The medical associate professionals (MAPs) situation is an unqualified mess. The debate—occurring at the same time as doctors’ pay disputes—has created a cohort of medical trainees asking why these roles exist and why they have no regulatory framework or definition of scope. Trainees are looking at the weirdness of it all, unable to attend training days or pick up training opportunities, while MAPs do. Cue understandable friction.

These roles are also being introduced at a time when numerous challenges face the medical workforce. One of the most rapidly growing groups is doctors who are “other”—not consultants, GPs, or in formal training programmes. These are conglomerated in data points under the label “SAS/LED” (specialist, associate specialist, and specialty doctors; and locally employed doctors).

These doctors, who are often international graduates, have no structured career progression per se; they have varying degrees of supervision and support; and their roles are largely confined to jobs others don’t want to do.

Supervision and mentoring are key issues. Senior doctors don’t have time to supervise or mentor SAS/LED doctors, who have also been ignored by trusts and Health Education England, whose remit was once limited to trainees but is now the whole workforce. A problem arises when trusts seem to have time to create pathways and support for associates, yet there’s a stark absence of any national policy or steer around LED doctors.

To get us out of this mess, here are some suggestions:

- Consultation—We should rethink the introduction of MAPs. What applied when the issue was originally subject to consultation in 2017 may not apply in 2023.
- Job title—This needs to be looked at again. If reviewing this helps to calm nerves around seeking “doctors on the cheap” then it’s worth it.
- Scope—The scope of MAPs’ training requirements and practice should be clearly defined. Seniors need specific guidance on what risks they take if an MAP they’re supervising acts beyond their scope.

• Regulation—If the GMC regulates MAPs it needs a separate administrative wing. There also has to be a separate way of allocating registration numbers to individuals in these new roles.
• Batting order—Have a clear priority list for deciding who is trained by senior doctors, or ensure seniors have adequate time to supervise everyone.

It’s a mess—yet a pause, a rethink, with calm heads and a consideration of how to ensure that all can work together, is key. Soldiering on by ignoring the growing chorus of voices, or trying to push the agenda through, ignores the simple fact that the existence of MAPs is, as things stand, dependent on doctors of all grades. If that relationship is fractured there’s a big problem, and old school bullying or gaslighting of those who raise their voice won’t settle the mood.

Partha Kar, consultant in diabetes and endocrinology, Portsmouth Hospitals NHS Trust drparthakar@gmail.com Twitter @parthaskar

Cite this as: BMJ 2023;383:p2689

A rethink, with calm heads and a consideration of how to ensure that all can work together, is key.
Associates and apprentices can be part of medicine’s future

The roles open non-traditional routes into the medical workforce—we must help pave the way for future students to succeed

Physician associates (PAs) and apprenticeships are seen by many in medicine as controversial.

Some doctors are concerned their training is being devalued and their roles undermined by less qualified staff.

We should be open to new avenues into medicine and support the incorporation of these roles into the medical workforce. PAs complete a two year masters programme in medical sciences and are trained healthcare professionals who diagnose, treat, and care for patients. Medical apprenticeships involve supervised hands-on training to become doctors and can improve access to medical school, modernise training, and provide support to students throughout their training.

The number of medical school places is set to expand at an unprecedented rate. Apprenticeships will challenge universities, many of which need to modernise their training and curriculums away from excessive emphasis on basic sciences to embrace issues such as data literacy, understanding of research methods, working in multidisciplinary teams, and critical appraisal to improve decision making.

Medical school is geared to prepare the future NHS workforce and should reflect broader society in terms of ethnicity and socioeconomic status. We need to maximise recruitment and retention—especially in areas of the country that are difficult to recruit into because of remoteness of location and social deprivation.

Recruitment and retention

The two key determinants of recruitment and retention in the NHS are where staff are brought up and where they train. Medical apprentices recruited locally are more likely to stay and work in their local NHS services, thus avoiding brain drain and keeping skills in local areas.

If we are to support apprentices in the workforce we need to tackle concerns that apprenticeships will create a two-tier system.

For apprentices, the final exam will be the same as for medical students, but they will have the opportunity to be mentored as part of an interdisciplinary medical team for five years, undergoing training and learning practical skills while receiving a regular income. This is important for students who do not have external financial support. The way forward is to evaluate pilot studies for apprenticeship training and to determine whether they are feasible and equivalent to traditional medical training.

Unlike apprenticeships which aim to train doctors, PAs complete a postgraduate qualification allowing them to diagnose, manage, and treat patients (excluding prescribing or requesting tests with ionising radiation), working with doctors. Associates can be a vital support when doctors are in short supply. In 2016, GP commissioners recognised the shortage of GPs and invested in new local training programmes for PAs. In the absence of central funding to train more GPs, there was nothing else on the table to resolve the shortage. If we want to tackle the crisis in GP numbers, we should establish a pathway for PAs to go on to train as doctors and for newly qualified doctors to go straight into five years’ training as GPs.

The medical profession pushes back against associates because of anecdotal examples of clinical mistakes and a coroner’s report that linked a patient’s death to a PA. There is also confusion among professionals and patients of location and social deprivation.

OPINION

David Nicholl

Medical associate professionals: we need to clear all the confusion

As Partha Kar says on page 357, the whole situation around medical associate professionals (MAPs) is “an unqualified mess.”

The latest development in the debate is that the BMA has called for a pause in the recruitment of MAPs to allow time to resolve the matters of practice scope, supervision, and statutory regulation. Expansion of MAPs was a key part of the NHS Workforce Plan, which proposed introducing 10 000 physician associates by 2036. But doctors have voiced their concerns about the risks of MAPs performing tasks that they haven’t been trained for, the extra workload it will put on supervising doctors, and the lack of clear regulatory oversight. It’s time to pause the recruitment of MAPs until these doubts are worked out.

