this week

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PAs should not diagnose, says BMA

Physician associates must be barred from making diagnoses or from claiming to be "one of the medical team" without stating their job title, says new BMA guidance.

The national guidance is the first document to clarify suitable tasks for medical associate professionals (MAPs), including physician and anaesthesia associates, and the tasks that they should never carry out under any circumstances.

The guidance was written "by doctors for doctors, to address the uncertainty caused by the lack of a defined safe scope of practice and for patients who we know are confused by these roles," said Phil Banfield, BMA chair of council, at its launch.

The guidelines recommend that associates' work be defined by a traffic light system: green for a task they can do alone, amber for when they need supervision, and red for tasks they never do under any circumstances. Red light tasks include referring patients for procedures, making initial assessments of "undifferentiated" patients, and prescribing. PAs must make it clear to patients they are not doctors and should not be on doctors' rotas.

Banfield said the guidance was needed because of the government's "clear intent to expand the numbers of MAPs in the medical workforce without clarity on the scope of their skills and responsibilities." Patient safety concerns have "dramatically increased" with the rise in numbers of MAPs, he said.

In October 2022 Emily Chesterton, 30, died from a blood clot three weeks after a PA dismissed her symptoms as a sprain and prescribed propranolol for anxiety. Welcoming the new BMA guidance, her mother, Marion Chesterton, said her daughter would still be alive if the BMA's "efficient and clear" guidance had been in use.

Last month the House of Lords heard of a further 70 instances of avoidable harm to patients and near misses caused by MAPs.

The BMA urged medical royal colleges to adopt the framework as the basis for their MAP practice guidelines. Fiona Donald, president of the Royal College of Anaesthetists, told *The BMJ* it will include the guidance in its consultation on developing a scope of practice for anaesthesia associates.

But Sarah Clarke, president of the Royal College of Physicians, expressed concern that the new guidance could result in multiple guidelines, causing confusion. "The college was offered no involvement in shaping the BMA document even though we represent many of the specialties covered," she said.

Jane Feinmann, London

Cite this as: *BMJ* 2024;384:q589

Phil Banfield, chair of council, hopes the BMA's traffic light system to define the roles and responsibilities of associates will be quickly implemented

LATEST ONLINE

- Plans for same day GP access hubs in London are scrapped after concerns
- Biden vows to protect reproductive rights and lower drug prices in state of the union speech
- NHS handed £6bn funding boost in spring budget

SEVEN DAYS IN

More than one in 10 NHS England staff report sexual harassment at work

SEE LI/PICTURE CAPITAL / ALAMY

Some 13% of NHS staff in England were sexually harassed while at work last year, the annual staff survey has reported. For the first time the survey asked employees if they had been the target of unwanted sexual behaviour from patients, members of the public, or colleagues. The inclusion of the questions came after a joint *BMJ* and *Guardian* investigation last year revealed a huge number of sexual safety incidents reported to NHS trusts in England and a lack of dedicated policies at many trusts for dealing with sexual assault and harassment.

Of more than 670 000 staff who responded to the new question, 9% said they had been the target of at least one incident of unwanted behaviour of a sexual nature in the workplace from patients in the past 12 months. The highest responses were from ambulance staff: 23% said that they had experienced such behaviour, which included offensive or inappropriate sexual conversation, including jokes, touching, or assault. Overall, 4% of NHS staff said that they had been the target of such behaviour from staff or colleagues.

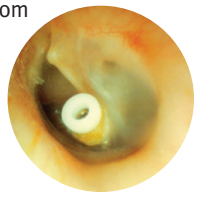
Emma Runswick (left), deputy chair of BMA council, said the results were "deeply troubling and utterly unacceptable, underscoring the urgent need to incorporate third party harassment into any measures aimed at safeguarding staff from sexual harassment."

Jacqui Wise, Kent **Cite this as: *BMJ* 2024;384:q590**

Artifical intelligence

App may help diagnose otitis media in children

A smartphone app that uses artificial intelligence (AI) to help accurately diagnose acute otitis media could reduce unnecessary antibiotic use in young children, a study in *JAMA Pediatrics* found. US researchers developed two AI models to analyse a few seconds of video taken from an otoscope connected to a phone camera to detect acute otitis media by assessing features of the eardrum, including its shape, position, colour, and translucence. Bulging of the eardrum was most closely aligned with the predicted diagnosis and was present in all acute otitis media cases in the test videos.



HIV

Resistance to antiretroviral drugs rises, surveys show

The World Health Organization has reported a "worrying" increase in resistance to the first line HIV antiretroviral drug dolutegravir. Surveys conducted in Malawi, Uganda, and Ukraine found that levels of resistance among people receiving dolutegravir based antiretroviral treatment with viral non-suppression ranged from 3.9% to 8.6%. Previous clinical trial data suggested a resistance level of below 3%. Resistance reached 19.6% among treatment experienced people who had begun taking dolutegravir while having high HIV viral loads, in a survey in Mozambique.

Physician associates

GMC announces "A" prefix for physician associates

The prefix A will be used in GMC registration reference numbers for physician associates and anaesthesia associates to differentiate them from doctors. The GMC says that it will also prominently label each profession type on its public facing registers and in search functions. Una Lane (below), the GMC's director of registration and revalidation, said, "Bringing these professionals into regulation will help assure the public that PAs and AAs have the required knowledge, skills, and experience to work safely."

RCGP alters stance on PA regulation

The Royal College of GPs has shifted its stance on the regulation of physician associates in general practice, after its council voted against their regulation by the GMC. College chair Kamila Hawthorne said that, while the college recognised regulation was overdue, "there was deep concern among members that if the GMC takes on the role of regulator of PAs this will create further confusion for patients over the differences between doctors and PAs."

Cardiovascular disease

Campaign to find "silent killer" is launched

The NHS launched a new national campaign to find the "missing millions" of people with undiagnosed high blood pressure. High blood pressure affects around 32% of adults, but it remains undiagnosed in around three in 10 of those, equating to 4.2 million people in England. The campaign says that there are often no clues as to who might have high blood pressure and urges people over 40 to get a free blood pressure test at a participating pharmacy.

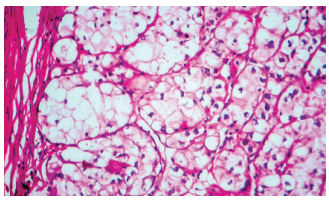
General practice

GPs to vote on contract changes

A BMA referendum has opened for GPs in England to voice concerns about contract changes for 2024-25. The changes include a baseline rise of 1.9%—the same as last year's contract despite rising costs and patient demand—and no expansion of the additional roles reimbursement scheme, so practices cannot use the funding to recruit extra GPs or nurses. The BMA's General Practitioners Committee has rejected the changes, and the referendum does not constitute a ballot on industrial action. The referendum is open until 27 March.

