DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

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A View From the Chair: Eric Watts

The Threat to Democracy in the NHS

This is now more important than ever as such little democratic input that does exist will be weakened as a result of the 10 year plan unless urgent action prevents it.

Democracy is important for many reasons, not least that we own the service and that on its foundation the NHS was designed to promote public good and the management was considered to be accountable, as Bevan famously stated that 'a dropped bedpan in Tredegar will echo through the corridors of Whitehall.'

Not only was it good political rhetoric but it underlines the important principle of accountability at the highest level. We now need to examine to see what has gone wrong that this level of accountability has fallen and how we need enhanced democracy or democratic input, not the diluted form presented in the 10 year plan. There are two important aspects: abolition of Healthwatch, and abolition of hospital governors.

Healthwatch

Healthwatch England was established by the Health & Social Care Act of 2012 and began operating in 2013. The most important role was to articulate the patient voice through its involvement with local communities and to be accessible to patients and public.

The need for an independent voice is long established and Community Health Councils, which included local councillors to give the patients' voice, did a good job until they were abolished (possibly for being too effective?) in 1974.

I know of two excellent examples of their good work.

In Essex they looked into the 2013 claim by NHS England's urgent care lead that '40% of patients in A&E should not be there'. The Healthwatch team visited local departments and advertised public meetings so that people who had used A&E could report their experiences. The results were that 80% of attendees were there on the advice of a health professional and the other 20% were there because they had an urgent problem.

The Essex hospital planners were aiming to downgrade two DGH A&E units which would have reduced access to patients needing urgent treatment but the plans were revised and one A&E unit enlarged.

In Sheffield the local Healthwatch group investigated the effect of long Covid on patients and the community leading to a more comprehensive multi-agency approach to this complex issue.

There has been widespread concern about the proposed abolition and many local councils and ICSs have acknowledged the good work they have done. It will take further legislation to abolish NHS England but at the local level some groups will survive (in some form) if the local authorities continue to fund them.

As reported in the *Health Service Journal* (1), Lord Philip Hunt of King's Heath was an energy minister until he retired from frontline politics last spring. He was a health minister in the 2000s, served in several shadow health teams, and is a former NHS leader. He expected government to come under 'huge pressure' to ditch its proposed abolition of Healthwatch, the public voice organisation, when the bill is discussed in the Lords.

As a minister in the early 2000s, Lord Hunt oversaw the abolition of community health

councils, a predecessor of Healthwatch. He said he had the 'scars on his back' from driving the change through Parliament. He added:

> **'It was very, very tough and there's nothing like being at the dispatch box when you unite the whole house against you. [*The government*] wants to get rid of Healthwatch. They've got to come up with something that is strong in terms of public representation, and use it in the health service…. I can't see how an ICB can be expected, essentially, to mark its own homework.'**

Asked about the government's overall approach to managing the NHS – with the abolition of NHS England, centralising ICB leadership, a stronger role for NHS regions, and new provider league tables – Lord Hunt said it was summed up by 'command and control from the Department of Health and Social Care'.

"Whilst in the NHS there are many examples of excellent leadership and good clinical outcomes there has not been sufficient scrutiny of what happens with the poorly performing hospitals."

Management and leadership

We have seen many examples of poor management and leadership causing difficulties, often severe for those professionals who have tried to address the relevant problems.

Dr Susan Gilby, former CEO of the Countess of Chester Hospital NHS Foundation Trust, was awarded £1.4 million in a January 2026 tribunal settlement for constructive unfair dismissal and whistleblowing detriment. The payout, one of the largest in NHS history, followed her 2022 suspension after raising patient safety concerns and facing a campaign to remove her.

My experience of being a governor has provided me with much insight into what can go wrong when high standards of management and leadership are not followed. A fundamental point, relevant to our purpose as *Doctors for the NHS*, is the way hospitals are managed and governance scrutinised since NHS trusts were formed, which means that too often clinical quality and patient safety issues have not been prioritised.

Whilst in the NHS there are many examples of excellent leadership and good clinical outcomes there has not been sufficient scrutiny of what happens with the poorly performing hospitals and how they can be improved. It has been my pleasure to work on some excellent hospitals where the system works well; those of us who've worked in leading centres can introduce best practice when we move to a different hospital.

In contrast what I have seen in hospitals which need improvement is to reject suggestions on the basis that 'we do things our own way here'. Through a variety of agencies, professional associations, Royal colleges, GiRFT and national audits we can see a picture of well-performing hospitals, and those in need of improvement the CQC's league tables tend to mirror what we have known through these various reports.

The challenge to those in the poorly performing hospitals is, how to move forward? This is where the clash between different management paradigms and professional standards occurs. I have been keen to improve safety through analysis of human error to the relatively simple business of patients being given the wrong blood for transfusion. This is a good place to start because it is such a straightforward case of something going wrong that it should be simple to fix. Detailed investigations have shown that numerous factors relevant to

the individuals involved, the circumstances and the organisation itself can all play a role in that the most important point is to learn from every error and to make the necessary changes which may involve the individual or the local operating procedures to prevent a recurrence.

The crucial point is safety requires total openness and transparency and this is where management and leadership problems emerge. The philosophy of constructive error management has been part of professional practice for decades and became high-profile with the publication of 'to err is human' in 1999. The NHS responded with guidelines regarding a reporting culture but in 2019 the Patient Safety Strategy (2) reported that reporting culture has not been implemented universally and that staff need a place of safety. In too many hospitals this has not happened.

My own attempts at promoting safe practice or greater awareness of constructive error management as a governor testifies to the problems with management and leadership. I was elected chair of the service user group where we learnt of numerous problems for patients and from members of staff but the managers and directors were not interested.

I was an observer on the quality and safety subcommittee where safety problems were regarded as inevitable and there are always more exciting issues on the agenda and the committee did not want to get to grips with issues that needed attention. This attitude is described perfectly in the report by Professor Graham Martin about boards failing to sense danger published in our newsletter, in 2024 (3).

In short, telling truth to power remains a major problem and too often boards react to legitimate challenge from governors by supporting each other, closing ranks and group think. In February there was an excellent piece on leadership from Helen Bevan (4) describing one aspect of the problem:

'I want to reflect on a new Manfred Kets de Vries article (5):

'…"seeing" is an active leadership discipline, needing patience and humility. Change is less likely to be derailed by technical error than by psychological blindness: familiarity is mistaken for understanding, data for perception and analysis for awareness.

'Curiosity must override certainty. Certainty is seductive, signalling competence, control and momentum. It also shuts down sense-making, especially if people are anxious. Curiosity keeps leaders open to contradiction and surprise. It reframes "what's going wrong?" into "what's being protected here?" and slows premature action.'

Put simply, too many hospital trusts have a fundamentally wrong attitude in that they do not share mistakes for learning purposes and try to present only the good news about their hospitals. Too many directors especially NEDs come from a commercial background where they seek to promote themselves and are reluctant to accept any criticism. One hospital had a NED from a reputational management background specifically so that she could put a gloss on the hospital image and prevent any bad news which may spoil that – which prevents learning from mistakes and spreading the learning.

It is generally considered good manners to praise in public and criticise in private but some hospitals performance is so bad that, especially when the concerns have been raised and denied,

it is appropriate to share information to help understand how factors impact performance. MSE hospitals repeatedly refused to listen to concerns from whistleblowers so the concerned staff had to go public and there are examples in the public arena.