Draft legislation would give the GMC powers to regulate associates but has been repeatedly delayed. Frustration is understandable, given that PAs have waited 20 years to be regulated like any other healthcare professional.

Now is the time for the royal colleges to speak out. MAPs are spread across 46 specialties, so it would be a challenge to solve all the problems before the government plans to present the legislation at the end of the year. The Academy of Medical Royal Colleges has written to the GMC expressing concern about the lack of a separate second register. Medical defence organisations are concerned by the “disparities” in regulation between MAPs and doctors.

The royal colleges are ideally placed to settle matters of scope of practice and levels of supervision. The Royal College of Physicians, which has hosted the Faculty of Physician Associates since its establishment in 2015, has urged the “government to maintain its commitment to lay legislation on anaesthesia associates and physician associates regulation by the end of 2023 as planned.”

If regulated and supervised appropriately with a clear scope of practice, PAs could be a valuable part of the health workforce. They are non-rotational staff so can provide continuity of care. But the risks of PAs making mistakes or not being supervised are greatest in areas...
A surgeon, I’m focused on the NHS’s huge waiting list for elective surgery. But, given that only 13% of hospital bed days are used for elective surgery, this isn’t what’s depleting the NHS.

I recently did seven different conference presentations in a week. The most effective was for a public event about the health benefits of active travel, especially a slide of the chief medical officer’s (CMO) annual report showing places where over 25% of the population will be over 75 by 2043. We can’t afford the costs of our ageing population to healthcare, social care, and the economy unless we change our passive expectations of ageing.

In the NHS, 70% of bed days are used by people aged over 65. But hospital stays are damaging to older people, as they can lose as much as 5% of their muscle strength a day. Data, stories, and images can be powerful in understanding why change is needed and galvanising people into action. But we need “how” as well as “why”; people need practicalities, organisations need strategies.

First, we need healthy lifestyle champions in all communities. We’ve known for decades that the risk of dementia, frailty, and hip fractures can be reduced or even prevented by physical activity, social connections, avoiding smoking, and eating healthily.

Second, we need more geriatricians, with teams to support them. Older people with multiple conditions and complexity need general care from all team members, as well as specific, personalised care planning. The British Geriatrics Society has highlighted the need for “optimisation of physical function and mobility for all, and a personalised multidomain intervention for those at high fall risk, including deprescribing.”

This workforce shortage is fixable. There are competition ratios of over 2:1 for training posts in geriatrics and emergency medicine—so more than half of doctors who applied in 2022 were turned away. Training posts could be increased quickly by a few hundred and would be a cost effective investment. When geriatricians lead a perioperative care service, this saves over £1100 a patient.

Third, we need to improve cross-skilling across care pathways. NHS England’s recent report on intermediate care highlights the need to train staff in key skills to avoid waiting for an expert and to empower each patient. We need teams led by senior clinicians where all staff can ensure the “simple” things are done well and that critical decisions are made with the involvement of experts and patients.

Most major operations are in older people, most cancellations are due to a lack of beds, and complications are at least four times as likely if someone is frail or inactive. Creating standalone surgical hubs will work only for the people fit enough to go there. We need a multipronged approach such as that described by the Centre for Perioperative Care, including a population-wide fitness drive and surgical units co-located with hospitals’ expertise—otherwise, health inequalities will continue to worsen.

We need to redefine ageing, health, and activity to improve the NHS and social care. We can’t afford not to.

DISSECTING HEALTH Scarlett McNally

An age rethink can help the NHS recover

that involve unselected patients, such as emergency medicine and primary care—38% of PAs practise in primary care. Patient safety and trust must remain our top priorities. We must avoid creating a two-tier system between patients who receive care from regulated professionals versus unregulated PAs.

Finally, the processes of revalidation for PAs and establishing time for clinical supervision need to be determined. Given the importance of these matters, and despite the delays there have already been, the BMA’s request for a pause is the most sensible way forward. The royal colleges should resist pressure, such as from NHS England, which rejects any suggestion of a pause on recruitment.

Our patients and colleagues deserve a safer, regulated, supervised, and fully scoped healthcare system—nothing less will suffice.

David Nicholl, consultant neurologist, Birmingham

Cite this as: BMJ 2023;383:359

about the role’s title, its limits, and the lack of a regulation system. These are legitimate points and this new role needs to evolve.

Mistakes happen when PAs work outside their area of competence and are unsupervised because of a shortage of senior clinicians. This can also apply to junior doctors. Associates can improve access for patients to care and continuity when integrated into a wider team. No evidence suggests that PAs make more mistakes than others in the team.

Junior doctors may argue that PAs are paid more. Our response is that junior doctors need a pay rise but they must consider they will receive pay uplifts after completing their training, unlike PAs. After four years a junior doctor will be earning more than a physician associate.

Logically, PAs would be regulated by the GMC. Their training is clearly geared towards working with doctors rather than as independent practitioners, and the GMC is well placed to clarify the different roles.

Aneez Esmail, professor (emeritus) of general practice, University of Manchester

Sam Everington, GP, barrister, Tower Hamlets

Cite this as: BMJ 2023;383:p2789

We can’t afford the costs of our ageing population unless we change our passive expectations

Our patients and colleagues deserve a safer, regulated, supervised, and fully scoped healthcare system—nothing less will suffice.

