the UK” with companies.

“We are determined to solve this,” he said, adding that the government would not sit back and watch the decline of the industry as has happened for the past 10 years.

“We have to act. Now is a pivotal moment . . . to try and get this right.”

Jacqui Wise, Kent
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THE BIG PICTURE

Doctors join French national strike against austerity plans

Healthcare professionals in cities across France, including Paris (main image) and Le Mans (inset), joined around 600 000 demonstrators during a day of strikes over government plans to cut the national budget by €44bn (£38bn).

Most of the country's pharmacists also closed their shops to mark the 18 September protest, angry at the proposed reduction of commercial discounts on generic drugs, a measure deemed catastrophic by the profession.

Alison Shepherd, *The BMJ*

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J LUDOVIC MARIN; JEAN-FRANCOIS MONIER / AFP / GETTY

Backing the Global Fund to Fight AIDS, TB, Malaria

UK must step up to support global multilateral efforts to tackle disease

The Global Fund to Fight AIDS, Tuberculosis, and Malaria was established in 2002 as an international financing mechanism and partnership to end the three epidemics. It works to expand access to prevention, treatment, and care and strengthen health systems.

Since its establishment, annual AIDS deaths have fallen from 2.1 million in 2004 to about 630 000 today, while malaria deaths fell from about 861 000 in 2020 to 597 000 in 2023, and tuberculosis (TB) deaths from about 2 million a year in 2010 to just over a million in 2024.^{1,2}

These declines in mortality are the result of an unprecedented domestic and global mobilisation of governments, non-governmental organisations, and other multilateral and bilateral initiatives—of which the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) have been a part. The Global Fund invests up to \$5bn a year to support programmes and health systems strengthening in more than 100 countries. It is by far the largest global funder of TB and malaria control and, together with PEPFAR, HIV programmes.

Commitment waning

But commitment to a global response on HIV, TB, and malaria is waning. The US administration's decision to cut PEPFAR funding threatens to reverse decades of progress and risks a resurgence in new infections, particularly in the poorest countries.³ Official development assistance for health fell by 21% between 2024 and 2025, as governments face shrinking budgets and rising debt and growing geopolitical fragmentation weakens international cooperation.⁴

We now have a suite of transformative innovations to treat, prevent, and diagnose HIV, including long acting pre-exposure prophylaxis



Without sustained investment, innovations remain a promise rather than reality

(PrEP), self-testing, and powerful antiretroviral therapies. These could achieve very low rates of death and new infections in most communities.⁵

Likewise, we have better diagnostic tools and therapies for TB, such as molecular tools for drug sensitive and drug resistant disease and effective shorter duration combination antibiotic therapy.⁶

While substantial progress has been made in malaria control, including developments in vaccines, coverage of effective interventions remains vital, especially in Africa and children under 5 years old.

But without sustained investment and political commitment, these innovations will remain a promise rather than a reality for millions.

As an example of what is possible, London was one of the first cities in the world to exceed the UN's 95-95-95 targets, an indicator of effective clinical management of people living with HIV. By 2022, 98% of people in the city with a diagnosis of HIV were receiving treatment, and 97% of those achieved viral suppression.^{7,8} However, new infections continue to occur, and the UK government has now rightly raised its ambition, pledging to end new HIV transmissions nationally by 2030.⁹

Similarly, the UK has had periods of success with TB, the incidence of which has been driven upward by disease developing in people who have been infected elsewhere in the world. Innovative programmes such as active case finding using the find

and treat mobile digital x ray platform have proved cost effective.¹⁰

International action, domestic results

But while a domestic response is crucial, a domestic-only response is ultimately self-defeating. If we fail to reduce HIV transmission and TB spread globally—or worse, we enable infection levels to climb—domestic infections may increase as people move throughout an increasingly interconnected world.

The Global Fund hosts its eighth replenishment in November, seeking to raise \$18bn for the next three years. It estimates this funding will save up to 23 million lives and prevent 400 million new infections across these three diseases by 2029 if delivered synergistically with the domestic efforts of affected countries.² In low income countries, such assistance for health represents nearly 30% of total health expenditures, with a higher percentage for the three diseases covered by the Global Fund.¹¹ When others are stepping back, the UK's leadership, as co-host with South Africa, of the Global Fund's replenishment matters more than ever.¹²

With intense pressure on resources, questions arise about whether specific funding for HIV, TB, and malaria remains justified as a priority. And indeed, there are calls for reform of disease specific programmes and other global health organisations, including the Global Fund, to ensure local ownership, capacity, and resiliency. Yet the scale of the fund's impact is undeniable.¹⁻¹⁴

The UK government must resolutely support the Global Fund, at a level not below the £1bn given in the last replenishment. Adequate funding is essential to preserve the gains in terms of lives saved and ending HIV and TB as public health crises throughout the world.

