DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Neoliberalism and the NHS – page 6

Also:

- Can the NHS survive this Labour government?
- AGM 2025 – reports
- Peter Fisher Essay Prize 2025 first runner-up

OCTOBER – DECEMBER 2025

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A View From the Chair: Eric Watts

I begin my second term as chair following excellent leadership by Colin over the last 8 years. We are very grateful to him for his energy, political insight and savoir faire and in particular his grip on the many important issues and threats which we now face.

Our last issue and the notes from the AGM in this issue summarise our situation and I see the next year as one where we must concentrate on our strengths.

Briefly, these are the expertise of decades of experience of life in the real world of the NHS, the regular publication of a respected newsletter, the educational value of our annual meetings, and the Peter Fisher Essay prize which encourages new ideas and new blood.

Whilst Colin has been working on the national scene I have been more involved with local issues. DFNHS has rightly focused on national priorities and whilst it is easy to think that local issues are parochial in nature, many of the difficulties many hospitals experience are a combination of local history and national policies.

Following retirement I became a governor of my local hospital and whilst governor sounds like an important title the reality is very different and it is more like being an individual MP, along with many others. Governors only have power when they speak with one voice. At my trust this was hard to do as there was very little opportunity to get all of us together and there was never time on the agenda for sufficient discussion to achieve a united voice.

I shall return to this as I know from meeting other governors at national conferences that many of our problems also arose at other trusts. Whilst the 10 year plan proposes abolition of governors there is much to learn from this attempt at local democracy in the service. [Please let Eric or Alan Taman know of your own *experiences relating to trust governors.*]

Next year we shall be 50 and there will be a special celebratory newsletter so anyone with memories of past campaigns, events or just memories, please send them in.

The Current Big Issues

Our biggest issue is the erosion of the founding values that define the NHS. The basic principle that everyone pays and everyone benefits has been the mainstay of the service. It is not only the highest aspiration of a civilised society but also in practical terms the most efficient way of achieving better health for all. The evidence is not hard to find as the service was the envy of the world for around 50 years. There had been a consensus that the NHS was doing a good job but needed more investments and plenty of evidence, particularly from the Commonwealth Fund (table of international comparison) rankings to support that.

Now other countries, like Norway and the Netherlands, rank higher overall. While the UK was ranked first in the 2017 report, it had dropped to fourth place by 2021.

At its best the NHS is publicly owned, publicly accountable and delivered according to public priorities. There has been erosion of public provision of services. Often this has been in the belief that the private sector can deliver better value but without the realisation that handing over management to the private sector too often means loss of control. Too often it means loss of the public service ethos and far too often it means loss of accountability.

Although the service has been battered it is essential to restore pride and the good work done by the vast majority who work for it, mostly believing that there are doing the best they can and until recently having faith in the system. There has been much criticism of productivity in the NHS but it is worth asserting that pride and productivity come and go together. The genuine pride that comes from people working in the NHS comes through knowing you and your work are valued. This is a powerful motivating factor.

For most staff, working for the NHS has meant being a member of a high-performing team with high aspirations, universal high standards, generating and feeding on enthusiasm and goodwill. The current policies of fragmentation and commercialisation undermine the achievements of decades of hard work and it is high time to recognise what really matters to the workforce: to have a purposeful satisfying job and what matters to patients – to be treated by people who give their best as they feel secure and supported.

We have been right to take pride in the service. Not only have polls in the UK shown high levels of public support but having been involved in several international conferences I have been impressed with how many countries still see our model of care as the best available.

All countries have difficulties matching resources to their healthcare needs and over the years I have found doctors at international conferences to ask 'what are you doing in the UK?', looking forward to a hopeful answer. More recently it has been 'what on earth are you doing and why?'

My involvement with patient groups and people in the community over the last few years has convinced me there is much we can learn from getting closer to our public.

I have been particularly keen on improving safety. The NHS with other agencies has done much work on this and yet the most visible evidence of improvement comes from two projects motivated by the families of deceased relatives, namely Martha's Rule and Jess's Rule.

My interest in safety was sparked by work using sophisticated IT to reduce errors in the blood transfusion process where it was clear that the errors that were most dangerous were not because of lack of expertise or the resources but were failure to observe the basics. The same is true looking at medical errors in general.

One vital point to grasp now is how so many recent changes undermine good practice, in particular continuity of care. If we look at the events that lead to Martha's and Jess's rules we see lack of continuity and missed opportunities. And they are only two cases that made the headlines.

At the time of writing we are considering an in-person AGM, probably in London in October 2026. We have discussed a possible joint meeting with DAUK with whom we share our aims and objectives. One topic being considered includes safety and the role of all staff and whistleblowers in developing a safety culture.

This edition contains my reviews of two books that give insightful descriptions of areas needing improvement. One by a physician and one by a surgeon, they both describe in detail of problems learned through painful experience. I am most grateful that they have shared their problems of what should never have happened and alert us to a lack of justice and humanity in the system which needs to be addressed for the benefit of staff, patients and the service as a whole.

The purpose of the NHS is not just a means to operate hospitals, GPs and community services but to bring high-quality healthcare and equity linked with public accountability and can only improve through meaningful engagement with patients and the public.

As the NHS Consultants Association we helped establish KONP to do this. We also helped to establish the NHS Support Federation (not to be confused with the NHS Confederation) which carries out detailed research into the background issues.

The *Ten Year Plan* been reviewed by John Puntis, at this time we do not know enough about

proposals on patient and public representation. We know that hospital governors and Healthwatch are to be abolished but not how they are to be replaced beyond feedback through the NHS App. This would be a poor substitute for the good work by governors and patient representatives who understand the context and ramifications of individual patient experiences which go far beyond a score on a digital app.

We know the problems and that it is once again time to get on the front foot. We are a relatively small group of doctors but we have the experience to know that we understand what the public wants, what works and what doesn't. We shall work with like-minded colleagues in health and in the public such as Health Campaigns Together to achieve more influence in our common goal of reviving the NHS.

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Read any good books (etc) lately?

The newsletter will be featuring more book reviews in future, with the aim of increasing members' awareness of the excellent and critical books which align with our objectives: relating to the NHS and its underlying founding principles, medicine, or sociopolitical issues that affect them. Not necessarily non-fiction: 'works of fiction' can tell the story of what is happening to our health services, the profession and the wider political issues better than many texts 'based on fact'. And stories matter. They are what people can believe in, can be motivated by, can bring about change with. Good, evidence-based argument is one of our strengths, of course, and every year there are many titles that add weight to the calls to protect our NHS. Members will probably not have heard of all of them. The reviews will bring at least some of these to members' attention.

If you would like to write a review for the newsletter (or suggest a book, movie, TV programme, play or podcast which you think shuld be reviewed), please let Alan Taman know:
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Neoliberalism: The NHS's Greatest Foe

George Monbiot writes regularly in the *Guardian* and has lead a career as an international investigative journalist (including working for the BBC) as well as campaigning in the UK on road building and conservation. He has published several books on the current state of democracy, and more recently has spoken out at length on the damaging effects of neoliberalism (*The Invisible Doctrine*, co-written with Peter Hutchinson, has been reviewed in this newsletter (1)). Interviewed by Alan Taman

You've written extensively on the effects of neoliberalism on the UK and elsewhere. How would you define 'neoliberalism'?

Neoliberalism is the dominant ideology of our times. It tells us we should strip away anything that interferes with the discovery of a natural order. It believes that wealthy people deserve to be wealthy and poor people deserve to be poor and that there is a 'natural hierarchy' of human beings. It also believes that anything such as taxation, regulation, trade unions, public services, protest and in some cases democracy itself interfere with the discovery of that natural order. So these should by one means or another be minimised or shut down completely. You end up with a world in which decisions are made at an economic level rather than a political level, which means that the power of money rules supreme.

Why do you think this is so harmful?

Because what neoliberalism does is grant almost unlimited power to corporations and the people who run them. It has created a global class of oligarchs, some of whom seem to be more powerful than democratically elected governments. It disempowers the rest of us. It undermines the enabling state, public services, effective regulation, and the power of people, and puts us on the road to plutocracy instead (the rule of money and those who possess it).

In The Invisible Doctrine *(2), you and Peter Hutchinson describe an almost insidious nature for neoliberalism, where it has become so established in our lives that many people fail to see its presence. Have you any thoughts on how this 'grand illusion' can be overcome, or at least made more obvious?*

One of the things we need to do is what Peter and I were attempting to do in the book, which is to name it and bring it into the light. The great theologian Walter Wink described a succession of steps which you need to take to challenge power. One of them is naming the powers. When something has a name and it has a definition and when people recognise what it is, that is the first step towards challenging that thing. But if it can operate namelessly and below the radar it's very difficult to challenge. That's step number one. Step number two is explaining the problems with it and why it is causing so much social harm. Step number 3 is creating a viable, attractive alternative to it which people would vote for and invest in, in various ways, and see as an effective way of running society better than neoliberalism does.

Is neoliberalism the root cause of economic inequalities in the West?

I think what we've seen is a significant rise in inequality, particularly in wealth inequality. What that leads to in turn is a great political inequality, because those with tremendous economic power can easily translate it into political power,

as we've seen with Donald Trump, Elon Musk, Jeff Bezos, Larry Emerson and so many other multi-billionaires, and that pushes democracy to the sidelines. Neoliberalism has greatly enhanced and accelerated that process.

How damaging to health equality do you think neoliberalism has become?

Extremely damaging to health equality and public health as a whole. We see in extreme neoliberal societies, and the USA is the exemplar, how while very rich people might have access to better and better health, poorer people have worse and worse healthcare. We see in some cases even reductions in life expectancy and a whole load of diseases associated with anomie, despair and alienation, which neoliberalism also is a very powerful breeder of.

