this week

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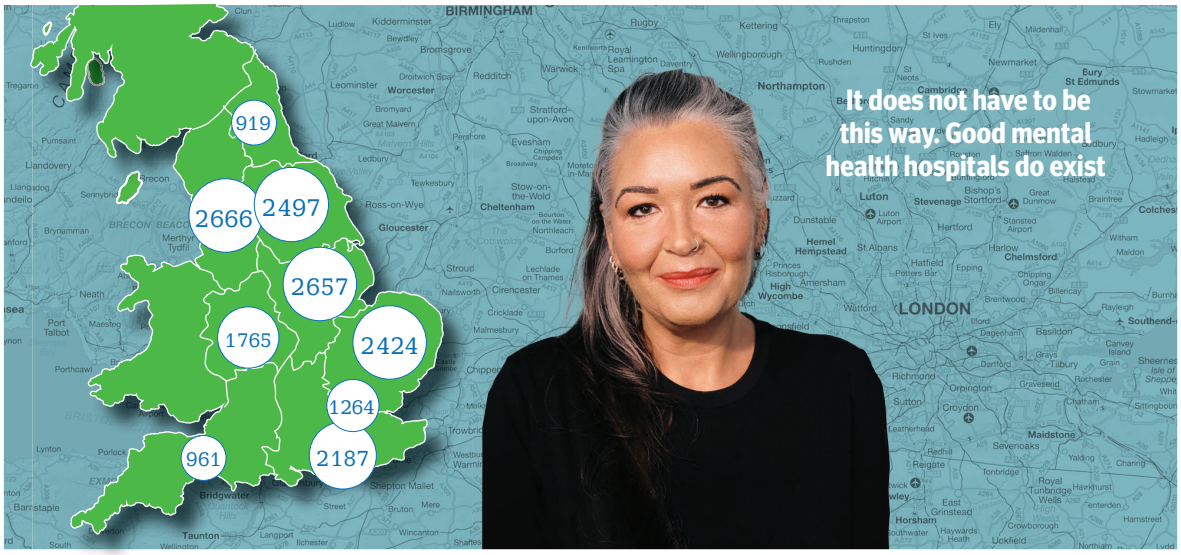


Figures reveal "scale of mental care crisis"

Mental healthcare staff across England reported a serious incident to the Care Quality Commission on average twice every hour in one year, an analysis has shown.

Between 1 April 2022 and 31 March 2023 17 340 serious incidents were reported to the regulator, an analysis of CQC data by the mental health charity Mind showed. Many involved people being treated for self-harm, eating disorders, and psychosis.

The vast majority (15 254) related to care provided in private settings, where many NHS patients receive care because of pressure on capacity. The remainder occurred in NHS community and residential settings.

Sarah Hughes, Mind's chief executive, said the "deeply worrying" figures highlighted the scale of the crisis in mental healthcare and urged ministers to prioritise investment and support to fix "a broken system."

Hughes said, "We knew this was a crisis—now we know the scale. Families are being let down by a system that's supposed to protect their loved ones when they are most sick. The consequences can be and have been fatal.

"Too many people are bearing the brunt of the crisis in mental health services. It is clear these failings are systemic. But it does not have to be this way. Good mental health hospitals do exist."

Incidents reported included:

- injuries to patients that caused probably long term sensory, movement, or brain damage or that physically damaged them
- Prolonged physical pain or psychological harm, or shortened life expectancy
- Abuse, including those involving police, and
- Injuries for which a patient needed treatment to prevent them dying.

The North West region of England had the highest number of reported incidents (2666), followed by the East Midlands (2657). Data show that around 17% of people accessing secondary mental health services in 2021-22 were seen by a non-NHS provider.

A Department of Health and Social Care spokesperson said, "Any death in mental healthcare is a tragedy, and we are clear people should expect high quality, safe services. That's why a series of national investigations into mental health inpatient care settings will soon be launched.

"We also commissioned an independent rapid review into how to improve the way data and evidence are used in mental health inpatient settings to identify risks to safety. We'll respond to this review in due course."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;383:p2348

Sarah Hughes, Mind's chief executive, said the number of reported serious incidents across the country showed systemic failures

LATEST ONLINE

- Northern Ireland: More than half of consultants want to cut their hours
- More than 200 new medical school places created in England for 2024
- US public health agency recommends prophylactic doxycycline to reduce STIs

SEVEN DAYS IN

Doctors should ask patients about gambling, draft guidance recommends

SHUTTERSTOCK

GPs should ask patients about gambling in the same way that they ask about smoking or consumption of alcohol and other substances, NICE has recommended. The draft guidance says there is evidence that alcohol and drug (particularly cocaine) addictions, mental health problems, violence or domestic abuse, engagement in crime, family history of gambling, and homelessness may indicate an increased likelihood of harmful gambling.

People taking certain medications or with neurological conditions may also be at an increased risk. Any of these factors should prompt GPs to ask the patient about their own or another person's harmful gambling, the guidance says.

Patients should be encouraged to complete a questionnaire on the NHS website, which is based on the problem gambling severity index (PGSI). A score of 8 or more indicates that the patient may need to seek support and treatment.

Other options include discussing whether the patient can use self-exclusion techniques to limit their gambling or methods that limit their access to money. Cognitive behavioural therapy is another option, and altrexone should be considered if psychological treatments have not worked. Consultation on the draft guidance closes on 15 November.

Jacqui Wise, Kent Cite this as: *BMJ* 2023;383:p2298

Tobacco control

England plans to raise legal age of purchase each year

The government tabled plans to raise the legal age for buying cigarettes in England by one year every year, so that children who turn 14 this year will never legally be sold a cigarette. Proposed legislation to create a "smoke-free generation," announced on 4 October by the prime minister, Rishi Sunak, will make it an offence for anyone born from 1 January 2009 to be sold tobacco products—effectively raising the legal smoking age by a year each year until it applies to the whole population.

Mental health

National emergency "needs to be reprioritised"

A continuing lack of resourcing for mental health services has left them overwhelmed, and other services such as A&E are left to cope with patients who cannot find other help, health leaders warned the NHS Confederation, which represents providers in England, Wales, and Northern Ireland. This leaves thousands of patients stranded in hospitals waiting for housing and social care packages, which delays treatment for patients with physical conditions. Leaders called for mental health to be reprioritised and for the implementation of the clinically led review of standards for mental health, which includes A&E related mental health targets.

Rotterdam shooting

Medical student is held over three deaths

A medical student was remanded in custody in the Netherlands after the fatal shooting of three people in Rotterdam on 28 September. The victims included Jurgen Damen, 43, a GP and teacher at Erasmus University Medical Centre. The suspect, named only as Fouad L, had previously shown "psychotic behaviour" and had a conviction for animal abuse, public prosecutors confirmed—information they had previously passed to Erasmus. On 4 October the court's examining magistrate ruled that the suspect would be held in custody for an additional 14 days, with the investigation ongoing.