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Healthcare professional regulation in the UK

Future role of GMC under challenge

The recently expanded remit of the General Medical Council (GMC) to regulate physician and anaesthesia assistants (PAs and AAs) has given rise to political tensions. The BMA's failed legal challenge to this change raises fundamental questions about how, and for whom, healthcare regulation should function.^{1,2} The GMC has a longstanding statutory duty to protect the public interest by regulating the medical profession and has historically served as both a licensing authority and an adjudicator, but its role is now under increased scrutiny, including for how it interacts with ethnic minority doctors and its dealing with sexual misconduct cases.^{3,4}

After the Shipman inquiry criticised the GMC's role,³ the independent Medical Practitioners Tribunal Service (MPTS) was created in 2012 to separate investigation from adjudication. The GMC refers cases to the MPTS, which comprises lay and professional members, for judgment on fitness to practise. However, the GMC has the right to appeal outcomes if public protection is at risk.

This has proved controversial, and the 2018 Williams review recommended the removal of that right after the Bawa-Garba case, when the GMC had appealed the MPTS outcome as too lenient, leading to a "loss of trust between the GMC and doctors."⁵ Leaving decisions to appeal fitness to practise outcomes solely to the Professional Standards Association (PSA) would put the GMC in line with the other nine regulators of UK health professions.

In 2024, both the GMC and the PSA challenged an MPTS outcome involving sexual misconduct and racism, raising concerns about MPTS functionality, overlapping authority, and regulatory disparity.⁴ Debates about the optimal investigation and adjudication process continue, and individual regulatory bodies



RICHARD H SMITH

The GMC's role is now under increased scrutiny

take different approaches to the separation of decision making, both in the UK and elsewhere. Health minister Karin Smyth has announced the GMC will lose the right to appeal MPTS outcomes under upcoming regulatory reforms.⁶

The GMC has responded to concerns and made progress. In 2021 it set targets to deal with disproportionate regulatory referrals of ethnic minority doctors and disadvantages in medical education and attainment, due to be met by 2026 and 2031, respectively.⁷

The government's decision to bring regulation of PAs under the remit of the GMC brought a new challenge. In April 2025, a judicial review was held into the BMA's legal challenge to the GMC's standards document, *Good Medical Practice*, being applied to PAs and AAs.

Case for single healthcare regulator

Doctors may believe that they need to be judged by doctors to be fairly treated. Healthcare professionals have different risks, responsibilities, and training pathways, which may not be amenable to a universal regulatory model. There are, however, serious inconsistencies that need to be addressed. For example, research for the PSA showed that fitness to practise sanctions for doctors with proved allegations of sexual misconduct were more lenient than those for other regulated health professions.¹⁰

The PSA responded to the 2021 government consultation into regulatory reform by advising that

a single regulator could be a first step towards a more consistent framework.¹⁰ The resulting Health and Social Care Act 2022 granted the secretary of state power to "merge or abolish healthcare professional regulators"¹¹ a provision still in force.

There are multiprofessional models both in the UK and elsewhere that work. The UK's Health and Care Professions Council has achieved a level of regulatory harmony and consistency between professions few thought possible in 2001.¹² It regulates 15 different health professions, including paramedics, psychologists, and operating department practitioners, at considerably lower cost than the GMC.^{13,14} Australia has had a single professional health regulator for 15 years with responsibility for 16 health professions, including doctors, dentists, and nurses. It has one legal framework, a single registration system, and national boards with lay and professional members for each profession. Over the past five years, it has worked to reform its fitness to practise investigations, acknowledging the harm they cause, working collaboratively with stakeholders to counter common regulatory myths, and restoring trust, while delivering more compassionate regulation. Its responsive, risk based approach has resulted in faster decision making, focusing resources where sanctions are necessary to protect the public.^{15,16}

As evidence continues to emerge on the damage caused to complainants, registrants under investigation, and witnesses in the fitness to practise process,¹⁵⁻¹⁸ constructive multiprofessional dialogue in the UK should explore building a streamlined, evidence based, regulatory framework that puts patients first and holds everyone to the same ethical standard.

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Abortion is not a modern intervention—and history shows that prohibition fails

MPs in the UK recently voted to decriminalise abortion, but reproduction rights continue to be curtailed in many countries. In her new book **Mary Fissell**, a US professor in the history of medicine, illustrates how ending pregnancies is nothing new. She tells **Shivali Fulchand** what lessons doctors can learn

? What motivated you to write *Abortion: A History*?

In spring 2022 my agent asked if I had considered writing a book on abortion history. Coincidentally, I had, because we saw the *Dobbs v Jackson* decision looming (see box, right).