Do you think ideas of deservedness ('the undeserving sick') also accompany health inequalities?

Yes, I think that's a very powerful strand in it. It certainly becomes particularly powerful when in the cause of cutting state budgets, which is an important neoliberal tenet, governments then try to exclude people from disability benefits, and they maintain that a lot of people who are actually very sick are not very sick and they are malingerers. We see this for example particularly with the case of MECFS [*Myalgic Encephalomyelitis/Chronic Fatigue Syndrome*] sufferers. MECFS is an absolutely devastating condition. It's made more devastating by a culture of disbelief and dismissal, and treating people as if they're just faking their symptoms, and they just need to get out of bed and pull themselves together, do some exercise, and then they'll be fine. We know that actually that is far from being an effective way of treating MECFS, it actually makes people's symptoms much worse.

How else do you think neoliberalism has affected and is affecting the NHS?

We've seen governments who have clearly wanted to privatise the NHS. I think it's pretty clear that that was the Tory ambition. When we saw Andrew Lansley's reforms they could scarcely have been better designed to destroy the NHS as an effective entity. Of course they couldn't take it all away because it's an extremely popular institution and they would have found themselves voted out of office. But it's been death by a thousand cuts: outsourcing here, privatisation there, underfunding everywhere.

A really important element, which is often neglected, of the difficulties facing the NHS is the huge legacy of the Private Finance Initiative (PFI). While it was at its peak during the New Labour years from 1997 onwards I was very strongly opposed to it. I saw it as being a classic neoliberal attack on the NHS, where in the guise of providing more money and more services it was actually handing over large chunks of the NHS to the private sector on terms which were designed to minimise private sector risk while maximising private sector gain. What you ended up with was the state taking on the risk and the private sector taking on the profits, and this huge legacy of costs being dumped on the NHS as a result, which many hospital trusts continue to struggle with.

NHS dentistry has almost died, and that's by design. That's absolutely catastrophic. From what I can see, the only people still practising NHS dentistry are doing so out of the kindness of their hearts, cross-subsiding it with private practice because they believe they ought to be doing it. But there's no financial incentive, in fact you lose a huge amount of money by doing NHS dentistry. The way I see it, is that NHS dentistry is like the laboratory for what they would like to do to the NHS as a whole if they could get away with it. From the point of view of pushing people into the private sector, the private sector is doing very well out of it; but from the point of view of patients it's been an absolute catastrophe. There are the cases of people trying to make their own fillings and sticking them in with superglue, pulling out their own teeth, or just going without any dentistry at

all and living in constant pain. It's effectively back to the days of before there was an NHS where dentistry is concerned and we see the results of that. For instance Reform, which pretends to be this patriotic, nationalistic movement, is quite the opposite. It's in hock to foreign plutocrats and it's a highly neoliberal party (actually a company). What it would like to do to the NHS is what has already been done to NHS dentistry.

You described recently (3) a 'citizens' revolt against the propaganda of power'. How much hope do you feel for a similar shift in public attitudes towards restoring and protecting the NHS from the market forces you've described?

The NHS is in a very difficult situation at the moment. A lot of people feel let down by it, which isn't the fault of the NHS at all let alone of its remarkable and dedicate staff but the result of massive underfunding and of loading other aspects of the failed state like social care (13% of NHS beds are occupied by people who should instead be in social care). The NHS is a sort of dumping ground for anything the state doesn't want to do anywhere else. That combination has had a massive impact on NHS services, on ambulance times, on waiting times in A&E, on the waiting lists.

The amazing thing is that despite all that people still recognise it's not the fault of the NHS, and there's still enthusiasm for the NHS. I can't cite any specific polls, but what I pick up is that people are desperate to see the NHS properly funded. I strongly suspect that large numbers of people would be prepared to pay more tax if they could only see a more robust health service as a result.

What part do you think doctors could play in challenging the neoliberal effects on the NHS?

I don't want to load more onto doctors than they have on their plate already! I have the utmost admiration for staff across the NHS, who keep the NHS running. I would have been dead without the NHS, no question about it. Throughout the time of my treatment, I was very aware of the pressure the NHS was under but I was also aware of the way in which the whole system was kept together by the enthusiasm and dedication of the staff. If it were not for doctors, nurses and everyone else putting in the extra yards the whole system would have fallen apart. It's a system which relies on goodwill to an extraordinary extent because it's so under-resourced. We need a strongly unionised workforce which is going to stand up for itself, and use all the tools of protest and effective political dissent to try to protect the NHS, to protect their own jobs but also the service in which they're so heavily invested but we can't just rely on doctors to do this for us as a population. We should be doing everything we can to defend and improve the NHS.

Closing thoughts

The King's Fund suggests that over the Tory years there was a £200 billion NHS deficit: the gap between what should have been spent to maintain a modern, effective service which incorporates new technology and can work effectively with a growing, ageing population. So any extra funding that the government now gives making up current account shortfalls is still falling far short of the capital losses which have taken place over the preceding 14 years. It does seem to be that we need a much bigger funding settlement than the one we currently have.

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Can the NHS survive this Labour government?

New EC member John Puntis on the flawed path taken by the government over the NHS

A key Labour manifesto pledge was to rebuild the NHS. The government has made bringing down waiting times for elective care its main target in England, aiming for 92% of waits to be within 18 weeks by the end of the parliament.

However, after nearly 18 months in office, the waiting list of 7.6 million has been reduced by only 220,000. Furthermore, according to the Health Foundation (1), 'it is difficult to know how much of this change is attributable to the policies introduced by the new government, especially considering the broadly similar approach taken by the previous administration. It is also unclear how much of this improvement is due to successfully increasing the number of patients treated rather than recent validation exercises to review and correct waiting list data.'

The validation exercises anticipated that about 300,000 could be removed (2) from waiting lists by weeding out those for whom a specialist opinion was no longer deemed necessary. Even if the drop were to represent a real increase in activity and current trends continue, the target set for reductions in waiting list would still be missed by the next election.

'Winter' crisis

Currently, the NHS is faced with another (predictable and predicted) winter crisis, exacerbated by staff vacancies, lack of beds, a flood of admissions with 'flu and Covid, and the crisis in social and community care provision preventing timely discharge. In an interview with the *Guardian* newspaper (3), Secretary of State for Health and Social Care, Wes Streeting, warned that: 'I want to be upfront with people … there will be problems this winter, there will be hospitals where there are people on trolleys in corridors' (sic). Of course, many waiting in A&E already find themselves in this situation, and it is estimated that in 2024 over half a million patients (4) faced trolley waits of 12 hours or more. Reports during 2025 from the Royal College of Nursing (5), the Royal College of Physicians (RCP) (6) and Age UK (7) all show that corridor care has in fact become normalised.

One member of the RCP commented: 'Providing care in front of a vending machine is a new low for my patients and for me as a consultant. The last patient I had to care for here had a brain abscess. This cannot be acceptable'. According to Age UK, nearly 150,000 patients (8) aged 90 and above wait 12 hours in England's A&Es each year. Older people have been left in their own excrement and wet beds for hours and forced to watch and hear other patients die next to them. Waits for admission of 12 hours or more in emergency departments are already reckoned by the Royal College of Emergency Medicine (RCEM) (9) to account for some 16,600 avoidable deaths each year. This has received little attention from government, with NHS England (10) saying simply that it did not recognise the figures. Surely this is an unacceptable response given the RCEM findings are based on NHS data and published with full methodology in a peer-reviewed journal?

Wes Streeting

Wes Streeting (11) was elected MP for Ilford North in 2015. When Keir Starmer became leader

of the Labour party, Streeting was appointed Shadow Secretary to the Treasury, then became Shadow Minister for Schools in 2020 and, in May 2021, Shadow Secretary of State for Child Poverty. In November the same year he was promoted to Shadow Secretary of State for Health and Social Care. Although in the past he had been tutored by Patricia Hewitt (12) (remembered for being keen on private sector services and moving care from hospital to community!), some argue that he lacked the necessary experience for being Secretary of State.

This may explain why he is now failing in his task of rebuilding the NHS while showing an aptitude for antagonising staff. Bold and negative statements such as 'the NHS is broken' (13) that are both palpably untrue and counterproductive have not endeared him to staff covering for over 100,000 vacancies (14) and being urged to work even harder to improve NHS performance. Abolition of NHS England (without public discussion and risk assessment (15)) and restructuring of Integrated Care Boards is cutting a swathe through the ranks of experienced managers, something specifically warned against by Lord Darzi and contrary to recommendations made by the Francis inquiry.

Managing industrial relations should be a key skill for a Secretary of State, but rather than finding a way forward over pay restoration for resident doctors, Streeting has instead cast their dispute in terms of a 'war' with government (16) which they can have no hope of winning. He has now backed a below inflation 'pay rise' for NHS staff of 2.5% which will do little to improve morale, recruitment or retention. Predictably, health unions have reacted angrily given the cost of living pressures on their members, prompting calls for an end to the Review Body system in favour of direct negotiations over pay.

GPs have also been in the firing line, over keeping online portals open throughout their core hours. A 6-month delay before implementation was agreed so that safeguards could be put in place to stop practices being overwhelmed. GPs who pointed out potential problems were then derided as 'laggards' by Streeting, who contrasted the relative ease of getting a haircut (17) with the difficulty of seeing a GP. He recently insisted safeguards were now in place, despite this being vigorously refuted by GPs. Helen Salisbury (a working GP and BMJ columnist) regrets his lack of understanding of how general practice works (18), and explains that simply tinkering with access does not increase capacity.