Access to GPs

People in deprived areas use A&E more

People living in England's most deprived areas were 1.7 times as likely to have attended an emergency department last year as people in more affluent areas, and difficulty in accessing primary care services was a possible factor, found an analysis by the Office for National Statistics. Differences in underlying health only partly explained the differences in A&E department attendance seen from March 2021 to March 2022. Kamila Hawthorne (below), chair of the Royal College of General Practitioners, called for funding streams to be reviewed to enable more spending to be channelled into areas of greatest need.

Nobel prize

MRNA covid vaccine pioneers win award

Two biologists, Katalin Karikó and Drew Weissman, have been awarded the Nobel prize for biology or medicine "for their discoveries concerning nucleoside base modifications that enabled the development of effective mRNA vaccines against covid-19," the Nobel Assembly announced on 2 October. Their findings fundamentally changed the understanding of how mRNA interacts with the immune system and contributed to the unprecedented rate of vaccine development during the pandemic, it said. Karikó grew up in Hungary and met Weissman at the University of Pennsylvania in the 1990s, after which they worked together on potential applications of mRNA.

Preterm births

Incidence has changed little in a decade

An estimated 13.4 million babies were born before 37 full weeks of pregnancy in 2020, equal to around one in 10 live births and a reduction of just 0.14% since 2010, a study published in the *Lancet* found. Around 65% of preterm births in 2020 occurred in sub-Saharan Africa and southern Asia, where over 13% of babies were born preterm. The World Health Organization's Anshu Banerjee said that the findings showed an urgent need for investment in services for babies and their families and for more focus on "ensuring access to quality healthcare before and during every pregnancy."

MEDICINE

Labour conference

Plan to rescue NHS dentistry is unveiled

The Labour Party said that if it forms a government it will provide an extra 700 000 urgent dental appointments and reform the NHS dental contract, as part of measures to rescue NHS dentistry. It also pledged to introduce supervised toothbrushing in schools and to incentivise new dentists to work in underserved areas. New analysis of patient survey data indicates that 4.75 million people have been denied an appointment with an NHS dentist in the past two years. The £111m yearly cost of the plan will come from abolishing the "non-dom" tax status, said Labour.

Labour has pledged to spend £111m on NHS dentistry if elected

Party would tackle £2.6bn of covid related corruption

Labour also said it would create a "covid corruption" commissioner to help recoup billions of pounds lost during the pandemic through waste, fraud, and flawed contracts. The commissioner would have the power to bring together public agencies, including HMRC, the Serious Fraud Office, and the National Crime Agency, to pursue at least £2.6bn of the estimated £7.2bn in "lost" public funds. Rachel Reeves, shadow chancellor, said that just 2% of fraudulent covid grants had been recovered.

Lung cancer

Indoor wood burning raises risk in women

A US study reported that use of an indoor fireplace or wood stove increases women's risk of developing lung cancer, when compared with those who don't use wood heating, even among those who never smoked. More frequent use raised the risk, the research by the Sister Study, which assesses the health of 50 000 US women who had sisters with breast cancer, found. When compared with those without a wood stove, women who used wood heating for more than 30 days a year had an elevated rate of lung cancer.

Malaria

WHO recommends second vaccine for children

WHO has recommended a second malaria vaccine, R21/Matrix-M, for children, after a review found it to be safe and effective. WHO aims to reduce the half a million or more malaria related deaths every year, as supply of the other malaria vaccine, RTS,S, is limited. "This second vaccine holds real potential to close the huge demand-and-supply gap," said WHO's regional director for Africa, Matshidiso Moeti. The new vaccine was developed by Oxford University and the Serum Institute of India, using Novavax's adjuvant technology.

Obesity drugs

GLP-1 agonists are linked to adverse GI events

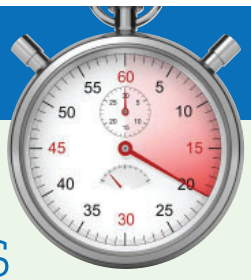
The use of GLP-1 agonists was associated with increased risk of pancreatitis (adjusted hazard ratio 9.09), bowel obstruction (4.22), and gastroparesis (3.67), but not biliary disease (1.50), when compared with bupropion-naltrexone, reported a research letter published in *JAMA*. "Given the wide use of these drugs, these adverse events, although rare, must be considered by patients," said the researchers.

Cite this as: *BMJ* 2023;383:p2335

CANCER

More than **2m** years of life are lost to cancer every year in the UK, but the average annual number of years of life lost has fallen by **15%** over the past 30 years

[British Journal of Cancer]



SIXTY SECONDS ON . . . LONG COLD

DON'T YOU MEAN LONG COVID?

No. It looks as though ongoing symptoms in the aftermath of an acute respiratory infection (ARI) may not be restricted to covid-19. Researchers have found that some people experience long term symptoms after infections such as colds, influenza, or pneumonia, just as they can after a bout of covid-19.

SHOULD I BE STOCKPILING TISSUES?

And other types of soft paper products perhaps, such as toilet paper. The team from Queen Mary University of London reported in *eClinical Medicine*, published by the *Lancet*, that some of the most common symptoms of "long cold" included coughing, stomach pain, and diarrhoea more than four weeks after the initial infection. But the experience of "brain fog" seems to be restricted to people who have had covid.

WHO TOOK PART IN THE STUDY?

The research, which was part of the Covidence UK study, involved more than 10 000 UK unvaccinated adults who filled out questionnaires about their symptoms between 21 January and 15 February 2021.

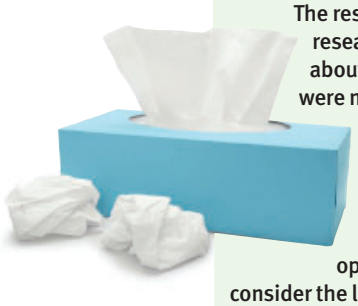
IS IT GOING VIRAL?

The team compared the prevalence and severity of long term symptoms after an episode of covid versus an episode of another ARI (in those who had a negative SARS-CoV-2 test). They found that 22% of people with covid-19 reported prolonged symptoms after infection, as did 22% of those who had a non-covid ARI.

WHY DO ONLY SOME PEOPLE GET IT?

It's snot clear. Researchers said severity of illness seems to be a key driver behind the risk of long term symptoms, but that more research is needed to understand why some people experience this and others do not.

DO SPREAD IT AROUND . . .



The researchers have said that more research and greater awareness about long term post-viral symptoms were needed—which is lucky as the study was widely reported in the media. Lead study author Giulia Vivaldi said, "As research into long covid continues, we need to take the opportunity to investigate and consider the lasting effects of other acute respiratory infections."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2023;383:p2336

Labour's pledge to cut waiting lists relies on "paying staff properly"

Labour's plan to clear England's NHS backlog could be in jeopardy if doctors' pay is not restored, the BMA has warned.