David Nicholl, consultant neurologist, Birmingham

Cite this as: BMJ 2023;383:p2789
Training in the medical model

There’s been much discussion across the media about the role of physician associates (PAs) and anaesthetic associates (AAs). Who exactly are they, and how are they trained? The Department of Health and Social Care says they’re “trained in the medical model”—but what does this mean? Among many possible meanings, a paper from 2005 defines it as “the flexible application of knowledge and skills to needs of the individual patient rather than working to predetermined protocols.”

The medical model I know is the one I experienced and have also taught. It involves learning a lot of basic science (anatomy, biochemistry, physiology, pharmacology, pathology, and more) and then understanding how these subjects relate to symptoms in patients and how we can investigate and treat illness. Many courses now weave these strands together, aiming for vertical integration of the curriculum and spiral learning, where you return to the same area but with more depth and complexity in successive years of study.

As medical knowledge expands there are debates about what a doctor really needs to know—for example, the amount of anatomy taught to undergraduates has been reducing. And of course every academic believes that, if more of their subject was taught, the students would be better doctors.

When refining the curriculum, the question at the forefront of our minds must be: what knowledge and skills do doctors need to practise safely? We need to ask the same question when it comes to associates. If we believe that becoming a GP takes five years of medical school and another five of postgraduate training, why do some PAs in general practice receive less supervision after two years of training than a GP registrar after nine?

Our GP trainees have debriefs with a supervising doctor at the end of every surgery, but for many PAs this isn’t happening beyond their first year, at which stage NHS England recommends monthly supervision. In theory, PAs, as dependent practitioners, always have access to a qualified GP to answer queries; in reality, there are many reports of PAs working semi-autonomously with minimal input from GPs.

Experience is often used as a proxy for competence, the idea being that these new members of the workforce “learn on the job.” However, we must be alert to the dangers of experience without training. If no one’s looking over your shoulder or discussing your cases—not only those you struggled with but also the ones you handled well—you may never know what mistakes you may have made or how your diagnosis, advice, or treatment could have been improved.

Experience boosts confidence, but without supervision and feedback it doesn’t improve competence. In the interests of patient safety the BMA has called for a pause in recruitment of these roles until their scope, regulation, and supervision requirements are better defined.

Experience is often used as a proxy for competence

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Helen Salisbury
GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury

Cite this as: BMJ 2023;383:p2793

LATEST PODCAST

Talk Evidence: Cancer screening and low carb diets

Each episode of the Talk Evidence podcast dives into topics that are in the news to help listeners understand what it all means for clinical care, policy, or research. In this episode, the team talk about cancer screening tests, prompted by a paper in JAMA that showed most have no effect on all cause mortality.

Barry Kramer, former director of the Division of Cancer Prevention at the US National Cancer Institute, discusses what matters when we think about cancer screening tests:

“Some of the language that is frequently used in connection with cancer screening tests is that they save lives. To many, if not all, patients that means that if they take the test, they’re likely to live longer—that is, they have a longer life expectancy. This particular paper calls into question whether we have that evidence in hand and if we should let participants continue under the impression that they will live longer as a result of the test. For most screening tests, all we really have is evidence that a screening test reduces the risk of dying of a specific cancer or not. And so we have to be very careful with the precision of our language.”

The team also explores the role of low glycaemic index foods in weight loss, with guest Khadidja Chekima, a nutritional researcher at Taylor’s University in Malaysia, explaining how to define low glycaemic index foods, and why it’s so hard to research their role in diet:

“When it comes to self-reporting and when we’re talking about the food frequency questionnaire, the reliability of this is a little bit questionable in that it depends on the memory of the individual. A person might easily misinterpret the number of times they consumed a specific type of food.”

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Edited by Kelly Brendel, deputy digital content editor, The BMJ
Female genital mutilation: the UK’s policy response needs an urgent rethink

Sakaria Ali and colleagues argue that the national reaction is disproportionately focused on criminal prosecution rather than community-based prevention and providing appropriate care to those living with the consequences of FGM/C among health and other professionals have brought increased attention to this practice, acting as a possible deterrent and complementing community-led prevention campaigns that have shifted societal norms around FGM/C (for example, being cut not bestowing social advantage) in the UK.

Since the initial prohibition of FGM/C in the UK in 1985, criminal penalties have been increased alongside safeguarding provisions to detect cases. However, as of late 2023, there have been just two successful prosecutions for FGM/C offences in England and Wales, which many advocates for change consider a collective professional failure given the large numbers of girls in the UK believed to be at risk according to UK government policy. We suggest an alternative explanation is that the scale of this practice in the UK is far lower than assumed, and that policy approaches should shift to reflect this.

There have been just two successful prosecutions in England and Wales

Prevalence of FGM/C in the UK

Although there are problems with completeness, the NHS FGM enhanced dataset, where healthcare providers in England record when a patient is identified as having had FGM, shows that between April 2015 and June 2023 around 35,000 women and girls in England were identified as having had FGM/C, most of whom had the procedure before moving to the UK. A 2022 review of available prevalence indicators, corroborated across multiple sources (including the NHS dataset), suggests that there are few new cases.

Box 1 | WHO definition and classification of female genital mutilation

The World Health Organization defines female genital mutilation as all practices involving the “the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons.” Increasingly it is argued that these practices should be referred to as female genital cutting because of inconsistencies and biases associated with the word “mutilation.”

