

comment

"Being on the receiving end of online trolling can be deeply distressing" **JOHN LAUNER**

"It's hard not to see it as the government thumbing its nose at GPs" **HELEN SALISBURY**

PLUS The destruction of Gaza's health services; NHS staff survey 2023

OPINION Partha Kar and Anton Emmanuel

If racism is everyone's problem, it's no one's

There's been a spate of recent tribunals and cases from NHS staff on the grounds of workplace discrimination. The extent of discrimination is depressingly well described: several iterations of data from the Workforce Race Equality Standard (WRES) have shown its pernicious, widespread, and enduring nature.

A new report from the charity Brap should make for uncomfortable reading among senior NHS leaders. The glacial pace of change means either they've taken little action or that their efforts have been ineffective. Brap analysed eight tribunal cases brought against the NHS over racism at work and identified common themes. Staff were also surveyed to see how well the conclusions reflected their experience. Patterns of wrongdoing among employers include defensiveness to reports of racism, with staff having to "prove" racist intent; poorly conducted internal processes; use of non-credible HR witnesses; and retaliation, in that staff who reported problems went on to experience further discrimination.

Racism is a massive, ongoing health crisis. So, why the lack of urgency to tackle it in the NHS? Healthcare leaders must act against racism or be complicit in perpetuating it. Disrupting entrenched power structures requires coalitions of people with the clarity and integrity to tackle the problem. Such coalitions in the NHS are rare and somewhat freeform, made up of leaders with an understanding of the institutional nature of the problem and the need to tackle this problem at its root. And we must call out the failures of the worst offending leaders.

We must ask who's in charge of tackling discrimination in Europe's largest workforce, which has over 300 000 ethnic minority employees—24.2% across NHS trusts.

There's been enough reflection on the data, now we need to create a clear accountability framework to ensure the safety of staff and prevent financial damage from further lawsuits. Reducing racism will also improve patient outcomes: only last month a report into the death of a pregnant

black woman in Liverpool found that racial biases had delayed her treatment.

In our view, intersectionality is a term that's misused by NHS leaders. The concept aims to understand the additional burden that comes from having multiple protected characteristics; instead, it has been used to discourage an "excessive" focus on problems of race in favour of other protected characteristics.

Since the middle of last year there's been a change in mood in the NHS. A drive to make racism "everyone's business" has ended up making it no one's business. NHS England's merger with Health Education England has resulted in racism becoming even less of a priority, with a stripping out of dedicated roles to tackle it. The leaders involved need to be explicit about why these decisions were made, or they should have the honesty to say racism is no longer a priority.

It's almost a year since two seminal events: first, a tribunal case against Michelle Cox, a senior nurse who won a "landmark" tribunal case against NHS England for racial discrimination, and second, publication of the action plan to tackle racism in the medical workforce. The question is, what datasets exist to show that the implementation or learnings from these initiatives are making a difference? Without focus or accountability it is inevitable that poor behaviours will be emboldened.

The recently published 2023 NHS staff survey shows the folly of not prioritising action to tackle racism. Not only did staff from ethnic minority backgrounds report more discrimination than colleagues with other protected characteristics but this has increased. If leadership is defined by outcomes, then in the world of the NHS and its stated aim to tackle racism there's no greater indictment of failure.

NHS England's merger with Health Education England resulted in racism becoming even less of a priority

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Gaza's collapsing health system endangers wellbeing and dignity

Healthcare must be protected as a neutral and basic human right

As a mother and paediatrician, and now the World Health Organization's regional director for the eastern Mediterranean, the crisis in Gaza weighs heavily on my heart and strengthens my commitment to advancing healthcare for all people across the region.

In just over four and a half months, almost 5% of Gaza's population has been killed, injured, or remains missing under the rubble. Unicef estimates more than 17 000 children have been orphaned, and the horrors of war are leading to the widespread post-traumatic stress disorder, anxiety, and severe depression.

Health workers, traumatised and facing their own survival challenges, are stretched thin. UNRWA, the UN agency for refugees in Gaza, reports that 70% of civilian infrastructure is damaged or destroyed, with only about a third of hospitals operating, albeit at limited capacity. Médecins Sans Frontières has warned the UN that Gaza's healthcare system is no longer functioning.

The number of trauma patients with infected

wounds or facing unnecessary amputations is rising due to lack of specialised care and medical supplies. Outbreaks of hepatitis A and diarrhoea have been reported, while acute respiratory, skin, and other infections are increasing due to overcrowding and poor sanitation. To make this catastrophic situation worse, the spectre of famine looms.

Harrowing testament

The timeline of the crisis is a harrowing testament to the degradation of health, wellbeing, and human dignity. In the first week after 7 October, WHO's trauma and surgical supplies were quickly used up on streams of injured patients, mainly women and children.

As the hostilities expanded, more hospitals depleted stocks of trauma and surgical supplies. Trucks loaded with supplies airlifted from WHO's logistics hub in Dubai stood just 20 minutes away on the Egyptian side of the Rafah border crossing, waiting for approvals to move. Fuel shortages and initial communication blackouts left emergency and ambulance services in Gaza unable to operate. Three weeks



Seventy per cent of civilian infrastructure is damaged or destroyed

passed before aid convoys were allowed to cross into Gaza. By then, the supplies they carried were not nearly enough to cover the immense needs.

Despite enduring 16 years of blockade and access restrictions, the occupied Palestinian territory's health system had been achieving good outcomes before 7 October: the maternal mortality rate in 2020 (20 deaths per 100 000 live births) and infant mortality rate in 2021 (9.3 per 1000 live births) were among the lowest across the region.

The crisis has severely undermined functionality. To date, almost 1200 critically injured and sick patients have been evacuated for specialised treatment while 8000 more in need of evacuation remain inside Gaza. WHO has supported the deployment of three field hospitals and 12 emergency medical teams, but these cannot replace health service delivery.