The party's leader, Keir Starmer, announced ahead of conference this week that a Labour government would commit an annual £1.1bn to provide two million more hospital appointments to tackle the waiting list of 7.7 million people in England.

The commitment would be funded by ending the non-domicile tax status for the richest people, Starmer said. It would rely on existing NHS staff, who would be paid overtime to work evening and weekend shifts.

Starmer told BBC's *Sunday with Laura Kuenssberg* television programme on 8 October that a plan to reduce waiting lists was "desperately needed" and insisted staff were receptive to it. He said, "We've seen examples of this working in different parts of the country. We have spoken to the staffing organisations across the board . . . They are up for this because they know bringing down the waiting lists will reduce the pressure on them in the long run. We need to do this."

The plan relies on staff taking on extra hours while the workforce is demoralised and burnt out from plugging gaps left by chronic shortages Sally Warren

Neighbouring hospitals would be encouraged to pool staff and use shared waiting lists to allow them to work more efficiently and make the best use of available capacity. Patients would be given the choice to travel to a nearby hospital for treatment in the evening or weekend, rather than wait longer. Funding will be allocated to local integrated care boards, which would set targets for increased activity to ensure return on investment.

In the longer term, Labour said, it would recruit more NHS staff but shorter term measures were needed to lower the waiting lists.

Additional funding would also be allocated to Scotland, Wales, and Northern Ireland to allow the devolved governments to bring down waiting times, with the total cost of the policy reaching £1.5bn.

Philip Banfield, chair of BMA council, said that most doctors already took on extra work and that "for far too long it has been our goodwill keeping the health service afloat." He added, "Paying doctors properly for overtime is not only the right thing to do but would be more cost effective than using the private sector or making extracontractual payments. While this

KEIR STARMER annouced that a Labour government would commit an annual £1.1bn to provide two million more hospital appointments a year to tackle waiting lists

COVID INQUIRY Ministers "abandoned" public health principles

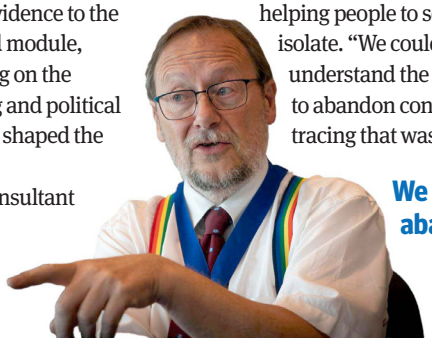
The government "lost control" of the covid pandemic in its early stages through poor testing infrastructure, a lack of public safety measures, and inadequate personal protective equipment, the BMA's chair of council has told the public inquiry.

Philip Banfield (below) said the lack of PPE and inadequate guidance on how to use it had contributed to the spread of covid in healthcare settings. He was giving evidence to the inquiry's second module, which is focusing on the decision making and political governance that shaped the UK's response.

Banfield, a consultant obstetrician and gynaecologist in North Wales who worked on wards throughout the pandemic, said, "People were treating patients either with no masks or with fluid resistant surgical masks, which don't protect from an airborne virus."

As covid emerged, Banfield said, the BMA was concerned the government seemed to be abandoning "basic public health protection measures" such as testing, contact tracing, and helping people to self-isolate. "We couldn't understand the decision to abandon contact tracing that was made on 11 or 12 March." Stopping contact tracing and waiting 11 days until enforcing a lockdown "had a huge consequence," because it led to more infections and greater pressure on the NHS.

He said the lack of testing capacity made it very hard to suppress the virus. Poor availability of PCR tests created NHS staff shortages as people isolated even if they weren't infected, he added. "In those early days . . . we were admitting patients to unsuitable areas with patients who hadn't got covid. So the chance of passing covid around a hospital was very high."



We couldn't understand the decision to abandon contact tracing Philip Banfield

Early in the pandemic, he said, public health colleagues highlighted the "risks of the disconnect between local health protection and NHS" and data didn't reach the front line of care because of separate systems.

Banfield also noted the pandemic's disproportionate effect on ethnic minority groups. He said, "People from an ethnic [minority] background are less likely to seek out and be upheld with their risk assessments, they are more likely to be posted to the front line and exposed to high risk cases. The recognition of that emerged across the pandemic, and it has been recognised by the NHS."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;383:p2320

move may very well incentivise further overtime, it is only once doctors receive restoration of lost relative value that we will be in a position to look at the impact that this extra overtime funding may have on waiting lists."

Julian Hartley, chief executive of NHS Providers, said extra funding to expand measures already in place at some innovative trusts was positive but that Labour's plan "needs to be part of a broader strategy that includes workforce growth and retention together with investment in infrastructure."

Workforce shortages

Sally Warren, director of policy at the King's Fund, said the plan had merits but relied on staff taking on extra hours at a time when the workforce was "demoralised and burnt out from plugging the gaps left by chronic workforce shortages and industrial action—goodwill and discretionary effort may prove to be in short supply."

Sarah Clarke, president of the Royal College of Physicians, welcomed the announcement but said, "The devil will be in the detail to ensure it is widely and fairly available to patients and that staff are able to work through lists in the most targeted and effective way."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;383:p2345

Police launch corporate manslaughter investigation into Letby's hospital

Cheshire Constabulary is investigating the Countess of Chester Hospital for corporate manslaughter after the conviction of the nurse Lucy Letby for the murders of seven babies.

Simon Blackwell, detective superintendent, said the investigation would focus on the indictment period of the charges for Letby from June 2015 to June 2016 and would "consider areas including senior leadership and decision making to determine whether any criminality has taken place."

During that period doctors raised concerns with management several times that Letby had been the only nurse on duty when babies collapsed on the neonatal unit, but managers resisted removing her from the unit.

Blackwell said the police were not investigating any individuals for gross negligence manslaughter "at this stage." He added, "The investigation is in the very early stages, and we are unable to go into any further details or answer specific questions at this time.

"We recognise that this investigation will have a significant impact on a number of different stakeholders, including the families in this case, and we are continuing to work alongside and support them during this process. You will be notified of any further updates in due course."

Difficult to prove

Corporate manslaughter is a difficult charge to prove. In 2016 the first case of corporate manslaughter against an NHS trust collapsed when the judge directed the jury to deliver a verdict of not guilty part of the way through the trial.

In that case, Maidstone and Tunbridge Wells NHS Trust was charged with manslaughter over the death of a teacher, Frances Cappuccini, who died from a cardiac arrest after an operation. The trust was said to be criminally liable for appointing doctors it knew or should have known lacked the training, qualifications, and competence for their roles, as well as failing to ensure that a specialty doctor in anaesthetics was supervised by a consultant.

We are continuing to work alongside families during this process
DSI Simon Blackwell

The judge said that, while there was evidence that the Maidstone and Tunbridge Wells trust had breached a duty of care, there was no evidence on which a jury could properly conclude that the breach was gross or that it had caused Cappuccini's death.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2023;383:p2299

SAS and locally employed doctors need support, says GMC

The rapidly growing number of specialist, associate specialist, and specialty (SAS) doctors and "locally employed" (LE) doctors need targeted support to make the most of their expertise, the GMC has said. These doctors are the fastest growing part of the medical workforce, rising by 40% in four years, said the regulator. This was largely driven by overseas doctors working in UK hospitals.