As a governor I observed a NED criticising the NHS Patient Safety Strategy on the grounds that it was too expensive. It was no surprise to see the hospital very near the bottom of the league tables and that the 2025 November CQC Well led assessment was 'inadequate'.

A recent health service select committee showed West Streeting and Jim McKay (NHSE CEO) taking questions including one for the MP for Thurrock where she specifically asks about the problems with MSE and Jim McKay acknowledged them saying that improvement measures were underway, without any further comment

The key figures on the board of directors have now moved on but it is a classic example of why we need better scrutiny and why I recommend not only preserving hospital governors but giving them more power, possibly re-instigating the CHCs.

The obvious point is that if there had been better means of communication between those of us on the ground seeing the problems ie patient staff and governors and the NHSE hierarchy these problems could be dealt with sooner.

The bottom line is that hospitals would benefit from better public and patient representation and it is not too late to campaign for this through MPs and councillors before the abolishment legislation is passed.

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Margaret Clark: Founder Member

***Doctors for the NHS* is 50 years old this year. DFNHS member Margaret Clark, now 90, was one of the original 'founder members' in 1976 (the 'Gang of Four' – Margaret, Sam Baxter, Peter Fisher and Paul Noone). Here she talks to Alan Taman about her life, career, and the reasons for helping to set up DFNHS.**

'I was born in the Lake District. I originally wanted to be a vet, but in those days my relatives, being farmers, laughed and said "you'll never earn a living as a woman". I asked them how many of them it took to deal with a cow or a horse. But people were very scornful about women in those days. I got a scholarship to do medicine at Leeds University in 1953. I qualified in 1959. I gradually moved down the country. One of my earliest jobs was at Pendlebury Children's Hospital, then at Hope Hospital (Salford)) and the Salford Royal. So I got to know paediatrics and neurosurgery. By then I'd chosen anaesthetics and intensive care, and that's what I spent most of my time on.

'I gradually moved towards London. I was Senior Registrar at St Mary's and then got a consultant job in Edgware. I got very interested in symptom control, so I helped set up a symptom control support system in Barnet General Hospital with some other healthcare professionals.

'By then I'd got really cheesed off with the way the health service was going, because I felt they were promoting privatisation. I was really fed up with people in their private practices when I would be called out sometimes in the middle of the night because the person officially on call was dealing with a private patient. They'd get the end of my tongue the next day, but it never stopped them. They didn't even offer me a tip! No one really questioned private medicine until then.

'I came from quite a poor family. My mother was ill a lot and she got lousy treatment which she had to pay for because there wasn't an NHS. During the Second World War I was very ill as a child. The GP told my parents they had to get me to the nearest hospital because the Army had commandeered all of the ambulances, but we didn't have a car. The GP just walked off and shrugged his shoulders. I'd already had the Last Rites at the age of 5!

'But our next door neighbour was a mechanic, and he took somebody's car for a very long test drive with me in the back! The army doctor who saw me in A&E had just come back from the tropics, and he diagnosed something very rare for the North of England – amoebic dysentery. I would definitely have died, but he saved my life – so I've always had a soft spot for people in the military.

'I had all these not very pleasant memories but everybody seemed to think that private medicine was going to be better than the public sector. I remember feeling delighted that some other people had the same concerns as myself. I think

we all got together because we had resigned from the BMA! I thought we had to do something, and quite a lot of people had the same thoughts and did their best to save the NHS. We wanted to make as many people as we could in the profession aware of what was going on. A lot of people just shrugged their shoulders and said "we can't do anything about it", but we thought if we publicised it in a civilised way it would have some effect, eventually get through to the powers that be. The people who ran the NHS didn't seem to appreciate what was going on under their noses.

'Unfortunately I think things have come full circle. I thought the NHS was the best thing in the world. But it seems that probably due to bad management and bad politics, as well as staff shortages, it seems to have slipped quite a bit.

'I retired from the NHS in 1996. One thing I would ask the young doctors of today is, why did you go into medicine, if it wasn't for the ideals of trying to help people? When I first started out, we did about 120 hours a week and for a pittance though we did get free board and lodging so we didn't need a lot of money. Whereas people today have to pay rents and God knows what else. So I'd say to young doctors today, stick to your principles – if you go into medicine, it's to help people. Stick to the ethics and the ideals.

'It's important that the NHS doesn't move backwards. The NHS needs to take advantage of research, new drugs and treatments, etc. Make scientific progress – but not lose the human factor. I am currently involved with a charity, Cherry Lodge Cancer Care. One of the things that comes across is, it's not just about waiting times, or things happening at the last minute, people get very isolated. They need to see their doctor as a friend, not as somebody who looks over their glasses at them and makes a pronouncement using words people don't understand. Many doctors on the whole are not very good at talking to people, in ordinary language, not jargon.

'I'm really grateful people to those people who have kept the association going – and changed it to a less cumbersome name!'

What's Your Story?

To commemorate 50 years of campaigning, members' stories will be featured in forthcoming issues.

What's your story? What brought you here? If you would like to let other members know what moved you to join and how you have seen the NHS and the profession change over the years (for better or worse!), please contact Alan Taman (healthjournos@gmail.com).

The NHS and care services would collapse without overseas workers

The NHS has always needed overseas workers but racism and violence are on the increase, writes John Puntis

Why do we have workers from abroad?

The NHS and the wider UK economy have been dependent on migrant labour (1) to fill job shortages for decades. As Conservative Minister of Health (1960–1963), Enoch Powell actively championed and launched campaigns to recruit thousands of doctors and nurses from overseas, particularly from India, Pakistan, and the Caribbean, to address acute NHS staffing shortages. In 1971, 31% of all doctors working for the English NHS were born and qualified overseas. Pay freezes, rising workloads, and inadequate training places have meant home-grown staff numbers have fallen short of what is needed. This has led to a continued reliance on migrant labour and agency staff.

Recruiting trained staff from abroad is much cheaper upfront than training them in the UK. In addition, across many countries and professions, migrants are not a random sample of the population they come from. On average, they tend to have higher levels of education or skills, better language ability and greater ambition, resilience, and willingness to take risks. In the UK, fewer employment protections, less regulation, and more low-wage jobs have created the demand for more flexible migrant labour. NHS workforce planning has generally opted for a conservative estimate of numbers of staff needing to be trained and used migrant labour to temporarily (or permanently) fill any shortages.

How many workers from overseas are there?

Around 325,000 of the 1.5 million NHS staff (nearly 1 in 5 (2)) have a non-British nationality. In England, 9.9% are Asian, 5.2% European Union (EU) nationals and 4.2% African. Since 2015, the proportion of Asian and African staff has doubled while there has been a slight fall in EU staff. Regions vary, with London having the highest proportion of overseas staff (32%) and Yorkshire and the North East the lowest (13%). As a proportion of particular groups, staff from overseas account for 36% of doctors and 30% of nurses. No data is collected on the nationality of GPs, but their place of initial training is recorded. For England as a whole, 34% of GPs qualified outside the UK. In addition to health staff, around 25% of the adult social care workforce (3) in England also have a non-British nationality.