As sickness, hunger, and disease spread, Gaza's health system faces increasing threats:

NHS survey's depressing findings and worrying implications

The 20th annual NHS staff survey report is an informative piece of work. Some 1.4 million staff were approached across all professional groups in clinical, non-clinical, and care settings. More than 700 000 responded, continuing the tradition of a big response rate to surveys of this nature.

Because the survey is annual it allows for change to be measured and compared and for new questions to be added. The 2022 survey had shown some of the worst ratings in its history across a variety of domains. Small improvements on some scores occurred in 2023, such as reduced levels of burnout, sickness absence, and a modest fall in staff considering leaving.

The overall picture remains depressing and mirrors findings from patient and public



Only 71% said they'd feel safe raising concerns about unsafe clinical practice

surveys, key performance data on waiting times, and rates of workforce attrition.

Some things struck me in particular. Only 57% of respondents felt supported to develop their potential, and only 60% said they had the right learning opportunities. In a service struggling to retain staff and facing high levels of attrition, not least in early career clinical staff, we simply have to improve this.

Perhaps most worrying of all were the findings on attitude and culture around patient safety; the professional and statutory duty of openness, transparency, and candour; and the need for a just and learning culture.

Only 71% of respondents said they'd feel safe raising concerns about unsafe clinical practice, and only 56% were confident their organisation

would act. Only 62% felt safe speaking out about concerns affecting their organisation, and only 50% believed those concerns would be listened to or acted on. Only 61% would recommend their organisation as a place to work, and only 64% would recommend it as a place for their own friends or family to receive care.

What of improving care or work experience? Well, only around half of respondents felt able to make improvements happen or be involved in change. Only 44% believed their organisation showed it valued their work, although two thirds did feel valued by their peers, with over 70% saying they felt listened to and supported by their line manager.

The best headline figures in the survey were about values and commitment in the NHS. Nearly nine in 10 thought their role made a difference to patients, and seven in 10 said patient care was their organisation's top priority. Those findings may be mirrored in



ABED RAHIMI KHATIB/ANADOLU VIGETTY IMAGES

specialised health personnel, fuel, clean water, food, and supplies are lacking; hospitals are attacked, and patients and health workers are killed, injured, or detained.

Healthcare must be actively protected as a neutral and basic human right. And while reports of militarisation of health facilities by Hamas raise serious concerns—and, where it is proven, condemned by WHO—any military action against such facilities must be consistent with the principles of proportionality, distinction, and precaution..

WHO continues to call for adherence by all to international humanitarian law. Humanitarian corridors must be respected, and all parties must safeguard the sanctity of medical facilities and personnel.

Only through dialogue and diplomacy can a sustainable solution be found that tackles the conflict's root causes and ensures the health and wellbeing, rights, and dignity of all people in Gaza.

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the British Social Attitudes Survey's findings about the NHS: people value it as an institution and a model of care, despite deterioration in performance and their experience of services.

The data are also reported at individual employer level, and it is striking some do much better than others, even within a region. The poorly performing organisations should use their results to focus improvement. The catch-22 is that, if they were able to do this, they wouldn't be at the bottom of the league. Perhaps peer support and mentorship might help them provide staff with better working lives.

Most of all, we must do far better at creating environments where staff feel confident and safe in raising concerns about safety and quality of care—and about risks to them. The 2023 survey's findings were better a few years back, and could improve again if we chose to make a concerted effort to tackle them.

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TALKING POINT John Launer

Troubled by trolls

Trolls are imaginary creatures in Scandinavian folklore who are dim witted, live far from human company, and are generally unpleasant when encountered.

In modern slang the word refers to disagreeable individuals on social media who persistently respond to other people's posts in negative ways, ranging from discourtesy to threats and intimidation. If you write for the medical press and try to maintain a social media presence it's almost impossible to avoid trolls.

Depending on its scale and tone, being on the receiving end of trolling can be deeply distressing. Higher profile medical writers than me have had far more troubling experiences, in some cases having to involve the police to protect themselves. At the less extreme end of the spectrum, being trolled still gives you an impression of some aspects of the human psyche that you might prefer not to know about but probably should.

One of these is that some people are "rage reactors." A word, a phrase, or the mention of a particular subject will set them off on a stream of invective—even to the extent of construing what you've written as the opposite of what you actually said. Another feature is the lack of inhibition on social media: people will express thoughts in insulting or menacing language that the vast majority of them wouldn't remotely consider using if they met you socially.

Most people who troll use

pseudonyms, but a surprising number not only post under their own name but may be professional colleagues of some standing who seem to lose their manners and moral compass once they hit the keyboard. Some are supported by followers who provide a seamier echo chamber and who may not be constrained by professional regulation. Thus, a distinguished professor might send a disapproving comment in his own name (it nearly always seems to be men) but then endorse or forward further remarks by an entourage of supporters whose timelines turn out to offer an unappealing package of misogyny, racism, antisemitism, and conspiracy theories.

An additional grey area is the ambiguous message without overt hostility, suggesting that dialogue of some kind may be possible. In these cases I generally send one straightforward reply to test the waters, and occasionally this leads to a polite agreement to disagree on respectful terms or even to finding some common ground. Sadly, this is the exception rather than the rule.

Internet trolls don't seem to increase the sum of human happiness any more than their Nordic predecessors. On the whole, I recommend the standard advice given to anyone being pursued by them:

"Block, don't bicker."

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A polite agreement to disagree is the exception rather than the rule



Time for GPs to push back

Sometimes I wonder if I'm doing general practice wrong. So many consultations not only take longer than the time allotted but also create more work for the end of the day: letters to read, referrals to write, things to look up and pass back to the patient. This means I rarely leave the surgery until the cleaning staff have been and gone.