SAS doctors are specialty and specialist grade doctors with at least four years of postgraduate training, including two in a relevant specialty. LE doctors work in a range of specialties and are employed by a trust on a local contract, usually in a non-permanent post.

The GMC's report highlighted the doctors' vastly different experiences, depending on whether they graduated in the UK or abroad and on how long they had worked in the UK. The report was based on a 2022 survey of 919 SAS and LE doctors.

Charlie Massey, GMC chief executive, said, "We hope this paper will help healthcare systems consider how to address the diverse challenges these talented doctors face."

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2023;383:p2334

KEY FINDINGS OF THE GMC'S REPORT

SAS doctors

- A higher percentage of SAS doctors (63%) feel generally satisfied than other types of doctors (50%).
- More SAS doctors who qualified overseas than those who qualified in the UK are happy with their workload (44% versus 31%), but more of them often carry out work normally done by more junior doctors (29% versus 23%).
- Overseas qualified SAS doctors who are less established in UK practice need better access to development and learning opportunities. Overseas SAS doctors who have worked in the UK for longer say they want better recognition and support.
- Many UK qualified SAS doctors report routinely coping with heavy workloads.

LE doctors

- Overseas qualified LE doctors who are newer to UK practice take frequent leave related to stress (12% take it at least once a month, compared with 4% of UK qualified LE doctors who are newer).
- Overseas qualified LE doctors who have worked here longer need more development and learning opportunities and better support from colleagues.
- UK qualified LE doctors less established in UK practice report heavy workloads, difficulty providing patient care, and feeling less supported, which can mean they take steps to leave UK practice.

Evidence to support use of AI for lung cancer diagnosis is insufficient, says NICE

Watchdog says more research is needed into diagnostic artificial intelligence, reports **Jacqui Wise**

A ringfenced £21m fund for artificial intelligence diagnostics was announced by the Department of Health and Social Care in June. NHS trusts were invited to bid for funding to use the most promising AI tools, including those to analyse chest x ray pictures.

Making the announcement, the health secretary, Steve Barclay, said, "I'm focused on adopting the latest cutting edge technology across the health and care system to ensure we can continue to deliver the best care for patients and cut waiting times, which is one of the government's five priorities." The minister for science, innovation, and technology, Chloe Smith, described AI as a "game changer."

But on 28 September NICE rejected use of AI derived software to analyse chest x ray pictures for suspected lung cancer in adults referred from primary care, saying there was insufficient evidence to support it. NICE said that, although the technology "shows promise" and may help to reduce time to diagnosis and treatment, it should not be used for clinical decision making in the NHS until more evidence was available. Centres using AI derived software to review chest x ray pictures for adults referred from primary care may continue to do so but only under an appropriate evaluation framework and only alongside clinician review.

NICE's diagnostics advisory committee considered the evidence on 14 AI diagnostic tests for detecting and measuring nodules and other abnormalities in chest x ray images. The committee said it was concerned that the cost of the software, which includes a one-off set-up cost, may not be offset by cost and resource savings later in the pathway. It found there was no evidence to show how accurate software assisted clinician review would be at identifying lung abnormalities when compared with clinician review alone in people referred by their GP for chest radiography.

"Using this software could lead to lung cancer being missed or people having unnecessary scans, which can cause anxiety. This could also increase costs and overburden computed tomography services," the advisory committee said.

Arjun Nair, a consultant radiologist and honorary associate professor in respiratory medicine at University College London, said, "NHS England definitely wants to champion technology that has been robustly evaluated and shown to add value for both patients and clinicians and does not want to be seen to be lagging behind. But a balance needs to be struck between being a champion of innovation and ensuring that innovation has proved its worth."

KATERYNA KON / SPL

A balance needs to be struck between being a champion of innovation and ensuring that innovation has proved its worth
Arjun Nair

We need to make sure we can capitalise on the benefits of AI while making sure we are keeping patients safe
Katherine Halliday

Nair added that the NICE evaluation was timely. "It underlines how much further we have to go in tackling the latter point. They are right to be cautious." He pointed to new research that found that radiologists outperformed AI in identifying the presence or absence of three common lung diseases.

International research

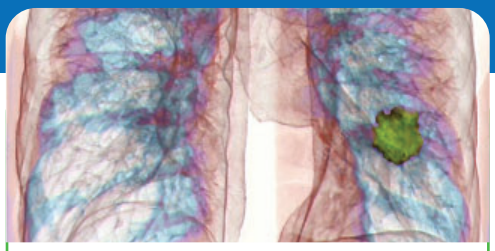
Researchers in Denmark compared the performance of four commercially available AI tools with a pool of 72 thoracic radiologists in interpreting 2040 adult chest x ray pictures.

The study found that the AI tools achieved moderate to high sensitivity rates ranging from 72% to 91% for airspace disease, 63% to 90% for pneumothorax, and 62% to 95% for pleural effusion. But they produced more false positive findings than radiology reports, and their performance worsened for smaller sized target findings and when many findings were present.

Nair said, "This shows how such technology can underdetect abnormalities compared with radiologists when four or more abnormalities are present on a chest x ray while at the same time 'crying wolf' and increasing the number of unimportant findings that a radiologist would dismiss. All of this costs money, time, and people—three things the NHS has in very short supply."

NICE called for more research on several outcomes, including the diagnostic accuracy of AI derived software, the risks and consequences of false results, and how using the software affected healthcare costs.

One of the concerns expressed by the committee was that the research supporting the use of AI tools came from retrospective rather than prospective studies. Evidence from prospective studies is starting to be



AI tools achieved moderate to high sensitivity rates ranging from 72% to 91% for airspace disease, 63% to 90% for pneumothorax, and 62% to 95% for pleural effusion

gathered. For example, University College London Hospitals recently announced a study to evaluate the AI tool qXr. The Lung Impact trial will evaluate whether the tool can help flag which patients would benefit from an urgent scan review by a reporting radiographer and bring down diagnosis times.

Unmet need

GPs in England request around two million chest radiographs every year, and NICE acknowledges there is an unmet need for quicker reporting. Long waits for x ray reports to be returned to a GP can increase the time to a computed tomography scan for diagnosis and treatment. Factors leading to this delay include a backlog of x ray pictures needing review and not enough radiologists and reporting radiographers.

Katharine Halliday, president of the Royal College of Radiologists, said, "With a 29% shortfall in radiologists, anything that helps free up time for a workforce under huge strain should be embraced. Patient safety is paramount, however, and NICE is correct to show caution. We need to make sure we can capitalise on AI while making sure we keep patients safe. In this instance there is insufficient evidence to support the software's implementation, but NICE has clearly highlighted what we need to collect."