We use the abbreviation FGM/C in recognition of this controversy. WHO classifies four major types:

- **Type 1**—Partial or total removal of the clitoral glans or prepuce, or both
- **Type 2**—Partial or total removal of the clitoral glans or labia minora, or both, with or without excision of the labia majora
- **Type 3** (infibulation)—Narrowing of the vaginal orifice with creation of a covering seal by cutting and opposing the labia minora or majora (or both), with or without partial or total excision of the clitoral glans or prepuce
- **Type 4**—All other harmful procedures to the female genitalia for non-medical purposes—e.g., pricking, piercing, or cutting

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**KEY MESSAGES**

- The number of new cases of female genital mutilation or cutting (FGM/C) experienced by UK resident girls is low, but there are many older women living in the UK who had FGM/C as children outside the UK.
- Despite this, UK government policy is focused on criminal prosecution of new cases rather than providing support for people living with long-term consequences of FGM/C.
- Greater support is needed for prevention through education and providing appropriate care for those already affected.
- Communities affected by FGM/C should be more meaningfully involved in research agenda setting and policy making.
Box 2 | Key FGM legislation and policy in England and Wales

Prohibition of Female Circumcision Act 1985

- Made it an offence for any person to excise, infibulate, or otherwise mutilate any part of the labia majora or labia minora or clitoris of another person, or to aid, abet, counsel, or procure the performance by another person of any of those acts on someone else.
- Distinguished between surgery that was “necessary for the physical or mental health of the person . . . and performed by a registered medical practitioner” and procedures relating to “custom or ritual.”
- Made offences punishable with a fine or 5 year maximum term of imprisonment, or both.

Female Genital Mutilation Act 2003

- Made it an offence for any person to aid, abet, counsel, or procure a girl to excise, infibulate, or otherwise mutilate any part of her labia majora, labia minora, or clitoris.
- Made it an offence for a UK citizen to assist a non-UK national or UK resident to undertake FGM/C outside the UK on someone who is a UK national or permanent resident.
- Extended the maximum term of imprisonment from 5 to 14 years.

Serious Crime Act 2015

- Further enlarged its territorial jurisdiction to include any individual who is habitually resident in the UK, as well as those who are UK nationals or UK permanent residents.
- Made failing to protect a girl from the risk of FGM/C an offence, punishable with a maximum term of imprisonment of 7 years.
- Introduced anonymity for persons against whom an FGM/C offence is alleged to have been committed.
- Introduced a mandatory reporting duty for social care, education, and health professionals requiring them to make a report to the police if they discover that FGM/C appears to have been carried out on a girl who is aged under 18.
- Introduced civil FGM protection orders for women/girls considered at risk of FGM/C. They are granted by family courts and can vary from withholding the passports of children for long periods to mandatory genital examinations.

Female Genital Mutilation—Information Sharing (FGM-IS)

- Since 2014 allows authorised healthcare professionals and administrative staff throughout England to view information about girls under the age of 18 with a family history of FGM/C.

NHS FGM enhanced dataset

- Since 2015 requires clinicians in acute trusts, mental health trusts, and general practices to record in the patient notes and submit data to NHS Digital when patients with FGM/C are identified, including the type of FGM/C.

among girls resident in the UK. For example, data collected in the NHS dataset from 2015 to 2020 indicate that there may have been as few as eight new FGM/C cases among girls aged under 18 during this period.4

The idea that fewer girls are at risk than previously assumed is supported by the British Paediatric Surveillance Unit study from 2021 in which all consultant paediatricians were asked each month whether they had seen a case of FGM/C over two years.16 This study identified 103 cases of FGM/C in girls aged 16 years or younger, and only one was performed in the UK, which resulted in a prosecution.

Based on these patient surveillance data from the UK and an analogous Australian study, most women and girls experience FGM/C before they migrate.16,17 Nevertheless, it remains unclear how many UK resident girls under 18 years of age are currently at risk of FGM/C.4

Qualitative research conducted in Europe shows that communities largely abandon the practice on migration.18-19 Part of this change in attitudes has been linked to the effect of new societal norms, education, and a generational shift, with young people leading abandonment campaigns in their new countries.20-22 Some people hold negative attitudes to FGM/C before migration.6,23 Survey based research also indicates attitudes shifting against the practice in high prevalence locations.22

Despite this growing body of evidence, the 2023 updated UK government FGM resource pack issued by the Home Office continues its messaging about the “hidden” practice of FGM/C, implying a large undetected prevalence.24 This perpetuates the assumption that the small number of prosecutions for FGM/C means current policies are ineffective.

FGM/C legislation in the UK and Europe

In the UK, legislation tackling FGM/C was introduced through the Prohibition of Female Circumcision Act 1985 and later enhanced in a series of legislative changes (box 2).10 Following the 2014 Girl Summit, the UK government published the first FGM national plan, which included measures to change what it described as a “historically passive approach to FGM” by police and the Crown Prosecution Service.25 Mandatory reporting of FGM/C and FGM protection orders were introduced in England and Wales as part of the Serious Crime Act 2015, following a one month consultation process with limited involvement of stakeholders outside government.7 The new guidance for professionals following this act led to increased activity among health and other professionals, including new national information sharing across services.26 It also introduced the FGM enhanced dataset, where health professionals record positive responses when asking patients about experiences of FGM/C during medical encounters.28 However, publicly available findings from this dataset on FGM prevalence, mandatory reporting, and health complications remain scarce.

Other parts of the UK have taken different directions. Northern Ireland uses existing child protection procedures to respond to suspected FGM/C, which includes mandatory reporting for all child abuse.27 The Scottish government undertook a detailed consultation process with statutory, community, and third sector stakeholders, which produced the Scottish National Action Plan for FGM in 2016.28 In 2019 it evaluated this national plan and included FGM protection orders, although none has yet been issued.24 These varied perspectives on FGM/C legislation within the UK raise the question of what a proportionate and effective response to ending FGM/C should be.