But when I look at the alternative models being touted, which promise an efficient service where doctors can concentrate on complex patients while "simple" cases are seen by others, it doesn't look like an improvement. If my patient's problem is straightforward I can see them quickly, usually building on an existing relationship. If it turns out to be more complicated, I have the training to detect that.

New members of the team (pharmacists, physiotherapists, and specialist nurses) bring their own expertise, which we welcome, but they don't replace GP colleagues. Indeed, one of the reasons given for expanding non-doctor roles is the shortage of GPs. However, there are now reports of GPs losing their jobs because practices can't afford to employ them. There are also many more young doctors applying to the GP training scheme than there are places to train them: the ratio of applicants to places last year was 2.67:1, meaning only 3935 of 10 514 hopefuls secured the opportunity to train as a GP. The number of posts available was 5% lower than in 2022.

The down-skilling of general practice is often euphemistically referred to

as a "diversification of the workforce," but it's hard not to see it as a deliberate attempt to deprive patients of expert medical care. The motives may relate to cost, despite it being well documented that high quality general practice with built-in continuity saves money in the long run (as well as lives). Perhaps it's about control, as GPs are notoriously averse to obeying orders.

The 2024-25 contract between NHS England and GPs—the third one that hasn't been agreed but is about to be imposed—offers a 2% uplift to practice incomes, which is a cut if you take inflation into account. It's hard not to interpret this as the government thumbing its nose at GPs. Cost neutral ways in which more surgeries might stay afloat, such as using the money in the Additional Roles Reimbursement Scheme to pay for doctors and practice nurses, have been rejected by NHS England. The availability of resources to pay non-doctors while maintaining there's no money available to pay actual doctors clearly underscores the intention of the government and NHS England to down-skill general practice.

A referendum of the BMA's GP members is under way, giving us the opportunity to accept or reject this contract, although how we respond beyond that is still under discussion. Many of us believe that it's well past time to push back against the destruction of general practice.

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GPs are notoriously averse to obeying orders



LATEST PODCAST



Sharp Scratch: the lonely medics club

Medical students spend a lot of time working in a team, yet medical school can be a lonely place. This episode of the Sharp Scratch podcast explores some of the drivers of loneliness at medical school and how we can challenge it. Clare Dixon, a clinical tutor at Lancaster Medical School and a clinical psychologist, begins by describing what loneliness is and what factors may compound it:

"It's very much a perception that somebody lacks social connection. So it doesn't necessarily have to be something that's objective—we can be surrounded by people and we can have lots of hobbies or relationships with different people, but we can still feel lonely within that.

"Social media can be helpful in the sense that we are much more connected to other people who are much further away. But I also think social media can be really problematic in terms of loneliness. We spend a lot of our time, me included, with a screen in front of us engaging in something that doesn't make us very present. I wonder whether we're learning ways to be in the world that are actually detrimental to our ability to connect with other people around us."

Judith Ugwuja, a fourth year medical student, describes what helped her to deal with feelings of loneliness:

"Reaching out to the university wellbeing team was something that really helped me when I was struggling, as well as reflecting on why I was feeling lonely. Was it being far away from home, was it feeling incompetent, or was the feeling also a fear that maybe people just didn't want to be around me? Reflecting on why I felt this way helped me to adjust the way that I would react whenever I would feel lonely."



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Raising the bar for disclosure of industry payments to doctors

David Menkes and colleagues argue that mandatory accessible reporting of pharmaceutical payments to doctors is an important first step to managing harms from conflicts of interest

After a seven year delay, in 2022, drug companies operating in New Zealand made their first disclosures of financial relationships with individual health professionals. The information included payments for speaking engagements, consultancies, advisory board memberships, honorariums, travel costs, attendance at conferences, and other sponsored events.¹ This welcome development, sponsored by the industry trade association Medicines New Zealand, was intended to promote “transparency” and “public understanding.”² However, some members of Medicines New Zealand did not participate in the scheme, and several payment types were omitted from disclosure, notably food and drink provided by companies during sponsored events and sales visits.

While health professionals tend to favour transparency in principle, reporting standards for industry payments vary widely across countries. We compare New Zealand’s disclosure policy with that of other countries and consider what is necessary to effectively tackle the potential harms caused by doctors’ financial conflicts of interest.

Problems with industry payments to doctors

Accumulating evidence shows that drug company payments to doctors influence prescribing^{3,4} and other aspects of healthcare, including research and teaching (box).⁵ For example, industry influence has been linked to distortion of clinical guidelines and opioid over

Potential harms of industry payments to doctors⁵

- Influence on research agendas, practice, and publication
- Distortion of clinical guidelines
- Unnecessary or inappropriate prescribing
- Iatrogenic harm
- Increased health expenditure
- Medicalisation of normal life experiences
- Neglect of lifestyle and other psychosocial interventions
- Unconscious bias towards sponsor
- Inappropriate role modelling (colleagues, trainees, students)

prescription in the US.⁶ An analysis of one company’s multifaceted strategy to promote gabapentin, including sponsored research and continuing medical education, sheds additional light on how industry can distort medical knowledge, inflate health expenditure, and cause iatrogenic harm.⁷

Drug company payments to doctors are now disclosed in most industrialised countries, including across Europe, Japan, the US, UK, and Australia. Although medical experts can provide industry with useful advice about side effects, research methods, and clinical guidelines, payment for such advice is problematic—for example, industry payments to American oncologists for advisory board roles and consultancies were associated with larger shifts in prescribing than payments for food or education.⁸ There is also disagreement about the types of payments that should be reported. Funding of research is commonly excluded from disclosures, for example, despite it being linked to product promotion.⁹

New Zealand’s disclosures

Eleven member companies declared payments to 200 doctors, nurses, and pharmacists in 2021 (table 1 overleaf) under the Medicines New Zealand scheme; doctors received 90% of these payments.