Cancer

New treatment is advised for kidney cancer



NICE has recommended a combination of cabozantinib (Cabometyx) and nivolumab (Opdivo) as a first line treatment for adults with advanced renal cell carcinoma (above). Clinical trial evidence suggests people who have the combination treatment live longer and have more time before their cancer gets worse than people on other standard treatments. The draft guidance says around 1110 people in England and Wales could benefit.

MEDICINE

Diabetes

Yoghurt maker's claim of lower type 2 risk is allowed

The US Food and Drug Administration has said that it will not object if the yoghurt maker Danone North America claims that regularly eating yoghurt reduces the risk of type 2 diabetes. The FDA said that it would not object to a qualified health claim—for example, Danone can say, "Eating yoghurt regularly, at least 2 cups (3 servings) per week, may reduce the risk of type 2 diabetes, according to limited scientific evidence."

The FDA will not object to Danone's qualified health claim

Childhood vaccines

More than 500 new cases of whooping cough

The UK Health Security Agency is urgently calling on pregnant women and parents to take up the

pertussis vaccine offer for their children, after 553 new cases of whooping cough were confirmed in England in January, compared with 858 cases in all of last year. The proportion of 2 year olds who completed their six-in-one vaccinations as of September was 92.9%, down from 96.3% in March 2014. Uptake of the maternal vaccine has also dropped, from over 70% in September 2017 to around 58% in September 2023.

Measles cases continue to rise in England

Parents are being urged to ensure their children have received the recommended number of MMR vaccine doses, as more than 80 new cases of measles were confirmed in England in a week. This brings the total since 1 October to 733. Figures from the UK Health Security Agency show the West Midlands still has the highest proportion (34%), although case numbers there have stabilised. Meanwhile, cases have risen in the north west, which has low MMR vaccine uptake.

Mental health

Violence drives mental illness in women

A Royal College of Psychiatrists survey of more than 500 members indicated violence and abuse were the top influences on mental health of female patients. These were closely followed by relationships (49%) and home and family pressures (48%), the college found. Isolation or loneliness (24%) was also listed as a common challenge. The college has called on ministers to recognise these factors as causing poor mental health among women and for it to prioritise therapeutic support.

Smoking

350 young UK adults a day take up cigarettes

Around 350 adults aged 18 to 25 years start smoking every day in the UK, found University College London research commissioned by Action on Smoking Health (Ash). This amounts to 42 500 since the king's speech announced legislation to raise the age of legal tobacco sales from 18 by a year every year from 2027. Ash's chief executive, Deborah Arnott, said, "We urge the government to put the bill to parliament before Easter. Time is running out if the legislation is to pass before the general election."

Cite this as: *BMJ* 2024;384:q604

NHS DEMAND

Despite flu cases falling in England, an average of **1333** patients were still in a ward bed with flu each day in the week ending 3 March—more than three times the average in the same week last year

[NHS England]

SIXTY SECONDS ON . . . **10 000 STEPS**

ISN'T THAT FIGURE ARBITRARY?

The widely used target of 10 000 steps a day does seem to originate from a successful Japanese marketing campaign in the mid-1960s. A company called Yamasa wanted to capitalise on the popularity of the Tokyo Olympics and designed the world's first step counter, a device called a manop-kei, which translates as "10 000 step meter."

SO, THERE WAS NO REAL EVIDENCE?

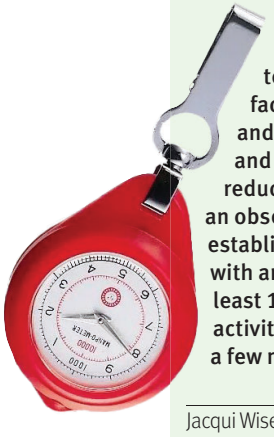
Not at the time, no. Since then, studies have been conducted to test whether 10 000 steps a day is optimal for health, and organisations such as the World Health Organization and the American Heart Association have even adopted the number as a daily activity recommendation. However, there have also been accusations that the target is built on bad science.

DO I NEED MY OLD STEP COUNTER?

Well, maybe. New research published in the *British Journal of Sports Medicine* shows that walking 9000 to 10 000 steps each day lowered mortality risk by 39% and the risk of incident cardiovascular disease (CVD) by 21%, when compared with a baseline of 2200 steps a day. The Australian researchers analysed data on more than 70 000 people enrolled in the UK Biobank study who had worn an accelerometer for seven days to measure their physical activity.

WHAT IF I DON'T HIT 10000?

The good news is that the study indicates that walking any number of steps above 2200 a day is associated with lower mortality and incident CVD risk.



BEST FOOT FORWARD

Although the researchers tried to account for other possible factors such as diet and smoking, and they had a large sample size and a long follow-up period to reduce the risk of bias, this was an observational study that couldn't establish cause and effect. That said, with an NHS recommendation of at least 150 minutes' moderate intensity activity a week for adults, trying to do a few more steps surely can't hurt.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;384:q598

Weight loss patients need clearer warnings of risks from overseas care, say doctors

EXCLUSIVE UK doctors are calling for a public awareness campaign to inform people of the risks of going overseas for weight loss surgery, including that their GP may not offer routine follow-up care once they return.

The British Obesity and Metabolic Surgery Society (BOMSS) told *The BMJ* that around 5000 people a year may be going abroad for bariatric surgery, about the same number as having bariatric surgery through the NHS in England (around 4500 in 2021-22). It warned that some overseas clinics were providing the surgery at a fraction of the cost offered by UK private providers, indicating that shortcuts may be being taken, and that doctors were reporting rising numbers of patients coming to them with serious complications after having weight loss surgery abroad.

BOMSS has called on the government to increase the public's awareness of these risks and what aftercare they can expect from the NHS once they return. The call has been supported by the Royal College of Surgeons of England.

"Tremendous problem"

BOMSS secretary and consultant bariatric surgeon Ahmed Ahmed told *The BMJ* he sees several patients a month who need emergency or follow-up surgery after going abroad for bariatric surgery. "It's a tremendous problem. And it drains our resources," Ahmed said. "When I started 15 years ago I don't remember seeing any patients like this, but in the past five years we've gone from around one patient a month to one or two a week."

Last year BOMSS published a joint statement with the British Association of Aesthetic Plastic Surgeons expressing concern that the boom in surgical tourism was leading to a rise in serious post-surgery complications and deaths.

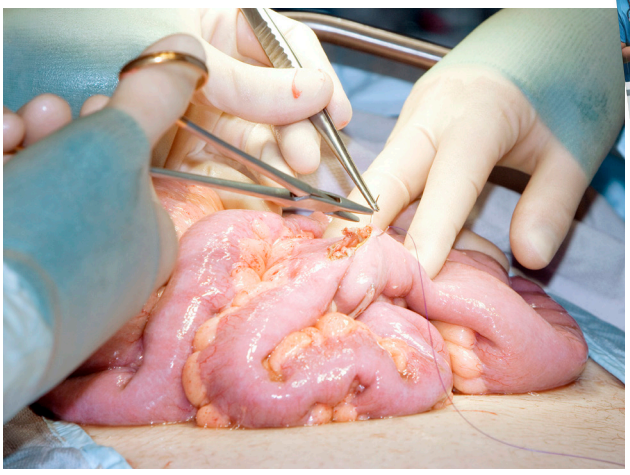
I've had patients come straight from Istanbul to my emergency department
Ahmed Ahmed

"I've had patients come back from Istanbul and then straight on a train to my hospital's emergency department. They're coming in with either blood loss or septicaemia and needing emergency surgery," Ahmed said.

