ANTISEMITISM page 58 • **GMC VETTING FAILURES** page 62 • **PROSTATE CANCER** page 64

Year round corridor care "new norm"

Doctors are treating patients next to vending machines because of a lack of space in NHS hospitals, a survey has found.

The Royal College of Physicians, which gathered the feedback in a snapshot survey of its members, said urgent action is needed to end the "unacceptable" practice.

While so called "corridor care" has commonly been reported in winter, when NHS demand soars, the RCP said its data confirm it is now a "year round" problem. Nearly three in five respondents (328 of 553) reported delivering care in a temporary space between June and August. Of these, 45% said they had done so daily or almost daily.

The RCP highlighted doctors' "harrowing experiences." One said, "Providing care in front of a vending machine is a new low for my patients and for me as a consultant. The last patient I had to care for here had a brain abscess. This cannot be acceptable."

Hilary Williams, RCP clinical vice president, said corridor care "has become an everyday reality, placing immense physical and emotional strain on staff." Patients deserve care in "safe, private, and properly equipped environments," she added.

The majority (94%) of doctors who provided corridor care this summer said patient privacy and dignity had been compromised, and 81% said clinical practice was physically difficult. Also, 66% said they believed this was the new norm.

Nearly one in 10 (8%) said the experience had made them consider leaving their role.

Helen Neary, co-chair of the BMA Consultants Committee, said, "Not only is corridor care unsafe and undignified for patients, it is also pushing doctors out of the door when we need them most. It is hard to feel professional pride in what you do when you're reduced to treating patients in cupboards and waiting rooms."

The RCP has published updated guidance on delivering care safely in "temporary care environments," recommending doctors adhere to its standards regardless of where the care is being provided. Zuzanna Sawicka, the college's clinical director for patient safety, said, "Our guidance aims to support clinicians to deliver safe care in these unsafe conditions. This is a response to reality, not a sign of approval."

A Department of Health and Social Care spokesperson said, "It is shocking corridor care has become a feature of the NHS and we are working at pace to turn around more than a decade of neglect."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;391:r2219

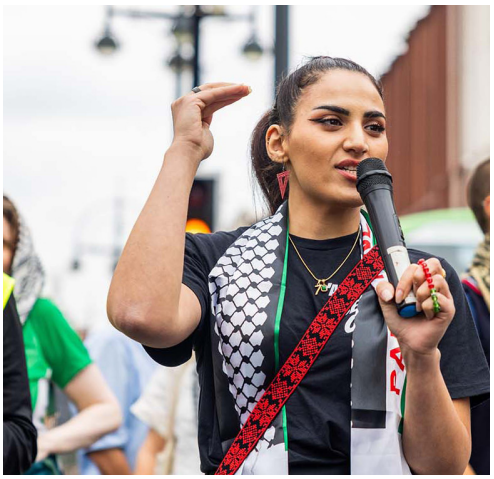
Hilary Williams, RCP clinical vice president, said patients deserve care in "safe, private, and properly equipped" spaces

LATEST ONLINE

- England braces for early wave of flu as cases surge among young people
- Measles: 139 children quarantined in latest US outbreak
- Infant formula: Government criticised for "inexcusable" delay in toughening marketing rules

MEDICAL NEWS

ANTISEMITISM IN NHS: **Starmer orders review and mandatory training for all staff**



Keir Starmer has ordered a rapid review of how healthcare regulators such as the GMC deal with allegations of racist or antisemitic behaviour in the NHS. The government will also roll out mandatory antisemitism and antiracism training for all 1.5 million NHS staff and has promised a "zero tolerance" approach to discrimination in healthcare.

The move follows a case in which British-Palestinian trainee doctor Rahmeh Aladwan (left) was allowed to continue practising pending a full Medical Practitioners Tribunal Service hearing into allegations she made antisemitic remarks.

Starmer has appointed John Mann, a Labour peer and the government's independent adviser on antisemitism, to lead the review. Health secretary Wes Streeting said, "I have been appalled by recent incidents of antisemitism by NHS doctors, and I will not tolerate it."

The Department of Health and Social Care said the review would look at regulatory processes, transparency in investigations, and reporting mechanisms. NHS England is reviewing its guidance on uniforms and workwear, and staff will be banned from wearing pro-Palestinian clothing or badges and other political symbols at work.

"The guidance will not impact staff's freedom to speak out on political issues, but it will ensure the political views of staff do not impact on patient care," the department said.

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2025;391:r2200

Child health

"Unacceptable" long waits are harming life chances

Almost a quarter of children needing community care services in England are waiting over a year for treatment, with one in 15 waiting two years, an analysis by the Nuffield Trust and the Health Foundation found. The think tanks said the "unacceptable" figures placed children's health and life chances at risk and should be a "wake-up call" for the government. Failing to tackle the problem could derail ambitions in the 10 year plan to move more care out of hospitals into the community, they warned.

General practice

Tax hikes would "deepen unemployment crisis"

The outgoing chair of the Royal College of General Practitioners urged the government not to exacerbate the profession's ongoing unemployment crisis by imposing tax rises on GPs. In her speech at the college's annual conference Kamila Hawthorne (right) also called for ministers to provide ringfenced funding to allow general practices to employ the growing number of doctors completing their GP training. The chancellor, Rachel Reeves, is reportedly considering plans to levy national insurance on partnerships, including general practices, to try to raise almost £2bn a year.

Warning over job advisers in surgeries

Putting job advisers in more general practices to help sick and disabled people back into work risks discouraging some patients from seeking medical help, doctors warned. The government is to expand the Connect to Work scheme, which puts specialist employment advisers in practices to support people who have a long term condition or disability, regardless of whether they claim benefits. People can self-refer or be referred by a GP. But GPs warned the initiative could undermine doctor-patient relations.

Smoking

Stopping even late in life "slows cognitive decline"

Doctors could try to motivate middle aged and older adults to quit smoking by telling them that stopping at any age can have meaningful benefits for cognition, researchers said. A longitudinal study using cognitive outcomes over an 18 year period showed that, in middle aged and older smokers with initially similar cognitive trajectories, those who quit smoking during the study showed a slower cognitive decline after

stopping than matched individuals who carried on smoking. The results were published in the journal *Lancet Healthy Longevity*.

AMR

One in six infections "now resistant to antibiotics"

The World Health Organization warned of a sharp rise in antimicrobial resistance (AMR), as one in six bacterial infections are now resistant to antibiotic treatments. WHO's latest global surveillance report found that AMR rose in over 40% of the pathogen-antibiotic combinations monitored from 2018 to 2023, with an average annual rise of 5-15%, depending on the combination. The problem was most severe in low and middle income countries and those with weaker healthcare systems, and resistance was present in a third of infections in some regions.

Mental health

Third of doctors and nurses have depression or anxiety

One in three European doctors and nurses had experienced depression or anxiety in the previous two weeks and more than one in 10 had experienced suicidal thoughts, the region's largest ever mental health survey found. The World Health Organization spoke to 37 864 doctors and 52 307 nurses in 29 European countries. It concluded that their poor mental health was a threat to the region's healthcare security.

Research

Journals auto-reject public health dataset papers

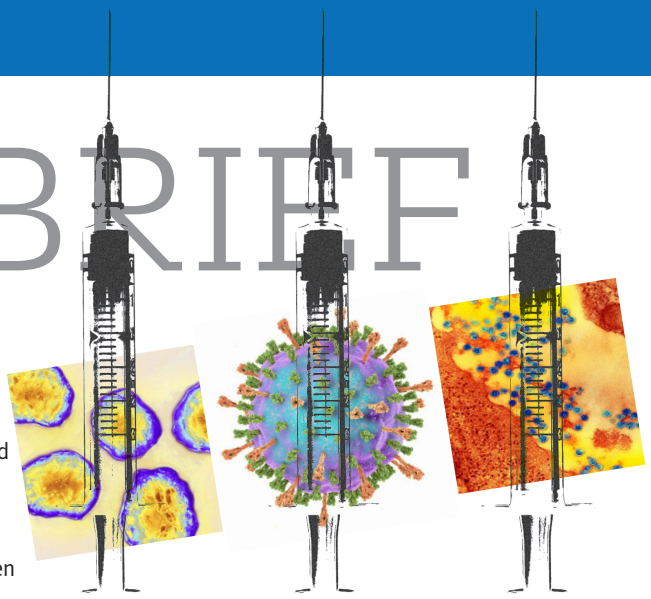
Two major academic publishers are automatically rejecting most papers submitted using public health datasets, sparking a debate over how to combat "paper mills" that are likely to be using AI to churn out research before selling it on. *PLOS* and *Frontiers* announced that any proposals using certain public datasets would be rejected, after an investigation showed that hundreds of similar papers reporting spurious findings had been published in leading journals.

IN BRIEF

Vaccines

Acting CDC director calls for MMR separation

Jim O'Neill, acting director of the US Centers for Disease Control and Prevention, said the combined measles, mumps, and rubella vaccine should be broken up into three separate injections and given at wider intervals. His comments came as he approved a decision to give the MMR separately from the varicella (chickenpox) vaccine and endorsed new guidance framing covid vaccination as a shared decision between patients and doctors. In September the Advisory Committee on Immunization Practices recommended that children under 4 years should receive the MMR and varicella vaccines separately.



CDC head chosen by Donald Trump has called for MMR to be separated into its component vaccines

US misinformation has domino effect in Europe

Vaccine misinformation and disinformation being spread in the US, including by senior politicians, is affecting patients and researchers in Europe, experts warned. At the World Vaccine Congress Europe in Amsterdam on 14 October public health policy makers and industry leaders warned of a "domino effect" of messaging from the US. The conference also heard that investment in vaccine development and technologies was declining as a result of negative sentiment in the US.