Data are posted on company websites rather than a centralised registry, and variation in content and format makes comparison difficult. The number of doctors receiving payments is likely to be an underestimate, considering five members did not file reports and that the organisation represents fewer than half of the companies operating in the country. Companies that are not members of Medicines New Zealand are under no obligation to report.

Disclosed payments to doctors fall into three categories: sponsorship of conference attendance, fees for consultancy or advisory board work, and payment for presentations at educational events. Sponsorship of conference attendance accounted for only about a tenth of declared drug company payments in 2021, but this is likely to be anomalously low because pandemic restrictions prevented overseas travel.¹ Recipients of fees for advice or educational presentations are often regarded as “key opinion leaders.” Payments to key opinion leaders are regarded as an extension of marketing,¹⁰ as their influence can distort medical knowledge and clinical practice,¹¹ including the promotion of drugs for unapproved uses.⁷

What’s missing?

Medicines New Zealand’s code of practice prohibits companies from sponsoring entertainment and stipulates that any hospitality must not be “excessive,” but the amount spent on food and drink remains unknown as it is not part of the disclosure regime. In Australia, drug companies provided hospitality at over 90% of industry sponsored events, spending A\$85m (£44m) between 2011 and 2015.¹²

KEY MESSAGES

- Policy and practice regarding disclosure of industry payments to doctors varies widely across countries
- Arguments in favour of inclusive, mandatory disclosure are supported by evidence that such payments affect clinical practice, medical knowledge, and teaching
- Strategies to optimise disclosure and other conflict-of-interest policies are needed in medical research, health economics, and clinical governance

Table 1 | Disclosure of payments by Medicines New Zealand members to healthcare professionals in 2021

Disclosure	Company
Reported payments*	AbbVie, AstraZeneca, Boehringer Ingelheim, GSK, Janssen, Novartis (two months only), Novo Nordisk, Roche, Sanofi, Seqirus, Vertex
Reported no payments	Astellas, Biogen, Eisai, Healthcare Logistics, Merck, Vifor Pharma
Did not report/no information	Aspen, Bioclect, MSD,† Pfizer, Takeda

*Amounting to a total of NZ\$ 342 760 (£ 165 000; € 194 000; \$ 209 000) to 200 people.

†MSD did not comply with the Medicines NZ reporting regime but told a journalist it distributed a further NZ\$ 113 659 to 133 health professionals during 2021.¹

Even small gifts induce an unconscious tendency to reciprocate. An analysis of US payment data from 2013 found a dose-response relation between the number of free meals doctors received from manufacturers and prescriptions for promoted products within each of four drug classes.¹³

Pharmaceutical sponsorship of medical conferences, also excluded from current disclosures, might be considered less problematic than company organised educational meetings, because Medicines New Zealand's code of practice requires that independent organisers control the programme. But sponsors often suggest speakers, distribute promotional material, and organise industry sponsored symposiums around conferences.¹⁴

Research funding and "ownership and investment" interests, which are subject to stringent reporting requirements in the US, are also missing from New Zealand disclosures. There is also no information available about payments from manufacturers of medical devices to surgical and other relevant staff. The US Sunshine Act requires identical disclosure requirements on device and drug companies, and recent evidence indicates that payments from device companies exceed those from the drug industry.¹⁵

International context

Court cases in the US have resulted in billion dollar fines for illegal pharmaceutical marketing by various companies,¹⁶ many including payments to doctors who were key opinion leaders. The Sunshine Act 2010 was introduced to expose and manage industry influence on healthcare and is the most comprehensive legislative requirement for reporting payments to health professionals. France, Denmark, Greece, Romania, Latvia, Italy, and South Korea also have sunshine acts,^{17 18} whereas other EU countries, the UK, Australia, New Zealand, Canada, and Japan rely on self-regulation. Table 2 compares the main features of the codes in New Zealand with other English speaking countries.

A key feature of the Open Payments database in the US is the requirement for

companies to state whether payments are related to one or more of their products. This feature, directly linking each payment to the product(s) the company aimed to promote, has allowed researchers to examine links between doctors' payments and prescribing. Dozens of studies using Open Payments data have been published, including national analyses of gift acceptance among doctors generally,¹⁹ as well as within various specialties.²⁰

Efforts to promote transparency are supported by a 2021 systematic review of 36 studies (35 American and 1 French) reporting consistent associations between financial payments to doctors and prescription of sponsors' products.⁴ This finding suggests that accepting personal

Limited evidence indicates better prescribing practice among doctors from institutions with stronger conflict of interest policies

payments from industry compromises doctors' ability to make independent therapeutic decisions and increases the risk of inappropriate prescribing and consequent harm to patients.

The US database has also enabled studies of discrepancies between industry reported payments and doctors' conflict of interest disclosures. These have shown that disclosures are often incomplete, including those made by clinical guideline authors, medical journal editors, and leaders of professional organisations.²⁰ The observation that doctors involved in generating clinical practice guidelines often misreport financial conflicts of interest²¹ is consistent with both concerns about perceived conflicts among influential doctors in affluent countries and the increasing use of language in disclosure statements that downplays apparent conflicts.²²

Available evidence indicates that industry gifts to doctors are also prominent in low and middle income countries, with drug samples and support to attend educational events comparable with those in high income countries, but typically without the same disclosure requirements.