The rise in people travelling abroad for elective surgery in the past few years has coincided with record NHS waiting times. "Before covid it was maybe a year to two years' wait, now it's easily three to four years," Ahmed said. At the same time, he said, overseas clinics were using aggressive marketing tactics and offering cheaper prices than seen in the UK's private sector, where an operation might cost £10 000 to £12 000.

"There's one clinic that offers a gastric sleeve for about €2500, including flights. I don't understand how they can do the surgery that cheaply. The instruments we use cost a lot more than that," Ahmed said. "Patients are not getting the high standards of care that they should be."

On top of the risk to patients, correcting such problems also lengthens NHS waiting lists, Ahmed said.



LIFE IN VIEW/SPL

AROUND 5000 people each year may be going abroad for bariatric surgery

Patients need to be aware of extra pressure placed on the NHS when things go wrong
Vivien Lees

Primary care is also feeling the strain. Suffolk Local Medical Committee's medical director, Peter Smye, said GPs there had seen a noticeable rise in the number of patients going to clinics abroad for weight loss surgery. "At the moment in Suffolk we have nowhere to refer for bariatric surgery," Smye explained. "That's what's driving a lot of the demand for overseas surgeries."

Patients in Suffolk can be referred to only one hospital, Addenbrooke's in Cambridge, for secondary care obesity services. Addenbrooke's has had to close its tier 3 obesity service list, however, as it has reached capacity. To access bariatric surgery (tier 4) patients must first go through tier 3.

A spokesperson for NHS Suffolk and North East Essex Integrated Care Board said it "recognises this disruption is upsetting for patients" and was working with the hospital to "restore access to services," although it "cannot say how long this will take."

Pressure on GPs

Suffolk GPs are now seeing patients who assume their practice can provide care after bariatric surgery abroad. "The patient, probably not unreasonably, turns up at the GP surgery thinking the NHS will pick this up because they've paid for the surgery. But it's difficult for GPs to do. It requires intensive monitoring of various vitamins and minerals and so on, which we just don't have the skill set to do," Smye said. "Additionally, no NHS bariatric surgery clinic will take these patients as outpatients."

After NHS bariatric surgery, patients get follow-up care through regular appointments at a weight loss surgery clinic for two years. Patients have their vitamin and mineral levels checked, are given diet and exercise advice and support, and have their physical and mental health monitored. After two years they have annual checkups with their GP.

In contrast, many patients who have

bariatric surgery overseas do not get such follow-up care, either because it is not offered or because they cannot regularly travel back to the clinic.

The matter has become so prominent in Suffolk that the integrated care board published guidance for GPs and patients explaining that "patients do not have the automatic right to re-enter NHS care (from private care)" and that for those who have funded their surgery abroad themselves the responsibility of aftercare "remains with the centre that performed the surgery."

Aftercare "knowledge gap"

Smye said many patients were surprised their GP won't necessarily offer aftercare and said this "knowledge gap" needed tackling. "That would be where the public awareness campaign comes in," he said.

Currently, there is guidance for those considering going abroad for elective surgery, including from RCS England. The government's foreign travel website also contains some medical tourism warnings for specific countries, such as Turkey.

But Ahmed said these warnings weren't reaching enough people. "They need this information and in an easier way than just two lines on a website that probably nobody reads anyway," he said. "People need to be aware of the potential hazards, and if they still want to go abroad then they need to spend time doing research."

RCS England vice president Vivien Lees told *The BMJ* she "fully supports" efforts to communicate the potential risks of surgery abroad to the public. "Patients also need to be aware of extra pressure that is placed on the NHS when things go wrong," she said, adding that although many overseas hospitals provided excellent care some "may take shortcuts to cut costs."

When asked to respond to calls for a public awareness campaign, a spokesperson for the Department of Health and Social Care said, "The NHS provides straightforward guidance that anyone thinking of going abroad should consider ahead of arranging treatment, including the key warning signs."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;384:q583

GUY BELL / ALAMY

NEWS ANALYSIS

DOCTORS' STRIKES ONE YEAR ON: **What will it take to end the disputes?**

Ingrid Torjesen reports on 12 months of industrial action across the UK and considers what the future might hold

A year ago this weekend junior doctors in England began strike action, calling for a 35% pay increase over time to restore their pay to 2008 levels. Twelve months on, resolution of the dispute seems no nearer.

Junior doctors in England recently staged their 10th round of industrial action, and there is no fresh pay offer from the government on the table. For 2023-24 junior doctors received what the government called a "final offer" of 8.8%, not enough to bring an end to the action.

In the meantime, industrial unrest has spread. In England, consultants joined their junior colleagues in strike action last summer, although that dispute is much closer to ending after an improved pay offer from the government. SAS doctors in England have also voted to strike after rejecting a pay offer. In Wales and Northern Ireland junior doctors have begun strikes, and consultants and SAS doctors look set to follow (box, overleaf).

Only in Scotland have hospital doctors remained at work. There, junior doctors accepted a pay deal of 12.4%, which also came with a commitment from the Scottish government to work towards pay restoration and reform of the pay review process.

What did Scotland do right?

In an interview with *The BMJ*, Vivek Trivedi and Robert Laurenson, co-chairs of the BMA's Junior Doctors Committee in England, said the Scottish government engaged with junior doctors early and listened, averting the need for doctors to strike. "Our government didn't afford us the same basic decency of having a conversation to start with," Trivedi said. "Unfortunately we had to resort to strike action to get our point across."

From the start, the UK government has followed an "irrational" and "ideological" approach of refusing to talk while strikes are planned, and that has not changed, said Laurenson. "The government is still happy to see strike action continue rather than try to solve it.

"Either it needs to change how it sees the problem or there need to be new people who approach the problem differently," he said.

Has anything been achieved?

Trivedi said junior doctors had made some progress by getting the government to the negotiating table at the end of 2023. "We went from being ignored—where our concerns about pay and its impact on morale, retention, and recruitment were going unheard—to having rounds of negotiations. The government has offered more for this financial year," he said. But he added, "It still seems all the government wants to do is to try to get an offer to stop strikes rather than tackling the concerns that doctors have, which underlie why doctors are striking."

Those concerns are primarily pay erosion and a loss of faith in the independence of the pay review body. The DDRB is supposed to be independent and to consider the cost of living, recruitment, and retention and not be swayed by pressures to reduce public spending. Then it is up to the government to decide whether to accept its recommendations.