Global health

WHO is forced to shed more staff in Europe

Dozens of staff in Europe have been cut at the World Health Organization in recent weeks as the US's withdrawal continues to hit the agency hard. Speaking at the Amsterdam Vaccine Congress, Robb Butler, director of WHO Europe's division of communicable diseases, environment, and health, said 32 staff had been cut from his division in the past three weeks. "We've taken a very heavy hit. The politicisation of health is a very raw and real thing," he said.

Inquest

Baby died after missed signs of bowel obstruction

An inquest into the death of a baby after an advanced neonatal nurse practitioner missed "red flag" signs of a bowel obstruction during a phone consultation concluded that there had been a "missed opportunity" to provide urgent medical care. Jax Miller died at 1 day old of volvulus, which occurs when a loop of intestine twists around itself. It is known to be a critical medical emergency. Doctors commenting on the case expressed concern about the lack of a face-to-face consultation.

Genetic conditions

New test for all newborns

The NHS announced it would routinely screen all newborn babies, within five days of birth, for a rare, genetically inherited metabolic disorder that can result in the need for a liver transplant. Hereditary tyrosinaemia type 1 (HT1) affects around seven babies a year in the UK. Untreated, it can lead to severe complications such as organ damage and liver failure.

Cite this as: *BMJ* 2025;391:r2203

CLAIMS AGAINST NHS

The government's liability for clinical negligence claims in England increased to

£60bn

in 2024-25

[National Audit Office]

SIXTY SECONDS ON . . . TYPE 5 DIABETES

THE FAMOUS 5?

This April the International Diabetes Federation (IDF) agreed to recognise type 5 diabetes, saying evidence supported a distinct classification. In a comment in *Lancet Global Health* earlier this month the IDF urged WHO to follow suit.

GIVE US THE LOWDOWN IN 5

Type 5 is a form of diabetes linked to chronic undernutrition and health inequalities. Some 25 million people (around 4% of the 589 million people with diabetes worldwide) are estimated to be affected, most of whom live in South East Asia and sub-Saharan Africa. While WHO recognised malnutrition related diabetes as a distinct condition in 1985, it removed the definition in 1995, saying there was insufficient evidence.

HOW TO DISTINGUISH THE TYPE

People with type 5 diabetes, like those with type 1, can't produce enough insulin. But type 5 is not caused by an autoimmune disorder and rarely causes ketoacidosis, a dangerous buildup of acid in the blood. Unlike people with type 2 diabetes, however, those with type 5 can use the insulin they make but don't create enough. Researchers believe type 5 is distinguished by chronic undernutrition and that being malnourished from the womb until adulthood is likely to affect development of the pancreas.

HARD TO SPOT?

Life expectancy after diagnosis is often just over a year. The IDF says treatment is worsened by frequent misdiagnosis. Because it is caused by malnutrition, telling people to lose weight is dangerous. So too can be injecting them with insulin, which may cause fatal blood sugar concentrations.

NO RESISTANCE HERE?

Not quite. Some experts argue there aren't enough data to distinguish type 5 diabetes from type 2. "Formal classification risks codifying what may be a spectrum of poorly characterised type 2 diabetes," Anoop Misra, an endocrinologist at the Centre of Nutrition and Metabolic Research in New Delhi, told the NPR Goats and Soda blog.

THE FIFTH AMENDMENT?

The IDF says it will push for recognition so type 5 can be better studied and treated. A working group will create diagnostic criteria and educate healthcare providers.

Luke Taylor, Rio de Janeiro

Cite this as: *BMJ* 2025;391:r2092

Doctor self-refers to GMC amid concerns over evidence in baby death

The leading expert on bone injuries in baby death court cases has referred himself to the GMC after a judge accused him of having a "closed mind" and making "repeated mistakes."

In a High Court family division case last year Mr Justice Keehan said David Mangham was "currently the only forensic consultant histopathologist accepting instructions in cases of suspicious death and/or inflicted injuries in this country." The judge added, "The consequences of this state of affairs, however, is that he has a huge workload."

Doubts over his evidence have since come to light. Three months after the judgment, Laura Langley was cleared at Preston Crown Court of murdering her 7 week old daughter, after two defence experts disputed Mangham's evidence about the cause of rib fractures, agreeing they were caused by cardiopulmonary resuscitation. Now three parents jailed over baby deaths are questioning Mangham's evidence in their cases, the *Times* reported.

> I WAS LEFT WITH A VERY REAL SENSE OF AN EXPERT OVERBURDENED WITH WORK
> Mr Justice Keehan

Last year's case, which sparked Keehan's comments, concerned a 21 month old girl who was found asphyxiated after falling from a bunk bed and becoming tangled in a scarf tied to bars of the bed. Keehan said Mangham "appeared to close his mind to the possibility that any of the rib fractures had been caused accidentally, including by CPR."

The judge ruled the fractures had been caused by the fall and the 90 minute attempt to resuscitate the girl, adding that fractures identified by Mangham were instead "features of the normal processes of bone growth and remodelling in the ribs which are commonly seen in babies and young children."

Keehan concluded, "With great regret, I was left with a very real sense of an expert who was overburdened with work, who had thus made errors and who had closed his mind to possible or probable accidental causes for the injuries. In any event, in this case, Professor Mangham had fallen below his own high standards as a forensic expert witness."

Reluctance among doctors

Doctors have been reluctant to act as expert witnesses after paediatrician Roy Meadow was struck off in 2005 over his evidence in the case of Sally Clark, who was wrongly convicted of murdering her two sons. Meadow successfully appealed to the High Court, and its decision was upheld by the Court of Appeal, but the number of doctors willing to give expert evidence has fallen substantially.

A Crown Prosecution Service spokesman said, "In light of the High Court judgment, prosecutors will consider disclosure of the judge's comments in all cases where Professor Mangham's expert opinion is in issue, so disputed matters can be robustly examined as part of a trial procedure."

The BMJ contacted Mangham but had received no response by the time of publication.

Clare Dyer, *The BMJ* **Cite this as: *BMJ* 2025;391:r2155**

Excluding doctors from covid vaccine programme "puts patients at risk"

Ministers' decision to exclude health and social care workers from the covid-19 vaccination programme is putting patients at risk and will have a major impact on an overstretched NHS, doctors warn.

Hospitals are currently seeing rising numbers of covid cases exacerbated by new variants of the virus, XFG (also called stratus) and NB.1.8.1 (nimbus), and some are introducing compulsory face masks in some areas.

In June the Department of Health and Social Care said that, after advice from the Joint Committee on Vaccination and Immunisation (JCVI), patient facing health and social care workers, including care home staff, would not be eligible for a vaccine this autumn, in contrast to every other year since the pandemic.

Doctor suspended for prescribing Ozempic to her partner

A doctor who prescribed weight loss drugs to a man with whom she was in a close personal relationship has been suspended from the UK medical register for nine months.

Josevania Martins dated "Mr B" for two months. She didn't tell him she was a doctor, a fact she decided to keep secret from him until their relationship was more established.

A medical practitioners tribunal found that Martins wrote prescriptions for semaglutide (Ozempic and Wegovy) in December 2023 and February 2024, naming a fake clinic at which she claimed to have practising privileges, but told Mr B a doctor colleague had written them.

Mr B raised concerns with the GMC shortly after the relationship ended. In his witness statement Mr B said, "The prescription is signed by Dr Martins, but I thought that was a random doctor who was a colleague, as she told me she knew someone who could get a prescription."

Martins runs her own private gynaecology and fertility clinic in north London.

Representing herself at the tribunal, Martins said she acted in a medical emergency, because Mr B's own GP had failed to act. She submitted that the false clinic name was a measure to protect her privacy and that the public would appreciate that no patient safety problem arose and she was acting out of compassion.

No informed consent

But tribunal chair Louise Sweet said the consequence of Martins's actions was that Mr B could not give informed consent to the treatment, and not knowing who treated him would restrict any actions he could take if a problem arose with his health.

It was, Sweet added, "misleading and seriously dishonest" to make up the name of a clinic and write it on a prescription.

The tribunal acknowledged that

A department spokesperson said, "The JCVI advised that thanks to high levels of population immunity most healthy adults are now well protected against severe illness from covid-19. The greatest benefit from further doses is for those at highest risk, such as older adults, people who are immunosuppressed, and NHS staff with underlying health conditions.

"That's why this autumn's programme is focused on protecting those groups most likely to become seriously ill. Healthcare workers remain eligible for the flu vaccine, which continues to play an important role in reducing transmission and workplace absence."

Alison George (right), a GP in Newcastle and member of Doctors Association UK's GP committee, told *The BMJ* the decision was "irresponsible" and "shortsighted."

"It is likely to backfire, with increased staff sickness, higher rates of hospital acquired covid, and cancelled operations and procedures," she said.

Private jabs cost between £75 and £99, which is likely to deter many healthcare workers, George added.

The decision contrasts with government policy on the flu vaccine, which is being offered to all patient facing healthcare staff, including non-clinical workers, to "help protect staff and those they care for."

Stephen Griffin, professor of cancer virology at the University of Leeds, said vaccinating healthcare workers against both covid and flu was an "absolute no brainer." He told *The BMJ*, "Not only are we experiencing a rising wave of the XFG omicron subvariant, but nosocomial transmission continues to be a major source of infection in hospital settings in addition to imported cases."