I was teaching about abortion history to my public health students, and I was galvanised by the history: women have always had abortions, prohibition doesn't work, and history shows us this repeatedly. Restriction just makes it more difficult—and more dangerous.

? Why was it important to tell the history of abortion through the stories of real women?

Abortion is an issue of hearts, not minds. It's stories that move hearts, not rational arguments. Good scholarship exists on the medical and legal side, but it's often a little dry. Women end pregnancies for many reasons. For many, it's not a choice—for example, working class women in the American south can't afford childcare, and enslaved women were seen as possessions.

? There were periods when abortion was widely tolerated, you write. What causes shifts in public and legal attitudes?

My students were stunned to know abortion was healthcare in ancient Greece. An incomplete miscarriage could be a death sentence, but there were things women and a good doctor could do. People have always been ending pregnancies with herbal preparations, or surgery, and now pills.

Historically, people often just looked the other way. But changes in religious politics, leading to concern about irregular sexual relations, or in gender relations, led to change. In ancient Rome and antebellum America [the five decades between the 1812 war and the civil war of 1861], we have similar moments when men are fretting about women's new liberties. Men feel threatened in some



What's different now is the valorisation of the fetus
Mary Fissell

way—also not new. This is also about power and ownership.

? Do you see any parallels between current restrictions and historical cycles of repression?

People are captivated by a nostalgia for an earlier America that never really existed. They want to return to some simpler era with more hierarchical gender relations, where everyone knows their place. That kind of nostalgia is powerful, as in the tradwives movement. Similar nostalgia existed in ancient Rome, where male critics said that it was much better back when women were more virtuous. This is simply an imagined past where men had greater control.

? Is there anything different about today's backlash against abortion rights?

What's different now is the valorisation of the fetus, increased by photographic technology that gives a fetus personhood. For most of history the fetus is almost irrelevant; now the equations are radically different.

A Texas man was recently charged with capital murder for slipping an abortifacient into his girlfriend's cup when she was six weeks pregnant. Before, the concern would have been the woman's life; now it's the fetus.

? How did race, class, and colonialism shape abortion, and what lessons are there for the modern reproductive justice movement?

Like the Roman era, enslaved women

in America—and their children—were seen as possessions and were forbidden from ending pregnancies. Later, their granddaughters were sterilised during the eugenics period. Race and class are still braided together in America. My generation's mistake was believing that *Roe v Wade* was a matter of choice, but it ignores the fact that many women still don't have the luxury of choice—we need to understand that in a more nuanced way. That “double burden” of production and reproduction is still there [being able to earn enough money while having children], which haunts women's lives and social arrangements.

? What concerns you about the future of abortion rights?

Recent polls suggest that men are increasingly anti-abortion, while women are increasingly pro-abortion. This suggests that the whole backlash argument is maybe real. If young men don't understand that their girlfriend, sister, or mother deserves those rights, how do we get that message to them?

There are also developments that Robert F Kennedy Jr, the US health secretary, is asking to re-evaluate the safety of mifepristone despite decades of proof of its safety. This is a move to restrict that is based on flawed science.

? You mention the role of medical professionals in both advocating for and opposing abortion access. How has the medical profession's role in abortion evolved?

Abortion was once a personal matter, with women using herbs independently. Aleck Bourne's 1930s UK case, when he performed an abortion on a 14 year old girl who was raped, helped to cement doctors' power to decide who gets an abortion. This consolidation of power to doctors narrowed access in some ways, but it also made access a lot safer—it's a double edged sword.

However, now we have a whole range of providers for abortion care, who are perfectly capable of providing reproductive healthcare, whereas they were seen as “off limits” by physicians before.

? Were there any individuals or cases in your research that particularly resonated with you?

Anna Harding, in chapter 3, is a 17th century German woman who was accused and killed for being a witch, in relation to her abortion practice. Her story amazed me because she was working as a “menstrual regulator”: she could effectively turn the taps on and off. Who knew that this was a thing in the 17th century? She was also a sex worker because she was trying to make ends meet after her husband died.

Her story affected me because she vigorously insisted that the healthcare she provided was not witchcraft—even under torture. I feel strongly that this woman was providing a service in a poverty torn, misogynistic era.

? Your book centres on western societies. How do the patterns and attitudes you describe compare with other cultures?

I’m just getting a glimmer of how things were when American servicemen were stationed in Japan and interacting with local women. Having mixed race babies would be an abomination, leading to abortions for profoundly eugenic, racist reasons.

Also, there are parts of the world where male children are so valued that female fetuses were differentially aborted. We also need that history, as these stories are different.

? Any final words?