Pay stagnation

Alex Bryson, professor of quantitative social science at University College London's Social Research Institute, said that pay review bodies were set up in "more benign circumstances," before the 2008 economic downturn, which was followed by a long period of below-inflation pay rises. More recently, he said, any wage

(Continued on page 384)

(Continued from page 383)
growth in the public sector had been well behind that in the private sector.

The history of industrial relations was straightforward, Bryson added. "Periods of serious pay restraint in the public sector do inevitably unwind over time. People seek to maintain their pay differentials, especially if they have the bargaining power to do so as highly skilled workers," he explained. "So there's a pay bill waiting for the government and it's not going to go away. Whether it's 35% or looks more like 13%, it's going to be a big number."

Trivedi said, "Doctors are coming out of medical school earning £15 an hour now, when many have been earning more than that for their part time jobs during medical school. It disincentivises people to stay in the profession."

David Oliver, a columnist for *The BMJ* and a consultant in geriatrics and acute general medicine at the Royal Berkshire Trust, said, "It's unquestionably the case that doctors have lost more in real terms than any other group in the public sector."

The government has said that paying doctors the same in real terms as in 2008 is unaffordable. But Trivedi argued that doing so now would cost roughly £1.5bn, rather than the £3bn that has been spent dealing with strike action.

At the start of 2023 Rishi Sunak made five pledges to voters: growing the economy, halving inflation, reducing NHS waiting lists, reducing national debt, and reducing illegal immigration. Laurenson said that ending the doctors' strike could help the prime minister meet the first four pledges but added, "It seems not wanting to be seen to give in to a union is an overriding factor."

STATUS OF 2023-24 PAY DEALS FOR DOCTORS

England

Junior doctors—First strikes staged 13-16 March 2023. Have staged 10 rounds of strikes so far. Latest mandate for industrial action ran out on 29 February 2024. A ballot on further action closes on 20 March.

Consultants—First strikes 20-22 July 2023. Turned down offer of extra 4.95% investment in pay from January 2024 on top of 6% from April 2023 (51% voted against with a 65% turnout) with exact amount dependent on the current stage of career. Now being balloted on an improved offer, which includes a 2.85% (£3000) uplift for consultants of between four and seven years, who received no additional uplift under the previous offer. Vote closes on 3 April and there is a mandate to strike until June.

SAS doctors—Recently rejected proposed pay uplift of between 6.1% and 9.22% for doctors on 2021 contracts, depending on experience and where they are on the pay scale. Have a mandate to strike until June, but no industrial action has been announced.

Unprecedented action—Juniors and consultants took strike action that coincided for the first time on 20 September 2023. This was followed by three days of coordinated strikes during 2-5 October. Junior doctors' six day strike over 3-9 January was the longest in the history of the NHS.

Wales

Junior doctors—First strikes took place 15-18 January this year. A second strike followed in 22-24 February, and further action is planned for 25-29 March.

Consultants—Backed industrial action in ballot, first strike scheduled for 16-18 April.

SAS doctors—Backed industrial action in ballot, first strike scheduled for 16-18 April.

Northern Ireland

Junior doctors—Balloted on industrial action in January 2024. First strikes took place 6-7 March.

Consultants—Not yet balloted on industrial action.

SAS doctors—Not yet balloted on industrial action.

Scotland

Junior doctors—Accepted a deal of 12.4% in August 2023 that came with a commitment from the Scottish government to work towards pay restoration.

Consultants—Believed to still be in talks.

SAS doctors—Believed to still be in talks.

There's a pay bill waiting for the government and it's not going away
Alex Bryson

Doctors have lost more in real terms than any other group in the public sector
David Oliver

There has been a complete breakdown in trust between government and unions
Nick Davies

Support for strikes holding up

The government may have hoped that junior doctors' morale and willingness to strike—and public support for them—will both wane as the dispute continues. But so far these have held relatively strong.

Data from NHS England indicate that around 28 000 to 29 000 staff took strike action each day during the first junior doctor strike in March 2023. Around 21 000 to 25 500 staff took action each strike day in January and February 2024.

An Ipsos Mori poll of 2000 people in January found that more people still supported junior doctors than not, despite support falling five points since last August. More than half (54%) thought the government had done a bad job negotiating with trade unions, but only 33% thought a Labour government would do a better job.

Problem for the next government?

Health commentator Roy Lilley believes that if the government was going to settle the strikes it would have done it by now and will be happy to "dump the mess and the costs in the lap of incoming Labour" if it won the upcoming general election.

Nick Davies, programme director at the Institute for Government, leading its work on public services and outsourcing, said if Labour did win little would change because public finances would remain in a poor state.

But he said a new government could bring a change of tone. "There has been a complete breakdown in trust between government and unions and particular workforces, and that makes it even harder to strike a deal, so even if the numbers don't change much the improved tone and willingness to work together and a collaborative approach could help," he said.

Laurenson agreed. "Shadow health secretary Wes Streeting saying he recognises that this is a journey not an event is precisely the kind of headspace that we're in—and that the doctors in Scotland and the government in Scotland were in as well."

Ingrid Torjesen, London
Cite this as: *BMJ* 2024;384:q591

Junior doctors think my generation has not protected the profession, says BMA chair

MARK KERRISON/GETTY

Junior doctors believe that their senior colleagues have not done enough to safeguard the future of the profession, says the BMA's chair of council, Philip Banfield.

In an interview with *The BMJ* Banfield reflected on how senior doctors felt about continuing to support the industrial action undertaken by their junior colleagues as part of their dispute over pay.

"The longer it goes on, I'm sure the more tired consultants will become," he said. "But the junior doctors would say—and I've got some sympathy with this—that the reason we're in the state we're in is because my generation has not protested enough, has not protected the profession, and has let the service deteriorate."

Banfield said that in many cases the industrial action had opened consultants' eyes to the working conditions of their junior colleagues. He explained, "A lot of consultants who have undertaken cover and shift work have said, 'We had no idea that this was what it's deteriorated to.'"

Seniors needed to "understand how much has changed" before commenting on the behaviour of the "people who have been left behind," he added. "I'm not surprised that the juniors are angry and upset about what has happened to them. They have been treated appallingly and deserve better."

Improved offer for consultants

Discussing the ongoing pay disputes, Banfield said that the pay offer recently made to consultants in England was "more in tune" with what the BMA's Consultants Committee wanted to achieve, especially regarding reform of the DDRB. Consultants in England rejected the previous offer in January, but the issues that most concerned members—such as consultants in their fifth to eighth year of work not receiving an additional pay uplift immediately—have now been resolved.

The new offer, Banfield said, "represents a significant effort and a significant benefit in the attempt to keep consultants in work and from taking early retirement, at a point at which we need our senior leaders in the NHS." While this may be an acceptable deal for consultants, he said, the government had a lot more work to do to end the dispute with junior doctors. The degree of pay erosion that these doctors had seen meant they would need "a course of action that restores pay over two or three years," he said.