Studies in Africa, the Middle East, Asia, and South America suggest doctors receive gifts not typically seen in wealthier countries, including cash, office supplies, air conditioners, cars, luggage, personal travel, home appliances, domestic cattle, and sexual "favours."²³⁻²⁸ Gift giving on birthdays and religious holidays is another distinctive feature, as is overt product promotion, with the monetary value of gifts linked to prescribing frequency.^{29 30}

An argument for retaining industry funding for continuing medical education, especially in low and middle income countries, is that funding for this activity is otherwise unobtainable. This rationale needs to be balanced against industry funding a more limited range of topics,³¹ the inability of doctors to perceive bias in such industry funded education,³² and the potential for harm from diversion of scarce resources to expensive promoted branded products.

Dissenting views

Some medical academics have vigorously defended the benefits of clinician interactions with industry,³³ arguing these have enabled spectacular progress in medical technology. In addition to concerns about stifling innovation, critics of conflict-of-interest policies have highlighted their administrative burden and uncertain efficacy, pointing out rigorously designed studies have not been carried out to assess the harms these policies are intended to address.³⁴

As well as studies showing links between industry payments and impaired prescribing, limited evidence indicates better prescribing practice among doctors from institutions with stronger conflict of interest policies.³⁵⁻³⁷ Sceptics' insistence that proof of harm precede corrective action ignores the precautionary principle and would require stricter justification than for public health measures. Others have argued that "proof of harm [from physician-industry relationships] can be demonstrated via evidentiary standards widely accepted within the knowledge communities of public health scientists and epidemiologists."³⁸

Table 2 | Comparison of industry disclosure regimens in different countries

Country	Regulatory system	Opt out for companies?	Opt out for individuals?	Included healthcare professionals	Excluded payments	Organisations specifically included	Companies covered	Data availability
New Zealand	Self-regulatory	Yes	Yes*	All	Food/drink Research	All healthcare organisations Speakers at educational events	Medicines New Zealand members only	On each company website.† Format varies by company. Limited detail—no link to promoted drugs
Australia	Self-regulatory	No	No	All	Food/drink Research	Hosts of sponsored third party meetings	Medicines Australia members only	Searchable centralised registry. Limited detail—no link to promoted drugs
Canada	Self-regulatory	Yes (8/47 companies participate)	Individual payments not reported	All (not defined) grouped together	Uncertain	Total payments to healthcare organisations reported	Innovative Medicines Canada members only	On each company website. Limited detail—no link to promoted drugs
Ireland	Self-regulatory	No	Yes	Doctors, nurses, dentists, pharmacists	Food/drink Research (reported in aggregate by each company)	All healthcare organisations	Irish Pharmaceutical Healthcare Association members plus voluntary non-members	Central registry. Limited detail—no link to promoted drugs
United Kingdom	Self-regulatory	No	Yes	Doctors, nurses, dentists, pharmacists, others‡	Food/drink Research	Hospitals, medical centres, universities, medical societies;	Association of British Pharmaceutical Industry members only Non-members can opt in	Searchable centralised registry. Limited detail—no link to promoted drugs
United States	Legislated	No	No	Doctors, physician assistants, nurse practitioners, and specialists able to prescribe	None	Teaching hospitals	All drug and device companies selling products in the US Distributors (group purchasing organisations)	Searchable centralised registry. Rich detail including links to promoted drugs

* The New Zealand system requires signed “opt in” for individuals to have their data reported † Disclosure links published on Medicines New Zealand website ‡ Journalists and members of the public included

Recommendations

The recent disclosures of industry payments to New Zealand doctors are welcome but incomplete and reflect an industry led initiative in the absence of relevant government legislation.¹⁸ As with other self-regulatory reporting schemes, the New Zealand regime falls short of international best practice, in terms of both completeness and ease of access. It is also less comprehensive than many systems, with member companies choosing whether to report and recipients able to opt-out of disclosure. Given that Medicines New Zealand’s disclosure system was relatively late internationally, it might have been expected to reflect international best practice; instead, the organisation has implemented a limited and cumbersome system, from the standpoint of both patients and researchers.

As in the UK, New Zealand doctors are required to consent for their payments from industry to be published, although Medicines New Zealand encourages member companies to obtain consent when a payment is offered. No consent is required in countries with legislated reporting systems, including France, Portugal, and the US. New Zealand’s disclosure regime also excludes payments for hospitality, research, and conference sponsorship.

An important aspect of disclosure is the accessibility and user friendliness of information. Accessing information is difficult in New Zealand. For example,

to discover how much funding their doctor obtained from participating drug companies, a patient would need to search each company’s reports separately. Information on the nature and purpose of payments is inconsistent and often brief; similar problems exist in five of six European countries with industry self-regulation. The UK is the exception, with a centralised searchable database.¹⁸ Another aspect of user-friendliness is the ease with which health professionals can be identified. The US Open Payments system uses a unique identifier for each clinician and provides information on demographics, medical specialty, state licensing, and location of practice.

Implementing such stringent requirements internationally would be challenging given different political systems and expected pushback from industry and others who benefit from weak or absent disclosure policies. However, increasing recognition of the key role of drug industry payments to doctors in unethical marketing provides impetus for tightening disclosure requirements.³⁹ For example, in 2023, the UK government held consultations about a legislated reporting system, “to build trust and protect the health system from real and perceived conflicts of interest.”⁴⁰

Public access to information on industry payments to clinicians has increased knowledge about the patterns and extent of these, as well as enabling research into their association with overdiagnosis,

overtreatment, and iatrogenic harm.^{6 7} Transparent reporting of industry payments might be expected to discourage doctors from accepting payments, but this does not seem to have happened in the US. Despite mandatory, detailed reporting, the volume of payments seems unaffected, suggesting that transparency requirements alone are not sufficient to tackle undue industry influence.²⁰

Given that doctors, like other human beings, are generally better at recognising other people’s susceptibility to bias than their own,⁴¹ further steps are necessary to manage commercial influences on clinical decision making, research, and teaching. Strengthened disclosure requirements will generate data both to investigate these influences and inform policy to manage them. Available evidence indicates that restricting exposure to industry marketing during medical school³⁶ and postgraduate training^{35 42} has beneficial long term effects. Beyond disclosure transparency, institutional boundaries thus offer a promising means to protect medical practice and patients.