Government policy drives the NHS approach to staff recruitment

Between 1999 and 2005 the NHS's workforce grew by 24% (4) to achieve the government's objective of improving services and access to care, meaning that significant inflows of migrant labour were needed. The NHS's position as the largest, and sometimes only, employer has allowed it to suppress wage growth for healthcare staff (sometimes below international rates), which has pushed domestic staff to emigrate or leave the NHS. While the current underfunding of the NHS

is driving job losses (5), the hostile environment means retaining staff and filling gaps is becoming even more difficult. The clear risk is that the quality of both medical and social care provision for the UK population will deteriorate.

Racist politics and 'the hostile environment'

Professor Nicola Ranger, general secretary of the Royal College of Nursing (RCN) made the observation that: "A sustained campaign of anti-migrant rhetoric is fuelling a growing cesspool of racism, including against international and ethnic minority nursing staff, without whom our health and care system would simply cease to function." The RCN said the fear created by the recent display of Union and St. George flags (6) was part of an alarming wider picture. Because of the flags, some NHS staff who care for patients in their own homes fear that some areas have become no-go zones (7) for them.

Reform UK (8) has said it would be prepared to deport 600,000 migrants over 5 years if it won power at the next election. Prime Minister Keir Starmer was criticised (9) by many for his speech stating that we risk becoming an "island of strangers" without tough new policies on immigration. The hostile environment is both making overseas NHS staff leave to work elsewhere, and inhibiting new applicants.

"Reform UK has said it would be prepared to deport 600,000 migrants over 5 years if it won power at the next election."

Racism at work in the NHS

The NHS Workforce Race Equality Standard (10) analysing data from NHS Trusts noted that in March 2023, 26.4% (380,108) of the workforce across NHS trusts in England were of a black and minority ethnic (BME) background. This is an increase of 13% (43,070) from 2022. In 2022, the percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for BME staff (27.7%) than for white staff (22.0%). A higher percentage of BME staff (16.6%) than white staff (6.7%) experienced discrimination from other staff; a pattern that has been evident since at least 2015. A lower percentage of BME staff (46.4%) than white staff (59.1%) felt that their trust provided equal opportunities for career progression or promotion.

Consequences of racism for the NHS workforce

According to Jeanette Dixon, chair of the Academy of Medical Royal Colleges, the NHS is being put at risk because overseas health professionals increasingly see the UK as an "unwelcoming, racist" country (11). The bar for gaining permanent settlement is now being raised (12) and is likely to make the UK even less attractive. It is proposed that there will be a 10-year qualifying period with reductions for, among other considerations, high taxpayers and those who have volunteered extensively in their local communities. Legislation is being introduced to prioritise UK graduates for medical training posts (13) but without due consideration for international medical graduates already working in the NHS.

Nearly 5,000 doctors who qualified overseas left the NHS in 2024, a 26% increase over the previous year. Growth in the nursing and midwifery register has slowed, with a sharp fall in international recruitment over 6 months of nearly 50% (14). Dixon warned that without doctors and nurses from abroad the NHS "could quite easily fall over" and find itself without "a critical mass of people there to run the service safely". Overseas-born doctors and nurses were being put off by

antagonism from politicians towards migrants, media coverage of immigration, the racist abuse of international medical graduates by NHS colleagues and racist aggression by patients toward minority ethnic NHS staff.

Secretary of State for Health and Social Care, Wes Streeting, expressed shock at "the rising tide of racism and the way in which kind of 1970s, 1980s-style racism has apparently become permissible again in this country. I'm really shocked at the way this is now impacting on NHS staff" (15). He also criticised unnamed politicians who condone racism, adding: "I'm disgusted that a level of racism last seen when Britain was a very different country, 50 years ago, has made an ugly comeback and I'm frankly shocked by those in parliament who've leaned into it."

Violence towards staff

Nearly 300,000 violent and sexual assaults were recorded by NHS Trusts over 3 years (equivalent to 285 a day) (16). This has been described by the RCN as a national emergency for staff safety and is almost certainly an underestimate of the true figures. The British Medical Association (BMA) attributes the increase in violence and aggression by patients to a combination of anger about long waits for treatment, growing distrust of medicine fuelled by conspiracy theories about Covid, and a sharp rise in racism against staff of colour. Staff have provided harrowing accounts of what it is like to be on the receiving end of violence from patients (17).

Dealing with the rise in patient hostility has been hampered by staff shortages, budget cuts and police inaction. Other factors including a lack of beds for mentally ill adults and people with dementia have contributed to the increase in violent incidents. Between 2018 and 2022, the Health and Safety Executive found 60% of 60 NHS Trusts it inspected to assess their compliance with legislation were not doing enough to prevent workplace violence and aggression (18). There must be similar problems in social care where 1 in 4 staff are from overseas, but social care providers (eg residential care, domiciliary care) do not feed into a unified national incident reporting system specific to violence and abuse.

Some trade unions collect limited information about their members' experiences (19). A recent report by the RCN (20) based on a survey of 20,000 nurses found that more than 27% said they were physically assaulted by patients, their relatives or other members of the public in the past 12 months, with more than 10% reporting sexual harassment. Black respondents and those of a mixed ethnic background were most likely (around one third) to state they had experienced physical abuse in the previous 12 months. A high number of respondents (60.3%) also felt that when they had endured verbal abuse it was because patients/service users or relatives were dissatisfied with the service provided. In particular, many cited long waiting times and delays as common flashpoints. Four in ten nurses were considering or actively planning to give up their jobs. The main reasons for this included feeling undervalued (73%), low pay (61%), excessive pressure (60%) and emotional exhaustion (59%).

"Nearly 300,000 violent and sexual assaults were recorded by NHS Trusts over 3 years (equivalent to 285 a day). This has been described by the RCN as a national emergency for staff safety."

Government in action

The government has recently declared that "antisemitism is a scourge in the NHS" (21) and set up a rapid review headed by Lord John Mann to investigate how healthcare regulators tackle antisemitism. "Other racism" seems to have been

tagged on to this investigation. Mann was first appointed as government's independent adviser on antisemitism by Theresa May. A fierce critic of Jeremy Corbyn, Mann appeared reluctant to call out antisemitism among Conservative politicians (22). The government is also asking NHS England to adopt the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and set clear expectations that every trust, integrated care board and arm's length body does the same. The government press release quoted an unevidenced statement by the CEO of the Jewish Leadership Council that "Antisemitism in the NHS has been out of control."

Doctor members of the trade union Unite concluded that rather than tackling racism in all its forms, ministers were choosing to weaponise antisemitism in order to silence healthcare professionals from speaking out against the genocide in Gaza (23). In a letter sent to the Department of Health and Social Care, Doctors in Unite said that government plans to tackle racism and antisemitism in the NHS are "racist and dangerous" and should be abandoned. The letter was backed by 23 organisations, including Jewish Voice for Liberation and Health Workers and Allies for Palestine. Signatories were worried that antisemitism was being elevated above other forms of racism in the NHS, while entrenching "pro-Israel political bias into mandatory training for all 1.5 million NHS workers."

Concerns were also expressed over the call for the adoption of the IHRA definition of antisemitism. Critics of this definition and its accompanying examples include experts on antisemitism and Jewish studies as well as international human rights groups such as Amnesty International (24), who argue it has been used to stop criticism of the actions of the Israeli government. At the BMA's annual representative meeting in 2025, four motions relating to the genocide in Gaza were passed (25), including one stating that "criticism of the actions of the state of Israel is not per se antisemitic."