Political will

Despite how it had been characterised, the junior doctors' dispute was not about them wanting a 35% pay increase in one go, said Banfield, adding that it "suited the government to portray it as that."

Asked whether juniors were asking for a specific amount, Banfield said, "I know what that amount is. The juniors know what that amount is. Government knows what that amount is. It would be awfully useful if they just all got in a room and sorted that out." It was not the amount of money in question preventing an agreement but political will, he argued.

"Why go into a general election still battling with the doctors when it is eminently resolvable? You know that they're not asking for 35% in one go. You know there are different ways of getting there. You know that by talking to the junior doctor negotiators you can probably work something out."

He added, "It feels like, when the government says, 'We want the juniors to be reasonable,' it's saying, 'We want them to give up and accept that they're not going to be valued in the UK.' Our job is to persuade them that that is an erroneous way of thinking."

You are taking the brightest scientists and asking them to do an extraordinary job for very little pay in today's market
Philip Banfield

Learning from 2016

Banfield said that junior doctors were still feeling the effects of 2016, when a new contract was imposed on them after the BMA and the government failed to reach an agreement. "The big difference [this time] is that the BMA is geared to running a long dispute if it needs to," he said. "So, we as the BMA are not this time around saying, 'You've got to settle.' Settle when you get the correct deal that gives you a route to restoring the value of your pay—£15.63 an hour for five years in medical school is not a lot of money. It's a complete fallacy that this government can't afford it."

While the BMA had shied away from making the 2016 dispute about pay, Banfield said that the union had made a conscious decision to be clearer this time. He explained, "In 2016 we made it about patient safety and terms and conditions, and the point at which people realised that it was also about pay they got upset [and said], 'How dare you talk about pay?'

"In this dispute, we've made it very transparent. It is about pay. You are taking the brightest, most dedicated, passionate scientists and you are asking them to do an extraordinary job for very little pay in today's market."

The BMA shied away from making the 2016 dispute with health secretary Jeremy Hunt about pay

Looking forward, Banfield said ending the dispute was in the hands of this government or its successor. He said, "We obviously will hit a time when we go into the election period and we've got purdah. So, there will be no negotiations, and it will be over to any future government, who then face the same problem."

IT SUITS the government to portray junior doctors as wanting a **35%** increase in one go

Abi Rimmer, *The BMJ*

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THE BIG PICTURE

Voices from Northern Ireland's picket lines

For the first time in Northern Ireland, junior doctors earlier this month went on strike, after 97.6% of BMA members voted in favour of industrial action. *The BMJ* spoke to some of those who braved the picket line on 6 March during a 24 hour walkout at Ulster Hospital in Belfast.

William McKeown (top right), a specialty trainee year 7 doctor in geriatric medicine, said that while he loved his job and it was a privilege to look after patients the Northern Ireland Department of Health was making it very hard to continue. "We need to see this resolved urgently because it's a patient safety and patient care issue," he said.

For Ahlam Al-Abbasi (bottom right), an FY1 doctor working in trauma and orthopaedics, the restoration of the Stormont power sharing government has led to some optimism, but she argued it was "inappropriate" for a foundation doctor who carries a cardiac arrest bleep, and who has no break in a 12 hour shift, to be paid £12.81 an hour. "Either our system needs to change or we need to be compensated for the pressure we're under," she said.

Fiona Griffin (below), chair of the BMA's Northern Ireland Junior Doctors Committee, said doctors believed they had no choice but to take industrial action. "We are no longer going to put up with unacceptable pay and conditions: they are causing an acute workforce crisis that is not being taken seriously."

Emma Wilkinson, Sheffield **Cite this as:** *BMJ* 2024;384:q597


BMA
PAY RESTORATION NOW


FIX OUR PAY
RETAIN OUR DOCTORS
PROTECT THE NHS
BMA

EDITORIAL

Mandatory data and code sharing for research published by The BMJ

New policy requires authors to share analytic codes from all studies and data from all trials

The case for sharing data from clinical research is strong.[1 2] Clinical study data include all information collected during a study, which is then analysed using computer codes to generate results.

Unimpeded access to both data and code across the research community maximises the value of each research project. It shows respect for the efforts of research participants and the economic contributions of the public. It enables data scrutiny and re-analyses, which are essential for the self-correcting activities that contribute to good science and better patient and population outcomes.

It is important to put the public good ahead of personal, academic, and corporate interests

Deterring fraud

Code sharing, in particular, makes it possible to evaluate analytical decisions that cannot easily be described in the methods section of a paper but have an important effect on results. It is plausible, for example, that requirements for code sharing might have deterred submission, or prevented publication of, the fraudulent Surgisphere papers published during the pandemic.[3]

Although there are practical challenges and potential harms associated with data sharing, we believe they are outweighed by the benefits. There are fewer such concerns when sharing code.

The BMJ is committed to transparency in research. In 2013, we required authors of drug and device trials published in the journal to agree to share relevant trial data on reasonable request.[4] In 2015, this requirement was extended to all clinical trials published in the journal.[5] Sadly, not all authors honoured this promise, and sharing of trial data remains disappointingly low.[6 7] Barriers include the time and effort required to ensure data are organised and useable, and fears among some researchers that competitors might gain unfair academic or commercial advantages or misuse or misinterpret the data.

It is time for the next step. From 1 May, *The BMJ* will require authors of all submitted trials to post relevant trial data in an enduring, publicly accessible repository before publication. Repositories organise and store study data so that they can be retrieved and used by other researchers. We encourage authors of trials currently accepted for publication to voluntarily adhere to this policy. A link to the trial data will be included in the data sharing statement on every research paper published in *The BMJ*. Data sharing should not be confined to trials, and *The BMJ* intends to broaden its data sharing policy to non-trial research. But practical problems remain for observational studies and other non-trial research, such as permissions and privacy of data held in registries.

We will also require submission of relevant analytical code in a supplementary file that will be permanently accessible alongside each paper.[9] Our new policy on code sharing applies to all research we publish, and a new code availability statement will be included in research papers. Other journals are moving in this direction as well. Springer Nature has announced a policy to require code availability statements in articles in its journals, and to encourage authors to share code publicly and cite code they have used.[10]

Enhanced scrutiny

Details about this new policy, acceptable data repositories, and requirements for code sharing can be found on bmj.com in our advice to contributors (www.bmj.com/about-bmj/resources-authors/article-types). We hope that you will support us in enhancing transparency and scrutiny of medical research. It is important to put the public good ahead of personal, academic, and corporate interests. We welcome your views.