History doesn’t repeat, but it does echo. When I taught my abortion unit again this spring, women with incomplete miscarriages were dying in Texas and Alabama. We’ve known forever how to treat this, and we’re just choosing not to do it, and that’s appalling. However, I’m an optimist, and I think that moments of moral panic have recurred, but they don’t last. I want to see abortion decriminalisation enshrined in US law—and history is on our side.

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SANDY HUFFAKER/APGETTY IMAGES

Dobbs v Jackson: Landmark removal of the US constitutional right to abortion

Dobbs v Jackson was a landmark 2022 US Supreme Court case that overturned Roe v Wade (1973) and Planned Parenthood v Casey (1992), removing the federal constitutional right to abortion.

Jackson Women’s Health Organization, then the only abortion clinic in Mississippi, filed a suit against Thomas E Dobbs, state health officer with the Mississippi State Department of Health, who was responsible for enforcing a law that banned most abortions after 15 weeks of pregnancy. The organisation argued that the ban was unconstitutional under decades of Supreme Court precedent of the fetal viability standard of around 24 weeks.

The Supreme Court ruled in favour of Dobbs—upholding the 15 week ban, overruling 50 years of precedent set by Roe v Wade (1973). This triggered the immediate enforcement of strict abortion bans in at least 13 states, closing numerous abortion clinics, including the Jackson Women’s Health Organization, and raising widespread public concern.

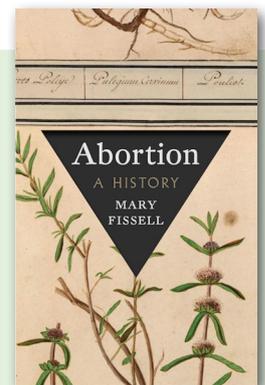
Eliza Wilson and Margaret Wheatley: Welfare cuts disproportionately affect the most vulnerable people

In Victorian Britain working class women endured the greatest dangers under anti-abortion laws, as shown in two stories from Mary Fissell’s *Abortion: A History*.

Eliza Wilson, an unmarried dressmaker who moved to London for work, became pregnant after an affair. Wilson sought help from a herbalist and then from a midwife, who performed a so called catheter abortion. Wilson died soon afterwards from infection—her tragedy compounded by having to give testimony on her deathbed.

From the same era, Margaret Wheatley’s story further illustrates the harsh realities women faced. Unable to afford a midwife owing to welfare reforms after the introduction of the New Poor Law in 1834, Margaret died in childbirth.

Both stories highlight how vulnerable women are left in difficult circumstances. Amid today’s cuts to the social safety net—with comparisons made to the UK slipping back to the social divides of the Victorian era—these stories are a reminder that such changes disproportionately harm the people most vulnerable.



Barnett Rhetta: A visionary physician willing to embrace change

The story of Dr Barnett Rhetta in Fissell’s book illustrates how the application of science and medicine is profoundly shaped by cultural context.

Early in his career Rhetta was a staunch opponent of abortion, famously publishing “A Plea for the Lives of the Unborn” in 1915. During this era the spread of eugenics particularly alarmed black intellectuals, who feared that it would be used to justify anti-immigration policies and the forced sterilisation of marginalised groups.

Rhetta’s transformation stands out: despite his initial opposition, he ultimately became one of Baltimore’s leading abortion providers and a respected community leader. In 1955, when he was sentenced to 10 years in prison for performing abortions, his age and civic contributions spared him incarceration.

Scientific and medical decisions are not made in a vacuum: they are shaped by prevailing societal norms and biases. This reinforces the importance of critically examining how a cultural narrative informs what we accept as scientific truth.



MALCOLM WILLET

WORKFORCE

A WASTE OF EXPERTISE: the doctors struggling to return after a career break

Many doctors face difficulties when restarting their practice. **Adele Waters** reports on support available

Leaving medicine for the second time was devastating for former GP trainee Vicky Tate. “Deciding to resign was such a hard decision to make. Part of me still regrets it,” she admits.

After taking 10 years out of practice to raise a family, Tate says she was delighted when in 2020 she got the opportunity to work as a supernumerary second year foundation trainee at her local hospital three days a week.

But after a couple of months in the role she was forced to quit. “I was having to get my head around a new job, trying to remember how to do all these practical things after not having done them for so long, with three children at home and my husband struggling to balance work and some homeschooling (it was during the pandemic).

“I just wasn’t able to balance everything. It wasn’t the right time so I decided to stop.”

Tate says a more formalised return to work pathway could have made all the difference for her. “I didn’t feel

clinically confident and I was nervous doing the practical things, so I would have found a structured programme where I could go over some of the basic clinical tasks, like taking bloods and inserting cannulas, as well as things like learning the new IT system, helpful. It would have made a big difference in building my confidence.

“And it would have been helpful to be networked with other people in a similar situation,” Tate adds. “I just think I needed a bit more hand holding.”