PRIVATE JABS cost between £75 and £99, which is likely to deter many healthcare workers

Griffin pointed out that, besides vaccines giving excellent protection against severe covid, many people in hospitals are immunosuppressed or otherwise at risk. He said, "Failing to maintain population immunity in the face of a fast evolving virus is well understood for influenza, so I cannot understand why this does not apply to the ongoing pandemic. Moreover, in addition to the acute consequences of covid it is critical to recognise that vaccines also protect against long covid and other latent sequelae, which continue to blight keyworker occupations and the public in general.

"We can ill afford unnecessary staff absences, either over the short or longer term."

Although current vaccines "may not confer long lasting protection from infection," they "are certainly usable to ward off the cumulative damage of covid waves coinciding with our seasonal endemic viruses," Griffin said.

A BMA spokesperson said, "We will continue to call for healthcare organisations to ensure they protect their staff from winter viruses, including access to adequate and appropriate personal protective equipment and good ventilation."

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;391:r2141

Martins, who qualified in Brazil in 1993, had practised medicine for 31 years and "had not lapsed before or since," and that Mr B did not regret having the treatment. Although Martins's dishonesty was sustained over a two month period and was serious, given the unusual factual context "the tribunal was of the view that it was not at the most serious end of the spectrum and was potentially remediable," said Sweet.

The tribunal accepted the GMC's submission that Martins's registration should be suspended for between nine and 12 months, opting for nine months.

At a review hearing "the onus will be on Dr Martins to demonstrate how she has remediated and developed insight," said Sweet.

Martins's registration will be suspended 28 days after notification of the tribunal's decision unless she lodges an appeal. If she appeals she will be free to practise without restrictions until the outcome is known.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;391:r2175

HIV prevention jab to be offered in England

A long acting injection to reduce the risk of contracting HIV will be made available in England for people unable to have a daily prophylaxis tablet.

NICE said its approval of the "groundbreaking" preventive therapy would support the government target of eliminating HIV transmissions by 2030.

Latest data show that new HIV diagnoses fell in England, from 2838 in 2023 to 2773 in 2024.

NICE's final draft guidance recommends cabotegravir (Apretude) as an option for pre-exposure prophylaxis (PrEP) alongside safer sex practices to reduce the risk of sexually acquired HIV-1 infection in adults and young people who weigh at least 35 kg. It is recommended only for adults and young people at high risk of HIV who cannot have a daily oral PrEP tablet.

Up to 1000 patients a year are expected to benefit. The injection, which works by blocking the enzyme integrase, which the virus needs to replicate, is given as two initiation injections given a month apart, with following doses every two months.

Rollout timeline

Rollout is expected to begin three months after NICE publishes its final guidance later this year, if not sooner.

Latest figures show that over 111 000 people accessed PrEP in England in 2024, a 7.7% increase on 2023. But the data also indicate challenges in reaching certain population groups. PrEP uptake is highest among white (79.4%) and ethnic minority (77.8%) gay, bisexual, and men who have sex with men. However, only 35% of black African heterosexual women and 36% of black African heterosexual men at high risk of HIV received the treatment.

This discrepancy is reflected in diagnosis statistics. New HIV diagnoses in England among gay and bisexual men fell 6% last year (from 859 in 2023 to 810 in 2024), whereas new HIV diagnoses among black African heterosexual men increased 15%, from 231 to 265.

Robbie Currie, National AIDS Trust chief executive, said, "While oral PrEP has been effective for many people, for others it is not practical or accessible. That's why an injection of PrEP on the NHS as soon as possible is so important."

Cabotegravir's list price is £1197.02 an injection, but there will be a discount for the NHS.

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;391:r2190

NEWS ANALYSIS

Doctors guilty of serious misconduct abroad are working in the UK—how are they slipping through the cracks?

The GMC has vowed to act after an investigation highlighted a failure to vet overseas doctors applying for NHS jobs. **Jane Feinmann** reports

What did the investigation find?

A total of 22 doctors on the General Medical Council register in May 2025 had been banned or had restrictions imposed on their right to practise by an overseas medical regulatory authority, a *Times* investigation found this month.

In an accompanying editorial the newspaper, which carried out the analysis with the US based Organized Crime and Corruption Reporting Project (OCCRP), accused the GMC of a "scandalous dereliction of duty that presented a clear risk to patient safety."

Responding, the health and social care secretary, Wes Streeting, ordered an urgent review of vetting procedures for doctors who qualified in other countries. He described the findings as "horrific" and a "serious failure in our medical regulatory system that I will not tolerate."

Overall, the OCCRP found more than 100 cases of doctors being licensed to practise in one country despite being banned or suspended in another jurisdiction.

What specific gaps in the process were identified?

The investigation reported that the GMC failed to pick up on data available in the public domain, including on the first page of Google searches of a doctor's name.

In one case Sujan Thyagaraj, a psychiatrist, lost his medical licence in New Mexico, US, in 2019 for having sex with a patient. He was subsequently barred from working in Montana and Hawaii by state regulators on the basis of his New Mexico suspension, the details of which appeared in a simple internet search, the *Times* reported.

Despite this, in January 2025 Thyagaraj obtained a UK medical licence and was employed by Bradford District Care NHS Foundation Trust. He has since been sacked, though the trust declined to comment on when it became aware of his history of misconduct.

The GMC does not conduct online searches on every application but has processes in place that may include search engines or other technology, a spokesperson told *The BMJ*. It is now piloting tougher verification and has signed a contract with the specialist analytics provider DataFlow, an organisation that "undertakes primary source verification of doctors' qualifications and experience on our behalf," the spokesperson said.

They added, "We are exploring how new technologies can help make our registration processes more efficient, consistent, and robust, while maintaining the highest standards of fairness, accuracy, and transparency."

In other instances the investigation found that overseas medical regulators could have shared information with the GMC if the UK regulator had requested it.

Sattar Kadhem, a radiologist, worked at the Royal Free London NHS Foundation Trust until 2022, at a time when he was subject to a Swedish probation order, the *Times* reported.

Kadhem joined the NHS radiology contractor Haxarad after losing both his Swedish and Norwegian medical licences for misreading scans in October 2023. He was fired by Haxarad after an approach by the *Times* and has now been referred to the GMC.

Ajit Pothen worked shifts at the Queen's Medical Centre campus in Nottingham after being suspended by Utrecht University's hospital for errors in treating four patients. He was struck off the GMC register in 2021 for wrongly discharging a 67 year old patient with breathing difficulties who died shortly after. He is now working as a doctor in Baden-Württemberg in Germany.

Other doctors cleared to work in the UK included one found to have sexually harassed colleagues in Canada, another facing stalking charges in Tennessee, and a third convicted in the US after an assault charge, the investigation found.

Reporters in 45 countries found more than 100 cases in which doctors disqualified from practice in one country had relocated and were practising in another. They included Iuliu Stan, a Romanian doctor struck off in the UK in March 2024 after a tribunal ruled he systematically subjected young men and boys to sexual abuse. He is now working in a Romanian hospital.

REPORTERS in 45 countries found more than 100 cases in which doctors disqualified in one country have relocated and are practising in another

What does the current UK system of checks entail?

Alongside evidence of medical qualifications and English language proficiency, the GMC obtains a work history for the past five years and the equivalent of a certificate of good standing from the regulator of every country where the doctor has practised in that period.

The relevant regulator sends these directly to the GMC.

"We always actively seek information from overseas regulators when doctors who have been working in other countries apply to register with us," a GMC spokesperson told *The BMJ*.

How big is the vetting job facing the GMC?

It's significant and increasing. More than six in 10 (63%) of the

23 838 doctors who joined the UK medical workforce in 2022 were overseas graduates.

The number of international medical graduates joining the NHS in England doubled from 6222 in 2018 to 12 148 in 2022.

The NHS in England currently employs 148 000 doctors, of whom about a third (57 000) are foreign citizens.

What are the rules for refusing an application for a UK licence?

The GMC has a responsibility to refuse a licence to practise medicine in the UK if a doctor's fitness to practise is called into question—whether the applicant is a UK or overseas graduate.

In the case of international medical graduates in particular, this depends on the GMC trusting the applicant to be honest and open, particularly about where they have worked during the previous five years, said Aneez Esmail, professor of general practice at Manchester University, who was medical adviser to the 2000 inquiry that investigated the crimes of the GP and serial killer Harold Shipman.

"The GMC has improved vastly since the Shipman inquiry," Esmail told *The BMJ*. "But it remains very difficult to regulate against bad people—the tiny proportion of aberrant, even criminal doctors who are determined to conceal wrongdoing."

What action has the GMC promised to take?

The regulator has pledged to "push for better international information sharing to stop doctors from hiding overseas sanctions."

In terms of how this will work in practice, the GMC is an active member of the Physician Information Exchange (PIE), an international resource set up in 2007 by the International Association of Medical Regulatory Authorities (IAMRA).

PIE members can submit and share information about doctors who make fraudulent applications for registration or who have had action taken against them and then try to practise in another country.

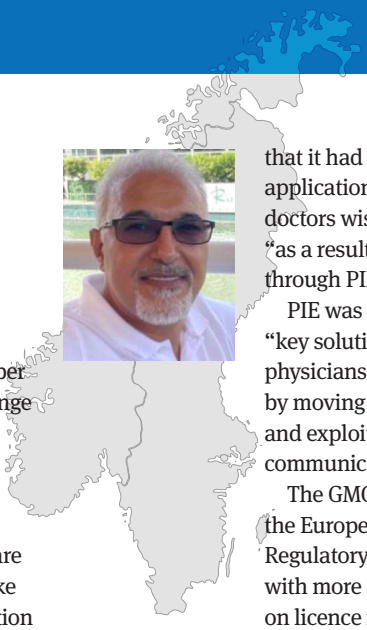
The GMC shares information with more than 70 overseas regulators through PIE.