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EDITORIAL

Changing policy landscape around elder abuse

Health and legal professionals must advocate together for the strongest possible safeguards

Predatory marriage and abuse of lasting powers of attorney are of growing concern in the UK

HUGH HASTINGS/GETTY IMAGES

Predatory marriage and abuse of lasting powers of attorney (LPA) are two forms of elder abuse that are of growing concern in the UK. Predatory marriages are under-reported but a rising problem.[4] LPA abuse of older people is also under-reported but may be more widespread, linked to the enormous numbers of LPAs registered annually at the Office of the Public Guardian: there are now almost seven million LPAs in the UK, with over a million registered in 2023 alone.

For most older people, LPAs are an important means of planning for trusted others to make decisions on their behalf if mental capacity fails. However, as the Law Society cautions: "The consequence of an attorney making a poor decision could result in the donor losing all their assets, being admitted into a care home against their wishes or even premature death."[6] According to data from the Office of the Public Guardian, more than 20 000 investigations of attorney abuse took place from 2010 to 2023. Between 2010 and 2020, over 4000 such cases went to the Court of Protection for action.[7]

An editorial in *The BMJ* in 2021 highlighted safeguarding concerns about plans to "modernise" legislation around both marriage and LPAs in England and Wales.[8] Since then proposals by the Law Commission that may protect against predatory marriage have moved slowly. LPA "modernisation" has progressed much faster, however. The Powers of Attorney Act 2023, aimed at streamlining LPA procedures, is now law.[11] The act seeks primarily to digitise LPAs—giving donors the ability to sign and execute LPAs online alongside changes to witness and certification requirements, a streamlined approach towards registration of LPAs, and amended processes for raising concerns and objections.

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Mounting alarm

Legal professionals express mounting alarm about LPA abuse,[12] and for many the new law raises further concerns.[13 14] Most people making LPAs are older than 75 and may not have digital access or the skills to use online services securely.[15] Allowing donors to sign online, apparently without a witness, may undermine the safety of LPAs, especially given concerns about how the identities of signatories will be verified securely.

The Law Society is also concerned about the role of certifiers in the digital system—including whether they will be required to assess capacity or potential coercion of donors (or both) at the point of signing.[16] The Ministry of Justice has committed to an improved paper version alongside the digital plan but gives no details of how this will work.[17] Overall, the new law for England and Wales now contrasts starkly with safeguards in the rules of the Scottish Office of the Public Guardian, which require donors to obtain a certificate of capacity from a solicitor, advocate, or GP before their power of attorney can be registered and used.[18]

Healthcare professionals, particularly those in primary care, are often the first to speak with patients and formally evaluate when people's memory and cognitive status are in decline. They are often involved at key opportunities for protecting older people. The BMA warns: "Sadly, more and more health professionals are becoming aware that their patients may be victims of financial abuse. This can be particularly important in assessments of capacity in relation to the transfer of decision-making authority to proxies such as attorneys."[19]

We are now in a critical policy window for protecting older people in England and Wales from abuse. The Ministry of Justice is still working on the regulations needed to implement the Power of Attorney Act 2023, and the Law Commission's proposals are still in development.

In this context, health professionals have an even more important role in protecting older people. This requires, at a minimum, that all guidance on elder abuse produced for health professionals is kept up to date with changes in regulations.[19-21] Health professionals should also work with the legal profession to advocate that the strongest possible safeguards be incorporated into the Ministry of Justice regulations protecting older people from LPA abuse, and to support Law Commission proposals that may help protect older people from predatory marriage.

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JEFF GILBERT/ALAMY

COST-OF-LIVING CRISIS

How GPs are paying for rising numbers of people living in poverty

As costs rise beyond static incomes, primary care services are struggling to care effectively for patients, reports **Samir Jeraj**

"I've got one patient—the benefits she gets only cover her rent and bills. She has nothing left over for food," a GP in east London says.

"For the past few months she's been using that money just to pay for her sustenance. She doesn't go out of the house because she can't afford to do anything and she sits in the cold most of the time.

"She's in arrears now, and she's getting eviction notices from the council."

General practitioners are spending more time than at any point in living memory on supporting people whose main problems are driven by poverty—ranging from malnutrition to mental health conditions.

The Joseph Rowntree Foundation estimates that in 2021-22 six and a half million people in the UK were in "deep poverty," meaning that after housing costs they had less than 40% of the median income. This was one and a half million more people than at the start of the century. Four million people (including a million children) experienced destitution, meaning they were unable to stay warm, dry, clean, and fed, according to the foundation's 2024 report published in January. The UK is failing on poverty—and healthcare services are feeling the effects.

We see health deteriorate as a result of financial constraints
Rupal Shah

"We're seeing health deteriorate as a result of financial constraints that individuals and families are facing," says Rupal Shah, a GP in south London. Levels of poverty in the area had already been rising, she says, and the cost-of-living crisis has exacerbated this trend.

Poverty has a clear impact on her practice, where she sees increasing numbers of people coming in for housing support. "Homelessness is on the rise. People are coming in for support with their benefits as well," she says.

Shah is seeing more patients with mental health conditions, conditions related to nutrition and poor oral and dental health. "That's linked to the inaccessibility of healthy foods and easy access to cheap, sugary, and nutritionally poor foods. This has a particular impact on children," she says. Conditions such as obesity, diabetes, anxiety, and depression have a clear social gradient, with higher rates in areas with higher levels of poverty.

Picking up the pieces

These challenges are evident across general practice. A survey published last September by the Royal College of General Practitioners found that 73% of GPs had seen an increase in the number of patients with problems linked to the cost-of-living crisis. Some 93% were also concerned that the rising numbers of such patients would limit their ability to provide quality care. The college called on the government to reform the funding formula to put more resources into deprived areas.

"We've known for a long time that there are more health problems in socioeconomically deprived areas, in particular more physical and mental health comorbidities," says David Blane, a GP and senior clinical lecturer in general practice who works with the Deep End project in Scotland.

The project is made up of GPs that practise in the 100 most deprived areas of Scotland. It recognises that rising levels of poverty lead to higher consultation rates, but points to research showing less time in GP consultations, less funding per need adjusted patient, and higher GP stress levels in deprived areas. "All of these things are a manifestation of the inverse care law," Blane says.

"If you take a train across London from a deprived ward to a less deprived ward, there's a 12 year life expectancy gap," says Peter Matejic, chief analyst, insight and policy, at the Joseph Rowntree Foundation. The foundation's report found that more people were going without essentials such as decent food and heating, and this was leading to rises in poor health. "All of the evidence suggests that poverty and poor health is a vicious cycle," Matejic says.

Austerity and public sector cuts also mean those services that provide people with a place to go to meet others, such as libraries and community centres, are less available, if at all, to those who most need them. The few remaining local services, such as GP practices and schools, are therefore under greater pressure. This also contributes to workforce challenges in general practice where there are greater and more complex needs, but without the resources to meet them, leading to GP burnout. Between 2015 and 2020, deprived areas lost the equivalent of 1.4 more GPs per 10 000 population compared with richer areas.