"GPs who pointed out potential problems were then derided as 'laggards' by Streeting, who contrasted the relative ease of getting a haircut with the difficulty of seeing a GP."

Making matters worse, the health minister Stephen Kinnock (19) waded in to say claims that booking systems were unsustainable and unsafe were not credible given that one third of GP partners earned more than the prime minister! None of this will engender the goodwill and engagement vital to implementation of the Ten Year Plan for Health (TYP) (20). The British Medical Association (BMA) has now entered into formal dispute (21) with the government, warning that the sheer volume of online requests reduces the availability of face-to-face appointments and compromises patient safety.

No such a thing as a 'free lunch'

According to the Good Law Project, Streeting has received £372,000 from sources connected to the private health care sector (22). These may have been duly declared to parliament and the Electoral Commission, yet raise questions in terms of possible quid pro quo particularly since Streeting is keen to promote the use of so-called 'spare

capacity' (23) in a private sector with a current estimated market share worth around £13bn.

Just what happens to these kinds of donations to MPs is far from clear. Many of Streeting's donations are declared on his Register of Members' Financial Interests as being paid towards staffing costs in his constituency office, or for 'office support'. However, parliament already provides MPs with funds to cover expenses associated with their parliamentary and constituency duties, including staffing and office costs up to £247,000 per year (24). As Minister, he will also have a publicly funded ministerial private office in the Department of Health and Social Care, staffed by civil servants. While all officially above board, there are many who would point out that 'there is no such thing as a free lunch', and argue for full transparency about what donations are actually used for.

Meanwhile, new financial rules for the NHS are soon to be announced including changes to integrated care board allocations, phasing out 'deficit support', moving away from 'block contracts' for non-elective care, and scrapping system control totals (overall financial targets for a geographical area).

Speaking of these changes, CEO of NHS England Sir Jim Mackey referred to the possibility of destabilisation and described the speed and scope of changes as 'genuinely a bit scary'. While the TYP anticipates a return to some form of private finance for new Neighbourhood Health Centres, the much delayed New Hospital Programme is already 'quite close' to agreeing a plan with the Treasury (25) to use private finance for smaller schemes such as car parks and energy centres. The possibility of impending financial chaos, current restrictions (26) and the penchant for expensive private finance deals (27) draining the NHS of money spell further damage to services in the near future.

Summing up Streeting's record as Secretary of State, it is difficult not to agree with commentator Roy Lilley's assessment (28), that on his watch we have:

'an unfunded, unplanned ten-year-plan, with no impact analysis, or implementation plan; the chaos of an unheralded closure and merger of NHS England and the Department of Health; swingeing workforce cuts and unfunded redundancies; no parliamentary time to introduce the legislation needed to close NHSE and legislate for the successor organisation; a bewildered duopoly of committees and boards trying to run what is essentially a single organisation; waiting lists at best static; morale through the floor; social care hanging by a thread; Covid numbers skyrocketing and cuts to vaccinations; productivity grinding to a halt; primary care close to rioting; rows about physician associates and workforce planning; a looming barney with the pharmaceutical industry; and an unpaid bill of about £300m from the last round of strikes.'

"Lord Darzi's ... detailed observations now seem to have been ignored in many important respects ... yet he was able to present a clear picture of NHS failings."

Ten Year Plan for Health

Having commissioned Lord Darzi's report in order to gain a clear understanding of what ailed the NHS, his detailed observations now seem to have been ignored in many important respects. Darzi may have had a history of advising Labour governments to do things that end up not working and divert resources from where they are needed (29), yet he was able to present a clear picture of NHS failings including under-management and massive lack of capital funding.

One obvious question for Streeting was just what had he been up to in the two and half years as shadow health secretary, if not finding out about the underlying causes of poor NHS performance?

The TYP (aka the 'prescription' warranted by Darzi's diagnosis) rather than being welcomed as a game changer is now subject to ever-increasing critical scrutiny.

For example, a group writing for the BMJ Commission on the Future of the NHS (31) noted like others that it is not a plan as such, lacks detail on how change will happen and marginalises those who work in the NHS. Lack of evidence underlying many of the aims and the huge practical difficulties of shift to community care are rightly highlighted, as is the striking lack of clarity with regard to resourcing. In fact, the TYP considers that transformational reforms including service improvements and new technology are deliverable within the £29bn committed in the last spending review.

The reality is that this 'record investment/more money than ever before' represents a less than average historical annual rise in NHS spending and is far less than the last Labour government (31) committed to turn around the NHS from 1997.

"This 'record investment/more money than ever before' represents a less than average historical annual rise in NHS spending and is far less than the last Labour government committed to turn around the NHS."

In this respect, the NHS Confederation (32) pointed out that '£29bn won't be enough to cover the increasing cost of new treatments, with staff pay likely to account for a large proportion of it'. Underscoring this point, the Nuffield Trust also commented (33) that a funding uplift on this small scale (2.8%) is unlikely to be sufficient even to enable the NHS to keep up with the routine increases in activity expected of it, let alone implement further government demands. The cost of shifting from analogue to digital in health and adult social care alone is estimated to be around £21 billion (34). New cost pressures including redundancy payments, increased drug prices and strikes mean £3bn is urgently required (35).

The positives plucked from the TYP by the BMJ group amount mainly to finding evidence of government good intentions, while the increased marketisation of health care and the opening up of the NHS to pharmaceutical and med tech companies (36) are not given much attention. Neither is the increased reliance on using the private sector to plan, deliver and finance care, nor the telling remarks by Alan Milburn – once again an influential figure in the Department of Health and Social Care. Milburn insists that we must stop seeing the healthcare system as being about a single institution (the NHS) and see it rather as an ecosystem involving telecommunication and technology companies, private sector providers and (lastly) the public sector.

Labour argues wrongly (37) that as Health Secretary, Milburn's focus on transparency, choice, and use of the private sector delivered shorter waiting lists, whereas the data clearly shows it was the massive injection of cash that did this (31), with little if any benefit attributable to his ideologically driven reforms. Lord Darzi's point that: 'It is not a question of whether we can afford the NHS, rather, we cannot afford not to have the NHS' should be heeded by those in power. Neither can we afford to repeat the mistakes of the past. There is, therefore, an urgent need for a radically revised TYP that demonstrates learning from what New Labour got right: funding the NHS in line with need, tackling the social determinants of ill health and addressing prevention through a revitalised public health system. Without this, the future of the NHS as a publicly provided, delivered and accountable organisation providing comprehensive care looks increasingly in doubt.

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AGM 2025 Reports

Held online via Zoom Thursday 16 October at 2pm

Opening address: Colin Hutchinson, Chair

[All of the AGM reports can be downloaded in full from **https://tinyurl.com/4vsw42y4**]

Chair's Report 2025 Colin Hutchinson

The Annual General Meeting held in October 2024 discussed the challenge posed to the long-term sustainability of DFNHS in the face of continuing reduction of our numbers due to the age profile of the membership and the fact that the majority of us have retired from clinical practice. It is with sadness that we had to report the death since the last AGM of Matthew Dunnigan and of Pam Zinkin, who had both joined as members of the NHS Consultants Association and had been energetic members of the Executive Committee. We should reflect on their contributions to the campaign for an NHS that remains true to all its founding principles.

Over the past year we have responded to the consultation supposedly informing the Ten Year Plan for the NHS, which was summarised in the January edition of the Newsletter. I am uncertain how much traction was gained, but members may find it a useful account of this association's current views on the priorities for the coming years. We note with regret that the government did not take the opportunity to exclude the NHS from any future trade deal by a formal declaration of the NHS as a 'Non-economic service of general interest' and 'A service supplied in exercise of governmental authority'.

We have also been interested to note the government's acceptance of all the recommendations of the Leng Review into Medically-Associated Professionals (MAPs), although it is uncertain how vigorously or swiftly those recommendations are being implemented. We have been in correspondence with the GMC on the specific point of Recommendation 15: 'The GMC requirements for regulation and re accreditation of physician assistants and physician assistants in anaesthesia in Good Medical Practice should be presented separately to reinforce and clarify the differences in roles from those of doctors.' The GMC's current position is that they are waiting for clarification and agreement from the four governments of the UK before they implement this, given that they are a regulator for the whole UK. It is likely that the need to emphasise the value of a broad and deep understanding of disease and health gained through medical education and training, and reflected in the medical professional ethos, will be with us for some considerable time.

In association with this, we are extremely concerned at the scandalous waste of human talent that is the result of the powerlessness of Health Education England in commissioning the capacity of postgraduate training programmes to fill the enormous deficits in primary care, hospital services and other medical disciplines.

Last year's decision

At the 2024 AGM, it was agreed that we should increase our collaboration with other organisations that share our values, to maintain our relevance and profile through joint working,

while recognising that many of us already do this as individuals through membership of other organisations, including MEDACT, Keep Our NHS Public, Doctors' Association UK, EveryDoctor, Doctors of the World, the Socialist Health Association and other bodies, and we encourage that way of making best use of our shared professional experience and our energies.

In this vein, I continue as a member of the Executive Committee of KONP, which is campaigning effectively on many different fronts, bringing together the experience of local groups of activists, as well as working groups concentrating on specific areas such as primary care, mental health, data and trying to find ways of influencing government policy. I am grateful to John Puntis, the Co-chair of KONP, for his regular and detailed contributions to the DFNHS Newsletter.