No central support

The BMJ has spoken to several doctors who have faced difficulties in returning to practice after extended periods away. Many agreed that the toughest part was knowing where to start.

One doctor, who wished to remain anonymous, says she had a frustrating journey trying to get information when she attempted to return to practice. She completed her first year of foundation training and gained GMC registration in the UK before she

There is no single formalised route or structured programme for returning to practice

moved to the US. On returning to the UK after nine years, she contacted her local deanery and the GMC but eventually gave up on trying to return to medicine.

“No one seemed to have any idea. I was passed from secretary to secretary. I couldn’t find anyone to talk to about returning to medicine,” she says. “I ended up training as a secondary school teacher as it was easier to start in a new career than pick up my old one.”

Precisely how many non-working doctors are looking to resume their careers in the UK is unknown. There are no official data: since there is no single formalised route or structured programme for returning to practice, no organisation collects such figures. There are, however, indications that there could be thousands.

In 2020 the GMC and former UK education departments conducted a survey of 13 158 doctors who had left UK practice. Findings published in October 2021 showed that, after weighting the data to the total population of doctors (91 313), a third (35.2%) wanted to return. An

unknown proportion of these will be doctors who have been out of work for a significant or extended period (two or more years).

A difficult path

Cliona Ni Bhrolchain, a former paediatric consultant based in the Wirral, has experience in helping hospital doctors navigate a route back to work. She says that although there is usually support in place for resident trainees and those still employed (see Box 1), it's a different story for those who have left employment.

"If you are an employed secondary care doctor, then you're the employers' responsibility, but if you've been out for a long period and no longer have an employer then there's just no system to help. No network. There is no one who says, 'This is what you do.'"

Inevitably, she says, the longer doctors are off work, the harder it is to go back and the more support they



If you no longer have an employer then there's just no system to help. No network
Cliona Ni Bhrolchain

need. "If you had been out of work for a number of years, it could take you six to 12 months to get back to functioning the way you did before you left.

"Something needs to be done to support returning doctors," she says. "We're missing out on a huge number of valuable skills and it's not that difficult to do. If only someone took responsibility for doing it."

While there is a scheme for resident doctors in training in England, there are no routes for secondary care doctors outside of training. Typically, hopeful returners must secure a supernumerary placement and work voluntarily for months in order to get back to work.

Eleanor Morris successfully returned to practice as an anaesthetist in 2023, after a 12 year career break. She says it was not an easy path—her first step was a six month unpaid clinical attachment before working as a junior clinical fellow for a further six months and then applying for substantive jobs.

She has recently been appointed to a substantive post as a specialty doctor, and has identified three main factors that would have made her return easier. "The first is better signposting to resources that could help support return to work," Morris says.

"Local support is crucial, too—including departments like HR, IT, and payroll, as well as the clinical department.

"Separate from the clinical side of things, you also need help with the practical administrative tasks like GMC licensing, appraisal, and revalidation; local inductions; and ensuring accurate pay, annual leave, and sick leave entitlements. Finally, mentoring is key. Returning to work can be stressful, and there can be emotional as well as practical challenges."

Many hospital doctors think GPs are lucky to have access to their own returner scheme—the GP Return to Practice programme (see Box 2, overleaf)—but, says the Royal College of General Practitioners (RCGP), this is far from perfect.

Bureaucratic hurdles, delayed payments, and the administrative burden cause problems, says Kamila Hawthorne, below, chair of the college. "There is a need to streamline the process and provide more support to those who want to return," she says.

A sharp contrast is evident in the level of support given to nurses, who benefit from a national return to practice scheme that provides training and a route back into the NHS. The programme has supported 7978 nurse returners since its inception in 2014.

In June last year the BMA identified the lack of a clear pathway back to medicine for doctors wanting to recommence work as a key problem facing the profession. It has called for NHS returner and retainer schemes with appropriate central funding for all branches of practice across the UK.

There is a need to provide more support to GPs who want to return
Kamila Hawthorne



Box 1 | Schemes and sources of support

Schemes

- SupportT: a supported return to training scheme for hospital residents in training in England. kss.hee.nhs.uk/resources-information/supported-return-to-training-supportt/apply-for-srtt

Courses

- The London School of Paediatrics offers a free one day course for paediatricians, covering common paediatric emergencies and key updates in practice. londonpaediatrics.co.uk/trainees-home/returning-to-clinical-practice
- The GMC offers free Welcome to UK Practice workshops, which are suitable for UK doctors returning to work after a period of absence. The sessions provide practical advice, cover GMC key standards, and explore ethical scenarios doctors may encounter. www.gmc-uk.org/about/what-we-do-and-why/learning-and-support/workshops/welcome-to-uk-practice/doctors
- Welcome Back to Work offers bespoke courses and advice for GPs. www.welcomebacktowork.co.uk