Over-the-counter medicines can cost quite a chunk of a weekly household income
Azeem Majeed

Over-the-counter and social prescribing—but GPs can't cure poverty

GPs can help families struggling to meet the cost of over-the-counter drugs by prescribing them to patients exempt from charges, suggests Azeem Majeed, professor of primary care and public health at Imperial College London. "If you're a poor family, those over-the-counter medicines can cost quite a chunk of your weekly household income, just because you need some paracetamol," he says. This is despite guidance published by NHS England to avoid prescribing paracetamol.

Since 2022, primary care networks have a requirement to commission a "proactive" social prescribing service. Social prescribers are usually employed by GP practices or a community organisation working on behalf of the NHS. Social prescribers refer patients to services to help them with housing, employment, and other social determinants of their health needs, such as warm spaces and affordable energy schemes.

They can also refer them to cheap or free health promotion activities, such as exercise classes or meet ups. These have a direct benefit to the people accessing them, but their ability to change the larger structural forces driving poverty and ill health are limited.

Longer term there is also a challenge. Children who have been born into and grow up in poverty are more vulnerable to poor health and worse life outcomes. The number of children growing up destitute has tripled in five years. "The early years are a key part of a child's development; it is hard to make that back up over the rest of someone's life," Matejic says. That is not to say that it is impossible, he explains, but it requires concerted action. The Joseph Rowntree Foundation is calling on the next government to commit to an "essentials guarantee" to ensure that everyone can afford healthy food, heat, and housing.

"It is beyond the control of GPs to fix the welfare state and eradicate poverty. It goes back to the Marmot principles of reducing health inequalities—such as investment in early years development, employment, and living standards," says Blane. He says that means resource allocation according to need and using the influence of general practice both as an employer and as a trusted resource in communities to work across services and advocate for action on the social determinants of health.

General practice cannot "cure" poverty, GPs and social campaigners emphasise, it is determined by political choices about how to spend public money and run public services. "In the long term, we need more upstream policy reforms that are going to create better health outcomes for everyone," Shah says.

Samir Jeraj, freelance journalist, London
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WORK-LIFE BALANCE

The pros and cons of going less than full time

As more people choose to work LTFT, **Erin Dean** reports on what this means for the workforce and the NHS

Sam Naushahi is absolutely clear that he wouldn't still be working as a general practice registrar if he hadn't been able to cut down his hours from full time.

About 18 months ago, the 36 year old dropped to 80% of a full time post at his practice in Yorkshire, which means that he has every Monday off. He still works what many people outside medicine would consider full time hours, at around 38 hours a week, but the shift has helped him grasp a better work-life balance.

"I would never go back to full time," he says. "I have a long weekend every week and it has absolutely revolutionised my life. I get to spend more time doing what I like to do outside of medicine, like seeing friends and travelling, which I just wasn't able to do previously. Weekends were just catching up on sleep and chores, then going back to work." Naushahi doesn't have children and went less than full time (LTFT) to protect his mental health after realising he was burning out. After cutting his hours, he received a diagnosis of cancer, for which he receives ongoing care.

Naushahi's decision to reduce his hours was made before his diagnosis, but it did emphasise "the importance of looking after yourself and the importance of close family and friends." He thinks that his patients receive better care from him thanks to this arrangement. "When I am with patients, I am fresher, and I feel I am a better doctor," he says.

Naushahi is part of a growing trend of doctors seizing the opportunity to go LTFT to boost their wellbeing, their work-life balance, and, crucially, to manage the crushing stresses of being a doctor in the NHS.

"Well founded reasons" beyond childcare

LTFT working for trainee doctors used to be mainly available for parents juggling childcare and for health reasons. But a change made by NHS England in August 2022 means that all juniors in any specialty have the right to apply to train LTFT for any "well founded reason," including for their wellbeing or through personal choice.

Doctors in training tell *The BMJ* that they are seeing more of their colleagues seeking to reduce their hours to improve their work-life balance. In 2015, almost 12% of junior doctors were working LTFT; this year it is almost 20%, according to data from medical regulator the GMC.

Data extracted from the GMC's national training survey for *The BMJ* by the regulator show this rapidly growing trend. In 2022 a new option of "having a better work-life balance" was added to possible answers to the question of why someone has gone LTFT. This was selected as a reason (respondents could choose more than one option) by 44% of more than 8000 LTFT training doctors.

The number who had selected "childcare reasons" dropped from 73% in 2018 to 67% in 2022. For those who were full time but had applied for or were considering LTFT, 89% said work-life balance was the reason, and only 20% put childcare. A Kings Fund survey published in 2023 found that 41% of GP trainees plan to work part time in the future.

When I am with patients, I am fresher, and I feel I am a better doctor
Sam Naushahi

Regaining control

The pressures of working in the overstretched NHS are pushing many doctors towards cutting their hours to gain more control over their lives, says Emma Coombe, a specialty trainee year 8 paediatric junior doctor in Bristol.

"The intensity of the work is increasing and that is forcing people into [LTFT] to maintain their own mental health and also for a sense of autonomy," she says. "If you're working on a full time rota, the opportunities where you're allowed to take annual leave are so minimal that you're almost forced into when you can go on holiday. There is no flexibility, and that's so restrictive."

Many people going LTFT still pick up additional bank shifts and might work similar hours as before, but they have more control over when they take them, she says. Some doctors are using their additional time for "side hustles" to develop other work opportunities that might offer options away from the NHS in the future.

Coombe chose to drop to an 80% working week so that she could still have time for charity work and voluntary roles with the BMA and the Royal College of Paediatrics and Child Health. This was several years before she had children and after she had put a deposit down on a house. "I could afford at that point to not push myself constantly, and it was life changing," Coombe says. "I felt so much healthier than when doing a 48 hour week and doing postgraduate exams on top. It is too much. People are running from full time work and reducing their hours to get some breathing space. It is uncommon in paediatrics at my grade to find someone who is full time."

Happier doctors, better retention

Evidence from the pilot studies conducted by Health Education England into widening access to LTFT training indicates that it can make doctors happier. A survey found that 100% of the more than 100 juniors on LTFT agreed or strongly agreed that it increased their work-life balance and their sense of wellbeing. More than nine out of 10 (93%) said that it increased the likelihood of remaining in training.

Jon Hossain, vascular consultant surgeon, deputy postgraduate dean for Yorkshire and Humber, and UK lead dean for LTFT, tries to make it simple for trainees to access LTFT as he has seen the effect on reducing burnout and boosting retention. "In my day it was always specialty and job that was the most important thing; for this generation now, it is work-life balance, especially after everything they were put through during the pandemic," he says.

Going LTFT is growing rapidly in popularity, with 80% roles by far the most popular choice, he says. "There is something about people having a day to reflect, reset, and get off that treadmill, and that has made 80% very popular," Hossain says. "I often find that the doctors spend that other day doing something towards their work, such as a PG Cert or other qualification."

Workforce planning needed

This greater move towards LTFT training is challenging for employers who need to fill rotas, but they need to think about the importance of retention, Hossain says. "A doctor for 80% of the time is better than nothing, and I find the LTFT doctors really want to be at work and do a lot."