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Selling NHS patient data

The next government must resist a retail model of data management

The NHS is in crisis.¹ Resolving it is a major focus of the forthcoming general election, and several high profile publications have recently set out recommendations for the next government. The recommendation from former party leaders Tony Blair and William Hague that NHS data should be harnessed for commercial purposes has garnered considerable attention. They propose establishing an NHS data trust as a public-private company to facilitate use of NHS data for both public health research and commercially successful artificial intelligence (AI) innovation.²

This has been widely, and correctly, interpreted as a recommendation to sell NHS data to fuel a cost cutting and efficiency boosting AI revolution.^{3 4}

The recommendation itself avoids using the word “sell.” Yet the discussion in the full report, published by the Tony Blair Institute for Global Change, makes the “selling” interpretation unavoidable. The BBC is used as an exemplar of a public organisation that also experiences commercial success: it generates revenue by selling products and services. In addition, reference is made to citizens “trading” their data for access to social media services: social media companies sell access to data for profit, and users are presented with targeted advertisements intended to drive further profit making activity.

No benefit to the NHS

No government should be encouraged to sell NHS data. Pragmatically, commercial entities sell access to data, not data in their raw form. Data themselves have no inherent monetary or scientific value.^{5 6} Their value depends on their use. Monetary value may be extracted derivatively from the sale of a commercial product or service



MARK THOMAS

It is unrealistic to expect that patients and citizens would accept or trust any purely commercial transactions

developed using NHS data, but then the revenue would be earned by the purchaser of NHS data, not by the NHS.

This hurdle could be overcome if the NHS could profit from the sale of products or services derived from its data or gain early or cheaper access to the resulting product or service. The report alludes to this option. Yet, such agreements are unlikely to be beneficial to the NHS. For commercial entities to be willing to pay revenue generating rather than cost recovery prices for NHS data, the data must need no preparation from the purchaser. As the report notes, this would require the NHS to be fully responsible for data cleaning, curation, and standardisation: skilled, resource intensive, and ultimately expensive ongoing tasks⁷ that would substantially reduce any potential profit.

Furthermore, revenue might be derived from secondary products or services that may be unrelated to health and may undermine it. Finally, this sort of secondary benefit sharing would be useful to the NHS only if the derived product or service was shown to be safe and efficacious for all potential patients. Evidence is insufficient that data, or AI, derived products or services can consistently meet these criteria.^{8 9}

Upfront governance, and commitments to privacy, cannot guarantee that subsequent uses of sold NHS data will be acceptable

to the NHS and the patients and public it represents. It is therefore unrealistic to expect that patients and citizens would accept or trust any purely commercial transactions.^{10 11}

Without trust, many patients and citizens may opt out of their data being made available in the proposed data trust, making the data less representative and less “valuable.”

Alternatives

The next government must steer away from a retail model of NHS data management and towards a more socially acceptable model. One option would be to create a tiered “rental” model run by a non-profit, community interest company. To operationalise this, population level, algorithm-ready (that is, cleaned, curated, etc) datasets would be kept within suitably functional trusted research environments, access to which could be rented (price tiered based on type of accessing organisation) for purposes pre-approved by a patient and citizen board according to democratically agreed access criteria.

Ownership of NHS data would never change hands, access could be revoked if data were used for undesirable purposes, and strict licence agreements would be developed for any of the data derived products and services, ensuring they are used only for socially acceptable purposes.

We urge the incoming government to take heed, learn from the incumbent government that it is detrimental to ignore matters of public trust and social acceptability with regard to NHS data,¹² and acknowledge that it is possible to use NHS data as an asset without resorting to profit seeking models that risk undermining the NHS's core values.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK



Decline in child health is a national scandal

The steep decline in children's health under the current government's watch is a national scandal, documented in the Academy of Medical Sciences scathing report (This Week, 10 February). Levels of destitution not seen since the earlier 20th century are just the tip of an iceberg of poisonous inequality, insecurity, and destruction, comprehensively chronicled by Dorling. The unprecedented increase in infant mortality is the last straw. A "unifying vision" by any government aiming to improve child health must include as a priority the reversal of these lethal injustices.

Besides necessary public health initiatives—such as cleaner air, reducing teenage pregnancy, support for breastfeeding, dental health, restoration of health visitor numbers, and universal vaccination—we can add:

- *Multidisciplinary perinatal teams for complex or confusing cases*—While families in the antenatal clinic are at their most accessible and vulnerable, any mental, physical, or social problems may overlap and be missed, a unique opportunity wasted. A regular meeting of midwives, social workers, psychologists, paediatricians, and others is not simply a means of allocating patients in need to a "pathway" but a method of discussion and discovery. Teamworking is a developmental skill.
- *The introduction of paid parental leave*—This could encourage more parents to delay a return to work and is associated with a reduction in infant mortality. Data show that the UK lags behind almost all European nations in spending on parental leave.
- *The restoration of Sure Start*—The current plan to provide (yet to be evaluated) family hubs, while helpful to those in specific need, will never generate the social capital provided by open access local family centres. Sure Start changed the lives of thousands of the poorest children, well into adolescence, and saved millions in public expenditure. In the decades since then, many new interventions have been evaluated that could be incorporated in revived children's centres.

Sebastian Kraemer, honorary consultant, London

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RISING MEASLES RATES

Increasing MMR vaccine uptake in primary care

Bedford and Elliman warn that measles cases are increasing, putting the health of unvaccinated children at risk (Editorial, 10 February). What can primary care teams do to boost MMR vaccine uptake?