Bullying and harassment

In November 2025, the NHS Race and Health Observatory announced a new scheme to tackle "rampant levels of bullying and harassment" experienced by ethnic minority staff in the health service (26). The initial plan, however, is simply to 'pinpoint problem areas where interventions can be best targeted and work to identify potential solutions that can be implemented across NHS trusts.' This came after an open letter to the *BMJ* from doctors and healthcare staff warning that a rising 'wave of racism' and far-right groups in the UK is affecting patients and staff, with some ethnic minority doctors trying to relocate because far-right activity is making them fear for the safety of their families (27). The letter pointed out that the divisions opening up in our communities have the potential to blight all our lives, and especially those of the young people.

Concluding thoughts

International competition for medical staff is increasing (28). This means that we need to become less reliant on the generosity of migrants and the countries and health systems which pay to train them. Government wants to cut annual intake of non-UK doctors from 34% to under 10% as part of 10-year plan for health (29). This will require the state to take on a larger role in terms of workforce planning and regulation, and more serious investment by the NHS in training and retaining staff.

There can be no doubt of the vital role played by overseas workers in contributing positively to the health and care of people in the UK. Those who care about the NHS should stand with migrants (30, 31), oppose all forms of racism (including antisemitism), and support the rights of health and care staff to express support for Palestine (32). Violence against the workforce is being fuelled by ceding the narrative on migration to right-wing groups, but also from under-resourcing and

under-staffing of services and a failure by those in power to value, respect and support staff. This must change if we are to nurture those employed by the NHS and promote the highest standards of care for patients.

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Service Not Profit: The need for evidence-based policy-making

Colin Hutchinson on the need to keep bringing our evidence-based arguments to lawmakers, and the progress '99%' are making with the help of DFNHS

One of the strengths of the NHS that has maintained public support for more than 75 years has been the simplicity of the underlying concept: none of us know when illness or disaster is going to strike.

It is impossible, as an individual, to prepare for every eventuality, but if we come together as a society and pool our resources, we can make sure that help is available when misfortune occurs, to preserve life and reduce suffering and disability, for everyone.

That simplicity was reflected in the NHS Act 1946 running to a mere 98 pages. There was no excuse for any of our elected representatives to feel that they could not understand how the system worked and have a view on its merits and demerits. The legislative contortions that have taken place in the last few decades have changed all that, in an attempt to find a way for commercial interests to profit from such an important element of public spending. The result has been massive and increasingly frequent structural reorganisations alongside huge volumes of statutory and secondary legislation, making it difficult for all but the most dogged MP to feel that they truly have a grasp on the way in which the whole system works. This is compounded nowadays by the level of decision making that takes place outside the public gaze, in the interest of 'commercial sensitivity', because private companies are so intimately connected to NHS bodies.

We have a massive task to help our elected representatives see the wood for the trees, so that they can understand what is going right, what is going wrong and how any damage can be repaired. At the same time, it has become increasingly difficult for an organisation like DFNHS to establish any dialogue with most MPs.

Before the NHS was founded, healthcare was largely seen as a commodity that could be bought and sold, except where it was bestowed in an act of charity, resulting in wide variation of health between rich and poor, and the ever-present threat of family destitution if a breadwinner died, or worse, became incapacitated. Despite the achievements and popular support for the NHS, it has not erased the concept of healthcare as a commercial endeavour, to be traded for profit; and doctors, as a profession, have often been strident in preserving their right to benefit from illness or the fear of disease. The NHS Consultants' Association (NHSCA) was established in 1976 to fight against BMA policy of the day, and calling for a clear separation between private and social healthcare, because of the dangerous conflicts of interest that often arise when commercial interests become entangled with the needs of our patients.

Fifty years on, *Doctors for the NHS*, the successor to NHSCA, continues to bring together those who believe that the fight needs to be continued and to find allies wherever possible to combat powerful organisations and individuals who see ill-health, and the fear of its consequences, as a route to their personal enrichment, particularly if they can tap the enormous resources of the state, underwritten by the British taxpayer. One of those allies has, for many years, been *Keep Our NHS Public*, but more recently we have also been working with the 99% Organisation, set up by Mark E. Thomas, who formerly worked in a

major international consulting firm, and has been bringing together a loose coalition of individuals from a wide range of backgrounds, united by a concern that the prevailing economic model that drives government policy and is reshaping society, is leading to our children being more impoverished than our generation, and the prospects for our grandchildren being even bleaker. This had not been the case for over a century, but has become the case for all but that vanishingly small sector who are doing very nicely for themselves, thank you.

Learning the right lessons

Mark's book *99%* (1) sets out his analysis of this decline in general living standards, but more importantly, what we can do about it. He has also been bringing together a number of working groups to develop and apply the concepts that he has described to influence those who have the ability to bring about meaningful change. Given the importance of the NHS to the wellbeing of the nation and the national economy, its track record of fluctuating success and failure, and its position on the frontline of the conflict between private wealth and public benefit, it is fittingly the focus of one of these working groups, on which I have been representing DFNHS. There has also been strong representation from *Keep Our NHS Public*, alongside economists, academics, people from the world of business, the political world and people with first-hand experience of managing the NHS. Discussions are refreshingly wide-ranging, drawing on this breadth of experience.

In February the group was invited to address one of a series of meetings of parliamentarians at Westminster, sponsored by Richard Burgon MP. The topic for discussion was 'Why we should be concerned about the nature, extent and impact of healthcare privatisation in the UK' and the aim was to challenge the oft-repeated myth that there is only a soupçon of private sector involvement, about 7%, and that it is not increasing and, anyway, the public aren't concerned about who is providing their care as long as it is free at the point of delivery. The evidence-backed arguments are set out in detail in the report from the working group that was presented at this meeting (2). I encourage members to read the report and share it widely (3).

Governments have repeatedly told us that 'The NHS is not, and never will be, for sale' and 'The NHS is safe in our hands', but privatisation and its distorting influence and the channelling of public monies into corporate and individual profits is about much more than the sale of public assets: who needs ownership if you can securely drain off as much as you need without that risk? The tapeworm thrives by co-existing with its host: it weakens it, but if it kills the host, the tapeworm dies too. The World Health Organisation has a much wider definition of privatisation (4) and when that is applied, the percentage of NHS spending with commercial organisations in England is revealed as around 30% and increasing, and that figure excludes NHS spending on general practice, drugs, equipment, energy etc.

> "Privatisation and its distorting influence ... is about much more than the sale of public assets: who needs ownership if you can securey drain off as much as you need without that risk?"

We wanted to emphasise the turnaround in the NHS that had been achieved by the last Labour government, underpinned by the ambition to bring health spending up to the EU average, which resulted in it being rated the best-performing health system in the world overall by the Commonwealth Foundation. We wanted today's politicians to recognise which of those policies contributed to the success, and which did not, to avoid making the mistakes that were undoubtedly made.

One of the main concerns discussed was the

prospect of a resurrection of Private Finance Initiative (PFI), the original forms, PFI and Son of PFI (LIFT) having been officially abandoned by the Conservative government in 2018 following the National Audit Office's report on their very poor value for money. Their reincarnation as a vehicle to build a constellation of Neighbourhood Health Centres across England, funded by private capital, seems bizarre when public dividend capital is always less expensive in the medium and long-term. We have been told that 'Lessons have been learned', but ask our parliamentarians to look closely at the evidence.