There are several ways in which junior doctors are funded, but for centrally funded posts, about 50% comes from NHS England, Hossain says. This makes trainees much cheaper to employ than non-training staff, and this can disincentivise hospitals from embracing LTFT trainees, he says.

NHS England says financial changes brought in last April will help tackle this and incentivise employers to have LTFT trainees. Money is being offered to trusts to make it easier to manage rotas and LTFT trainees. "Deaneries are providing employers with extra top-up funding to allow slot shares (where two doctors share a rota slot), to reduce gaps in rotas, maximise training opportunities, and help trusts provide the service," Hossain explains.

Hossain says that, anecdotally, although there are not robust data, doctors who go LTFT in training tend to stay part time as

CASE STUDY

The F2 on 80%—"The best decision I ever made"

Cora Marks, a foundation year 2 doctor from Liverpool, says that reducing her hours to 80% to get a better work-life balance is "the best decision I ever made."

"I did my FY1 [foundation year 1] full time, but the hours are so long, the NHS is so busy, and the responsibility huge, so you just don't have any time for life outside work," she says. "My first week as a doctor was 70 hours. I mentioned reducing my hours at FY2 to my programme director, and they were really supportive."

Having a little extra time each week has helped her feel more rested, refreshed, and enthusiastic when in work. On Marks's extra day off, she can get through chores, have more time for friends and family, and study.

The 27 year old, who doesn't have children or serious health conditions, has found senior colleagues supportive, and most peers did not even realise it was an option. "It's definitely made me a better doctor," she says. "At the moment, we can get a lot of frustration from patients and their families, and I cope with that much better now."

Although Marks has less annual leave, she says that, because she pays less tax, the drop in pay is not that substantial. As long as she meets all the demands for her portfolio, which she currently is doing, she will not need to extend her FY2 year.

She would like to continue LTFT if it is an option when in specialist training. "I want to be happy in my life now, rather than always trying to rush to the next career step, so if it takes an extra nine months to do the first three years of specialist training, then I'm fine with that."

Marks says that dropping to a 40 hour week will probably help her work longer in the NHS. "It just gives you that breathing space, and the opportunity to look after yourself a bit better."

CASE STUDY

The GP partner who went from 60 to 48 hour weeks—"Happy clinicians are more effective"

Like many doctors who reduce their hours, GP Mark Williams could hardly be described as part time. But he used to work around 60 hours a week as a GP partner, a clinical director at a mental health trust, and a prison doctor—and now he does more like 48 hours and, crucially, has a greater degree of flexibility.

"I was struggling with Crohn's disease in 2019 and reduced my hours to around 50 hours a week," he says. Then last June he stopped being a clinical director as he wanted more flexibility over how he spends his time. Williams tops up his regular three days as a GP with locum and extra shifts over which he has far more control.

Freeing up a little time and having extra leeway has allowed him to feel healthier and to pursue interests such as writing. "I've spent far more time with my family, been able to keep fit and pursue my interests. I was also at risk of becoming a bit burnt out, trying to juggle two jobs that required a lot of my time and thought. I can't think of any drawbacks of reducing my hours. I earn a bit less, but that is a trade-off for what I gain."

Williams feels like a better doctor these days. "I think the productivity issue in the NHS is in part related to the number of senior clinicians who are burnt out," he says. "Happy clinicians are more effective. I forget things less and I feel less sorry for myself when I have a bad day."

GUZELIAN

I can't think of any drawbacks of reducing my hours
Mark Williams

consultants. "This is something we need to be planning for in the workforce."

The King's Fund says the NHS must get to grips with the numbers of doctors planning to work flexibly, ensure that it doesn't affect career progression, and recognise that those working flexibly are no less committed than their full time peers. Alex Baylis, assistant director of policy, says, "This may make it even more challenging for team leaders to ensure staffing levels and continuity of care. But flexible working is hardly a brand new invention; there are many resources out there to help.

"We need a better balance between the organisation's needs and the individual's. Otherwise, ultimately, staff may vote with their feet, and more vacancies are the last thing the NHS needs."

Downsides—especially for surgeons

Working LTFT seems to bring doctors many benefits, but there are some downsides. "When you are rotating to a new hospital, you always feel like the problem trainee, and my pay is never right," Coombe says. "Also, of course, there is a pay cut."

Some doctors might be seen as less committed for dropping hours, and this can be more acute in areas where LTFT rates are lower, such as surgery, she says. There are marked differences between specialties in rates of part time work. For training grades, paediatrics is highest, with 51% LTFT this year, followed by emergency medicine at 40%, anaesthetics at 34%, and obstetrics and gynaecology at 33%. Surgery has the lowest rate, at 10%, GMC data show.

One female trainee working in surgery says that many colleagues are surprised at her choice. She took a career break to spend time with family members with ill health, and on her return to work was able to secure permission to reduce her hours to 80%, as she was doing a masters degree. This was before the changes allowing LTFT for "any reasonable reason" were introduced. "I was at a different trust when I went LTFT, and I perceived it to be more accepted there," she says. "There are more challenges to being LTFT at my current hospital, as the culture and expectations are different. In talking with my colleagues, there is still an expectation in surgery that the job comes first."

She does think that there could be some disruption to continuity of care by doctors being LTFT but says that, if she hadn't been able to reduce her hours, she might not still be in medicine at all. "People ask if I have children and are surprised that I don't, as if they can't imagine what I do with the time," she says. "But I still work what most jobs would consider a full time role, and I don't feel the need to rush to be a consultant—I enjoy training."

Flexible working is hardly a brand new invention
Alex Baylis

Going LTFT could have a negative effect on a surgeon's career, evidence gathered by the Nuffield Trust, published in 2023, found. It reduced the chances of getting a training spot, and seemed to make some surgeons less likely to progress to the next year of the specialty training programme. "Some surgeons report feeling pressure not to work LTFT, that they have a responsibility to 'fill their slot' and to not do so was letting people down," says Billy Palmer from the Nuffield Trust.

One trainee doctor in the third year of her internal medicine training in south Wales dropped to 80%—and her only regret is not doing it sooner. "By the time I went to LTFT, I was burnt out and had lost my love for medicine," she says. "Just having that extra day a week made so much difference, and I didn't feel I was missing too much in terms of training and being part of the team." But she has felt negativity from colleagues that part of her rota slot is unfilled and that she is somehow less committed than others.

Her experience echoes other doctors who spoke to *The BMJ*, that dropping their hours allowed them to stay working in a system that was relentlessly driving them towards burn out. Those who have gone LTFT feel like better, more productive doctors when at work, and happier in their work and personal lives.

"There's lots of negative views of going LTFT, as colleagues think they're not as committed, that they're not going to be as productive," the internal medicine trainee says. "But actually, I think when I've been 80% I am more productive in work. I am a better trainee as well as a happier person."

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