I am also participating in the work of the 99% Organisation. Members might recall that Mark E. Thomas, the founder of that organisation, spoke to our Annual Meeting last year. They meet fortnightly as a group of diverse individuals with a wide range of expertise, who are trying to build a better understanding of the NHS and the economy in Parliament, through publishing reports and holding meetings with parliamentarians in the Palace of Westminster. I recommend *The Rational Policy Maker's Guide to the NHS* and *The Rational Policy Makers Guide to Rebuilding the NHS* as useful starting points for discussion with your constituency MP, or journalists, or the man on the Clapham omnibus. They have made liberal use of evidence compiled by the Centre for Health and the Public Interest, particularly in publicising the adverse impact of the outsourcing of cataract surgery to the private sector.

Need for a decision this year

In the face of slow attrition of membership numbers, and the accompanying reduction in our income and our ability to influence the debate on the future of the NHS and the role of the medical profession in the NHS, the Executive Committee has asked me to open informal discussions with organisations with which we feel we could enter into some stronger degree of collaboration, such as formal affiliation. We would like this to be considered carefully during this AGM, so that we are clear about the wishes of the wider membership and any particular preference for which organisation would be the preferred partner.

With a membership of close to 500, and a considerable body of collective experience spanning most specialties and disciplines, we have the ability to speak with authority on many issues, but my feeling is that our voice would be even stronger and more relevant if it was reinforced by more members with daily experience of working in today's NHS. Affiliation with organisations such as DAUK or EveryDoctor could bring together that depth of experience with an increased confidence that our arguments are relevant to the current situation – that we are not fighting yesterday's battles. [*See update on Page 21.*]

You will be aware that we are not holding our traditional Annual Meeting this year. Despite interesting programmes of speakers, the attendance at these meetings has been disappointing for many years and it becomes increasingly embarrassing to ask speakers to devote often considerable energy into presentations to audiences of 20, or fewer. I know quality is more important than quantity, but there are limits. Affiliation to another organisation could allow joint meetings, sharing the costs and increasing potential audiences, and increasing awareness of our association. Those of us that attended the conference in memory of Dr Jenny Vaughan, organised by DAUK during the summer, were treated to an exceptional range of speakers, covering many of the topics that are of vital interest to DFNHS members, and giving some indication of the level of interest that can be generated amongst a larger potential audience.

We have a strong impression that the DFNHS Newsletter, in its printed format, is one element of membership that is still highly valued, and I am grateful to our Communications Manager, Alan Taman for his continued efforts to source and

compile interesting articles and interviews, and also to all those who have written contributions. As Alan has described in his report, there are plans for further improvements to both our printed and online publications. Affiliation could expand the potential circulation of this work and extend our reach, and potentially attract new members.

A further element of our work which we think is particularly valuable is the Peter Fisher Essay Competition, encouraging resident doctors to think more widely about the way in which healthcare is delivered and their experience of the system within which they are working. I must particularly thank our long-serving Treasurer, Peter Trewby, for his sterling work in publicising, co-ordinating and judging this competition. I am sure he will say more about this in his report. We had some excellent entries this year, with the given 'How can medical education be improved for the benefit of the patient?' and I congratulate the winner, Dr Ke Wei Foong, on a mature and thought-provoking essay which gave me a sense of optimism for the upcoming generation of doctors. We hope that the competition has helped increase awareness of DFNHS amongst resident doctors: unfortunately this has not been reflected in any substantial increase in new members.

I would like to make the suggestion that these three activities – the Newsletter, an annual conference, and the Peter Fisher Essay Competition – should be core to our ongoing focus as DFNHS in any future formal collaboration and that we should seek a relationship that would allow us to build on those strengths. I would also like to explore ways that affiliation could help us to rebuild a wider representation from all the four nations of the UK as they evolve in ways that are increasingly distinct.

Fresh ideas welcomed

The Executive Committee of DFNHS is responsible for day-to-day decisions on the priorities of this association and will be overseeing any negotiations with potential allies. I would like to encourage anybody who is interested in shaping and promoting the aims of DFNHS to put themselves forward to join us [*John Puntis was elected to EC at the AGM*]. I would be very happy to explain more about how the committee works and the level of commitment required, and I am sure that any of the current committee members would be similarly willing to give their views: our contact details are on the website and in the Newsletter.

Along the same lines, I feel that DFNHS would benefit from a refresh of the Chair, so I will be standing down at the AGM. I have had the privilege of heading the association for 8 years and I am sure that there will be benefits from a new approach. I would encourage anyone who is interested, or who just wants to learn more about the role, to get in touch with me [*Eric Watts was elected Chair at the AGM*]. I am grateful to our members for sticking with us, and to my fellow members of the Executive Committee, and Alan Taman, for their continuing advice and support over the years, and I wish DFNHS success in reshaping itself as we move into our fiftieth year.

Treasurer's Report: Peter Trewby, Treasurer

Summary

Total Amount in feeder account on 14/10/25 was £4,515 and £3,500 in our current account. Our principal outgoings over the past 12 months have been £900 for Junior Doctors' essay prize, £8-900 quarterly magazine costs including postage and £1000 pcm to our Communication and Publicity manager. We have given no money in the past 2 years to KONP, NHS Fed or other recipients. Figures 1 and 2 show fluctuations in our deposit balance over the past 12 months and over the past 5 years respectively.

Subscriptions

Since our last AGM meeting, we have lost 51 members (9 known deaths) and this year we have

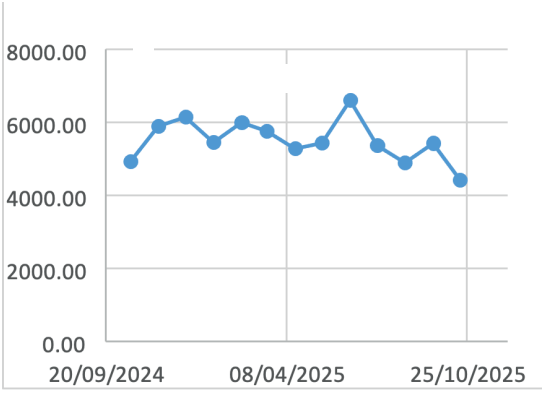

Figure 1 This year's balance, Oct 2024 - Oct 2025

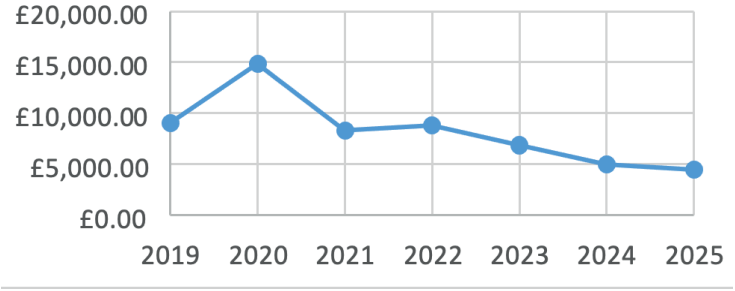

Figure 2 Historic deposit account balance Sept 2019-25

Year	New members	Losses	Net loss
2025	2	51	49
2024	2	45	43
2023	4	41	37
2022	3	30	27
2021	2	50	48
2020	13	25	12

Table 1. Membership gains and losses 2020-25

only gained 2 new members (both from this year's essay prize). Table 1 gives membership statistics over the past 6 years.

We currently have 475 paid-up members including 26 GPs and 12 trainees.

£700 Essay Prize

This year's title was " How can medical education be improved for the benefit of the patient?" There were 45 entries.. This year's winners were Ke Wei Foong first, and Jack Gamble, Ramili Rashad and Hannah Chow equal runners-up. The prize-winning

entries were submitted to the *Journal of the Royal Society of Medicine* for consideration for publication.

In summary

No pressing issues but we must take note of the steady 10% reduction in numbers annually, and hence income.

Communication Manager's Report: Alan Taman

Alan emphasised that from a communications viewpoint, *Doctors for the NHS* commands a unique position. This group remains the only exclusively 'stand-alone' medical campaign group, allowing only qualified doctors to join. It has a well-received regular publication, which regularly examines relevant issues in some depth as well as providing summary overviews of the current threats to the NHS. Journalists do not doubt the accuracy of what we say as a result.

But the gradual decline in numbers should not be dismissed. There will come a point when numbers make continued functioning of the group increasingly difficult, then impossible. By Alan's own calculations, assuming a steady drop, we are some time from that point: several years. It would, however, be a sad moment if the group were to face formal winding down just after its 50th anniversary [*2026*]. That is something Alan is keen to avoid.

Alan proposed expanding what is undoubtedly one of the group's greatest strengths – its newsletter – into the virtual world, by developing its presence on 'Substack', allowing online access by anyone. He will also develop more interviews with prominent people and campaigners, increase the book reviews, and add sections on local campaign issues, to broaden its readership as well as its reach. He welcomed the moves we are making to more planned, extensive collaborative working on carefully chosen projects through more formal affiliations.

The very fact that we stand alone, as 'medics only', gives us a far more powerful voice than our numbers might suggest. But we need to harness it with other groups, and work more effectively as a result. Alan believed that in itself will bring in more members.

Looking at specifics for the past year:

- **The newsletter** remains well received. Nearly all members prefer a printed version, which inevitably increases production and delivery costs, but these are still produced for a total cost of under £3 per issue per member.
- **The website** continues to be updated regularly with posts in topical issues, as well as hosting back-issues of the newsletter in PDF form and telling visitors who we are and what our aims are.
- **Social media:** we retain our followers on 'X'. Substack newsletter development will hopefully increase interest more widely over the coming months.
- **National media:** more difficult to gain traction than it was a few years ago, chiefly because more of the traditionally more 'well regarded' media sources are now saying what we always have about threats to the NHS! But journalists regard what we have to say in advice as reliable. Collaborative working on joint projects will allow better coordination of timely statements moving forwards.