Support

- The GMC expects employers to support doctors who have had a career break with induction, supervision, and support. **GMC advice line: 0161 923 6602**
- NHS Resolution offers a practitioner performance and assessment programme for doctors who are still employed by the NHS but promises to help

those on a placement or honorary contract to devise a return to work action plan. **resolution.nhs.uk/services/practitioner-performance-advice**

Networks

- PMGUK (Physician Mums Group UK) Returners/ Long Career Break Group is a subgroup of Physician Mums UK. www.facebook.com/groups/1502095813434231

Guidance

- Back on Track is a good practice guide from NHS Resolution. resolution.nhs.uk/resources/back-on-track-a-good-practice-guide
- There is a guidance page on the BMA website. www.bma.org.uk/advice-and-support/career-progression/finding-the-right-role/returning-to-clinical-practice-after-absence
- The Academy of Medical Royal Colleges has online guidance. www.aomrc.org.uk/wp-content/uploads/2017/06/Return_to_Practice_guidance_2017_
- Resources on the legacy website of the Career Refresh for Medicine programme, a pilot programme that launched in 2021 by HEE but is now inactive. www.hee.nhs.uk/our-work/return-practice/career-refresh-medicine
- Individual royal colleges and associations may also have their own guidance

Hit and miss

Clare Gerada, past president of the RCGP and former medical director of the largest practitioner health programme in the country, agrees, saying current support for any doctor returning to work is too variable across the UK.

“It’s hit and miss. For some it can be easy and for others it can be incredibly difficult,” she says. “Whether you’re sick, whether you’re suspended, whether you’re under supervision, whether you’re under conditions, whether you’ve been out of the country—it’s definitely confusing. It’s a dog’s breakfast.”

But this need not be the case, she says, if there was central funding to support re-entry packages.

She says that all returning doctors should have an enhanced appraisal by a medical director to identify learning needs and how these should be met through a mix of work placements, assessments, and supervision. She suggests they all be supernumerary for three to six months, depending on the learning needs.

“That should be standard for all doctors, for GPs and hospital doctors, from first year foundation trainees to 60 year old consultants who wish to return after four years out looking after very elderly parents.”

Three years ago, doctors Sarah McKelvie and Rachel Rummery set up a Facebook network for female doctors who have been out



Returners are a diverse group. The ideal would be funding for structured, flexible support
Sarah McKelvie



I had many advantages so, if I found returning difficult, it might be even harder for others Rachel Rummery

of medicine for at least two years. PMGUK (Physician Mums Group UK) Returners/Long Career Break Group now has 763 members who left medicine for a range of reasons, including having children, prolonged illness, and child or partner bereavement.

“There are lots of doctors out there who have taken time out, want to get back to work, and don’t have support—it’s just luck some have found our group,” says McKelvie, a former GP trainee, who, after a struggle, returned to medicine after a 13 year career break in 2020, aged 42.

Rummery returned to practice in 2011 also after a 13 year break to raise two children. Despite a supportive family and getting a paid part time post, she says she found it difficult. “It took me six months to feel confident in the workplace and two years to get on to a training programme. I felt strongly that I had many advantages so, if I’d found returning difficult, then it might be even harder for others.”

What makes a successful return is dependent on many factors, McKelvie and Rummery say, including the circumstances of the returner, their specialty, and the local appetite to support them. Both believe there should be a national professional network to link doctors to sources of support, as well as a re-entry programme.

Rummery, who was the return to practice lead at Health Education England, says, “As returners are

a diverse group, the ideal would be funding for structured, flexible support, including information, resources, and placements.”

“If there was some programme that you could apply for if you’ve been off work for more than five years, it would make such a difference,” agrees McKelvie. “It could include an unpaid attachment with online lectures, a practical skills refresher, and a supervisor. There could also be an exam that you sit beforehand to encourage you to revise again.”

Through PMGUK, women who have successfully returned to work share their tips and intelligence with others looking to do the same. The group has helped around 50 doctors return but there are many who have “just given up as they don’t see it as a possibility.”

“It shouldn’t be down to us to help them,” says McKelvie. “There should be something set up nationally. I would be interested in working with NHS England to create a scheme.”

The BMJ put that offer to NHS England but it did not respond. A spokesperson said, “We would encourage any member of NHS staff considering a career break to discuss it with their employer in advance so they can agree a plan for their return.”

Responses from all the UK health departments show that helping doctors return to work after extended periods is not an active area of policy development. Only the Welsh government said it is considering putting in place a national policy.

Without government action, however, doctors who want to return after considerable time out will face the same struggles as those who have tried before them.