Halliday said the college was committed to working closely with NICE and the NHS AI Laboratory to gather the evidence as rapidly as possible. "We must be proactive in making the most of the opportunities AI has to offer, while protecting patients and not wasting resources on unhelpful technologies."

Jacqui Wise, Kent

Cite this as: *BMJ* 2023;383:p2284

Chloe Smith, minister for science, innovation, and technology, described AI as a game changer

Trust in legal battle with woman over her treatment can be named

University Hospitals Birmingham NHS Foundation Trust has been named as the trust that cared for a 19 year old woman at the centre of a court battle over her treatment.

A High Court judge has lifted an order banning the naming of the trust that had wanted to offer only palliative care to Sudiksha Thirumalesh but ruled that clinicians who looked after her may not be named until November, after a "cooling-off period."

Mr Justice Peel ruled that any expert witnesses in the case could be identified immediately, but the clinicians who cared for her in intensive care for a year may not be named until eight weeks after her death on 12 September.

Thirumalesh, who had mitochondrial depletion syndrome, wanted to go to Canada or the US to take part in one of three trials of experimental nucleoside treatment. Her parents wanted to be able to name her and crowdfund for the trip and the treatment, but doctors insisted that she was "actively dying," and she died before the court could consider whether going abroad for the treatment or having palliative care only would be in her best interests.

Transparency order

Her parents and brother applied for the transparency order to be lifted. Peel said they wished to publicise their concerns about how the case was handled by the NHS and the court system. "They wish to identify individuals who they believe made errors during Sudishka's treatment," he said.

"They refer to what they term an error during a peripherally inserted central catheter line insertion on 22 October 2022, and a second incident in May 2023 when a doctor used what they say was a tube of the wrong size when replacing [Sukishka's] tracheostomy. They intend to explore a clinical negligence claim and have, I understand, made a formal complaint to the General Medical Council about one clinician."

Staff are concerned release of videos may lead to adverse public reaction
Justice Peel

Mrs Justice Roberts made a preliminary ruling in August that the teenager lacked the ability to make her own decisions about treatment because she was unwilling to accept her medical prognosis or accept that what doctors were telling her was correct. She believed that her deterioration was caused by long covid, not by the progression of her illness, as doctors told her, and insisted, "I want to die trying to live."

She and her parents were investigating three trials of nucleoside treatment, two in the US and one in Canada. But lawyers for the trust said that she had not yet been accepted on to any of the trials. A neurologist told the court that the prospects of her receiving nucleoside treatment or receiving any benefit from it if she did were "vanishingly small."

Interest to cool off

The trust supported the eight week delay in naming clinicians, to allow renewed media and public interest from the publication of the family's identity to cool off. Outlining the trust's arguments, Peel said, "The parents made numerous complaints, which staff felt were unjustified. They 'harassed' nurses and tried to interfere with care. The parents recorded a number of videos on mobile phones of staff working with Sudiksha, and staff are concerned that such videos may be released and might lead to adverse public reaction directed towards them."

In cases involving disputes over treatment at the end of life in the care of two children, Zainab Abbasi and Isaiah Haastrup, the High Court made indefinite orders banning the identification of clinicians, and the president of the court's family division later dismissed applications to lift the orders after the children had died. The Court of Appeal lifted the orders last March, ruling that the parents had the right to "tell their story" and that indefinite anonymity orders "will be very much the exception rather than the norm." That decision is being appealed to the UK Supreme Court.

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2023;383:p2279

THE BIG PICTURE

Thousands killed in Afghanistan quake

The death toll from a series of earthquakes close to Herat in western Afghanistan has risen to more than 2000 people, the Taliban government has reported.

aThe region's only hospital was overwhelmed, with injured people arriving from across Herat and nearby provinces. It has been reported that the Taliban has appealed for female doctors, previously banned from practising, to return to the hospital.

Médecins Sans Frontières has set up five tents within the hospital compound to accommodate up to 80 patients. But as the rescue continues international agencies fear there will be more loss of life and the spread of infectious diseases through unsanitary and overcrowded makeshift shelters.

Alison Shepherd, *The BMJ*

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AIMAL ZAHIR/XINHUA/ EBRAHIM NOROOZI/AP/ALAMY

WORKFORCE

Strikes: what will it take to end the pay dispute?

The headlines are about salaries, but pay review reform, recognition of doctors' value, and trust between them and ministers are key to de-escalating the joint action, writes **Ingrid Torjesen**

Last month junior doctors and consultants in England took joint strike action for the first time. They stood shoulder to shoulder in front of their hospitals with a shared sense of purpose, discussing what exactly it would take to end the strikes. The answer for both groups: something akin to the junior doctors' deal in Scotland.

Last week, the joint strikes were back, and the BMA issued a formal invitation to ministers to talks facilitated by the Advisory, Conciliation and Arbitration Service (ACAS). So what will need to be on the table to move things forward and end the disputes—for consultants and juniors?

The Scotland deal includes an above inflation pay rise for 2023-24 (12.4%) plus a commitment to work towards pay restoration and reforming the pay review process: exactly what Vishal Sharma, chair of the BMA consultants committee, outlined in a previous letter to the prime minister, Rishi Sunak, and the secretary of state for health and social care, Steve Barclay, two days before the joint strike on 20 September.

The BMA said in that first letter that it was "willing to consider investment in non-headline pay areas, to help reach agreement." This would mean negotiating on areas outside of basic pay such as out-of-hours rates, pay scales, or prioritising investment towards specific pressure points such as acute and emergency care. The letter makes it clear that "constructive conversations" have taken place with "officials," but that a firm offer that the BMA can put to members is needed before consultants' strike action can be halted.

The pay review system is a completely broken process
Vishal Sharma

Sharma reiterated this position on 3 October, addressing a rally of striking doctors outside the Conservative Party conference. "We have…given the government four weeks from today to enter formal talks and present us with a credible offer," he said.

Press coverage suggested that, with the Retail Price Index averaging 11.4%, an offer of around 12% for consultants in England for 2023-24 would be sufficient to end the dispute. This was frustrating for doctors on the picket line, says Tom Dolphin of the BMA consultants committee, who visited them at UCL and Charing Cross Hospitals in London on 20 September, "because the key thing is the end point: pay restoration and the mechanism to getting to it."

According to Sharma's first letter, this means restoring the independence of the Review Body on Doctors' and Dentists' Remuneration (DDRB) in line with its founding principles; the DDRB assessing what a consultant should be paid; and the recommendations being implemented.

Reform of the DDRB process

The DDRB worked well until recent years, Sharma tells *The BMJ*, but now "it's a completely broken process" and the reason why consultants' pay has fallen by more than a third (34.9%) in real terms since 2008.

The DDRB was established, after a Royal Commission report in 1960 prompted by a pay dispute, "to take all the politics out" of negotiations on pay and conditions and provide independent recommendations, says Sharma.