A multifaceted approach is needed. Assigning a team member to lead the vaccination programme ensures focused oversight. All staff must be well informed about the programme, including eligibility criteria and the benefits of vaccination for individuals, families, the NHS, and society. This knowledge can be enhanced through free online training.

Accuracy of medical records is essential, especially in areas with high population mobility. Practices should consider the cultural and linguistic diversity of their patients, using appropriate materials and partnering with community organisations to enhance outreach. Accessible clinics are also essential.

Monitoring vaccine uptake and actively following up unvaccinated patients can significantly improve vaccination rates. Motivating staff with incentives and collaborating with community groups can further improve uptake.

Azeem Majeed, professor of primary care and public health, London

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MEDICAL MISINFORMATION

Benefits of discussing healthcare on social media

Stokel-Walker's article on medical misinformation on social media raises many important matters (Feature, 10 February). The online environment has hugely accelerated the spread of medical information, whether accurate or not. We need to be aware of the online medical environment, as our consultations with patients may be affected by preconceptions from their online research.

As well as acknowledging the risks, we should also consider the benefits

of discussing healthcare on social media platforms. One example is patient advocates who document their healthcare journeys online, raising awareness and providing valuable support to others. Readers may remember Deborah James (@bowelbabe) who discussed her bowel cancer on Instagram. The fund she set up has raised £12.6m for research. Nicky Newman and Kris Hallenga both raise awareness about breast cancer and encourage self-checks. These social media accounts can also be valuable for doctors, giving us insights into the reality of living with chronic conditions.

Isabella V C Watts, internal medicine training doctor, London

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NHS DENTAL RECOVERY PLAN

Let dentists exercise clinical discretion

The new NHS dental recovery plan, although showing glimmers of hope with confirmed prevention policies such as water fluoridation and expanded roles for the dental team, ultimately falls short (The Big Picture, 17 February).

The increasing cost of living has made dental care less affordable for many people, leading to a concerning trend of one in five people avoiding dental visits for financial reasons. The goal is for people to have easy access to comprehensive dental care, ensuring timely treatment and preventive measures are in place for optimal oral health outcomes.

Scottish dental payment reform was introduced on 1 November 2023. It focuses on prevention rather than reactive treatment, compensating dentists for both. This would be welcomed across the UK, allowing dentists to operate in a system characterised by high trust and low bureaucracy, so they can exercise clinical discretion in providing a comprehensive package of both oral health promotion and treatment.

C Albert Yeung, consultant in dental public health, Bothwell

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OBITUARIES

Maisara Al Rayyes

Doctor and Chevening scholar, who was committed to improving health in Gaza

Maisara Al Rayyes (b 1995;
q Al Quds University, 2018), died in
an airstrike on 5 November 2023

Palestinian doctor Maisara Al Rayyes was an inspirational young health leader who was committed to improving health among his community in Gaza, where he was killed in an Israeli airstrike.

Al Rayyes, an emergency doctor and medical supervisor who worked for Médecins du Monde (Doctors of the World) for two years from October 2021, died, aged 28, when his home in Gaza was hit on 5 November 2023.

He worked extensively with community based, government, and non-government organisations in Gaza and had researched the impact of conflict on patients and doctors. He also worked in obstetrics and gynaecology at Al Shifa medical complex.

An outstanding medical student, Al Rayyes studied at Al-Azhar University Gaza and was president of the International Federation of Medical Students' Associations (IFMSA) in Gaza (2016-17).

As a project coordinator for the Palestine Children's Relief Fund (2017-2019), he led the training of medical students to become life saving first aid instructors and gain skills to act in emergency situations.

Time in the UK

In the UK he undertook a masters in women's and children's health at King's College London (2019-20) on the prestigious Chevening scholarship programme run by the Foreign, Commonwealth, and Development Office (FCDO).

"It was obvious from the outset that Maisara was a very bright and articulate clinician and student," says Kim Jonas, senior lecturer in reproductive physiology and course co-leader for the King's masters degree, who interviewed him.

His personal statement was "one of the strongest I have read, both academically and emotionally," Jonas told *The BMJ*, saying it expressed so well how he wanted to develop his knowledge, research studies, and leadership skills to help improve patient care.

Al Rayyes researched the impact of



BRITISH CONSULATE GENERAL, JERUSALEM

Al Rayyes researched the impact of blockade and conflict on maternal and child health services in Gaza

blockade and conflict on maternal and child health services in Gaza and also explored doctors' experiences and training needs. In one study, published in 2022, he and colleagues wrote that Gaza "lives in a protracted emergency crisis." It concluded that there was a lack of infrastructure to support primary emergency care and primary care providers needed continuous education and training in disaster preparedness and response.

Al Rayyes was well known for his leadership traits, resilience, and commitment to medicine, "especially the instructorship part of it," says Bahzad Al Akhras, who studied with him at King's.

Al Akhras told *The BMJ*: "Maisara decided to go back to Gaza after he finished his degree in the UK. In Gaza he started working with Médecins du Monde as an emergency doctor instructor. He was training medical staff from the Ministry of Health on acute trauma life support (ATLS) and on emergency preparedness protocols at the ministry."

Al Rayyes received his official internationally recognised licence as an ATLS instructor after he passed the exam in Amman, Jordan. He was studying for medical exams required to be registered as a doctor in the UK.

In September 2023, Al Rayyes was photographed in Jerusalem alongside other Palestinian Chevening scholars meeting James Cleverly, who was then UK Foreign Secretary.

King's College London held a memorial gathering in November 2023, where tutors and fellow students spoke of Al Rayyes' achievements and influence.