Similar questions are being considered elsewhere in Europe. Launched in 2011, the Istanbul Convention for action on violence against women was ratified by the European Union in 2023.29 The law offers an important deterrent and sends a message that certain practices are not allowed, but there are different legal responses to criminal prosecution in FGM/C cases.27 Some countries, such as Sweden and Switzerland, have specific legal provisions against FGM/C, but in Germany, France, and the Netherlands prosecution is through laws against child abuse and bodily harm.30-32

UK policy makers have drawn comparisons with France, which has had more than 40 criminal prosecutions for bodily harm caused by FGM/C (most in the 1990s), as a reason for focusing on prosecution as a deterrent.33
Mandatory reporting

Clinicians in general practice and NHS acute and mental health trusts in England must record FGM/C disclosures in the FGM enhanced dataset, which sits within the national information sharing system for health and social care (box 2). Until March 2020, only 2.5% of general practices and 62.7% of NHS trusts had submitted information to the dataset. 35-37 Clinicians are mandated to submit information such as personal details, family history, and type of FGM/C to the dataset, without consent from the women or girls concerned. Instead, clinicians are advised to inform patients about this secondary data submission and provide an opportunity for them to object to it. 35-37

Similarly, the new FGM information sharing system in England and Wales flags the medical records of female infants born to women with FGM/C without requiring parental consent. 23 Women report feeling re-traumatised by clinicians repeatedly collecting information about their past experiences of FGM/C, and they say this distracts from their other health needs. 18 These experiences can be alienating and stigmatising for women in vulnerable moments accessing health services. 14 39 To date, the UK government has not evaluated the potential harmful consequences of these information systems on the people involved nor established any use to inform policy and practice which might justify them.

In addition to new mandatory information sharing, health professionals are required to report to the police if they establish that FGM/C has been carried out on a girl aged under 18 years. Freedom of information data show that among the police forces that did not have data suppressed, in 2020-21 there were 55 alleged FGM/C offences recorded under the mandatory reporting duty in England and Wales. 40 There is some suggestion that mandatory reporting may have increased the willingness of health, social care, and education professionals to detect and report FGM/C. 36 41 However, the wider effect of the mandatory reporting duty of FGM/C in girls under 18 is not yet known. 41

The mandatory reporting duty has been criticised for extending the reach of criminal law responsibilities to health and other professionals outside the criminal justice system. 33 This has contributed to inexperienced professionals reporting FGM/C in girls who were in fact not cut, which has unintended harmful consequences. 31 A study from 2020 evaluating the presentation of 148 children referred to a specialist children’s FGM/C clinic in London during 2014 to 2019 found that more than 60% had not had FGM/C. 43 In England and Wales, concerns about children with suspected FGM/C referred to police and social care may result in joint agency investigations, and even children being removed from their families, before a medical assessment has been conducted and FGM/C confirmed. 31 44

Women report feeling re-traumatised by clinicians repeatedly collecting information

Up to 2023, most attention has been directed at women with infibulation as it leads to more acute and chronic health complications than other types. 3 46 However, only around 10% of women with FGM/C, both globally and in the UK, have infibulation. Although types 1, 2, and 4 (box 1) are more common, they are harder to identify on physical examination. 16 As a result, women living with these other types of FGM/C may not be recognised by inexperienced health professionals and therefore their health difficulties may not be addressed. Health services need to give greater attention to the complex physical and psychological needs of all women with FGM/C (not only those with infibulation or those who are pregnant).

Health professionals require training on sensitive approaches to identifying FGM/C to avoid potential over-reporting among children and under-identification in older women and taking proportionate safeguarding approaches when children are identified to be at risk. 38 Although FGM/C can cause different short and long term health complications, women living with FGM/C point out that clinicians must not automatically assume that their particular health problems stem from this cause. 14 46 In addition, given the documented attitudes against FGM/C, it should not be assumed that girls born to mothers with FGM/C are necessarily at risk. 14 48

The challenge for the UK government, and its European counterparts, is to protect women and girls from all forms of violence, while not causing harm through invasive and inappropriate interventions. People who have experienced other forms of child abuse are not asked to submit intimate information to service providers, and such requests have been described by women and girls affected by FGM/C as retraumatising. 39 Such intrusive and disproportionate measures lead to families losing both trust in statutory service providers and their sense of belonging in Britain. 44 Grassroots educational initiatives in communities where FGM/C is historically prevalent have been successful in reducing this practice and changing attitudes. We urge the UK government to support this work, which is mostly done by charities who provide counselling for affected women; train health, teaching, and social care professionals on dealing with FGM/C; and link policy makers with the experiences of affected communities. 38 Prioritising community enabled prevention work and health improvements sends a strong message of support to communities affected by FGM/C.

Policy makers should invite meaningful inclusion of women with a diverse range of FGM/C lived experiences. Their views should be sought in setting research agendas as well as in policy development and implementation across health services. By actively involving FGM/C affected communities in policy making we can build on the progress made over the past decade to protect girls from FGM/C using less punitive measures and support those already affected.

UK policy needs to shift away from primarily pursuing criminal prosecutions for FGM/C and centre on healthcare for those living with the consequences of this practice. 11 40 The available evidence suggests that FGM/C is not common among UK resident girls, 13 but there are still thousands of older women affected by FGM/C, and health services need to better reflect the needs of this group.