The *Times* investigation cited 17 cases where a doctor flagged by the PIE system had received a sanction in the UK. In all 17 the GMC had shared the information with overseas regulators through the PIE system, a GMC spokesperson told *The BMJ*.

"We share updates on each doctor who receives a UK sanction through PIE as well as a monthly circular that is sent to over 70 regulators overseas," they added.

It is then up to overseas regulators to make use of the information.

The GMC also confirmed to *The BMJ* that it had "refused registration applications" from overseas doctors wishing to work in the NHS "as a result of information shared through PIE."



PIE was named by OCCRP as a "key solution to the challenges of physicians evading accountability by moving between jurisdictions and exploiting gaps in regulatory communication."

The GMC is also lobbying for the European Network of Medical Regulatory Authorities to provide it with more comprehensive information on licence revocations by EU states, after Brexit meant the UK lost access to a common European database of medical licensing.

Why doesn't PIE catch all doctors facing sanctions?

It's largely down to the willingness of international regulators to report erring doctors, it seems.

Use of PIE is "steadily increasing, with some IAMRA members heavily using PIE while others are just beginning to use the resource," Paul Shinkfield, IAMRA's executive director, told *The BMJ*.

Furthermore, the EU's internal market information alert system was barely or never used by "some countries," the OCCRP reported. Only seven of 49 regulating bodies in and around Europe publish data on banned or suspended doctors, the OCCRP said.

OCCRP reporters had dozens of freedom of information requests rejected for "privacy reasons."

"The quality and consistency of information we receive from overseas varies," the GMC told *The BMJ*.

Should the NHS be involved in vetting overseas graduates?

The GMC says the NHS should share responsibility for vetting applicants for jobs.

Esmail agrees, saying, "Employing authorities largely pass the buck. But there is no reason why an employer shouldn't carry out checks on doctors, including using search engines to check that they are not hiding overseas sanctions."

The work histories of Sattar Kadhem (above), Ajit Pothen (below left), Iuliu Stan (centre), and Sujan Thyagaraj (right) have all been brought to the attention of regulators

Jane Feinmann, London

Cite this as: *BMJ* 2025;391:r2209

PROSTATE CANCER: **Sunak criticises doctors' opposition to screening as experts warn of limited evidence**

High profile politicians have thrown their weight behind calls for a testing regime for men at risk, but are potential harms being sufficiently considered, asks **Kate Bowie**

The government has been clear that screening must be evidence led
David Lammy

We don't want poor quality tests pushed by lobby groups
Margaret McCartney

A very complicated topic is being made unnecessarily simple
Hashim Ahmed

Targeted screening for prostate cancer carries "significant overdiagnosis risks," and this must not be ignored amid intense cross party lobbying for a national screening service, experts have told *The BMJ*.

Implementing a national screening programme for men considered at risk of prostate cancer from age 45 could mislead patients and cause healthcare harms, experts said, adding there was no evidence from UK studies that it would cut deaths.

The warning comes amid growing calls from high profile figures—including the former Conservative prime minister Rishi Sunak and current Labour deputy prime minister David Lammy—for a targeted prostate cancer screening programme in the UK.

Prostate cancer is the most common cancer in men in the UK, with an estimated 63 000 diagnoses every year and more than 12 000 deaths.

PSA followed by MRI

Last week the charity Prostate Cancer Research released a report calling for a screening initiative focusing on men at higher risk of the disease, including black men and men aged 45-69 with a family history of prostate cancer.

Under the proposed programme, men at higher risk would undergo a prostate specific antigen (PSA) blood test. If their PSA was raised they would then undergo MRI scanning and potentially a biopsy.

The charity calculated that a targeted programme such as this would cost 0.01% of the annual NHS budget (around £25m a year) and would require UK diagnostic activity to rise by around 23%.

These calls come as the UK National Screening Committee is due to decide on whether to recommend prostate cancer screening before the end of the year, although reports from the *Times* have suggested that the committee is set to reject the idea.

Speaking at a parliamentary event launching the Prostate Cancer Research report, Lammy said, "The government has been clear: it would like to see screening. But we've also been clear that it must be evidence led, and that's why the [screening committee] is reviewing this as a priority."

Sunak added, "Some things transcend party politics, and this is one of them." He emphasised the need for a targeted screening programme, adding that it could "give thousands and thousands of families more precious years together."

Sunak also criticised doctors who had raised concerns about the risk of overdiagnosis—for example, that unnecessary treatments for prostate cancer, such as radiation therapy and radical prostatectomy, may cause negative effects such as incontinence and erectile dysfunction, without any benefits for the patient.

"I know that many in the medical community have worried that screening would lead to too many false positives, too many unnecessary interventions," he said. "But the facts have changed, so it is now time for them to change their minds.

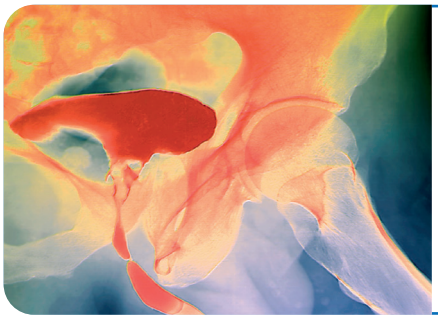
"MRIs are a game changer. They mean that we can be confident that we are now accurately identifying those who need to be treated."

Uncertain benefits

Responding to Sunak's comments and the charity's report, experts warned that the facts were "very complicated" and did not show that the proposed programme would be beneficial.

Last year Margaret McCartney—a GP, writer, and senior clinical lecturer at the University of St Andrews—expressed her concerns in *The BMJ* that a call for wider access to prostate cancer screening made by the Olympic cyclist Chris Hoy, who has metastatic prostate cancer, was leading policy makers to focus too much on headlines and not enough on evidence.

She told *The BMJ*, "The best way to establish whether there is enough quality evidence in support of prostate cancer screening is via high quality systematic reviews and critical analysis of research. This is done by the UK National Screening Committee to a very high standard."



Prostate Cancer Research calculated a targeted programme would cost 0.01% of the annual NHS budget (around £25m a year) and would require UK diagnostic activity to rise by around 23%

McCartney, who is an expert adviser to the Bristol Evidence Synthesis for Screening group, which supports the screening committee, added, "Lobbying does not help do this better. It may make it worse, misleading men and driving more healthcare harm.

"We should want our health systems to offer evidence based interventions to men—and not poor quality tests pushed by lobby groups and media stories which neglect evidence based and fair information about the pros and the cons of health screening."

"No primary evidence"

Hashim Ahmed, chair of urology at Imperial College London and chief investigator of the Transform trial, which is using MRI and blood testing to trial prostate screening, also raised concerns about the Prostate Cancer Research report. He told *The BMJ*, "While it might make intuitive sense, there is no primary evidence that targeted screening in high risk groups has the correct harm-to-benefit ratio over the long term."

Reflecting on points raised by Sunak, Ahmed said, "There is no denying that men referred into secondary care from their GP have an MRI first and that this has cut back on biopsy rates and overdiagnosis in that population." But he added, "You cannot extrapolate data from a secondary care population, which is predominantly symptomatic, to a screened population, which is predominantly asymptomatic. The pretest probabilities of cancer and the performance of MRI need to be confirmed within a much larger study. That is exactly what we are doing with Transform."

Ahmed added that, while results from several northwest European countries had linked screening to a survival benefit in the European Randomized Study of Screening for Prostate Cancer, "the results of that cannot be simply extrapolated to the UK, when the UK study itself showed no survival benefit."

He added, "I think that a very complicated topic is being made unnecessarily simple, when there are lots of factors to consider. The voice of men who had an unnecessary biopsy, or those not insubstantial men who were treated with significant side effects from surgery and radiotherapy and now regret their decision, must not be overlooked."

Acting on evidence

Prostate Cancer Research told *The BMJ* that it welcomed debate and agreed that screening must be guided by robust evidence and careful consideration of benefits and harms. "But the reality is that the evidence has evolved—and the question now is whether we act on it," the charity said.

It pointed to international studies and UK pilot programmes in saying that MRIs reduced overdiagnosis. "When screening is done properly—using MRI to target biopsies and identify only those cancers that matter—the balance between benefit and harm shifts decisively in favour of early detection," it added.

"Of course, the Transform study will add valuable new evidence—and we fully support it—but it has not yet begun recruiting, and the UK cannot afford to wait another decade for its results.

"When other major cancers already have organised screening programmes, it is time to ask why men are still being left behind."

PROSTATE cancer is the most common cancer in men in the UK, with an estimated **63 000** diagnoses every year and more than 12 000 deaths

Data from Cancer Research UK indicate that one in six men in the UK will receive a prostate cancer diagnosis in their lifetime, although black men face a higher incidence, with one in four receiving a diagnosis.

Overall survival rates for the disease are high, with around eight in 10 patients in the UK living for more than a decade after their diagnosis.

Kate Bowie, *The BMJ*

Cite this as: *BMJ* 2025;391:r2173

THE BIG PICTURE

Just say no to drug price hike, activists demand

The campaigning groups 38 Degrees and Just Treatment present three petitions—totalling 250 000 signatures—to the Department of Health and Social Care opposing plans for the NHS to pay pharmaceutical companies 25% more for drugs.

Activists sporting Keir Starmer and Donald Trump masks also held a giant cheque to show what they claim is the cost of the UK "caving" to the demands of US president, Donald Trump, and big pharma on drug pricing.

A Just Treatment spokesperson said, "We are already paying over the odds for medicines these companies price at eyewatering amounts thanks to their patent monopolies."