“It just seems like a huge waste,” says Morris. “There are many doctors who have stepped away from clinical practice for whatever reason and it’s difficult to find a way back in.

“These doctors have skills and experience to offer but it seems like they are a forgotten group. But there is potential, because with the right support it is possible to safely reskill and to return to work relatively quickly and inexpensively.”

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BOX 2 | THE GP RETURN TO PRACTICE SCHEME

GPs wanting to return to work after a break of two or more years can apply to join the Return to Practice programme.

Jointly developed and supported by NHS England, the GMC, the RCGP, and the BMA, it offers a personalised pathway back to work based on the needs of each returner.

Doctors have an educational lead to guide them through the programme, which requires them to work in practice or do a placement and complete assessments and maintain a portfolio.

Returners must find a practice to support them through the programme. Financial support is also available under the scheme, including a bursary and funding for indemnity and childcare costs.

All four nations in the UK offer the programme, although there are some variations.

- **England:** medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/return-to-practice/registering-for-the-programme 
- **Scotland:** www.scotlanddeanery.nhs.scot/your-development/gp-induction-and-returner-programmes/scotland-gp-returner-programme 
- **Wales:** heiw.nhs.wales/education-and-training/general-practice-gp/overseas-gps/gp-international-induction-and-return-to-practice-programmes/gp-return-to-practice-programme 
- **Northern Ireland:** www.nimda.ta.gov.uk/gp-careers/return-to-practice-rtp-and-international-induction-iip-programmes 

ROLE MODEL

Darren Green

The consultant nephrologist talks to **Helen Jones** about how growing up in a deprived area has made him a better doctor

I grew up in an area with very high levels of deprivation, high rates of unemployment, and not many prospects,” says Darren Green, consultant nephrologist at the Northern Care Alliance NHS Foundation Trust and honorary professor of cardiovascular sciences at the University of Manchester.

“As a young boy, I wanted a job with complete job security, but probably more importantly, I wanted a career where I would feel valued and respected. Because when you’re young and you’re in that kind of setting, feeling valued and respected is nothing you’ve ever really experienced.”

Green says his decision to pursue medicine was “entirely selfish,” but that his background has helped him connect with patients. “A lot of the problems we have engaging with patients are pretty much to do with the same things—around being valued and respected. Patients’ frustrations with the healthcare system are usually that they don’t feel like their voice is heard. I think my own experience probably made me better at my job than I otherwise would have been.”

He credits his parents for pushing him towards medicine. “I was quite lucky that my parents, particularly my mum, were good at pushing me. They



saw it as an opportunity for me to get out of the situation we were in,” he says.

But the path wasn’t straightforward. “You don’t really get guidance for that sort of thing. There were no mentors or role models that I could follow.” He adds that even within medicine, there are barriers to getting access to opportunities. “It’s pot luck whether you end up on the team that fits what you want to do. Half the time you don’t even know what you want to do when you’re a junior.”

Because of that, he makes a point of supporting those who ask. “Anytime anyone junior comes to see me and says, ‘Can I help you out with X, Y, Z?’ the

When you’re young and you’re in that kind of setting, feeling valued and respected is nothing you’ve ever really experienced

answer is always yes. Because finding those opportunities is difficult.”

Green’s route into nephrology was shaped by his interest in complex, long term conditions. “I bounced about not quite knowing where I belonged in medicine. Then I realised that where I belonged was with people living with complex, long term conditions, where the social constructs are a massive part of their health. Deprivation is a huge part of that.”

NOMINATED BY REUBEN ROY

“I’ve had the pleasure of working with Darren for a total of seven years now. In this time, he has, time and again, shown himself to be supportive of the career aspirations of trainees, and readily contactable for reasons great and small. He is modest and good humoured despite the multiple plates he spins—many of which could be rightly regarded as prestigious.

“Darren has proved to be a patient and kind supervisor, often sending an encouraging message at what seems to be the perfect time for a trainee’s morale. He happily takes on the more challenging cases and never dismisses the concerns of patients or their families or advocates. He also makes a point to communicate complex ideas in non-technical language and is keen to encourage trainees to pursue research if they ever express an interest, however fleeting.”

Reuben Roy is a specialty trainee year 7 in renal medicine, North Western Deanery.

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

He also tried to balance nephrology with acute medicine and academia. “I used to do a lot of acute medicine. I had to give it up. I wanted to try and balance the outpatient work of nephrology with inpatient work of acute medicine and the academia, but I just couldn’t. I feel bad because I think acute medicine is a massively undervalued specialty.”

Failure, he says, is inevitable—and useful. “We all face failure, unfortunately probably more frequently than we meet success. The best thing you can do is try and understand why it happened. If you nail that, then you learn a huge amount.”