Conclusions

The coming year will present new opportunities for DFNHS which will allow us to assess whether the planned collaborative working is both achieving more campaign goals, and giving us more time, with new members joining.

Keep Our NHS Public Report: John Puntis, co-chair of KONP

February 2025 marked KONP's 20th anniversary and a renewed commitment to campaigning for a publicly funded, provided and accountable NHS, based on its founding principles. This was marked by a rally outside parliament with about 50 people and short speeches from supportive campaigners and MPs including We Own It, 7 left Labour MPs, Adrian Ramsay from the Greens, independent MP Iqbal Mohammed, John McDonnel and Lord Prem Sikka. There followed a month of actions by KONP groups around the country.

The election of a Labour government last summer brought some hesitant optimism, rapidly dispelled by its pronouncements on plans for the NHS, and the November 2024 budget. The latter made clear that New Labour's lesson that improved services and public satisfaction came from increased investment in NHS staff and facilities had not been learned. Manifesto commitments to the New Hospital Programme and reversal of outsourcing were quietly dropped and the private sector further embraced. The commitment to 'public funding' is now in doubt as a new wave of PFI for the new Neighbourhood Health Centres is under active consideration.

KONP membership has remained steady at a little over a thousand but the number of active groups has fallen to 46. Many of these organise local events, hold street stalls and members attend ICB, Trust, Health and Wellbeing and scrutiny committees to put questions and hold health officials to account. There is concern about a failure to attract a younger and more diverse demographic into membership as well as onto the EC, and ongoing discussion about succession planning.

Meanwhile, regular bulletins go out to over 30 thousand contacts around twice a month, and monthly members and supporter's meetings are held on line on the first Wednesday of each month, regularly attracting around 80 participants. We have held detailed discussions about refining and refocusing our campaigning strategy now we have a Labour government that is continuing to starve the NHS of funds, including the way we toxify privatisation.

Members around the country have been active in supporting staff involved in a number of different disputes. Work to reach out to new Labour MPs and sympathetic politicians from other parties progressed in conjunction with the 99% Organisation. MP Richard Burgon supported our first meeting in the House of Commons in March, where the 99%'s report on Rebuilding the NHS was presented, with co-chair Tony O'Sullivan representing KONP on the expert panel. A series of meetings are now planned with MPs being invited to drop in, under guidance from Richard and his team. The next is in November and will explore how the proposals in the Ten Year Plan for Health stand up to scrutiny as well as highlighting the breadth and depth of privatisation in the NHS and its negative impact.

Both co-chairs held a constructive meeting with Adam Ramsay, until recently the joint leader of the Green Party, and Tony O'Sullivan has addressed the Socialist Campaign Group. KONP continues to provide a steady stream of quotes and interviews for the press each month, being recognised as the main campaigning organisation for NHS services.

Working groups continue to be active, producing papers to assist campaigners, available on our website. KONP supported the June march in London organised by the People's Assembly against austerity and in support of public services, with John Puntis speaking on behalf of KONP at the rally. In July, groups organised events to mark the NHS birthday with actions in Bristol, Leeds, Cambridge, Lewisham, Oxford, Lambeth, Southampton and Newcastle. We continue to build our trade union facing activities through Health Campaigns Together and published three bulletins for distribution at union conferences and elsewhere.

KONP continues to campaign vigorously for the NHS, recognising the many challenges that face

campaigners. We are determined to expand our influence with MPs and policy makers as well as strengthening and building local groups, influencing public opinion and supporting the struggles of health workers, many of whom remain both poorly paid and under huge pressure. Through our SOS NHS coalition we are working to strengthen a broad alliance of trade unions and campaign groups (including Just Treatment, We Own It, 99% Organisation, EveryDoctor, the Socialist Health Association, NHS Federation, People's Assembly, Doctors for the NHS, Doctors in Unite, Medact, etc) and have recently held a second strategy conference around more effective and joined up campaigning. KONP also acknowledges its long association with *Doctors for the NHS*, our common values, and its important contribution to defending a public NHS over many years.

Closing Discussion: Main points

Election of Executive Committee

EC members were re-elected for a further year. Eric Watts was elected Chair. John Puntis was elected onto EC. Members are invited to join EC at any time if they wish to contribute: please contact Eric Watts about this.

Plans for the Future

Colin informed the meeting that he had made initial approaches both to Doctors' Association UK (DAUK) and EveryDoctor UK (EDUK) about some form of affiliation following discussion at September's EC meeting. DAUK had responded positively, and suggested a joint EC meeting to consider options and details further. Alan Taman was arranging this.*

Helen Fernandes [*Helen is co-chair of DAUK and also sits on DFNHS's EC*] said that DAUK's governing committee was very enthusiastic about joint working, with most of their members 'at the other end of the age demographic'. DAUK was in a good financial position, with its higher subscriptions (£10 monthly). Newsletter sharing of the DFNHS newsletter electronically would be very welcome.

On being asked from the floor, Colin explained that EC had agreed not to pursue any form of merger with another group, because the unique features of DFNHS would disappear within another organisation, and members were already at liberty to join these groups so it was unclear what advantage this would confer, even if a majority of members agreed and another group agreed to consider it (which was felt unlikely given the higher subscription fees charged). Merger would therefore mean winding down for DFNHS. DFNHS also continued to have a viable voice and remained an effective campaigning organisation.

It was agreed to explore affiliation with DAUK only in the first instance, then review after the membership had been informed of any definite proposal and a majority decision to proceed obtained. Colin was happy to offer Eric any further assistance with this process.

*[*__Update:__ An initial meeting between EC members of DFNHS and DAUK has now been held, with initial positive discussions about how affiliation arrangements could be made to the mutual benefit of both organisations. More are planned. Members will be kept fully informed by e mail and in the newsletter, and any affiliation agreement will be put to members for comment and ratification before proceeding further.]*

The Peter Fisher Essay Prize 2025 Runner-up

This year's Essay Prize drew over 40 entries, again another record. The essay question was 'How can medical education be improved for the benefit of the patient?' There was an impressive range of interpretations and styles. Dr Jack Gamble's essay, published here, was joint runner-up with two others; the remaining two essays will be published in the next issue. You can also read the essays on the website: https://tinyurl.com/2vj92tdn/

Medical education is replete with voyaging metaphors – undergraduates embark upon their 'first steps' to become a doctor, then after several years must decide which 'training pathway' they will set off upon, whilst senior clinicians must constantly demonstrate they are continuing along their 'lifelong learning journey'.

But if the General Medical Council's National Training Survey is to be believed, this educational journey is an Odyssean one – an arduous and brutal expedition that tests the limits of human endurance, with foul and wicked dangers at every turn. Their most recent 'State of medical education and practice in the UK' report opens with these gloomy lines: 'UK health services are in a critical state and those who work within them are at breaking point…Doctors in training are now more likely to be at high risk of burnout than any other group' (1). In these dire circumstances, how can medical education be rescued, not only for the wellbeing of trainees, but ultimately, for the benefit of the patient?

In order to survive the unpredictable and chaotic journey of medical education, a wise and experienced guide is needed.

This essay argues that the practice of clinical mentorship holds significant promise for cultivating compassionate, insightful and capable physicians. A typical description of mentorship speaks of 'influence, guidance, or direction' (2) but a precise definition is elusive. In order to appreciate its multifaceted aspects, and to demonstrate how these may be relevant within medical education, mentorship will be explored within three different contexts – the world of the artisan, the athlete and the advocate – before addressing objections and suggesting some routes of implementation.

Mentorship: The Artisan

Japanese swordsmithing, guitar luthiery and Orthodox icon woodcarving appear at first glance to share little in common with clinical medicine. However, these are highly specialised crafts that rely on novices committing to lengthy apprenticeships under a distinguished master craftsman prior to embarking upon independent practice. This apprenticeship model has a rich history within medical education, and was the norm throughout the early modern period in Europe. However, in the last two centuries, the rapid expansion of biomedical discovery has moved the locale of learning to the academy (3,4). Whilst resulting in more rigorous standards within the profession, this has led to the loss of the master-apprentice dynamic.

The analogy of a master imparting rare and complex skills through close-quarters tutelage extends well to procedural clinical specialties. Mentorship in technical skills is vital to achieving clinical excellence – observing an expert's proficiency, and then attempting to replicate the task under their scrutiny. However, the current

assumption is that healthcare service provision in itself produces the requisite environment for mastery. The emphasis is placed upon an isolated individual learner simply 'getting their numbers up'. But this is fatally flawed. Psychologist K. Anders Ericsson's seminal paper 'The Role of Deliberate Practice in the Acquisition of Expert Performance' (5) popularised the concept of elite performers requiring 10,000 hours of deliberate practice before attaining mastery in a chosen domain. Whilst the notion of 10,000 hours of training has gained traction, the deliberate nature of the practice has not. Quantity, not quality, has gripped the popular imagination. In contrast, the expert surgeon observes their student, makes subtle technique adjustments and gives specific advice to prevent reinforcing bad habits and to nurture good ones. Patients do not want to suffer under mediocre doctors, and they do not want to be practised on. Contemporaneous feedback ensures quality and patient safety, whilst also maximising the learning potential of the encounter.

Mentorship: The Athlete

Any discussion of high performance must pay homage to the sporting arena. It is unsurprising that elite athletics has such a degree of overlap with the medical sphere. In the acute specialties, the ability to perform complex demanding tasks in a rapidly changing environment is required nearly every day of the week. And yet, whilst Team Sky invested millions of pounds into sports psychologists, ergonomic advancements and the pursuit of marginal gains in order to win a cycling trophy (6), clinicians with human lives in their hands are often left to work it out for themselves.