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2025;391:r2212

Healthcare and policy activists take their campaign to the Department of Health and Social Care in London on 13 October


Date 13TH OCT 2025
£ 1,000,000,000s
CASH
38Degrees
people power change
38Degrees
just TREATMENT
259,142
of us say
Defend our NHS against
Big Pharma!

EDITORIAL

Threat of imposter participants in health research

Inconsistent detection risks undermine research integrity

Online recruitment has become central to modern health research. The speed and reach of internet based recruitment, particularly since the covid-19 pandemic, has transformed how we collect data.[1-3] However, alongside this digital transformation lies a growing and under-recognised phenomenon: imposter participants.

Imposter participants (sometimes called fraudulent or suspected participants)[4] provide deceptive or inaccurate data in order to take part in health research.[5] They can be divided into two categories: the first is humans who provide deceptive responses, such as lying about having the condition under investigation. The second is increasingly sophisticated automated computer software (bots) which mimic human behaviour and responses.[6] The undetected presence of imposter participants in quantitative datasets threatens the integrity of health research and, by extension, the policies and clinical decisions built on it.

Imposter participants were described as early as 2011.[7] However, articles investigating their prevalence in health research have grown in recent years. A 2025 scoping review found that 96% of identified studies describing methods to detect imposter participants had been published within the past five years.[8]

The motivations of imposter participants remain unknown, although a focus on financial incentives suggests that monetary benefit is a driver. Several authors have reported that suspected imposters often make multiple inquiries about the timing and format of payments.[9-11] However, not all studies that identified imposter participants offered financial incentives,[8] indicating that other motives contribute. Proposed alternatives include boredom, curiosity, or even an ideological intent to disrupt research.[4]

Health research now faces the same risks of fraud that have plagued non-health spaces

Health research now faces the same risks of fraud that have plagued non-health spaces such as market research.[12] However, the stakes are higher; health research informs clinical decisions, service design, and resource allocation. Results clouded by imposter participants may affect clinical treatment.

Problems for quantitative health research

The 2025 scoping review also reported that 18 of the 23 studies which looked for imposter participants in their datasets, found them.[8] The variance in the detected prevalence of imposter participants was notably wide, from 3%[13] to 94% in an online survey investigating communication during ovarian cancer treatment.[14]

The cancer treatment survey received 576 responses within seven hours, with most submitted between midnight and 4 am. The authors judged 94% of responses to be fraudulent and the remaining 6% suspicious, with no participant deemed unquestionably legitimate. As a result, they closed and relaunched the survey with stricter protocols to prevent imposter participants, yet continued to detect fraudulent responses.[14]

The problem extends beyond survey research. In the iDEAS randomised controlled trial[15] evaluating an alcohol reduction app, 76% of online enrolments were identified as bots at screening.[16] A further 4% of participants were identified as deceptive human respondents.[16] Without measures to detect imposter participants, such as face-to-face eligibility assessments, even intervention triallists may report large sample sizes with spurious results, not realising that much of their dataset is contaminated.

Approaches to tackle imposter participants

It is essential that researchers who recruit online critically evaluate their datasets for imposter participants. Various detection strategies have been proposed, including checking for implausible home addresses (eg, business or charity addresses)[16] or submissions from multiple formulaic email addresses (eg, surname-plus-two-digits@domain.com).[4] Proposed prevention strategies include identity verification procedures[17] or CAPTCHA tests (asking participants to complete a task such as to read and type distorted letters).[8] After the introduction of CAPTCHA tests in the iDEAS trial, no further bots were detected.[16] However, other reports indicate these tests do not prevent all bot submissions.[18]

Imposter participants are more than a nuisance; they are a systemic threat to health research. Their effect is demonstrable and their detection inconsistent. In an age where online recruitment underpins everything from randomised controlled trials to surveys,[2] they risk undermining the integrity of health research and the decisions built on it.

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EDITORIAL

Global resurgence of pertussis in infants

Tackling rising cases of whooping cough will require a coordinated approach

Vaccination has reduced the global burden of pertussis (whooping cough), but the disease has recently resurged.[1] After a temporary decline during the covid-19 pandemic, China has witnessed one of the most pronounced resurgences of pertussis.[2] In 2024, a total of 476 690 cases and 31 deaths were reported, roughly a 12-fold increase compared with 2023, before a modest decline was observed in early 2025.[2 3]

The UK has seen a similar pattern: confirmed cases rose from 856 in 2023 to nearly 15 000 in 2024, with 11 infant deaths, before early signs of easing in 2025.[3]

Although the resurgence is global, a notable decline occurred in cases in the African and South East Asia regions. This could be partly attributed to the improved coverage of vaccination and gaps in surveillance reporting systems, as well as limited laboratory confirmation capacity and possible underdiagnosis of pertussis in these regions.[3 4]

The biggest concern is the renewed burden among infants under 3 months, who are the most vulnerable to the disease. Many European countries, including the UK, Italy, Austria, Croatia, and Denmark, have seen an increase in cases among infants.[5]

Underlying drivers of the increase

Globally, the current resurgence of pertussis is probably driven by many converging factors. The main drivers are waning vaccine induced immunity and persistent immunity gaps because of disrupted routine immunisation during the pandemic.[9]

In China, several interlocking factors might explain its resurgence. The first contributing factor is waning vaccine protection over time, particularly since the country introduced acellular pertussis vaccines in 2006. The protective efficacy of acellular vaccines has been shown to fall from 95% at age 1 year to 55% by age 9.[2]

SAMUEL ASHFIELD/SPL

Maternal vaccination can be effective, especially in countries with high infant incidence of pertussis

Second, biological changes in *Bordetella pertussis*, including the emergence of strains with the ptxP3 and ptxA1 alleles and the loss of pertactin or filamentous haemagglutinin, may facilitate partial immune evasion from vaccine induced protection.[9] In addition, the increasing reports of macrolide resistant strains of *B pertussis* raise concern, as antimicrobial resistance could compromise treatment efficacy and containment measures. Genomic surveillance has shown that strains that are not covered by vaccines—particularly ptxP3 lineages and macrolide resistant strains—were predominant in the 2024 pertussis outbreak in China.[10]

In many high income countries adolescents and adults have become the main source of pertussis transmission. Waning immunity among these groups has been exacerbated by vaccination hesitancy and the absence of systematic booster programmes. Furthermore, although acellular pertussis vaccines provide high protection against severe disease and death, they are less effective at preventing infection and transmission at population level.[10]

Adolescents and adults remain less vulnerable to severe disease and death than newborns and young infants in these countries but increasingly drive transmission and sustain community circulation.[9]

Addressing the resurgence will require multifaceted solutions. High and middle income countries should optimise immunisation strategies. For example, China has reduced the age for the first dose of the diphtheria, tetanus, and pertussis vaccine from 3 months to 2 months to provide earlier protection to infants.[2] International aid cuts make sustaining immunisation programmes in low income countries a serious challenge, but other areas could be improved, such as strengthening local delivery systems, restoring routine immunisation, and expanding outreach programmes in remote and conflict affected regions.[9]

Maternal vaccination

Vaccinating mothers during pregnancy is another strategy proved to protect infants through transplacental antibody transfer, especially in countries with high infant incidence of pertussis.[3] A meta-analysis of 29 studies estimated that maternal pertussis immunisation reduced the risk of infant infection before routine vaccination by 78%.[10]

Many high income countries have introduced vaccination during pregnancy, including Australia, Belgium, Israel, New Zealand, Switzerland, the UK, and the US.[3 9] However, vaccine hesitancy during pregnancy remains a major barrier.[11-13] Maternal vaccination coverage has plateaued at around 55% in the US and has declined from 76% in 2016 to 58% in 2023 in the UK.[5] These gaps leave young infants, who are most vulnerable to severe disease, insufficiently protected.

Pertussis remains a serious public health threat that continues to cause outbreaks despite widespread vaccination programmes. With sustained commitment to vaccination, the next pertussis epidemic cycle need not result in preventable deaths of infants.

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How attacks on healthcare sites have become a strategy of war

Gaza, Ukraine, and Sudan have put a spotlight on attacks on health facilities and staff in conflict zones. BMJ writers look at the data, which seem to show a deliberate intent to remove civilians' access to care

Attacks on healthcare are rising

The number of military and other hostile attacks on healthcare infrastructure and staff in many of the world's major conflict zones has risen markedly in the past five years. Data for 2020 to the end of 2024 from the Attacks on Health Care in Countries in Conflict dataset show that the number of attacks has nearly tripled overall (fig 1), with the conflicts in Ukraine and Gaza boosting numbers of attacks and the resulting deaths and injuries (table below).

"This is a very disturbing trend, and it's a product of the types of wars we're seeing right now," says Len Rubenstein, professor and director of the Program on Human Rights and Health in Conflict at Johns Hopkins Bloomberg School of Public Health, Baltimore, in response to the data.

"It's a five year trend, not a 10 or 50 year trend, but at least in this period we've seen recent wars in Myanmar, Sudan, Gaza, and Ukraine where highly explosive weapons are being used throughout the areas of conflict and beyond—missiles, rockets, air power, bombs—in which the combatants do not distinguish between military and civilian targets, or they deliberately target hospitals and other civilian infrastructure."

Rubenstein adds, "These wars are characterised by the enormous use of explosive weapons," and he points to the 14 year Syrian conflict (2011-24) as a turning point. "The use of air power against hospitals became prominent," he says. "That has been the trend and explains some of these disturbing numbers."