The commission set out three areas that the review body should consider: "cost of living, the movement of earnings in other professions, and the quality and quantity of recruitment in all professions" to ensure that people continued to be attracted to medicine. It also noted that pay should not be restrained to reduce public spending or for fear other professions might make similar demands and that doctors

The mood on the picket lines is a mixture of defiance and resignation
Tom Dolphin (above)

"must have some confidence that their remuneration will be settled on a just basis."

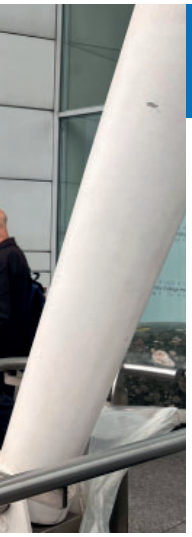
Sharma complains about the government having changed the terms of reference to say that the DDRB must consider the government's inflation targets and departmental expenditure limits and its unilateral appointment of DDRB members. The BMA has continued to make representations to the DDRB about doctors' falling pay, but the government has "capped" the recommendations in seven of the past 13 years through public sector pay freezes or caps that limited what the DDRB could recommend.

"That's why it's our primary ask to restore that process to the way it should be, so that it's completely independent and it only looks at those three things. The DDRB then gives a recommendation; if the government thinks it can't afford it, that's for the government to say, but at least it's transparent. Then ask the pay review body to say: what should a doctor, particularly a consultant, now be paid, what are they paid currently, and how do we bridge that over time? And similarly, for this year, while that's happening, don't give us a real terms pay cut."

Earlier in the year, there were "constructive" talks on the pay award and reform of the pay review body. A deal was quite close but wasn't achieved before the ballot that led to consultant strike action.

"We've tried to keep talks going, we've written to the secretary of state repeatedly to say we need to talk about pay," Sharma says. "And the reply that comes back is, 'We will not talk about pay.'"

Before Sharma's second letter, a spokesperson for the Department of Health and Social Care reiterated that position: "As the prime minister has said, this pay award is final…The health and social care secretary is clear his door is open to discuss non-pay issues if the BMA call an end to this damaging disruption." In response



We are tired of false promises and weak excuses Oba Babs-Osibodu (right) and Peter Fahey

to the 3 October letter, the spokesperson added: "We have repeatedly urged the BMA to put patients first by ending their hugely disruptive strikes immediately. We're giving doctors a fair and reasonable pay rise."

Valuing doctors

At a headline level the disputes are about pay rises, but in reality they are about the impact of pay erosion. Juniors who are paid "incredibly poorly for the work they do" are "really struggling to make ends meet," Sharma says. For consultants on higher salaries, it is more about not feeling valued, working conditions, and the wider effects that loss of pay is having on recruitment and retention.

Consultant anaesthetist Rachel Henley spoke to many colleagues on the picket line outside Royal Derby Hospital during the joint strike, and they all shared a similar view: "We've got to promote the value of being a doctor in the NHS. If we don't do it now, then the care for patients in the future is going to be so much worse." In the past few months, three or four consultants in Henley's department have moved overseas or to less pressurised roles in smaller trusts for a better quality of life.

And it is the juniors leaving that really worries Sharma, because they are the consultants of the future. A study of more than 10 000 medical students published in *BMJ Open* found that one in three plan to leave the NHS within two years of graduating to work abroad or in other sectors.

A decade ago, an advertisement for a consultant's post vacancy in Sharma's department would have attracted 10 plus applicants, he says, but now some go unfilled. The most recent Royal College of Physicians Census of UK Physicians in 2022 found that 58% of departments had at least one consultant vacancy (the average was 2.2) and that 81% reported that an advertised consultant post in their department had not been filled. Data from NHS Digital show that, as of June 2023, there were 10 855 vacant doctors' posts in hospitals.

Shattered trust

More hospital doctors could walk out across the UK as winter sets in, as so far only junior doctors in Scotland have agreed a pay deal. Consultants, juniors, and specialists, associate specialists, and specialty (SAS) doctors are set to be balloted on industrial action in Wales. In Northern Ireland, junior doctors and consultants are being balloted on industrial action, and an indicative ballot is being held for SAS doctors. An indicative ballot of SAS doctors in England ends on 16 October. Those on 2021 contracts are locked into a multiyear deal so have been excluded from DDRB recommendations for the past two years while inflation rates have soared.

Consultants and juniors in Wales have been offered a 5% pay rise—below the DDRB recommendation—despite a commitment last year from the Welsh government to work towards pay restoration. Oba Babs-Osibodu and Peter Fahey, co-chairs of the BMA's Welsh junior doctor committee, brand the pay offer "insulting" and say that it has "shattered the trust of hardworking junior doctors in Wales." They add: "We are tired of false promises and weak excuses. It is now clear that these negotiations were not conducted in good faith from the beginning."

Ali Nazir, chair of the BMA's Welsh SAS committee, says that the sub-inflationary rise in pay for all SAS doctors in Wales "was a huge blow" and "demeans our value and the care we give to our patients."

Doctors in Northern Ireland have not been offered a rise for 2023-24—not even that recommended by the DDRB. David Farren, Northern Ireland consultants committee chair, says, "Northern Ireland is not even paying the 5-6% uplift that colleagues in the rest of the UK are getting, despite their ongoing disputes. We have been told that any money that did become available would instead be used to address a budget deficit not of our making." In Scotland, talks with consultants and SAS doctors are still ongoing.

Chris Smith, chair of BMA Scotland's junior doctor committee, says that the Scottish government had been "open to negotiations, even when strike dates had been announced," which "definitely helped to foster an environment where we achieved an offer that we could eventually recommend to members." He says, "The fact the UK government has been unwilling to do that is a clear and damaging choice, which is costing the taxpayer money that would be better used actually paying doctors fairly and dealing with the urgent need for pay restoration."

The UK government made a clear and damaging choice not to be open to negotiations Chris Smith (above)

Doctors' trust, particularly in England and Wales, will be a big issue if deals are brokered—because pay restoration and reform of the DDRB will take several years. "We've been let down many times in the past by government saying one thing and then doing another. If we get to an agreement, it needs to be a credible offer that's fully worked out with assurances that we can put to our members; it can't just be kind of a vague promise," Sharma says. "We've seen those vague promises broken not just in England but in Wales last year."

The mood on the picket lines during the joint consultants and juniors strike in England on 20 September was a "mixture of defiance and resignation," says Dolphin. The government shouldn't underestimate doctors' resilience, he says. "When it comes to doing things that are unpleasant and physically difficult, and onerous, for long periods of time, it's going to be doctors that are good at that."

Sharma said on 3 October that, if no credible offer is forthcoming within four weeks, consultants in England will announce further strike dates. "The ball is well and truly in the prime minister's court. The government has run out of excuses not to negotiate in good faith. But they need to know that, if they fail to negotiate, we are not going anywhere."