Medical students memorise algorithms to manage emergencies, but, in stark contrast to their nursing student peers, have little experience of the practicalities of enacting the resuscitation. To make matters worse, current team configurations conspire against clinicians. The medical emergency team, who respond to the most critically unwell patients in the hospital, have been described as an example of a 'smash team' (7) – individuals who do not work together regularly and may never have met, who are called together at a moment's notice to manage a time-critical crisis situation in an unfamiliar location with no prior preparation. This is in contrast with elite sports teams who develop a shared mental model by spending an impressive proportion of their lives together – rehearsing tactics, perfecting plays and analysing performances.

This highlights the need for coaching medical teams through simulation. This allows the testing of a learner's knowledge and their procedural skill, but crucially affords a window into their non-technical capabilities – how they interact with their environment, especially other participants. Once again, feedback from a mentor is what develops quality. Granular critique of their situational awareness, non-verbal communication and choice of words can elevate not only how an individual performs, but how the wider healthcare team performs as a unit. Patient-centred outcomes are improved less through individual brilliance and more significantly through effective teamwork.

Mentorship: The Advocate

It is evident that any implementation of mentorship involves a significant amount of time. And time, as the adage goes, is money. Is mentorship worth the investment? It is worthwhile to turn to a sector where value is unambiguously assessed by its ability to drive revenue. The corporate world uses mentorship as a crucial method of professional development: 84% of US Fortune 500 companies use one-to-one mentoring programs, and the top 50 companies use them without exception (8). In many instances, this involves an experienced professional championing a junior colleague, supplying them with opportunities for career progression alongside sage advice.

This professional mentorship role has been replicated under the guise of an educational supervisor. However, in contrast to a long-term mentor who is actively engaged and invested, educational supervisors are transitory and

beholden to a mountain of administrative tasks. A vision of impactful advocacy would feature a seasoned clinician who journeys alongside their mentee. Over the course of several years, they would be able to use their professional connections to open doors and opportunities. They would also utilise their own insights to guide students and residents through the various paths and pitfalls that they have personally experienced. This has enhanced relevance for non-UK medical graduates. The 'hidden curriculum' (9) is incredibly difficult to navigate for the uninitiated, and many cultural norms and social conventions are opaque to outsiders, and simply 'obvious' to insiders. Senior clinicians, particularly those who themselves have walked in these shoes before, have a unique position to guide, support and effect change where necessary.

It is in these relationships of trust and psychological safety that meaningful reflection may take place. Formal channels for facilitating reflection have garnered scepticism following the Bawa-Garba case, where concerns have been raised over the alleged weaponisation of her personal reflections (10). As a result, trainees are wary of recording anything other than vanilla narratives that outline banal lessons learnt. The wisdom and reassurance of a doctor further on up the road displaying their own vulnerability and weakness can allow for fruitful discussion and significant change. This is crucial not only for personal wellbeing and career longevity, but also for enhancing future patient care.

Brave New World?

In the midst of these treacherous waters comes the sweet Siren song of the tech-evangelists. To quote Irving Berlin with minor adjustment, 'anything you can do, AI can do better' (11). On face value, it is hard to argue against. Anyone with enough idle time and curiosity to sample ChatGPT could be forgiven for thinking that if anything can improve medical education, it is artificial intelligence (AI). Assistive technologies such as Nerveblox have used deep learning techniques to process ultrasonographic images and overlay sonoanatomical labels in real time. This has great promise for safely teaching novices how to perform peripheral nerve blocks. Students have described using large language models as a study sparring partner, prompting the chatbot to present a realistic exam viva scenario in a conversational format. At an organisational level, curriculum organisation, exam question setting and admissions could be all be efficiently streamlined.

AI is not without its drawbacks. It is expensive to integrate at an institutional level, its clinical conclusions require thoughtful evaluation (not simply blind acceptance) and its use raises a legion of ethical challenges. However, many of these are hiccups that will likely be overcome. But AI will not overcome its fundamental limitation of non-humanness. Its Achilles' heel is precisely mentorship's greatest strength. Doctors do not care for bits or bytes – they care for flesh and blood. Aspiring healers need to be disciplined in the art of compassionate care, being taught how to speak with comfort and candour. Patients, because they share with us their innate and inescapable humanity, do not simply care about the technical quality of their care, but how they were made to feel throughout it. Greying physicians pass on the secrets of this art, precisely because machines cannot robotically reduce this to an algorithmic science.

Implementation and Concluding Thoughts

A mentoring revolution within medical education would consist of both systemic and behavioural change. As with anything, system alterations are more difficult, less exciting, but have greater capacity for lasting change. Mentorship takes time, which is one of most precious commodities in the National Health Service. The pressure on trainers is immense – they have been found to be more likely to be dissatisfied than their non-trainer counterparts (1). A greater mentoring workload could only be

achieved if more resources and time were given to accommodate. Royal Colleges would also be able to creatively economise the administrative burdens placed upon tutors, in an effort to maximise the usefulness of learning encounters. This could all be facilitated with the help of various AI tools. Similarly, easing workload pressures for resident doctors would be essential for allowing them to maximise learning opportunities, in addition to considering the significant impact that non-physician medical staff have on training opportunities.

In conclusion, a wise and steady hand is needed to steer learners through these unchartered waters. Whilst the rise of AI may have many applications within medical education in the coming decades, it is through the intentional instruction of veteran clinicians that skilled, competent and compassionate doctors are developed. Despite all that is thrown at them, clinicians, like Odysseus, are enduring – 'strong in will to strive, to seek, to find, and not to yield' (12) to mediocrity and complacency. Their thirst for mastery and hunger to teach should not be presumed upon but encouraged and supported within our institutional frameworks, primarily because medical education is inseparably intertwined with patient wellbeing.

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Book Reviews

The Strange Death of Medical England: How the medical profession went from master to slave in a generation and why it matters to all of us
(£7.99, paperback)
William Hayes-Wood, 2025, 123pp.

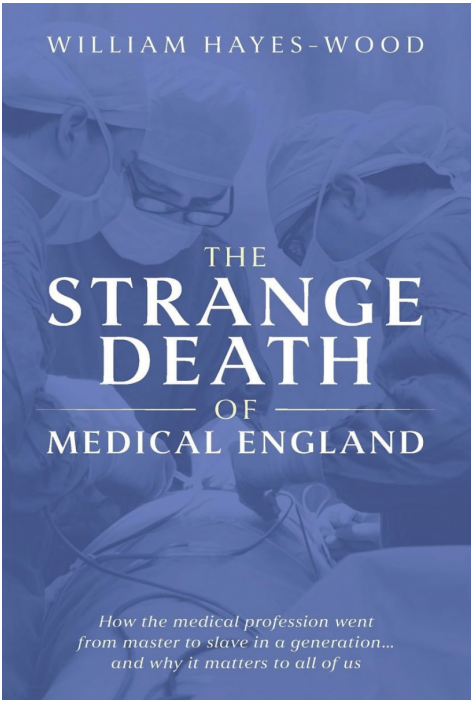
This brief sparely written book punches well above its weight, and offers a remarkably large view for such a short read.

Hayes-Wood is a recently retired veteran NHS consultant surgeon. He is clearly disillusioned with the trajectory of his pre-loved profession, yet remains idealistic enough to want to heal and reverse the major losses and damage he has witnessed. The subtitle of this pithy slim volume is 'How the medical profession went from master to slave in a generation … and why it matters to all of us'. These two questions are answered with great clarity and easy conversationally styled engagement – his narrative has a refreshing lack of academic or data references. History and current problems of great complexity are rendered very comprehensible for the non-specialist reader.

Early on, a central notion:

> '… healthcare in the UK is in danger because of a change in political philosophy at the very top of government which began 40 years ago and which successive governments have chosen to build on ever since … in order to achieve these changes it was an essential prerequisite to neutralise the power and influence of the one body that could frustrate their plans – the medical profession.'
>
> 'I have always thought, and this remains my view, that healthcare is better directed by doctors and other trained professionals working together, rather than by politicians or health insurers responsible to their shareholders.'

His outlined history of how this happened covers 80 years and, in some places, contains



details that will surprise many. For example, although the NHS was born and suckled within the first post-war Labour government, it was conceived earlier, in the midst of World War 2, by a coalition government. In particular, William Beveridge, Liberal politician and economist, and Conservative Health Minister Henry Willink were major contributors to the White Paper *A National Health Service*, published in 1944 – the year before Clement Atlee's Labour Party won power. Clearly there was, then, a political consensus of support across the political divide, for a universally accessible health service 'from the cradle to the grave'.

Such consensus did not initially extend so readily to the doctors, many of whom fought a suspicious and defensive battle against any government hegemony. Yet with canny toughness and clever diplomacy Labour's Aneurin Bevan managed to disperse this opposition and won the doctors' acquiescence or even tentative support. Remarkably, within a decade most doctors rapidly became vocationally committed to their NHS work.

In these early decades the acceptance and appreciation of such an NHS led Chancellor Nigel Lawson to say in 1992 'the NHS is the closest thing the English people have to religion'.

But such relative stability unravelled from the 1970s into the 1980s. The long consequences of post-war debt and damage, the dispersal of the British Empire, the crumbling of prior industrial and manufacturing supremacy, led to accumulating financial, employment, labour and social problems and then disruptions.

Both Labour and Conservative governments foundered and floundered in attempts to govern. Enter a new leader who did neither – Margaret Thatcher. She was convinced – and convinced many others – of a radical solution: neoliberalism [see *also Page 6*]. Hence competitive marketisation and monetised commissioning would be legally mandated wherever possible; waste would be cut; motivation, discipline and efficiency would be enhanced; and the State's burdens and responsibilities much reduced.