Worse than PFI

But if you think that PFI was poor value for money, it is dwarfed by the outsourcing of cataract surgery. The Centre for Health and the Public Interest (CHPI) used Freedom of Information requests to discover that the five main private companies carrying out NHS-funded cataract surgery made profits of £169 million in 2023/24, similar to the annual profit being paid to 100 PFI companies. The profit margin for cataract surgery was 32%, compared with 10% for a typical PFI project. Put in perspective, the combined deficit of all 42 Integrated Care Boards in England was £109 million that year: avoiding the profit leakage from cataract surgery would have eliminated that deficit, with plenty left over to expand services (5).

Cataract extraction is the most frequent surgical operation in the UK and an important contributor in combatting visual disability, but visual impairment due to cataract is reversible and rarely causes severe visual loss in the UK. The leading causes of preventable severe visual loss in the UK are macular degeneration, glaucoma and diabetic retinopathy and unless these are treated promptly and effectively, the damage they cause is irreversible. So how is it that the total NHS spend on ophthalmology has increased by just a half since 2018/19, but the spend on cataract surgery has doubled – four times as much of the increase going to treating cataract than on all the other aspects of the specialty, including round-the-clock emergency services for people experiencing sudden visual loss or injury?

Over the past 10 years a network of high-volume private cataract surgery centres has sprung up across England, run by five large companies, mainly funded by private equity, although two of the largest are owned, or their parent company owns, the two biggest chains of high-street optometrists in the country, Specsavers and Vision Express. The optometry practices are incentivised to refer people they identify as having cataract for consideration of surgery, whether their sight is causing them significant problems or not (5).

> "It is not just optometrists that are exposed to conflicts of interest. Most of the surgeons operating in these private cataract units are NHS Consultants."

People are being referred to these units with a level of vision significantly better than those receiving surgery at NHS units. Given that most people over the age of 50 are likely to have a degree of cataract, the potential market for surgery is almost limitless.

It is not just optometrists that are exposed to conflicts of interest. Most of the surgeons operating in these private cataract units are NHS Consultants or other career-grade ophthalmologists. In one teaching hospital in the North of England, half the consultants work in such units and that is probably not atypical. The NHS Consultant Contract introduced in 2003 makes it easy to reduce the time that you are contracted to work directly for the NHS, so that other activities can be pursued, while the NHS employer may still be liable for 'Other Professional Activities' such as training and education, as well as sick leave, annual leave and superannuation, none of which will be

regarded as an obligation of the private provider. In addition, CHPI identified 68 NHS Consultant Ophthalmologists who owned shares in private hospitals carrying out NHS-funded cataract surgery (the Competition and Market Authority has confirmed they are under no requirement to declare their interest to their NHS employer). It is apparently perfectly reasonable to be actively engaged in undermining your employer's interests: this is not a situation that would be permitted in the business world.

The number of cataract operations in England has risen from 480,000 in 2021/22 to nearly 700,000 in 2024/25, partly fuelled by the government's focus on elective waiting lists, and most cataract surgery funded by the NHS now takes place in these private centres.

The number of cataract operations in NHS ophthalmology units is actually falling and the resulting diversion of NHS funding away from NHS units is undermining their ability to treat everything else, leading to a situation described by Ben Burton, the President of the Royal College of Ophthalmologists, as some patients 'with very mild cataracts getting surgery at the expense of other patients going blind'. It has also had a severe impact on the ability to train the next generation of eye surgeons, because the private sector doesn't 'do' training – it interferes with patient flow and increases costs. It has been with great difficulty that some private units have been convinced to begin to run training sessions to a limited extent.

A balancing act

Integrated Care Boards (ICBs) are responsible for balancing all the competing demands on NHS resources, to ensure that they are prioritised to meet the most urgent need, but the legislation within which they have to work seriously undermines their ability to fulfil these duties. If a private company holds a contract with a single ICB anywhere in the country, it is able to claim payment from any other ICB for treatment of one of their patients, whether they hold a contract or not; 7% of cataract surgery is paid for outside any contractual agreement. In addition, the ability of optometrists to refer directly to private surgical units removes any opportunity for an NHS organisation to be involved in that referral, until it comes to paying the bill.

This undermining of the ability of ICBs to manage their budgets in the interest of the population they serve has been highlighted in ophthalmology, but is also taking place with hip and knee replacement, with neurodevelopmental assessments for conditions such as Attention Deficit Hyperactivity Disorder (ADHD) (6) and potentially for weight-loss treatments. There is some scope for Indicative Activity Plans to be used by ICBs to limit the activities of individual providers, but the attempt to include them in NHSE's elective payment rules for 2026/27 has been met with outrage, particularly from private providers. It remains to be seen whether NHSE will bow to that pressure (7).

There is also a need to be bold enough to challenge the shibboleth of the 'Right to Choose' which has been used to legitimise the application of 'market forces' to situations where the concept of a free market is never going to be appropriate, such as in healthcare. When will we recognise that individual choice and national interest are not always compatible? (8)

Our politicians need to restore the ability of Integrated Care Boards to plan and commission healthcare according to clear clinical priorities:

- Reform the regulations that permit uncontracted activity and strengthen the ability to enforce Indicative Activity Plans.
- Apply a cap to excessive profit-taking, as has already been applied to children's social care providers.
- Legislate to prevent for-profit organisations from involvement in the planning of care pathways, including through the Place-based Provider Partnerships that are proposed to take on much of health commissioning next year, so they cannot design pathways to fit their preferred business model (the

most profitable business model).
- Tackle conflicts of interest, including those of optometrists and NHS consultants, including the strengthening of Competition and Market Authority regulations and restricting the ability to refer NHS patients from one private provider directly to another.

The 99% Organisation is succeeding in gaining the attention of some of our lawmakers, although we recognise the power of lobbyists for the healthcare industrial complex. We need to maintain the hope that we can help them unpick the unholy mess that has been made of the NHS in England and return to its founding principles, in their profound simplicity. Then they could do the same with the UK's tax code.

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DOCTORS FOR THE NHS OPINION

NHS Bottom-Up Workplace Democracy: Avoid the Abyss and Change the World?

Mike Galvin's view on why redefining democracy is important for the NHS

'To Hell in a handcart' seems to be an appropriate description of our NHS. What is more, we could view our NHS as a canary in the mine for our treatment of the whole world, and therefore it is existential in its importance, as Noam Chomsky recently warned (1).

"I've got both good and bad news. The bad news: Electoral politics is beyond repair. The good news: Democracy isn't. We can fix it": this is the first line from Helene Landemore's new book *Politics Without Politicians: The Case for Citizen Rule* (see page 30). Helene also discusses her earlier book *Open Democracy; Reinventing Popular Rule for the Twenty-First Century* in a podcast (2). These are an apt start to this essay.

The decline of democracy throughout the NHS is reflecting the demise of democracy almost everywhere in this age of neoliberalism (3) and underlies the perilous state Chomsky grimly reminds us of. Those of us in DFNHS whose careers spanned this period have experienced (but maybe like me did not recognise) the erosion that was relentlessly advancing to the parlous present state.