Lujain Alqodmani, president of the World Medical Association and a former vice president of IFMSA, described Al Rayyes as a "highly motivated" leader who was determined to improve health for his community and overcome barriers put in his path.

How did he die?

Al Rayyes was killed along with several family members after their apartment building in Gaza City was hit in an Israeli bombardment on 5 November 2023. His parents and a nephew were found dead in the rubble the next day while it took longer to recover the bodies of Al Rayyes, his two sisters, and a younger relative, according to media reports. His two brothers were killed in a subsequent air strike on the same street.

The UK's government's response to the killings attracted widespread criticism.

On 8 November, FCDO posted a statement of condolence on X (Twitter) saying it was "devastated" to learn of the deaths.

Some Foreign Office staff were, however, said to be furious about how the incident was dealt with and others took to social media to accuse the UK government of trying to avoid criticism of Israel by not giving any details about how the deaths came about.

Husam Zomlot, head of The Palestinian Mission to the UK, said in a post on X that the FCDO statement was "unacceptable."

Asked to respond to the criticism, FCDO told *The BMJ* it had nothing to add to its initial tweet.

The Israeli military has not responded to questions about the incident, the BBC reported.

Maisara Al Rayyes leaves his wife, Laura Hayek, also a Chevening scholar.

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Caroline Richmond

Formidable science journalist, quack busting campaigner, and obituarist

Caroline Richmond (b 1941),
died on 24 December 2023

The 1987 Christmas edition of *The BMJ* featured a hilarious spoof by the outspoken and feisty medical journalist Caroline Richmond, who loved bright clothes and huge coloured spectacles. Her leaflet attributed the obesity epidemic to bright clothes and claimed that undyed clothes had “cured or improved” hyperactive children.

But this was not just a bit of seasonal fun. Richmond wanted to test public susceptibility. Her fear was justified. People wrote to her about their bright clothes allergies. Action Against Allergies even put Richmond’s leaflet, in all good faith, on its website—even though it came from the “Dye Related Allergies Bureau (DRAB), a subsidiary of the Food Additives Research Team (FART).”

HealthSense

Vincent Marks, professor of biochemistry at the University of Surrey and an international authority on insulin, recognised Richmond as a “kindred spirit” when they met as fellow speakers in London. Over lunch Marks told her he belonged to the US National Council Against Health Fraud. Richmond lost no time in setting up a similar body in Britain.

Later renamed HealthWatch and then HealthSense, the Campaign Against Health Fraud (CAHF) was launched in 1989 after a recruiting drive for influential members from medicine, law, and journalism. The initial corpus reflected Richmond’s persuasive powers. These emanated from a kind heart and a campaigning passion and commitment, not just to quack busting, but also to evidence based medicine (EBM).

What was best for patients was at the heart of Richmond’s concern—she knew better than most about what it means to be a patient. Her diagnosed conditions included arthritis, immune deficiency, myasthenia gravis, lymphoma, shingles, and normal pressure hydrocephalus, which in her last year affected her walking and bladder control—but not, to a significant degree, her thinking and reasoning. Fearing that the condition would sooner or later overwhelm her cognition, late last year



Richmond likened obituary writing to portrait painting with words

she stopped taking her immune deficiency medication as part of what she called a “planned death.”

Richmond became as highly controversial as a patient as she had been as a health activist and journalist.

In 1992 she went to St Thomas’ Hospital, London, for surgery for excessive bleeding. Finding a suspected tumour, Ian Ferguson, a senior consultant, performed a hysterectomy and oophorectomy—without Richmond’s consent. He was arrested after she had reported him to the police for assault, but the director of public prosecutions decided to take no further action. The General Medical Council cleared Ferguson of serious professional misconduct. Following a £50 000 damages award against the NHS in a civil hearing, Richmond made a second complaint to the GMC, but the council stood by its initial decision—much to Richmond’s anger.

Early life and career

The daughter of Cedric Ivor Smith, an Indian civil servant, and Kathleen (née Meeson), the exceptionally bright Caroline was born in Leicester but grew up in south London, where she had a “dysfunctional” upbringing. Expelled from Richmond Grammar School for Girls, she was sacked from an office job for absenteeism and

dismissed from the former Sir John Cass College after two years on a zoology course and a nervous breakdown.

After completing her degree at Portsmouth Technical College, she became a neuroscience doctoral student at University College London, only to quit after two years. But she had “a very happy time” at Birkbeck, studying for a physiology masters.

She wrote for *The BMJ*, the *Independent*, *New Scientist*, and, her personal favourite, the *Oldie*. She was also European correspondent of the *Canadian Medical Association Journal*. Last year she was elected as an honorary member of the Medical Journalists’ Association, making her one of a very small club.

Obituarist

As a journalist she was as forthright as she was compassionate. For example, she wrote unflinchingly in an obituary in *The BMJ* that the late David Horrobin, passionate promoter of evening primrose oil, “may prove to be the greatest snake oil salesman of his age.”

Angry responses by readers generated an 86 page printout, but the then editor, Richard Smith, robustly defended her. He said, “Medicine has a culture of not speaking ill of the dead. What quite a lot of our readers want is what I call glorified death notices, but we want serious journalistic pieces that tell stories and make a judgment on a character. We want more light and shade.”

Richmond devoted more and more of her time to obituaries. Speaking about the challenge of capturing the essence of an individual in a daunting 1000 words or so, she spoke about portrait painting with words. Obituary writing became one of the loves of her life, as was the Chelsea Arts Club. Founded by artists who, like writers, work alone, it is a bohemian place, where Richmond felt spiritually at home.

Her biggest love was her second husband, Jim Edgar, an IT analyst. Meeting through the *Guardian* SoulMates dating website in 2010, they married in 2015. She said, “We hit it off immediately. I was tongue tied he was so nice. As you know this is not my main attribute.”

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