Rohini Haar, an emergency physician and assistant adjunct professor at the University of California, Berkeley, who focuses on health and human rights, is also dismayed at the trend. "To see this kind of dramatic uptick is really disheartening and a little bit shocking," she tells *The BMJ*.

Haar says there was a "lot of hope" that the UN Security Council's resolution 2286, agreed in 2016 and which condemned healthcare attacks and called for an end to impunity for the people responsible, would lead to a significant decrease in such attacks. But the data show otherwise.

"Even one attack can break health systems down for years," says Haar, pointing to the pivotal Kunduz Hospital attack in Afghanistan that prompted the resolution. "They never rebuilt that hospital. They rebuilt a clinic, a smaller clinic, there years later. But there's no trauma hospital on that site now. It shows just that gap in services. And that's just one attack."

Fig 2 | Number of attacks by location

Even one attack can break health systems down for years
Rohini Haar

Attacks on healthcare facilities and associated deaths and injuries, in selected conflicts (2020-24)

Place of conflict (population in 2025)	No of attacks on healthcare and resulting deaths and injuries (per million population)		
	Attacks	Deaths	Injuries
Sudan (51 662 147)	649 (12.6)	138 (2.7)	137 (2.7)
Palestinian occupied territories (5 589 623)	2506 (448.3)	381 (68.2)	520 (93)
Lebanon (5 489 421)	492 (89.6)	408 (74.3)	430 (78.3)
Myanmar (54 850 648)	1425 (26)	124 (2.3)	90 (1.6)
Ukraine (38 980 376)	1719 (44.1)	267 (6.8)	234 (6)

Where healthcare attacks have occurred

Although attacks on healthcare facilities occur in every region, clusters are more marked in sub-Saharan Africa, the Middle East (Gaza, Lebanon, and Syria), Myanmar, and Ukraine (fig 2).

"We have to recognise that attacks on healthcare are not just one phenomenon," says Rubenstein. "People talk about them very often, understandably, as all the same, but the drivers of the attacks are different."

He points to the military in Myanmar, which has for decades targeted populations and health professionals to deny any medical care at all to groups that they consider rebellious. "That's been a major trend. It's the idea of denying people healthcare as a strategy of war."

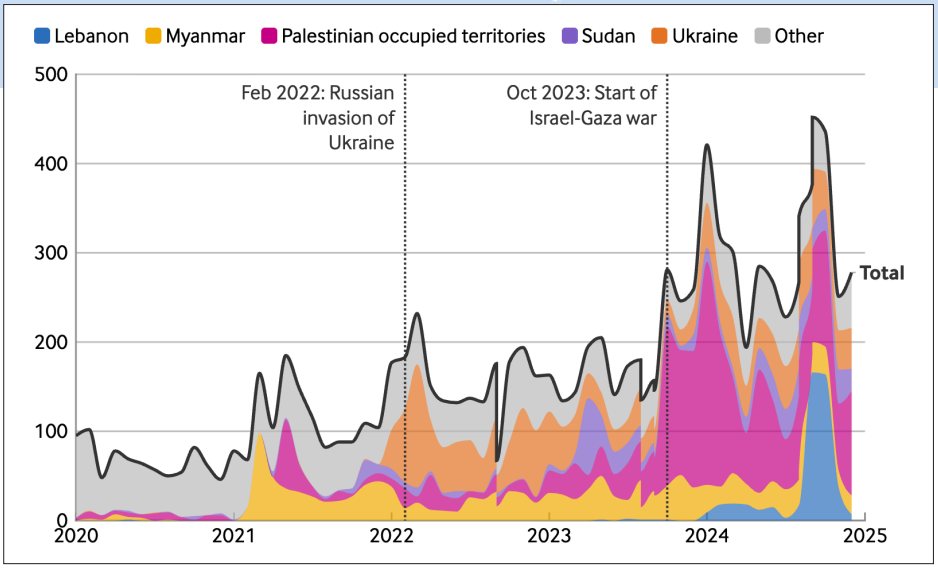


Fig 1 | No of attacks on healthcare facilities (2020-24)

Causes of death and injuries

The death toll isn't the only important consequence of attacks. Injuries to healthcare workers not only affect the individuals themselves, sometimes for life, but also severely hamper a health system's short and long term ability to function, particularly at a time of war.

The types of weapons used to inflict injury and death among healthcare workers differ with the context of the war (fig 3). In Myanmar and Sudan firearms are easily the most common, reflecting a more ground based conflict between ruling authorities and opposing factions and independent groups. The war in Ukraine features more artillery, ground launched explosives, missiles, rockets, and drones—the hallmark of Russia's offensive. In Lebanon casualties chiefly result from use of planes and explosives, reflecting the bombardment by Israeli forces.

The Palestinian occupied territories represent a mix. As with Lebanon, Israeli bombardment by planes and explosives is common, alongside drones and shelling in Gaza. However, raids by ground forces on hospitals, in which Israeli soldiers surround hospital complexes and then enter carrying firearms, arresting healthcare staff, and destroying equipment, have also become common.

Perpetrators, kidnappings, and arrests

Rubenstein points to a fundamental switch that seems to have taken place over the past decade: the type of perpetrator of attacks on healthcare (fig 4). He says, "It is important to recognise the distinction between state actors and non-state actors. From the data we have, there was [before 2010] an apparent trend that non-state armed groups were the principal or at least equal perpetrator.

The majority of healthcare deaths over the past five years have been caused by Israel, Russia, and Myanmar

"But, at least starting with the war in Syria, that trend has switched. So, we have many wars where the main, if not exclusive, perpetrator is associated with the state, whether it's the military, paramilitary, police, or other kind of state force."

The vast majority of deaths and injuries among health workers over the past five years have been caused by three state actors: Israel, Russia, and Myanmar.

But these are not the only types of harm resulting from these attacks on healthcare. Kidnappings and arrests of health workers can also disrupt health services and the functioning of opposition forces.

Arrests in particular are a common tactic of state actors, including Israel and Myanmar. "They either accuse the health workers of treating enemies or they label them as terrorists for having treated the enemies," says Rubenstein, "These are official acts of governments of some kind."

Kidnappings, meanwhile, tend to be perpetrated by non-state armed groups. Rubenstein says that in some places, such as parts of Nigeria, they're also a product of a policy of capture for ransom.

"In many kidnappings it's very difficult to tell what the motivation of the kidnapper is, whether it's for money or for some kind of military tactical purpose," he says.

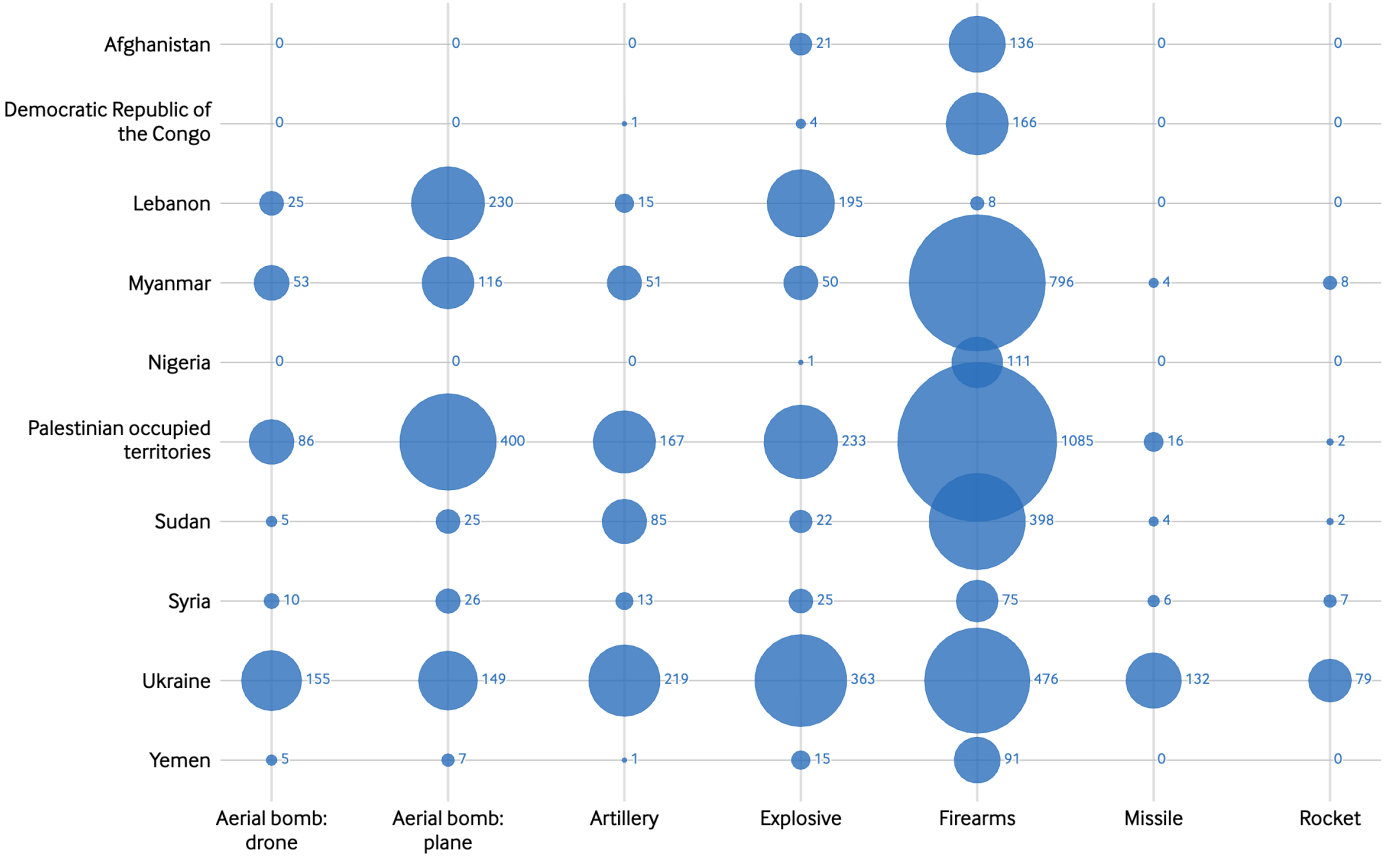


Fig 3 | Weapons carried or used in attacks in selected countries

Kidnappings are a common tactic of Colombia's guerilla groups and also happen more often in countries in sub-Saharan Africa than in other conflict zones. However, data are lacking on healthcare attacks in many African conflicts.