Thatcher included the NHS in this mission and employed Roy Griffiths, a Sainsbury's Supermarket director, to report:

'Coming from such a background it was clear that Thatcher expected Griffiths to look at the NHS as a private sector company rather than as a state-funded organisation providing essential services based on the citizen's requirements. Of course, the overriding duty of a private sector business such as a chemical company or supermarket is to provide monetary profit for its shareholders, a concept which is meaningless to a nationalised provider of healthcare. Moreover, if the company fails to make money it can be wound up, dissolved or cease to exist. Another concept inapplicable to the NHS.'

"Labour and Conservative governments foundered and floundered in attempts to govern. Enter a new leader who did neither – Margaret Thatcher. She was convinced ... of a radical solution: neoliberalism."

Another paradox was this: 'Griffiths stated that when it came to management and accountability in the NHS as he found it in 1983, basically there was none.'

The paradox here is that the NHS in 1983 was, for all its unevenness and inadequacies, comparatively, according to many international studies, offering the UK population the safest and most cost-efficient health service worldwide. For this to be true there must have been some very effective kind of management and accountability, but it was of a colleagueial and vocational kind – not recognisable to the likes of Griffiths and Thatcher, who understood corporate manufacture but not human welfare.

This paradox – or rather discrepancy – has continued, very problematically, until the present time. Much of what Hayes-Wood writes so painfully about derives from this. However much patients, practitioners or academics demonstrated the inefficiency or dislike of increasingly corporate neoliberalised micromanagement, the Griffiths-Thatcher folly has continued, despite successive

governments promising to reform the reforms:

> **'Thus, by the time Labour left government in 2010, there was more private sector involvement in the NHS than there had been in 1997 when it came to power.'**

Hayes-Wood points out a kind of reverse parallel process:

> **'It is ironic that the medical profession – somewhat wary of the NHS when it had been first set up by the Atlee government in 1948 – had morphed into some of the strongest supporters of state-run medicine and fiercest opponents of market-based economics being introduced into the NHS.'**

Herein lay the ruin Hayes-Wood so laments, because:

> **'Despite their initial scepticism, the doctors had soon become amongst the staunchest defenders of the nascent NHS. They did not realise that they were opening the door to their own profession's demise should an ideologically-driven government come to power which despised the post-war consensus.'**

And so, 30 years later, such a government did emerge and then:

> **'… the doctors were ill-prepared to resist and, indeed, for a long time did not fully appreciate what was happening.'**

Hence the medical profession's apparent inertia and discombobulation: the Thatcher-era reforms were responded to, largely, by a kind of post-concussional state. Many practitioners were uncomprehending of the suddenly strange and pugnacious new regime and retreated, if they could, into the work they knew and understood. A few, seeing clearly the changing power-tide, expediently became the government's agents and collaborators. Even fewer at the time were those both perspicacious and courageous enough to articulate effective opposition.

All this was like a very effective coup d'état by an ideologically-driven minority group. The fact that its consequences have since been, predominantly, unpopular and ineffective have not hindered its durability – financial interests of wealthy 'stakeholders' are very formidable. And – as so often in life – it is far easier to get into things than to get out of them..

Here this veteran doctor surveys a widespread panorama of what we are now struggling with. The displacement of medical responsibility and initiative by commercial and corporate protocols and diktats; the compliant submission of the General Medical Council and Medical Royal Colleges to government policies, thereby becoming de facto government agents or commissars (in spite of the majority opposition of their professional members); the discouragement of personal continuity of care in favour of depersonalised large-team working (hence the demise of the Family Doctor and the hospital consultant-led team); the default 'progress' of merging smaller accessible services into much larger, centrally-managed units; the quasi-militaristic corralling and directing the working options for younger doctors, impeding their choice and autonomous development…

Some of these receive particular attention in *The Strange Death*. For example the capitulation of both the GMC and the Royal College of Physicians to both train and register Physician Associates (non-doctors) despite massive opposition from their established professional membership. The government's plan here seems to make doctors more malleable and obedient by demonstrating their disposability and to make (short-term) savings … but creating a two-tier and less safe system.

There is a harsh irony here because in 1518 the prototypal College of Physicians was started autonomously by pioneering university-graduated

doctors to differentiate themselves from lesser-trained apothecaries and 'quacks'. Three hundred and forty years later, in 1858, parliament's Medical Act required the separate examination and registration of doctors to clarify the professional distinction from all other healthcarers.

The current government's specious initiative jettisons such safeguards.

The cumulative effect of all this has been erosive and egregious, and in so many ways. With medical staffing: instability and unhappiness through declining work satisfaction and trusting familiarity and colleagueiality – thence to sickness, drop out, poor recruitment, early retirement. Then, of course, patients: the thinning out of services that become inaccessible, peremptory, often rushed and error-prone … and the near-extinction of personal continuity of care. Our NHS becomes, inevitably, more unhappy, unsafe … and much more expensive. The last of these is, surely, a tragic paradox and indictment of the reforms Hayes-Wood so ruefully describes.

This book is a thoughtful threnody to a passing culture and imperilled values. At its end he writes:

> '… it really is up to you – as an ordinary citizen and voter – to speak out and try to do something about it. The politicians, despite many fine words and false smiles, will not help you. The medical profession cannot.

> '… a National Health Service which can give identical treatment to individuals so far apart in the social strata, entirely non-judgementally, is something very special indeed.
>
> 'Do not let them take it away from you. They will try.'

Hopefully he can galvanise useful recruitment more than evoking impotent grief.

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Wealth versus Health: Trump's global war on health and science
(£14.95, paperback, also on Kindle)
John Lister, 2025, 310 pp.

Cards on the table. Without John Lister, I would not be here. Not in the mortal sense. I mean 'here, writing this': John was my tutor for my Masters in health journalism, taken on leaving my Communications role in the NHS.

He taught one module, on international health systems. I would describe my realisation of what is really happening to the NHS as a monumental moment of professional epiphany. 'Hang on', I said to him after one lecture, 'so what is happening to the NHS is deliberate, grounded in this awful ideology [*of neoliberalism*]?' With one of the most knowing smiles I've ever seen, John's answer was as confirming as it was succinct: 'Yes'. So here we are. And, bringing to bear one of the strongest lessons he taught to all his students, what can a critical and informed eye make of his latest book?

The Foreword (written by EC member John Puntis) gives the most powerful clue:

> **'What happens to health care when a narcissistic and authoritarian member of a rich elite comes to power and starts to implement policies aimed at enriching a clique of business buddies including high finance, big tech, real estate and fossil fuels? This book spells out the answer.'**

Ah, but how? The (orange) devil lies not just in the detail, which is encylopaedic and rigorously laid out with reliable quantitative data, but is described with John's articulate style in a clear and logical structure which should lend itself to persuading anyone who is willing to consider the argument.

There then follow six chapters after a short introduction. The Introduction answers a key question: 'why focus on health in a book on Trump?' After briefly outlining the man's many failings (a feat of summary in itself), this is explained:

'This is one arena in which what Trump has already done in the US has inflicted deep and lasting damage affecting not just the US and Americans, but also billions of people in low and middle income countries …. By its attitude to health care, and especially to the care and support of the poorest and most vulnerable you can best judge the character of the Trump administration…. Among his victims will be many of the ill-informed, low-income Americans who were somehow persuaded to vote for him last year but some of whom are now beginning to feel the grim reality…. Many more people living outside the USA are also falling victim.'

The first chapter goes into the history and political changes surrounding and shaping the US healthcare system over time, explaining why the USA is 'the best of systems and also the worst of systems'. Taking as its starting point Trump's incredulous threat to annexe Canada, and the consequent massive opposition even to the principle by the vast majority of Canadians, it compares the health systems of the two neighbouring countries then maps out the history of US healthcare from around 100 years ago to the present. A tale of powerful corporations lead by the private insurance industry (and, yes, complicit or outwardly hostile doctors' groups lead by the AMA, with some heroic exceptions) hand in glove with government shaping a healthcare system pivoted towards private profit and often hostile to efforts to give working people a decent and fair service. Despite which, and reflecting the fact that by 1996 70-80% of Americans were 'very or somewhat concerned about being unable to afford necessary health care', there is still at least some (eg Medicare and Medicaid): but a more iniquitous result would be hard to plan (as this one in fact was). The health landscape when and since Trump took office in 2024 makes especially grim reading: 'a system bloated by fraud, waste and admin costs' seems a particularly ironic counterpoint to Streeting's vilification of the NHS for having 'too much waste'.

The second chapter turns to what created Trump, or rather made his presidency possible despite his many lies: the emergence of an ideological, right-wing school of politics culminating in 'MAGA' – neoliberalism. This newsletter has covered the nefarious effects of that hostile ideology elsewhere [see *Page 6*] and the chapter describes how it has mis-shaped healthcare in the USA and enabled Trump to continue to make matters worse. This includes the first signs of systematic attacks on science and global aid, and the catastrophe that was Trump's response to Covid. We also learn of the plan to enact many of Trump's destructive measures on gaining his second term, Project 2025, including its effects on US society and healthcare which are potentially downright dystopic if achieved. Effects which are already noticeable with the actions of key players like Elon Musk, or 'the ketamine-gulping, ecstasy-fuelled, chainsaw-wielding, Twitter-killing South African billionaire misfit'.

"The crowning irony in this chapter is that the proposed cuts *[to Medicaid and Medicare]* would actually cost the federal government more: hypocrisy that takes lives and ruins many more."