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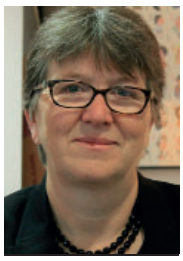
FEATURE

“Loopholes” in UK’s draft surrogacy law leave children and surrogates at risk

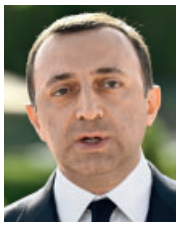
New UK legislation aims to support non-commercial domestic surrogacy to disincentivise commercial overseas arrangements that might exploit women. But with no international convention likely, does this effort to stem the opaque global trade go far enough, **Sally Howard** asks

By spring Georgia’s surrogacy industry had grown to be worth an estimated $200m—but then it became the latest nation to announce a ban on overseas surrogacy arrangements. Irakli Gharibashvili, the right wing populist prime minister, cited reservations about the “direct order” nature of the industry and ideological issues around same sex couples commissioning surrogate birth—“intended parents,” as they are known in the industry.

On social media, intended parents responded to the news of Georgia’s ban, which will take effect from January 2024, with disbelief, some seeking advice for shipping their gametes or embryos (eggs already fertilised in Georgian clinics) from Georgia to alternative and rising in popularity “surrogacy friendly” destinations, such as Colombia, Cyprus, Kazakhstan, Laos, and Mexico. “The industry is like a balloon that you squeeze in one country, and it pops up elsewhere,” says Susan Bewley, emeritus professor of obstetrics and women’s health at King’s College London and a vocal critic of “the easy way women’s bodies are bought and sold” through the commercial surrogacy industry.



The industry is like a balloon, you squeeze in one country, and it pops up elsewhere
Susan Bewley



Irakli Gharibashvili, PM of Georgia, which has banned overseas surrogacy

From the first legal commercial surrogacy contract, drafted in the United States in 1978, the global industry grew to an estimated $14bn in 2022. By 2032 that figure is forecast to rise to $129bn. The number of parental orders granted each year in the UK grew from 117 in 2011 to 413 in 2020. Yet the number of countries banning commercial surrogacy, like Georgia, is increasing (box 1). The UK, meanwhile, is applying more carrot than stick, with the Surrogacy (Regulation) Act 2023, published as a draft bill in March, aiming to encourage non-commercial domestic surrogacy arrangements—rather than those “in countries where there is a particular risk of the exploitation of women.” It has been welcomed for providing clarification and criticised for not going far enough. So where does this shifting landscape leave doctors, parents, surrogates, and children in the UK and elsewhere?

Opponents, proponents, and a new law

The 2023 bill was drafted after a consultation with organisations and individuals who endorse or oppose the practice of commercial surrogacy. Opponents say that the practice exploits women who lack economic opportunities, that surrogates and egg donors are at risk of coercion, that there are health risks to surrogates (box 2), and that there are poor data on the long term effects on children born to surrogates who might not know their genetic origins. These risks can be amplified in the shifting contexts of global surrogacy arrangements, through which there

Box 1 | Commercial surrogacy bans around the world

SIMONA GRANATI/CORBIS/GETTY IMAGES

A protest in Italy, which banned commercial surragacy in 2014

Georgia’s ban on commercial surrogacy follows similar bans in former surrogacy tourism hotspots.

India banned commercial surrogacy in 2018, citing concerns over the commodification of children, exploitation of surrogates, and legal issues.

Thailand banned foreign parents in 2015, after a public outcry around exploitation of surrogate mothers and the abandonment of children born through surrogacy, and Nepal banned surrogacy services in 2015, on the basis that the practice “exploits” the bodies of poor women.

In Ukraine—which was Europe’s leading surrogacy tourism destination until the outbreak of war, with an industry worth an estimated $2.5bn in 2021—the government has announced plans to pause medical fertility procedures for non-Ukrainians until three years after the conclusion of war, based on reports of difficulties getting children born by surrogacy out of the country.

Italy, which banned commercial surrogacy in 2004, has a bill under discussion to punish people who go abroad to seek out surrogacy arrangements with jail terms of up to two years and fines of up to €1m, the first such bill to criminalise intended parents.

This step is widely considered to be an attempt to deter same sex couples from becoming parents on ideological grounds, with Italian public prosecutors also seeking to remove the names of “non-genetic” parents from children’s birth certificates.

Box 2 | The health risks of surrogacy

For surrogate mothers, the health risks of carrying a surrogate child are similar to those of any pregnancy: miscarriage, preterm birth, gestational diabetes, high blood pressure, and pre-eclampsia (a serious condition that can lead to stroke, seizures, and death). Several of these risks are amplified.

A 2013 study found that Indian surrogate mothers are more likely to experience complications during pregnancy and childbirth including pre-eclampsia and eclampsia, urinary tract infections, stress incontinence, haemorrhoids, gestational diabetes, life threatening haemorrhage and pulmonary embolism, with a 2023 study finding that donated embryo pregnancies are associated with a raised risk of hypertensive disorders even for young surrogates.

Many jurisdictions permit the practice of transferring multiple embryos, which carries with it increased risks of preterm birth, stillbirth, and complications for the surrogate such as high blood pressure, gestational diabetes, and postpartum haemorrhage.

Studies by Zaina Mahmoud (right) at Birmingham University point to a rise in obstetric problems in countries where commercial surrogacy industries bloom. People in Georgia, meanwhile, complain that medical tourism, including reproductive, has driven up the cost of healthcare in the country, which operates on a public-private basis.

is also a risk that babies will be left "in stateless limbo." Opponents also argue that infertile couples, gay couples, and individuals can pursue other routes to family creation, such as adoption.

In 2015 the European Parliament similarly described surrogacy as "reproductive exploitation" that "undermines the human dignity" of women. A commission charged with advising the Swedish government on surrogacy in 2022 stated that it was "impossible to be sure a surrogate has made a truly uncoerced decision."

Proponents of commercial surrogacy argue that it allows infertile couples and individuals to have children and that surrogacy is "work" that deserves to be remunerated (rather than altruistic). They say that the practice is a route out of poverty for surrogate mothers and that there is little evidence of regret or poor mental health outcomes among former surrogates or in children born by surrogacy who are aware of their origins. They add that it carries low risks to surrogates' health if the birth occurs in a country with robust medical infrastructure. Groups who campaign for liberalised surrogacy laws argue that criminalisation of the practice promotes the activities of unscrupulous providers who take advantage of both surrogates and intended parents who are desperate to have a family.

The Surrogacy (Regulation) Act 2023 seeks to encourage non-commercial domestic surrogacy arrangements by: creating a new regulatory pathway for surrogacy overseen by non-profit regulated surrogacy organisations and the Human Fertilisation and Embryology Authority; allowing intended parents to become parents of the child from birth rather than waiting for a court parental order; banning commercial surrogacy (except for reasonable expenses incurred); and introducing a surrogacy register that will allow surrogate children to trace their birth origins later in life. The new bill updates the 1985 Surrogacy Arrangements Act, which did not ensure a pathway for intended parents' parenthood.