Rubenstein says, "The data are much harder to get for a variety of reasons—for example, because of insecurity or communication issues. We don't know exactly what the numbers are."

What data are available point to differing tactics among perpetrators. In Nigeria, for instance, attacks by the militant group Boko Haram mainly involve kidnappings, often for ransom (although it is not uncommon for victims to be killed or injured), whereas those by Islamic State affiliated groups tend towards injuries and deaths.

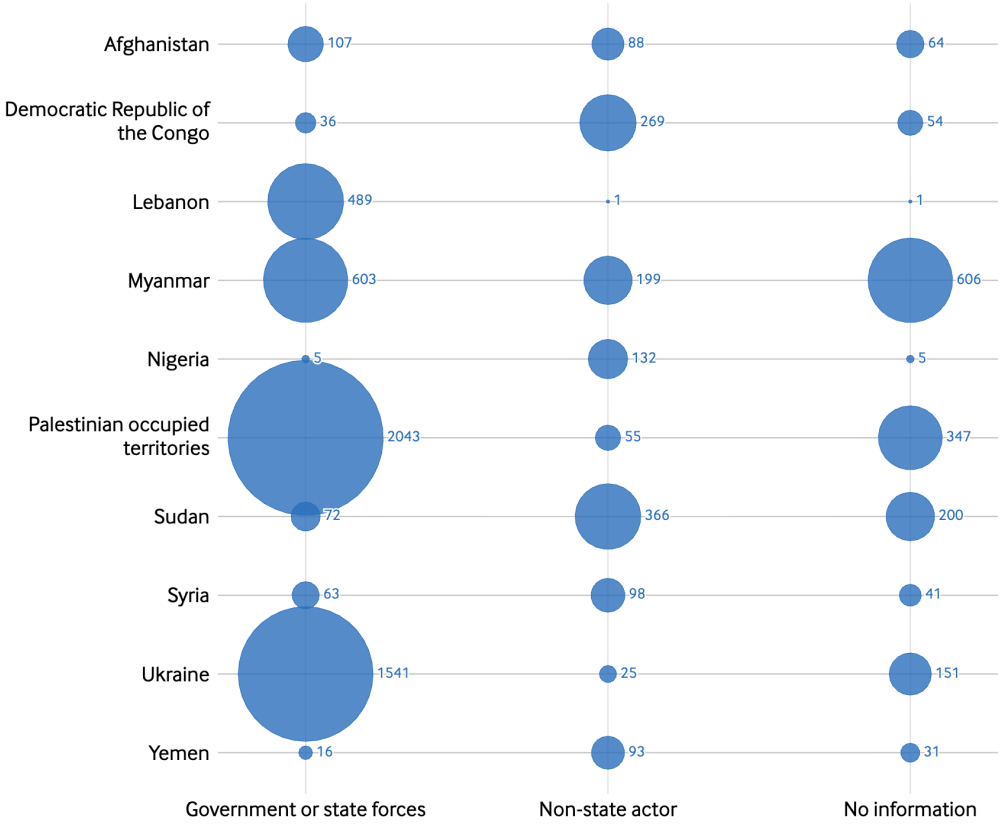


Fig 4 | Reported perpetrator types

Ukraine

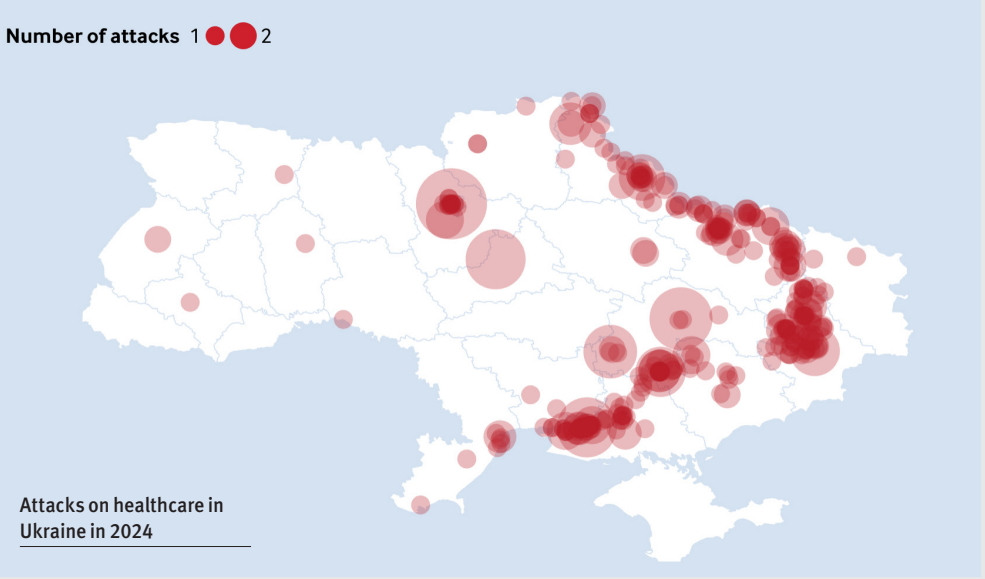
Since Russia invaded Ukraine on 24 February 2022, its attacks—mostly along the Ukraine-Russia border but also in major cities and infrastructure such as power stations—have been unrelenting, happening almost every single day. Data on the extent of Ukraine's infrastructure damage are not fully complete or publicly accessible.

Rubenstein says Russia's attacks on healthcare are "part of a broader strategy of undermining support for the war and undermining the [Ukrainian] government's will to continue by attacking the population."

He adds, "You can see from the location—the geographic distribution of the attacks—that while the attacks are concentrated mostly in areas where there's fighting they're actually spread throughout the country as well." This, he says, suggests "there's a strategy that Russia has (which is consistent with its attacks on the power grid and on other civilian structures) to attack the population as a whole.

"These attacks take place in places far from the fighting. I think that is a real indication of Russia's strategic purpose in attacking hospitals as well as other civilians."

Russian attacks are part of a broader strategy of undermining support for the war



Attacks on healthcare in Ukraine in 2024

Gaza

"I've not seen anything like it," says Rubenstein. "In my work [on human rights and healthcare attacks] over decades, I have not seen anything like the almost daily attacks on hospitals, the relentlessness of the repeated attacks, the indifference to the consequences of the attacks for patients and staff."

Attacks were constant throughout 2024, with several attacks a day and just 15 days with no attacks in the first six months. "These aren't just discrete incidents of attacks and bombings of a hospital," says Haar, "These are almost daily attacks, including arrests and detentions."

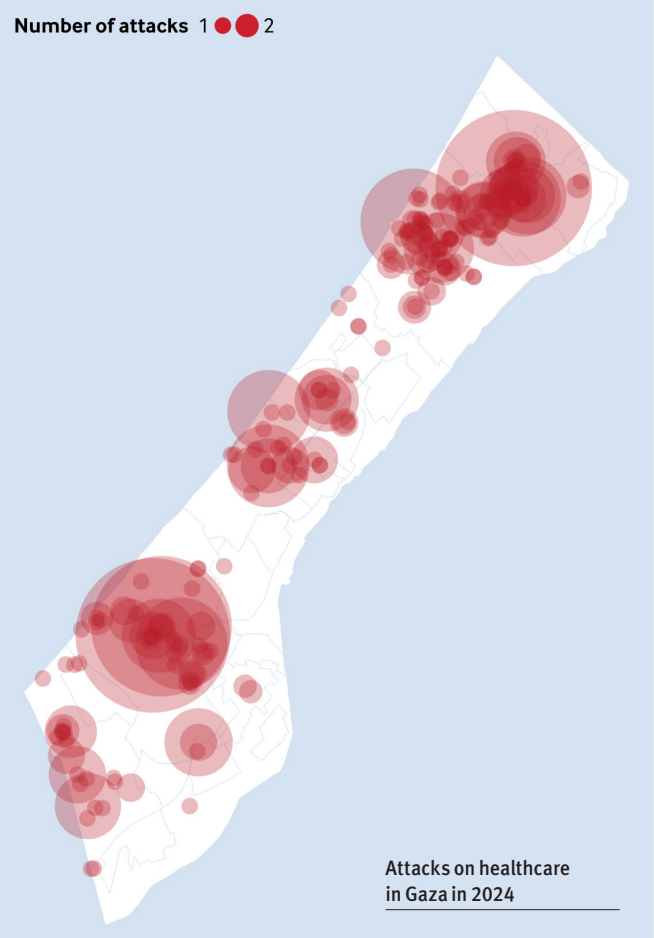
"In Gaza, the attacks have been happening everywhere," says Rubenstein, "They happen wherever the Israeli forces are developing campaigns. So in the beginning it was mostly the north, and when the fighting moved to the south—the attack on Rafah—we saw many attacks on hospitals. And now, with the attacks on Gaza City, here too we've seen attacks on hospitals, and even beyond the principal military campaigns there have been attacks on hospitals that occur regardless of where the main campaigns are."