Some women experience lifelong physical consequences, including repeated urine infections, back pain, and childbirth complications. 7 However, in a recent study conducted in Bristol, the most common unmet healthcare needs related to sexual functioning and psychological wellbeing. 45

Shaping a new UK policy direction

UK policy needs to shift away from primarily pursuing criminal prosecutions for FGM/C and centre on healthcare for those living with the consequences of this practice. 11 40 The available evidence suggests that FGM/C is not common among UK resident girls, 13 but there are still thousands of older women affected by FGM/C, and health services need to better reflect the needs of this group.

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Sakaria Ali, consultant paediatrician
Hazel Leamer, consultant paediatric and adolescent gynaecologist
Deborah Hodes, honorary consultant community paediatrician, University College London Hospital NHS Trust deborah.hodes@nhs.net
Saffron Karlsen, professor of sociology
Natasha Carver, lecturer in international criminology
Christina Pantazis, professor of zemiology, University of Bristol
Brian D Earp, senior research fellow, University of Oxford

Cite this as: BMJ 2023;383:e074751

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The term “virtual wards” gained fresh momentum in the NHS during the first waves of covid-19. Before the pandemic it had referred to community based, multidisciplinary teams case managing patients at high risk of acute hospital admission to prevent or respond to crises and keep them at home.

It was then repurposed in 2020-21 to describe telephone and digital monitoring of symptoms and physiological oxygen observations for people mostly with respiratory covid-19, to help support them at home with a direct link to a secondary care clinical team. Some trusts that reported local success with this model published their data or extended it to other respiratory infections or exacerbations and were then singled out as exemplars by NHS England (NHSE), which in turn picked up on the idea as a way of reducing demand and activity in acute hospital sites by providing a safe, cost effective alternative.

Having initially promised 7000 new virtual ward places in 2021, NHSE then set a target of 10 000 places in its 2023 Delivery Plan for Recovering Urgent and Emergency Care Services and provided an extra £450m over two years. It now says that more than 10 000 patients were treated in such wards in the year to March.

NHSE also claims that most of these virtual wards are effectively using the “hospital at home” model—a different, long established, and better researched model than the one more narrowly focused on respiratory illness seen during the pandemic, thereby muddying the terminology further. It also claims the hospital at home model is helping to reduce admissions. I find some of the developments and confusions problematic for several reasons.

First, in public communications NHSE routinely uses the terms “virtual ward” (in the covid era sense) and “hospital at home” almost interchangeably, although they’ve never been synonymous. The 10 000 beds are inevitably a patchwork of different models depending on local practice, with the label applied indiscriminately to claim expansion of places and the additional central funding. NHSE lumps together examples based on single (often respiratory) conditions and more generic ones for admission avoidance or early discharge in frail older people, as well as clinical teams of very different sizes, skill sets, and medical oversight. Yet NHSE Providers claimed in a recent article that patients on virtual wards received “consultant-led care, from multidisciplinary teams, overseen both locally and remotely.” Can we know that?

Feeding the numbers

Second, with a finite number of health professionals, there’s a risk of robbing Peter to pay Paul: the staff in virtual wards will have to be taken from elsewhere. The shift to community settings may place extra strain on primary and community care staff who are not part of the virtual ward. And that £450m could have been spent on existing community services to help patients out of acute hospitals. We now see patients with ongoing peri-acute problems being supported to leave or stay out of hospital, while others with no acute medical needs are stranded there for want of underfunded health and care services, feeding the virtual ward numbers.

Third, much of the existing evidence is patchy or inconclusive. Local service descriptions and good news stories are always interesting. But without rigorous, independent evaluation and data they provide no basis for central agencies to set big targets and roll out the model nationally. A recent rapid evidence synthesis in Age and Ageing found low to moderate evidence that clinical outcomes including mortality were probably equivalent or better with the hospital at home model. Subsequent residential care admissions were “probably reduced.” Evidence of cost effectiveness showed “methodological issues,” meaning results were uncertain.

Carers’ experience evidence was lacking.

A systematic review in 2021 of the hospital at home model—both for admission avoidance and early supported discharge—found that “for suitable patients, [hospital at home] generally results in similar or improved clinical outcomes compared with inpatient treatment, and warrants greater attention in health systems facing capacity constraints and rising cost.”

None of this means that virtual wards or hospital at home models are a bad thing. For some patients they can provide a more acceptable alternative to hospital, without the risk and complications of overcrowded hospitals. Two recent British Geriatrics Society position papers on care outside hospital and rapid community responses to older people have set this out clearly. But none of it is a good enough basis for setting ambitious targets or assuming that such approaches are a silver bullet.

Failing to learn

Fourth, we’re failing to learn from history. For two decades we’ve heard the health department, NHSE, and ministers announce the rollout of shiny service models, based on limited peered reviewed evidence. Retrospective evaluation found the models never delivered the promised reductions in hospital attendance, costs, admissions, or bed days at population level. Yet here we are again.

Finally, it’s a big assumption that all or most patients who are enrolled in a virtual ward or a hospital at home scheme would otherwise have been in hospital.

By all means, provide more out-of-hospital care because patients like and value it—and because, for selected groups, the outcomes can be at least as good as admission. But don’t assume it will solve the lack of acute hospital capacity, while ignoring the opportunity costs and taking decisions away from local health systems by setting their priorities for them.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire davidoliver372@googlemail.com Twitter @mancunianmedic

Cite this as: BMJ 2023;383:p2787
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Climate adaptations need to “spread like wildfire”

Accelerating climate change and loss of biodiversity have created a global health emergency (Editorial, 28 October). The record heatwave in France in 2003 was responsible for over 14 000 excess deaths. France has experienced higher temperatures since then, but its 2004 national heat wave plan meant that mortality was reduced by adaptations including better warning messages, heat reflective surfaces, housing insulation, safe cooling spaces, and shade trees in parks.