Chapter 3 looks at public healthcare, an often overlooked sector of healthcare in the USA which is not privately run. My advice would be to look soon – the Trump regime is doing its utmost to make it disappear completely despite the persisting strong bipartisan support for it, all justified through the neoliberal lens of 'cutting costs' by denying care and ignoring the healthcare providers themselves. Cuts to Medicaid alone of almost $1 trillion were made in Trump's opening attacks, and plans include stripping millions of poorer families and children of their health insurance. *Any* health insurance, and taking healthcare and other benefits off many service veterans. The crowning irony in this chapter is that the proposed cuts would actually cost the federal government more: hypocrisy that takes lives and ruins many more.

In chapter 4 we come to Robert F. Kennedy, Jr. Oh dear. We're a long way from JFK. The effects on vaccines and medical science even in the short time that Health and Human Services has been under the leadership of RFK have been 'seriously harmful': 'Kennedy has already left a

trail of chaos, destruction, and anger amongst health experts who have been pushed aside or summarily removed to make way for the Trump regime's bulldozers'. From mishandling a measles outbreak, to massive job cuts in agencies such as the Food and Drug Administration and the CDC, to questioning the role of fluoride in drinking water and stripping out experts and appointing known 'anti-vaxers' to positions of power in public health in an atmosphere of growing suppression of any opinion that does not align with the Trump ideology on health (or anything else, for that matter), the narrative of destruction leaves no doubt as to how this is affecting and will affect public health and millions of Americans. The case of a gunman opening fire on CDC offices after blaming a Covid vaccination for his troubles serves as more than a metaphor for the harm inflicted on health in Trump's America: public-health officials are increasingly vilified and violence encouraged.

The wider damage inflicted on global health is turned to in Chapter 5: withdrawing from the (admittedly flawed, but still worthy of support) WHO, the UN bodies affected by Trump's cuts, putting public health services at risk in some of the poorest countries with more budget cuts, cutting a further $1.6 billion from food aid and more, and what these will mean in human terms are mapped out. A topography of disease, suffering and avoidable death for people who have little or no possibility of avoiding their fate. A 4 *week* delay to HIV response funding alone has caused up to 28,000 excess deaths in sub-Saharan Africa, for example. These figures are hard to imagine – but they are the reality, with yet more cuts planned for next year: 'The MAGA onslaught has effectively ended any US role as a leader in health care', and many more dead people are its legacy.

The wider onslaught on science and knowledge is covered in the final chapter. The systematic replacement of knowledgeable and diligent scientists, researchers, leaders and even institutions by people and organisations whose only defining characteristic seems to be loyalty to Trump and unswerving belief in MAGA neoliberalism (and ignore the evidence) makes by now familiarly saddening reading, were it not also infuriating. We are now seeing a systematic, planned and resourced anti-science, 'anti-woke' agenda put into policy and practice by what historically has been a beacon of scientific reason and progress, complete with the stifling of any voices of doubt or opposition. The ability of the National Institutes of Health to issue pretty much any comment was stopped in the first few *days* of Trump coming to power last year. Some parts of academia have fought back against the onslaught, and have been attacked in turn (eg Harvard and Yale). The wider effects on health are described, such as climate change and environmental damage, all worsened by the Trump administration as reliable evidence warning about them is dismissed, ignored, censored, or rendered impossible to gather. The book ends with a succinct warning:

> **'Everything the Trump administration has done in its first six to nine months threatens the health of Americans and the rest of the world. They are waging a war on health and health care – and it's a war we cannot allow him to win.'**

At over 300 pages it's a relatively long book, and as I would expect. It's as rock solid in its evidence as we should be angry about what is happening to USA healthcare and globally thanks to this odious regime. We need to be. 'There but for the grace of God…' will not be enough to save our NHS from the same attack and demise. We need to fight. Books like John's can only help ensure we not only have strengthened will, but deepened faith and growing determination: **that this will not happen here.** But we know it could. It must not. The public need to know. If you do stocking fillers, this book will fit!

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UK Healthcare is in Crisis: Reform must also address poor culture
(£9.19, paperback) David Sellu, 2025, Troubador

This book by David Sellu is a valuable addition to the work on improving the NHS.

There is a particular focus on learning from adverse events including major scandals.

The author has a keen and clear insight into the problems as he was a victim of the poor system we have for managing these problems.

He was made to carry the can for multiple failings in the hospital where a patient with faecal peritonitis died. This is a serious condition with a 30% fatality and the authorities should have been aware of that. Other surgeons in the same situation have been lauded for their efforts in difficult circumstances but the legal system deemed him solely responsible for the death.

He was convicted and served time in prison before a retrial exonerated him and exposed appalling weaknesses in the prosecution and judgement. Whilst he referred to problems outside his control in his defence, pointing out that the hospital did not provide sufficient support (eg no anaesthetist or theatre were available when needed), the judge's reply was that the hospital was not on trial and that he was and therefore the system focused on him.

We are not to know what the system would have uncovered if it had focused on the problems of the hospital but a fair-blame system would have exposed these problems and recommended solutions.

To his great credit David has embarked on a mission to make healthcare safer and this book explains firstly the scale of the problem through many examples, coming right up to date in 2025 reviewing the measures the NHS has taken to make healthcare safer.

In the next chapters ('We are still not listening from adverse events', ' We are still not listening to or providing support for those affected' and 'How can we do better?') he sets the agenda for work to be done now.

Finally he reviews the many systems

introduced to improve safety. Although the most recent changes have not yet bedded in we can see some examples of improvement but he doubts they can match the scale of the problem.

Changing culture will be a very big task with clear obstacles. He gives examples of culture change eg in aviation where the air crew will be highly motivated as it affects them as much as the passengers. And in Oman where a comprehensive new service was created through a successful 5 year plan.

Oman is an absolute monarchy – avoiding the party political football we know so well; he then suggests an all-party commission as a way forward.

This book provides essential information, not only on the scale of the problem but its causes, what has been tried so far and the limitations to the progress, meaning we need to do more.

Unheard: The Medical Practice of Silencing
(£8.77, paperback)
Rageshri Dhairyawan 2025, Trapeze, 304pp.

This book begins with the autobiographical account of being admitted to hospital with abdominal pain to find that you are treated differently if you have a clear organic cause than if you do not.

It is written by a doctor of 20 years who learns a lot from this experience as a patient.

She states – 'With this book, I bring a new perspective to the conversation on addressing health inequity, arguing that better listening is needed throughout healthcare and research to close the gap for minoritised people.'

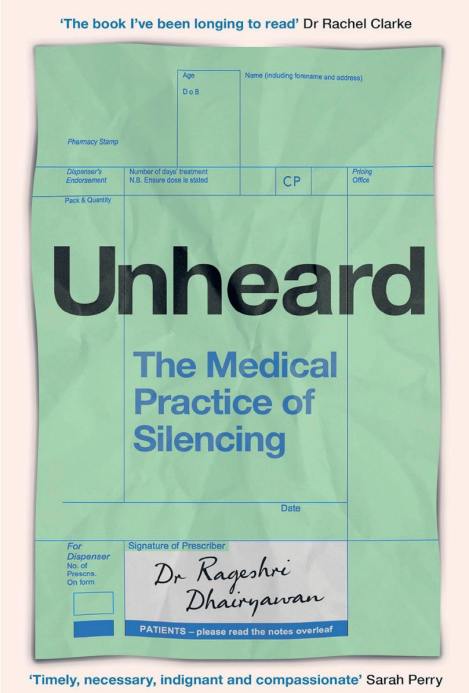
Dr Dhairyawan is an excellent writer and she describes herself on her website – Rageshri is a doctor, researcher and author. She is an NHS Consultant in Sexual Health and HIV Medicine based in London. Her clinical work, research, writing and advocacy focus on improving health equity and she is a sought-after speaker on this topic.

She makes her points very well, there are plentiful academic references and she introduces some philosophical concepts such as testimonial injustice – when a speaker's credibility is unfairly lowered due to prejudice based on their identity, causing their testimony to be dismissed or not believed.

She gives insightful comments on how medical students change as they work through the system. Initially being seen by patients as good listeners because they have not yet learned the doctors' skill in picking out only the medically important parts of the patient narrative.

She describes one report of protocolising nurses' work with the intention of reducing stress and staff turnover only to find it made matters worse; they were slow to appreciate the job satisfaction came from the human contact and natural empathic response.

The problems faced by minorities both as patients and as healthcare professionals



is described in detail. Each of the seven chapters is followed by a comprehensive list of recommendations for improvement. For unheard doctors she recommends the principles of self-advocacy.

The chapter I found to give the most hope was entitled 'Roar: how patients fought to get heard' where she describes the (mostly) American HIV activists and how they realised that they had to fight for themselves to get better treatment and pushed doctors and the research community to improve.

She ends with a chapter discussing health within society including the social determinants of health and the need for an holistic approach. She lists some areas where we can see improvement and asks if we are ready to go further.

The book has been well received by both doctors and patient groups with many enthusiastic reviews already published.

It is sobering to think that she would have gone through medical school long after the GMC published *Tomorrow's Doctors* (1993) [*out of print*] which recommended major overhaul of medical curriculum and more focus on the patient experience.

It is clearly an honest book and it was good to see that in spite of her criticisms of the establishment, that it is advertised on the Barts and London Hospital website. Hopefully they have got the message.

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Happy Christmas

The Executive Committe wish you the compliments of the season.

These are dark times for the NHS, but we firmly believe there are enough folk left with the will to fight for it – and the strength to make a difference together.

Thank you for your support, and for making a difference.

EXECUTIVE COMMITTEE : Elected at AGM 2025

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Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

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