Forces attack without any effort to minimise harm to people who are in desperate need of healthcare

Many hospitals have also been hit multiple times, Rubenstein explains. Sometimes strikes occur one shortly after another. "These are referred to as double tap attacks, where you attack and then the rescuers come in and you attack them as well," he says, citing Israel's double attack on Nasser Hospital in August, in which at least 20 people were killed, including healthcare workers, rescuers, and journalists.

"[Israeli forces] attack without any effort to minimise harm to people who are in desperate need of healthcare," Rubenstein says. "That pattern has continued from day one of the war—complete recklessness and indifference, which can amount in the end to an intent to inflict that harm."

Haar says, "When [attacks are] chronic like this, when they're every day, when they're all the time, they are felt very deeply in the community. They also take away health workers who each see maybe dozens of patients a day."



Attacks on healthcare in Gaza in 2024

She draws parallels with the chilling effect on people seeking healthcare in Syria. "It's not just that everyone wants to go to the hospital and then there's no hospital. You bomb the hospital, and then people are less likely to want to go to a hospital. People are less likely to want to be health workers. It becomes a dangerous profession so less people do it, and that has a generational impact."

A way forward?

Rubenstein thinks the trend for increased attacks on healthcare will continue. "If these wars end, I think there would be at least a temporary decline in that upward graph [of healthcare attacks per year]. But overall, I think that's what we're seeing: highly explosive weapons in wars where they do not distinguish between civilian or military structures and that deliberately attack healthcare.

"I think the absence of consequences is one of the most serious issues, which leads to the proliferation of attacks and the impunity with which these attacks are committed. We think of accountability as criminal prosecutions. They obviously take a long time and usually aren't completed until after the conflict is over."

But there are more immediate ways to act. "One of the aspects of accountability that we're seeing now as a major feature, for example, in Gaza, is ceasing the supply of weapons to the perpetrators. That could have, in many conflicts, a very dramatic effect because it harms the ability to conduct the war.

"Protection starts with commitments by leadership and political will to abide by the law," Rubenstein adds. "The message would filter to the military forces. That is the number one thing that would dramatically change what happens to people who are sick and wounded."

"States really need to act," agrees Haar. "Prosecuting individual perpetrators of war crimes is one arm [of action]. But I think states really caring about it and coming together and saying 'we're either not going to fund this or we're going to speak out against this, or we're going to put this ahead of other interests as a priority' is another.

"If there were that kind of commitment, and if that commitment were implemented throughout the armed forces, through training, through court martials for soldiers who disobeyed, or commanders who disobeyed, that would make the biggest difference."

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ROLE MODEL

“It’s effective and personal”—the ambulatory care professor who loves delivering hospital care at home

Helen Jones speaks to Dan Lasserson about his career switch from philosophy to medicine, and why he finds his role is so rewarding

NOMINATED BY TAMSIN CARGILL AND SAM MILLS

Dan Lasserson’s work in point of care diagnostics, including ultrasound for use in acute medicine and ambulatory settings, has enabled patients who would previously have needed to be admitted to hospital to be treated in their homes.

His vision and advocacy have transformed the acute care landscape nationally and internationally.

Tamsin Cargill, academic clinical lecturer in gastroenterology and hepatology at the University of Oxford, and Sam Mills, senior leadership fellow, Hospital at Home.

“I tried not to be a doctor,” says Dan Lasserson, professor of acute ambulatory care at the University of Warwick.

“A lot of people in my family are doctors and I wanted to do something different. I studied philosophy first. But eventually I turned to medicine,” says Lasserson, who also works clinically in acute ambulatory care for the University Hospitals Coventry and Warwickshire NHS Trust’s Hospital at Home service.

“The opportunity to work through complex problems helping people at moments of crisis in their lives was too compelling.”

Lasserson’s early career was spent in acute and geriatric hospital medicine before he became a GP. “I became disillusioned with the hospital process. But I also realised that general practice didn’t allow me to do what I wanted to do and deliver the kind of acute, complex care as close to where patients live as possible.” This led him to return to hospital medicine, but with a different approach.

“I wanted to deliver acute care in community settings—patients’ homes, care homes—where people don’t need to be admitted to hospital, but we can still deliver the care they need. Ambulatory care didn’t really exist at that point.

“It was a case of thinking the standard hospital approach isn’t quite right and the standard GP approach isn’t quite right either; we need something else. I was given the space to explore what that something else might be,” he says.

One of the biggest challenges Lasserson has faced is balancing clinical work with academic activity. “I need to spend at least half my time in clinical care. There’s a trend in academia to reduce clinical time to one day a week. I tried that. It didn’t work, it was miserable. I need to be a doctor as well as a researcher. That’s how I stay connected to the work and the patients,” he says.

The most rewarding part of his job is delivering care in patients’ homes. “You can make a diagnosis, explain it to the patient and their family, and start treatment—all without moving them. It’s effective and personal.”

I like treating people in their home, if that’s where they want to be. You see a completely different side of the person you’re treating and how they live their lives

He adds, “I like treating people in their home, if that’s where they want to be. You see a completely different side of the person you’re treating and how they live their lives—they might have a cabinet of ballroom dancing trophies, for example. It’s about making things better for them.”

Patients and their families are central to the decisions made about their care. “Many are willing to take risks to stay at home. When someone is acutely unwell, you can have a detailed conversation about what matters to them, where they want to be, what they’re willing to accept. That deep collaboration helps shape the care we provide,” he says.

Lasserson is now focused on building the next generation of acute medical care academics. “I’m trying to work out how more people can come and do this kind of work and this kind of research.”

“We have to think seriously about how we train people. Training programmes are too rigid and bypass novel care models. Innovation needs to come from experience, not just from a policy perspective,” he says.

Helen Jones, London

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NOMINATE A ROLE MODEL

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

CAREERS CLINIC

How can I prepare for specialty training interviews?

Elisabeth Mahase hears advice from those who have been through the ordeal of the selection process

Start preparing early

Alice Wakefield, specialty trainee year 5 acute medicine in south east Scotland

"Early preparation can massively pay off. Your interview will be heavily weighted in your total application score, so it's imperative to maximise points.

"Marking systems and interview stations will differ depending on your chosen programme so source this information well in advance. Additionally, you can enlist friendly registrar and consultant colleagues for interview practice. They have a wealth of experience, so use them.

"A wise friend advised me to treat each answer as a mini essay with a beginning, middle, and end. This will hopefully reduce the risk of waffling and introduce some much needed structure to your answers. Filming yourself answering questions can also improve your technique.

"Among several 'surprise' questions, you will inevitably be asked to demonstrate skills such as leadership, teamwork, and communication. Take some time to write down a few scenarios that you can adapt for these questions. Moreover, demonstrating how you've learnt from a particular situation will be more favourable to interviewers. Try not to memorise answers but instead have general concepts.

"Consider also the mandatory curriculum for your chosen specialty and how you could discuss this in your interview. I did a focused acute medicine ultrasound course before my interview, which is part of the acute medicine curriculum. It was easy to do and showed commitment to my specialty. You can also join your national specialty society and show you've engaged through relevant courses."

Ask for guidance

Vassili Crispi, National Institute for Health and Care Research academic clinical fellow, neurosurgery, in the West Midlands

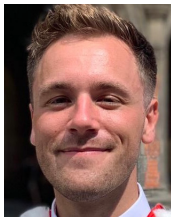
"Specialty interviews can be an extensive process and you might have been preparing for them for a long time already: pace yourself, it's a marathon and you need all your energy on the interview day.

There are plenty of resources to help prepare for the interviews, such as the Oxford medical handbooks or case histories books for each specialty. These are helpful for understanding common conditions, even ahead of your foundation job in your chosen specialty.

"You should reach out to colleagues who have recently been awarded a national training number and ask them to review your application, as well as for details on the format of the interviews, how they are delivered, and the expected level of competence. You can also ask them to mentor you as you prepare for the interview.

"Working together with other applicants to practise for the interviews in a structured manner, such as by going station by station and giving each other feedback on how to improve, can be helpful. If you can, ask your consultants and senior registrars to run mock interviews. As you're getting closer to the interview date, book leave in advance so that you are well rested and ready to perform on the day.

"Ultimately, you might do everything right, but the interview may not go as you intended. That's what happened to me the first time I applied. Don't lose hope. Keep working hard and consider reapplying. In my experience, perseverance and hard work will eventually pay off."



Practise, practise, practise

Callum Allison, neurosurgery registrar

"Make sure you dedicate enough time to practising your interview technique. I would strongly recommend enlisting help from either a peer going through the same process or someone who's recently gone through selection. You cannot have too much help or practice when it comes to interview preparation.

"As we are all too acutely aware, the number of applications to specialty training vastly outweighs the available posts. Once shortlisted, the interview provides you with an opportunity to demonstrate your suitability for the post and desire to work in that specialty, but remember, time is tight. Answers must be succinct with structure, but definitely not heavily scripted. The panel are human, and no one wants to listen to long winded, memorised, and monotonous speeches without personality.

"Well practised structure is the key to sounding professional and capable, which will stand you in good favour, especially for clinical scenarios—think of the A to E approach to deteriorating patients. When responding to a direct question and referring to an example to embellish your answer, remember PEE—point, evidence, explain. Similarly, you will be asked why you want to work in the specialty. The ideal answer should follow the CAMP framework: highlight your clinical, academic, management, and personal achievements, with the appropriate signposting, and chunking and checking along the way.

"Remember, you already know you're good enough for the job by getting the interview, you just need to demonstrate it."

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