It is more than 3 years since I reported to the AGM of DFNHS of my meeting in Brussels with Professor Isabelle Ferreras, co-founder of the Democratizing Work (4) movement, in which she assured me that the ideas in her book *Firms as Political Entities: Saving Democracy through Economic Bicameralism* (5) are entirely applicable to our NHS. I wrote an article about 'Democracy and the NHS: A way forwards' (6) and a review of Isabelle's book in the April-July 2023 *DFNHS Newsletter* (7) following that meeting and that AGM. A short cartoon in Isabelle's website (8) is very instructive as is a short, succinct and passionate video (9).

We can gain important insights about the ways democracy is needed in our NHS through looking across the world at health and healthcare in India. Our long (and inglorious) history with India provides both our countries with an extraordinary opportunity for solidarity and mutual learning. The independent state of India and our NHS were both born about the same time; India's health system was based on the British model; our NHS has, in common with many other countries, benefited from migration of many of India's doctors and nurses. Dr Abhay Shukla has described the current situation in India (10,11); a dreadful and shocking situation which as Kiran Kumbhar (12) has described is in no small measure a legacy from British rule. This legacy has over recent decades been rapidly worsened by the deadly embrace of neoliberalism with the ultimate consequence of global financialization and privatisation, with the attendant profit-driven pressure to serious and extensive malpractice.

The paradox is that a remarkable courageous group of both medics and non-medics who for over half a century have resisted and kept alive those vital principles pertaining to healthcare to which we all aspire (13) are now positioned and armed with insights from which we in the UK can learn; instead the UK is speeding in the wrong direction. In solidarity we could together re-learn and create a truly healthy world. Let me give a few examples of individuals and organisations from my personal engagement in India over 25 years (initially with my wife Hazel who died in 2014):

- Jan Swasthya Sayhog (14), Jan Chetna Manch Bokaro 2 (15) and Yogesh Jain (16-18).
- Anurag and Madhavi Bhargava who work on 'Enhancing TB Prevention and Care' (19) and the RATIONS trial (20) (recent WHO guidelines on TB have incorporated the lessons from this landmark trial).
- Amar Jesani's work in the founding and editorship of the *Indian Journal of Medical Ethics* (21). Amar has been recognised by the International Association of Bioethics with their 2021 Award for Bioethics Service in the Face of Challenges (22).
- The Tribal Health Initiative Sittilingi (23).
- Such outstanding individuals and organisations are representative of an amazing 50 year old association: Medico-Friend Circle in India (24) which aims to: "foster among health workers a current that upholds human values and aims at restructuring the health care system".

Embeddedness (25) within the community at a local level must be a hallmark of our health services. Something that can be accomplished only with a workforce that is enfranchised so that each individual is conscious of their individual contribution and how that relates to and is interdependent with each other member of their own immediate team and the entire structure in the service of the beneficiaries, ie all of us. Such mutual awareness, acknowledgement, gratitude and more already exists in small teams, the myriad thousands of which comprise our NHS. But this is increasingly under the duress of an increasingly brutal top-down and suffocating structure. It must become the norm for the entire workforce and be facilitated by a managerial system that recognises its role is to serve and facilitate the work at the coalface.

Peer supoort is something I am only just discovering (though undoubtedly have benefited from all my life). Citizen Network (26) is an amazing 'creation' and network of individuals and organisations: "We believe everyone is equal and each one of us brings unique gifts to the world. In order for us to flourish and to tackle the big problems the world faces we need to act like citizens. Together we can create inclusive and welcoming communities where everyone can share their gifts." The network pointed me to a People Focused Group on my doorstep (PFG Doncaster (27)).

A pioneering TB centre, Ekta Niketan (28) in Jharkhand India, is taking peer support to an unprecedented level. Local mainly indigenous tribal and marginalised people (where the marker disease of poverty, tuberculosis, is rife and on the increase) are recognising the signs, positively diagnosing including with sputum microscopy, treating and following the clinical response in their fellow villagers and documenting and maintaining the important data base.

Both the People-Focused Group in Doncaster and Ekta Niketan in Jharkhand are surely embeddedness with peer support at work in UK and India. Imagine such embeddedness spreading and underpinning the grass-roots democracy of an embedded health service.

Structural violence "wherein some social structure or social institution may harm people by preventing them from meeting their basic needs or rights" (29) is a term that should be in common use. It represents the social determinants of ill health and shortened life and the shocking slope of Marmot's 'Social Gradient of Health'

(30).The National Health Service is inevitably and rightly concerned with the downstream effects of the structural violence responsible for most disease; but what should be the answer of the largest employer in Europe to the first sentence in Marmot's *The Health Gap* (31):"Why treat people and send them back to the conditions that made them sick?"

Could Physician Associates be given a new focus on the upstream causes of ill health? Seeking out the social determinants of ill-health, identifying the structural violence responsible for most ill health and shortened life, naming it, documenting and shaming it in order to eradicate it. Acting as a bridge between the sharp clinical end and all levels of government, professional and civic organisations. They would be the front line of preventive medicine and the foot soldiers of Public Health.

What about a large geographic area (North East and Yorkshire Region?) to immediately implement the reversal from top down to bottom up; no need for new structures, just a new understanding? The lift in morale and satisfaction of everyone including the population served would inevitably and rapidly be adopted by the entire UK. The 'experiment' could be organised to bypass the economic obstacles by welding it to a parallel 'experiment' in the introduction for the geographic area of a Public Bank (all the references in the next paragraph are highly relevant).

'But where will the money come from?', many may ask. Of course money will be necessary. A new and growing body of academic economists generally referred to as Heterodox economists (32) are teaching us to understand the nature of money and the absurdity and damage of austerity still emanating from mainstream economists around the world. My introduction to economics in August 2015 was by Professor Bill Mitchell (he coined the term 'Modern Monetary Theory' (33) and left me gasping). I have included here a group of references (34-44) that I have found very valuable in trying to understand issues around money economics and the economy.

Sir Michael Marmot in his interview for this Newsletter (45) recounts his six pillars (later to become 8); in his writings he vividly describes the consequences of lack of autonomy in the workplace; I believe the third pillar needs amplifying, from 'Create fair employment and good work for all' to: 'Democratize Work and thus create fair employment and good work for all' (1). What a huge boost that would be to the global movement (46) already marching behind that banner!

> "Grass-roots democracy in the workplace will mean in practice putting into reverse the role of all managers from top-down to bottom-up.... The workers at the coalface will know better than anyone what they are doing."

Grass-roots democracy in the workplace will mean in practice putting into reverse the role of all managers from top-down to bottom-up. The workers at the coalface know better than anyone what they are doing and how best and most safely to do it; all the rest will be there to facilitate their effort. Wikipedia deals with top-down vs bottom-up (47) and clearly it is an issue in the field of management. Right now the dangerous point we have reached calls for the urgent need for bottom-up (9).

Part of that reversal to bottom-up 'management' inevitably will relate to remuneration. I believe that the close collaboration, transparency and trust that will ensue from the facilitation of the work at the coalface rather than the often brutal top-down imposition (48) we have blindly come to accept as 'normal', will ensure fairness and therefore be acceptable. Strikes will be a thing of the past. Unions will preferably merge or at least work in close and transparent collaboration. Isabelle

Ferreras's assurance to me that true grass-roots democracy is entirely feasible in out NHS remains an anchor for me.