The most rewarding part of his career? “The relationships that you build up. You get to know your patients really well over years. You value their health and wellbeing professionally, but you also value them on a personal level. I enjoy just sitting down with them and having a good natter. It’s a privileged position to be in.”

He feels the same about his colleagues. “If you’ve got that sort of warmth and sense of teamwork and belonging with your patients, you probably have that with your colleagues as well. I love working with the team I’ve got.”

His advice to those starting out is to “plan ahead—short term, medium term, long term. Understand what you can change and what you can’t. Learn from failure and have contingencies.”

Outside work, Green finds clarity in mountain biking and bouldering. “The only time there’s one thing and nothing else in my head is if I’m hurtling down Jacob’s Ladder in the Peak District. The only thing in my head is avoiding a situation where my face is going to hit a rock,” he says.

Helen Jones, London

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My colleague humiliated me— what should I do?

Humiliation is often dismissed as banter, but doctors don't have to put up with it, **Elisabeth Mahase** hears



Report it to leadership

Cathy Finnegan, GMC assistant director, standards and guidance

“Humiliation at work can erode your confidence, make you question your worth, and have a lasting impact on how you see yourself. It’s also a patient safety risk. Being subject to this behaviour can make you less confident speaking up and being visible, which undermines teamwork and the delivery of care.

“You have every right to expect support from your colleagues. When we updated our Good Medical Practice guidance in 2024 and strengthened the focus on behaviour between colleagues, we made clear that witnesses to poor behaviour should take action. They should consider how they can support you, challenge the behaviour, and report it. We also strengthened expectations of doctors with leadership and management responsibilities. You can expect to be heard and for your concerns to be tackled promptly.

“Too often, attempts to humiliate colleagues—even when they cross into sexual harassment or other forms of discriminatory behaviour—are dismissed as banter or the result of a personality or generational clash. These aren’t acceptable excuses. Work and training environments that tolerate this behaviour are failing the people who work and learn in them and are risking patient safety.

“Whatever form it takes, and whatever excuse is given, humiliation is a serious workplace problem. Support is available and there’s specific advice about racism and sexual misconduct on the GMC website’s ethical hub. Remember that you don’t have to tolerate this behaviour.”



Take a breath

Peter Cosgrove, emergency care paediatrician at the Royal Belfast Hospital for Sick Children

“You’re not alone—the 2024 NHS staff survey found that 17.6% of respondents experienced bullying from colleagues and 9.5% from managers.

“First: pause. Your brain will react emotionally at first. That’s normal. A slow breath buys you thinking time and engages analytical thinking. In such situations I wonder if I’m being defensive because my ego is bruised or is it genuinely unprofessional—or if it’s about my professional identity or just the specific situation. I try to respond to the behaviour, not the sting.

“Respond. If you can, acknowledge and label the emotion driving their behaviour. Name the concern, not the person’s character. You can say something like, ‘It sounds like you’re concerned about patient safety,’ or, ‘It feels like you’re frustrated with this approach.’ This is the same listening skill we use with distressed relatives. It de-escalates tension and shows you’re hearing beyond their words.

“Acknowledge the power dynamics—although I realise it is harder to do this with seniors or in public forums. I find it helpful to ‘mirror’ the last few words as a question and ask calibrated ‘how or what’ questions. This can redirect emotion while keeping dialogue constructive.

“Escalate. If communication fails, patterns repeat, patient safety is at stake, or you’re not safe to tackle it directly, seek an ally and escalate through proper channels such as your line manager, freedom to speak up guardian, or your human resources department.”



Look after yourself

Michael El Boghdady, specialty training registrar and director of education at the Association of Surgeons in Training

“Being humiliated at work can feel deeply personal, but it’s important to understand that such behaviour reflects the shortcomings of the person responsible, not any failing on your part.

“The most important step is to speak up. No one should have to tolerate this behaviour, regardless of seniority or power imbalances. Speaking up might be difficult but it is essential, and the earlier concerns are raised, the more likely it is that the behaviour can be stopped.

“If you feel able, first consider if the matter could be resolved directly with the colleague involved. Sometimes calmly explaining the impact of their words or actions can lead to change. If that doesn’t feel possible or appropriate, follow the escalation pathway outlined in ASiT’s anti-bullying, discrimination, and harassment guidance. This starts with raising the concern with your supervisor and escalating to your medical or clinical director, if necessary.

“If the problem remains unresolved and you are part of a structured national training programme, you can raise it with your training director. Beyond this, concerns can be escalated to the GMC, which also provides a confidential helpline for doctors who wish to report anonymously.

“Most importantly, remember that you’re not alone. Many doctors have experienced similar challenges and speaking up is both a professional duty and a step towards building a safer and more respectful workplace.”

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