In England “the possibilities for policy” have had a lower priority, and in 2022 its hottest days were associated with an estimated 4507 deaths. The heatwave season of 2022 served as a warning that the UK is not ready for extreme heat events.

English resources for adaptation are constrained by shrinking local authority funding. The biggest brake on action, however, is the difficulty most people have responding to a gradual, cumulative crisis. E M Forster described this fatal inaction vividly in his story The Machine Stops. We now have a new national adaptation programme but “each of the identified climate risks” is dealt with in isolation.

In summer 2022, wildfires broke out in many sites around London, almost overwhelming fire and rescue services. Rural drought interfered with harvests and tourism. In Canada over 400 fires devastated forests but also exacerbated respiratory disease over a vast area, including the US. Heat risks relate to interlinked problems: wider use among older adults. Any impact on antimicrobial stewardship is marginal compared with the low value care propagated by their poor positive predictive value.

Like climate risks, adaptive actions are often linked. Promoting biodiversity is one promising area for action. Nature based measures were recommended for the preparedness for heat risks. Greening urban areas of London, for example, not only provides shade for people, it also improves mental wellbeing and reintroduces wildlife.

Woody Caan, retired professorial fellow, Royal Society for Public Health, Duxford; Candice Howarth, head of local climate action, Grantham Research Institute on Climate Change and the Environment

Cite this as: BMJ 2023;383:p2670

TACKLING THE CLIMATE AND NATURE CRISIS AS ONE

What do we do if they ignore us?

Thank you for the joint editorial on the global health emergency (Editorial, 28 October). What do we do if these calls are not heard? What if our prime minister wants to dilute net zero commitments and license exploration for new oil and gas, which, if burnt, will take us beyond agreed global warming limits?

Two health professionals were arrested for spraying the dinosaur in the Natural History Museum with wipeable orange cornflour spray. Their only demand is that the government stops licensing new oil and gas exploration, it’s not unreasonable or impractical. Meanwhile, those who are actively reaping grotesque profits from the destruction of our natural world are above the law.

So, what if nobody listens? Will we support our colleagues taking risks? Will we urge the GMC to applaud, not condemn, them? Is it possible to go too far with non-violent resistance, when everything of value is at stake?

C H Blunden, GP, Southampton

Cite this as: BMJ 2023;383:p2751

LISTING AIR POLLUTION ON DEATH CERTIFICATES

Social determinants of health have fatal consequences

I agree that air pollution should be listed on death certificates (Opinion, 7 October). All social determinants of health that have contributed to a death should be listed. This would encourage local authorities and government to tackle the poor conditions that many patients live in.

I vividly remember a patient who presented several times to the emergency department with an exacerbation of chronic obstructive pulmonary disease (COPD)—and who later died of an exacerbation of COPD and pneumonia. The patient took their medication and did not smoke but lived in very damp conditions. No amount of steroids or antibiotics would have heated the home or fixed the double glazing. And no local authority would have been informed that someone had died from chronic exposure to mould because it was not mentioned on the death certificate.

Listing social determinants on death certificates highlights the fatal consequences of ignoring them.

Jahangir Alom, emergency medicine doctor, London

Cite this as: BMJ 2023;383:p2666

UNNECESSARY URINE TESTING

Time to stop using urine dipsticks in older adults

We thank Zhang for their response to our article on urine testing among older adults (Letters, 21 October; Practice Pointer, 2 September).

We don’t think the negative predictive value of urine dipsticks justifies their widespread use among older adults. Any impact on antimicrobial stewardship is marginal compared with the low value care propagated by their poor positive predictive value.

If better interpretation of urine dipsticks was the solution to overdiagnosis, educational approaches would be adequate. Yet decades of focusing on knowledge gaps without sustained practice change suggests otherwise.

The presence of pyuria on dipstick testing introduces cognitive bias in favour of infection, in the absence of specific localising signs or symptoms. Positive urine analysis results have been associated with increased probability of urine culture without appropriate indication, avoidable antibiotics, or both.

Diagnostic stewardship can overcome our cognitive biases but will require leadership. The de-implementation of urine dipsticks is an easy win.

Jerome A Leis, infectious diseases physician; Katrina L Piggott, geriatrician, Toronto

Cite this as: BMJ 2023;383:p2660
Cheung Yuen Ngan
GP (b 1958; q St Andrews/Manchester, 1982), died from renal cancer on 27 March 2023
Cheung Yuen Ngan was born in Hong Kong and came to the UK in his teens. He gained a place at St Andrews Medical School. After his preclinical years in Scotland, he moved south to Manchester to complete his medical degree. After graduating he stayed in the north west of England. General practice was Cheung’s calling, and he became a partner at the Brunswick Centre in Ardwick. Outside his NHS work, he was involved in setting up the Chinese Health Information Centre, a charity involved in improving access to health services and reducing health inequalities for the Chinese community in Greater Manchester. Even after Cheung’s diagnosis of renal cancer, he continued to work through both the covid-19 pandemic and his cancer treatments. He leaves his wife, two children, and one grandchild.

Michael Anthony Crilly
Consultant in public health medicine; senior lecturer University of Aberdeen; clinical epidemiologist; senior associate Centre for Evidence-Based Medicine, Oxford (b 1961; q Liverpool, 1987; MRCP, MPH, MD, FFPHM), died from fracture dislocation of the atlantoaxial joint on 2 July 2023
Michael Anthony Crilly ("Mike") had a particular research interest in cardiovascular disease and in the non-invasive assessment of arterial function using techniques such as pulse wave analysis. He was the public health strategic lead for the cardiovascular disease portfolio and led the response to infectious disease and environmental incidents. He was seconded to join public health protection colleagues full time, providing a response to cases and outbreaks of covid-19. He retired in September 2021. Mike died after a freak e-bike accident while out cycling. He leaves his wife, Heather, and three children.