Ultimately the most important outcome of workplace democracy is the shift in power it brings about from the haves to the have-nots. When all workers everywhere enjoy true democracy in the workplace, can anyone really believe that people will use the option to make guns and bombs rather than cycle tracks and beautiful public places to sing and dance? The title of this essay was with those thoughts in mind. Earlier I included a recent warning from Noam Chomsky; I think the text of a conversation (49) between Chomsky and Peter Jay from 1976 is interesting and relevant here.

Two visionaries over 100 years ago in parallel and through an intermediary (Édouard Le Roy) imagined a 'Noosphere' (50): a philosophical concept developed and popularized by the biogeochemist Vladimir Vernadsky and philosopher and Jesuit priest Pierre Teilhard de Chardin. Vernadsky defined the noosphere as the new state of the biosphere, and described it as the planetary 'sphere of reason'. The noosphere represents the highest stage of biospheric development, that of humankind's rational activities. In my imagining, it is an immaterial fabric with an organic weft and weave, with a thread count of near infinity, with strength beyond imagining, and nourished and driven by love.

Let us get behind democratising health and share our experience with our like-minded colleagues in India. Together, we can be an example in our own countries and the rest of the world how to emancipate our human-kind for the benefit of all living things.

In closing I would like to refer back to Amelia Horgan's book *Lost in Work* (2021) for which I wrote a review (51): "what is at stake is not only control over our own lives, but over our collective destiny, our shared freedom and our shared joy…". The cover of *Lost in Work* is a powerful message to end this essay.

Acknowledgement

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Care to Comment?

If you want to have your say on matters relating to the NHS and DFNHS, please let the Editor Alan Taman know [healthjournos@gmail.com].

Do you want to write an article for the newsletter? Articles of 1500-3000 words are preferred. If you prefer, Alan is happy to talk to you then draft an article for you to sign off.

DOCTORS FOR THE NHS OPINION

Doctor Substitution: A Growing Threat?

Andrea Franks asks: are doctors a threatened species?

'Perhaps most importantly, the compulsory licensing of medical professionals should be abolished. Anyone should be at liberty to practise as a doctor or nurse, with patients relying on brand names or competing voluntary associations to ensure quality.'

So the unfortunate patient would have to log onto something like Trip Advisor to see how previous patients got on – if , of course, they were alive and well enough to comment!

This idiotic statement is a recommendation from 'how to abolish the NHS' (1), a 2012 article by Richard Wellings, then Deputy Director (Academic and research) of Liz Truss's favourite think tank, the Institute for Economic Affairs. His hope was that the NHS would become less and less relevant as more people opted out and were treated privately, although of course the uncertainty about staff expertise and qualifications would be just the same in a private system.

Why, then, is NHS England encouraging a variety of other staff to work as doctors, in GP and on medical rotas in hospitals? We have, after all, been warned in the past about the risks of inadequate training.

Thomas Wakeley, writing in *The Lancet* in 1828, before the GMC was set up, described the situation as it then was: 'the public are unable to distinguish between the qualified and the unqualified practitioner; confidence is mistaken for knowledge and the sufferer becomes the victim of an ignorance which the law permits to masquerade as skill'. Even Florence Nightingale, in her 1860 publication *Notes on Nursing* (2) warned that 'to assume responsibilities for which one has not been trained is not kindness but cruelty. It places the patient in peril while concealing the peril from view'.

How are doctors being replaced? The Additional Roles Reimbursement Scheme (ARRS) was introduced in 2019 'to address workforce shortages and improve access to care'. It pays the salaries of a wide variety of other staff – 17 patient care roles in all – such as Physician Associates (PAs), Advanced Clinical Practitioners (ACPs), pharmacists, physiotherapists, dietitians and podiatrists to work in GP surgeries, but until late 2024 the money could not be used to employ any doctors, even qualified GPs. Even then only recently trained GPs could access this scheme, and only if they had not held a previous GP post. Meanwhile, the routine funding for general practice has not nearly kept pace with inflation, resulting in an effective 20% reduction per patient in the last 10 years, so the ARRS is often the only way to afford any new staff at all.

As a result, many fully qualified GPs are now unable to find work, while non-doctors in many surgeries are seeing newly presenting patients, sometimes acting 'autonomously' with little if any supervision.

At the same time, the budget of Health Education England was cut by 30% in 2017 with the stated aim of 'developing the non-medical workforce'. The huge resulting bottleneck for training places is making it very hard for young doctors to get

onto a training scheme, whether for GP or for hospital specialties, and many are unemployed. A small increase of 1000 training places, recently announced by Wes Streeting, will make very little difference as plans for further expansion of non-medical roles are continuing, with 39,000 more new ACPs intended in the 10 Year Plan.

The report of the Leng Review on PAs (3), commissioned because of public and professional concerns about PAs (including several well-publicised deaths) was published in July 2025. The recommendations were disappointingly mild – they did not advocate abolishing the PA role – but advised that the name should change to 'Physician Assistant' with a distinctive badge and uniform, and, importantly, that they should no longer see undifferentiated patients. To the BMA's disappointment, the review did not set limits on the scope of practice of PAs or AAs, but left this up to each employer.

Although all the Review's recommendations were accepted by the government, little has really happened. The name has not yet been changed as this will need an Act of Parliament, and advertisements still appear for PAs to 'act with a high degree of autonomy' and even to work on SHO or registrar rotas, even though in many cases even any previous experience of the relevant specialty is not required but only 'desirable'. Fewer PA jobs, however, have been advertised recently in spite of the (so far) non-implementation of Leng Report, and several PA courses have closed in anticipation of restriction of their scope.

The Leng Report, which was widely publicised, has slightly reduced the use of PAs to replace doctors, but many will be unaware of the other group of NHS staff increasingly working in medical roles, Advanced Clinical Practitioners (ACPs). At present there appear to be about 12,000 ACPs, but the intention is to increase this number by another 39,000 by 2035-36.

Who are ACPs? They are not the specialist nurses who play essential roles in specific areas such as diabetes, stoma care and many others, or specialist practitioners in other fields such as physiotherapy or dietetics. ACPs may start as nurses, but may also come from a wide variety of other NHS roles, such as paramedics, dietitians, pharmacists, podiatrists or occupational therapists.

In theory a trainee ACP should have at least a 2:2 degree in their healthcare subject and have worked in that field for at least 2 years, but some centres do accept trainees with no previous degree and with little previous experience. The trainee ACP is usually paid at AfC Band 7 (£48,000-£55,000/year for a 37.5 hour week, significantly more than a foundation doctor) and starts work in their role straight away. There is presumably some supervision, particularly as the ACP work may be completely unrelated to the individual's base profession. The 2-3 year ACP Masters course, which is funded by the NHS, is part-time and usually partly online, and is taught and assessed by other ACPs. There may be no formal exam at the end of the course, but just a portfolio and perhaps an open-book assessment. There is no national exam.

Once qualified, the ACP will usually be paid at AfC Band 8a and may work in general practice or in hospital. Both NHS websites and the courses themselves suggest that the ACP will be 'equivalent to a middle-grade doctor', and indeed most advertisements for ACP posts suggest work 'with a high degree of autonomy', or their 'own caseload'. Some advertisements actually say that the appointee will take part in the registrar rota. This is not just advanced practice in the base profession, as the ACP, irrespective of background, may be working in completely different areas and seeing and diagnosing unselected patients. Most of the advertised posts would offer useful experience to a qualified doctor, and it is impossible to see why the unit would not prefer to recruit either a specialty trainee or a specialty doctor.