The updated act also lifts the prohibition against advertising surrogacy in the UK. One of the more nuanced points is to continue to allow parental orders to be issued to intended parents of children born overseas without punitive measures for those who do not supply information of origin for these children.

Solicitors working in family law have welcomed the clarification that the act provides, as have intended parent interest groups and the Progress Educational Trust, a charity for people affected by infertility or genetic conditions. Yet many commentators think that this legislation will do little to tame the behemoth global trade of commercial surrogacy.

Loopholes, incentives, and risks

"There's an obvious loophole here [in the 2023 act]," says Katherine Wade, who teaches medical law, bioethics, and family law at the University of Leicester. "On one hand it [the act] rightly notes that children should have the right to know their origins, but on the other it provides a legal 'back door' for children born of obscure

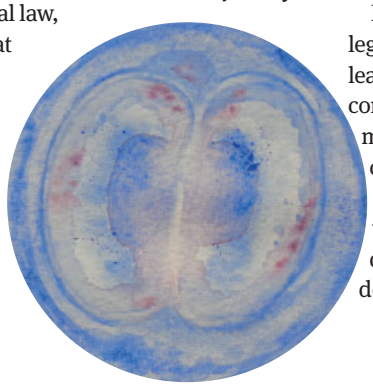
Children should have the right to know their origins
Katherine Wade

arrangements." (Wade was the principal investigator for the report *Children's Voices in Surrogacy Law*, which found that children born of surrogate arrangements in the UK had a more "functional" view of biological parenthood than non-surrogate counterparts.)

Wade says that some parents might prefer their children's origin to be obscured from others and the children themselves, and for this reason intended parents might prefer overseas arrangements. A 2019 survey by the Surrogacy UK charity found that the average waiting time for altruistic surrogacy in the UK was 3.5 years and that 40% of intended parents had been waiting for more than five years to find a surrogate, which might also be a "nudge" towards overseas commercial operations that promise "guaranteed baby programmes" with shorter timeframes.

Zaina Mahmoud studies the legal implications of international surrogacy arrangements at the University of Birmingham. She thinks that the new UK legislation risks a two tier system of children born of highly regulated and transparent surrogacy arrangements in the UK and, conversely, those born of overseas commercial surrogacy arrangements with little safeguarding of surrogates and where babies' genetic origins might be obscure.

Bewley adds that complex legal claims over a fetus can also lead to problems when there are complications that might lead to medical harms or in which parental claims trump surrogates' health. "Who makes the decision to abort when a child has severe birth defects, and how quickly is this decided, for example?" she asks.



Intended parents from outside Georgia are worried about how to transport fertilised eggs out of the country when its ban comes into effect in January

Globalisation and fragmentation

"What we are seeing in this huge global industry is increased fragmentation and opacity," says Mahmoud. "You have businesses operating out of [the Czech Republic] that use clinics in Georgia with Spanish eggs and Albanian surrogates, for example. Then you delve further and find the surrogacy agency is actually headquartered in Miami." Such fragmentation, Mahmoud adds, makes it difficult to track the provenance of gametes and to guarantee the welfare of surrogates.

Preventing exploitation of surrogates in such a shifting and globalised context, Mahmoud says, is difficult. "'Repro entrepreneurs' who run surrogacy agencies, most of whom are not medical professionals, will simply move to countries with lighter legislation."

Tessa Katz, a London based locum GP, says that British medical professionals should have concerns about the global boom in commercial surrogacy. "My concern is for the human rights of surrogates recruited internationally, where standards of antenatal care might be lacking, and free choice, particularly of socioeconomically deprived surrogates, is also likely to be lacking," Katz says. "As a GP I'm not sure I can support a situation, should a patient say they wished to do this, which is potentially damaging the mental and physical health of someone else."

A global legal approach?

In March 2018, the UN High Commissioner for Human Rights recommended that member states adopt clear and comprehensive legislation that prohibits the sale of children and create safeguards in the context of commercial surrogacy. This should include either the prohibition of commercial surrogacy until and unless properly regulated systems are put in place or strict regulation of commercial surrogacy.

So far, attempts to establish a global convention around surrogacy have come to nought. The Hague Conference on Private International Law first convened to discuss surrogacy in 2010, before establishing an experts' group in 2015 to further study the private international law issues around surrogacy. It established a working group in 2023 to review private international law matters related to legal parentage generally, including legal parentage resulting from international surrogacy arrangements.

Wade thinks that a global agreement is impossible. "To do this [establish a convention], signatory countries would have to agree that surrogacy is permissible, when many countries ban it outright." Failing an international convention, Mahmoud would like to see an acknowledgment of "trusted" commercial surrogacy destinations in UK law, including Canada and some US states, which have high quality healthcare, genetic origin safeguards, and safeguarding practices for surrogates. The average cost of surrogacy is about $100 000 (£80 000) in the US and C$85 000 (£50 000) in Canada, compared with $60 000 in Georgia, $90 000 in Cyprus (a popular surrogacy tourism destination where gay and single intended parents are allowed to seek commercial surrogacy), and $50 000 in Laos and in Mexico.

"There is clearly a need for international surrogacy law reform to highlight those destinations with excellent trodden pathways around the welfare of the surrogate (and egg donors) and any child born," says Michael Johnson-Ellis, a gay parent of two children born by surrogacy in the UK and founder of My Surrogacy Journey, an agency for gay parents that consulted on the draft law. It takes a liberal position on surrogacy.

Bewley fears that the UK's Surrogacy (Regulation) Act 2023, conversely to the UN position, prioritises prospective parents' interests, privileging a "happy family formation" trope promulgated by intended parent activists and commercial surrogacy agencies. "We shouldn't ignore the risk in creating a global child production line in the name of some parents' 'fertility rights,'" Bewley says, adding that some voices in the debate are too quiet.

"We rarely hear from surrogates in poor countries, and we can't hear the voices of overseas surrogate born children—mind you, they will have plenty to say in 20 years' time."

A SURROGATE'S STORY—VIKTORIA (UKRAINE)

"I don't like it when people say that I am being exploited or that my body is being treated like a machine. The way I see it, it is just a way of working with your body and no different to being a dancer or a gymnast. I have carried two babies, one for a couple in China and the other for a German couple: the first in 2019 and the last one in 2022 [overlapping with the outbreak of war], and both were natural births. I have three of my own children. For each of [the surrogate] pregnancies I got $20 000, and this helped my family and gave us the money to move from Melitopol [a city under Russian siege], so in this way I think it saved us. I would do it again [carry a baby for an overseas intended parent], but not until the war is over as I don't want to move across [Russian] checkpoints from a city where I am safe."

Attempts to establish a global convention around surrogacy have come to nought

Women demonstrate against commercial surrogacy in Mexico City last February

GERARDO VIEYRA/NURPHOTO/ALAMY

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