Kitty Mary Watt
GP Port Charlotte, Islay (b 1939; q Manchester, 1979), died from dementia on 13 October 2022
Kitty Mary Watt trained in orthopaedic nursing and physiotherapy. She worked until she married Alan and took a family career break. She then applied to study medicine, starting with A levels, which she achieved in one year. Partnership in Marple, Stockport, followed, where she worked full time until she first retired in 2000. She subsequently took an associate GP position on Islay, covering 13 weeks each year until 2011. Kitty and Alan loved their time with the wonderful Islay community. A talented artist, Kitty finally found time for her passion, spending free time with the Islay Quilters, exhibiting nationally and internationally. She was always active and busy, despite arthritis and cold agglutinin disease, until the dementia took its toll. She leaves Alan, two sons, and one grandson.

Maria Jadwiga Długołęcka-Graham
Consultant in public health medicine Edinburgh (b 1949; q Edinburgh, 1977; MBE, MD, PhD), died from a cerebral haemorrhage on 3 October 2023
Maria Jadwiga Długołęcka was born in Edinburgh and read medicine there. Her interest in medical education led her to obtain a masters in medical communication and a diploma in medical education. Maria married late—Cecil Graham was the former secretary of the Hibernian Football Club. She took early retirement, which enabled her to join him on the golf course. Her manifold activities earnt her awards from various Polish universities and an MBE for services to medicine and Scottish-Polish relations. On 27 September 2023 Maria had a cerebral haemorrhage, the cause of her death a few days later. Her family, friends, and colleagues will remember her scholarship, her passion, her mentorship, her generosity, and her enduring faith, which guided her in all she did.

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Linda Luxon

International leader in audiovestibular medicine

Linda Maitland Luxon (b 1948; q St Thomas’ Hospital, London, 1972; CBE, FRCP), died from a brain tumour on 2 September 2023.

Linda Luxon, whose clinical practice and research in audiovestibular medicine came to define an emerging specialty, is widely remembered as a trailblazer for women in medicine. “Her influence was huge, across the world,” says consultant Doris-Eva Bamiou, a professor in neuroaudiology at the University College London (UCL) Ear Institute. “Linda developed the neuro-otology approach that we use in the UK and beyond, put together the curriculum for the specialty by spearheading the masters programme, and published extensively,” says Bamiou.

In a profession dominated by men, Luxon became the first female NHS consultant, aged 32, at the National Hospital for Neurology and Neurosurgery (NHNN), Queen Square, London, in 1980.

She was the Royal College of Physicians’ first and only female treasurer from 2010 to 2018 and both a trustee and first female honorary treasurer of the Royal Society of Medicine (RSM).

Her grace, natural warmth, and kindness in these and many other roles, combined with a “scintillating intelligence” were deeply felt by her patients, students, and colleagues, friends have told The BMJ.

“Dr Balance”

“We used to nickname her ‘Dr Balance’ not only because she was a world expert on balance but because she was very balanced in her approach to everything else,” says RSM president Roger Kirby.

Audiovestibular medicine was first recognised as a specialty in 1975. Luxon became synonymous with it as she worked to deepen understanding of disorders of the vestibular system in the inner ear, which controls balance and spatial orientation and is essential for normal movement and equilibrium. She sought to improve diagnosis and care of people with conditions such as hearing loss, tinnitus, hyperacusis, dizziness, vertigo, imbalance, and auditory processing difficulties.

Traditionally, ear problems were treated by ear, nose, and throat surgeons, and the prevailing climate in which Luxon operated known as otoneurology). The subspecialty combines study of the ear and its conditions with neurology dealing with the brain and nervous system.

Luxon’s work promoted the academic disciplines of both audiological and vestibular medicine and most notably the genetics of hearing loss and characterisation of vestibular disorders. She helped to set up a paediatric audiovestibular medicine service at Great Ormond Street Hospital.

She became professor of audiovestibular medicine at UCL in 1991, joined the UCL Ear Institute in 2008, and was founder of the Ear Institute’s masters programme in audiovestibular medicine and its director for many years.

Luxon helped to organise workshops in countries such as China, Nigeria, Poland, and Thailand for masters students.

She was the founding editor of Journal of Audiological Medicine, a keynote speaker at conferences around the world, author or co-author of more than 175 peer reviewed papers and 70 book chapters, and editor of nine medical books.

For the RSM, Luxon led work on sustainability, which included organising a discussion series highlighting health impacts of climate change.

Luxon served as president or chair of the British Association of Audiovestibular Physicians, the British Society of Audiology, the European Federation of Audiological Societies, the International Association of Audiovestibular Physicians, and the UK Health Alliance on Climate Change.

In the RCP she led the establishment of the specialist advisory committee and curriculum in audiovestibular medicine and also served as a regional specialty adviser before becoming treasurer and trustee.

She was also an adviser to the World Health Organization, the Hearing Aid Council, the Royal National Institute for the Deaf, the Industrial Injuries Advisory Council, and the Department of Health. She was appointed CBE for services to medicine in 2010.

Luxon died after a 20 month illness following a glioblastoma brain tumour. She leaves four children and seven grandchildren.

Cite this as: BMJ 2023;383:p2587

Matt Limb, Croydon
mattlimb.uk@gmail.com