Whatever is going on here? The Leng Report on PAs and AAs was carried out in response to professional and public concern, and indeed the BMA members' survey raised a great many serious issues and patient risks, as well as real harms to medical training. PAs have all done a 2 year course

(taught and examined by other PAs) and in theory have passed a national exam (although some have not). They will all eventually have to be registered with the GMC.

The ACP course, however, involves even less teaching than the PA course. In Worcester, for example, the clinical content of the PA MSc is 90 credits, and the student has to take a final exam and two OSCEs. In the same institution, the MSc ACP covers only 45 clinical credits. There is a final 30 minute OSCE and several essays must be submitted, but there are no written exams. As with PAs, the course is taught and examined by ACPs.

ACPs remain registered with their original professional body, although a pharmacist or physiotherapist, for example, may well be doing work as an ACP – such as seeing new unselected patients in primary care – which is unrelated to their base profession. There is no national registration of ACPs and no national exam.

For PAs and for ACPs, the scope of practice depends entirely on the employer.

Is all this really a plan to replace doctors? It certainly seems to be, and indeed a GMC document in 2015 stated that 'there is an ambition – to make sure that maximum value is derived from medical role substitutes'. The Additional Roles scheme for primary care stipulated that the non-doctors whose salaries would be paid would have to see unselected new patients.

Can doctors apply for jobs advertised for PAs or ACPs, as many such posts appear attractive and well-paid and offer useful experience, while the bottleneck of training posts remains severe and many F2 doctors are facing unemployment? The answer seems to be that they will not be considered at all for PA posts, and would only be eligible for an ACP post if they have done an ACP course, even though their medical school education covers far more than that.

What is the intention behind doctor substitution? Presumably the aim is cost-cutting. But is this likely to be the result? It is cheaper to employ non-doctors than fully trained GPs. An Operose surgery staffed almost entirely by unsupervised PAs, which featured in a *Panorama* programme, admitted that this was the motivation. Hospital PAs and ACPs, however, are paid more than many junior doctors, and (in theory at least) do require supervision which requires staff time.

There will surely, though, be unintended costs of using less-skilled staff. More repeat visits will be needed, more tests ordered and more referrals will be made, which is very inefficient. US Physician Assistants, with more training than in the UK, order six times as many scans as doctors when working in primary care (4). All must be reported, and extra referrals dealt with even though they may overwhelm the service in question and decrease its quality. If things go wrong there will be litigation. Is the whole idea a false economy? Perhaps the only way it would make financial sense would be for services run by the private sector, who would be paid for each appointment, test or referral, but that would be far more costly for the NHS as a national service.

What about patient safety? The results of a BMA survey on members' experience of ACPs are not yet available. Hospitals (presumably deliberately) do not record clinical incidents involving PAs or ACPs even though their numbers are increasing. Does NHS England seriously consider that the scientific understanding and knowledge base of undergraduate and postgraduate medical training is unnecessary? Surely not; the UK system is, or was, internationally respected and comparable with medical training elsewhere, and covers knowledge and skills which have been found necessary for patient care. That said, however, the recent director of education and standards at the GMC, all of whose members are Government appointments, has declared: 'With up to date information at our fingertips, via trusted sources on our smartphones, we do not need the huge repository in our heads and from textbooks and lectures. Content in the curriculum can be streamlined'. Half-way through an operation you might be grateful for it!

There must be real concerns about the effect of doctor substitution on medical education,

as it reduces training opportunities for medical students and trainees, and this is likely to have a cumulative effect.

And for patients? Wes Streeting may think that a minimally trained person with access to AI can do all that is needed, but this is a very dangerous idea; an independent evaluation published in *Nature Medicine* (5) showed that Chat GPT failed to recognise nearly half of serious emergencies while advising large numbers of people with minor problems to seek urgent medical advice.

Medicine is difficult. Doctors can and do make mistakes, but replacing them increasingly with often non-doctors will harm the NHS and the whole future and reputation of UK medicine. And nurses are being replaced with nurse associates….

'There is a confidence which springs not from knowledge but from its absence, a familiarity with a narrow range of cases breeds assurance where wider experience would teach doubt.'

– Sir James Paget, Clinical Lectures and Essays, 1875.

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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. 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'. 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. 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: healthjournos@gmail.com

Book Reviews

Politics Without Politicians; The Case for Citizen Rule
(£17.99)
Helene Landemore, 2026, Allen Lane, 320pp.

'I've got both good and bad news. The bad news: Electoral politics is beyond repair. The good news: Democracy isn't. We can fix it.'

My attention, grabbed by this opening sentence (of Chapter1: Fixing a Broken System), never wandered throughout this amazing book. It is written in such an engaging relaxed conversational style and yet is packed with vital insights that profoundly affect our perception(s) of democracy. It is inspiring, hope-enhancing and a pleasure to read.

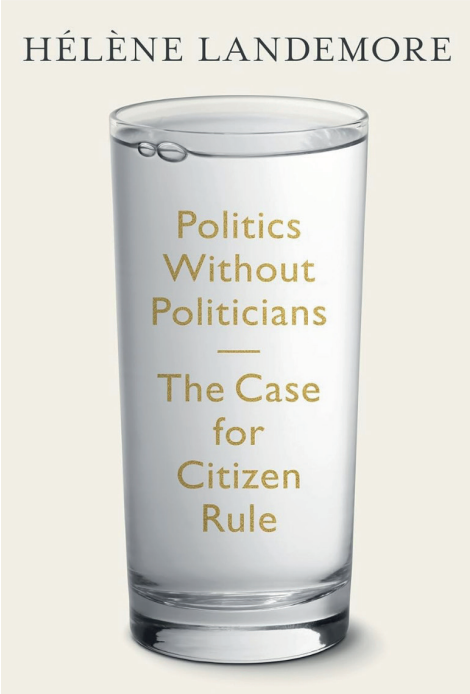
Eleven chapters (in 320 pages) with punchy sub-headings listed along with each punchy chapter heading so the reader is on a secure and orienting scaffold. This structure also makes for easy quick access when re-searching.

The book is about democracy, including the history back to Classical Athens and before.

Before going on to the good news we are invited to consider a number of glaring failures of electoral politics as reflected by the plummeting of confidence by the public of major world democracies despite which when 'the media cover politics they only talk about the horse race, the scandals, the strategizing, the posturing, and rarely – at best superficially – the substance of issues.'

At the outset we are disarmingly posed this fundamental question together with the simple answer:

> **'Why do most of us adhere blindly to democracy as we know it and struggle to envision alternatives? The answer is quite simple. It's inherently challenging to imagine a future that diverges from our current reality and move from what is to what should be. In my experience teaching political philosophy to undergraduates, I've observed that many struggle with the distinction between descriptive statements (what is) and normative statements (what ought to be)…. David Hume famously argued moral conclusions cannot be derived from purely factual statements or observations. In other words you cannot derive an "ought" from an "is".'**



A striking example of the punchiness that took my breath away in Chapter Two: The Problem with Politicians.

Under (6th) Subheading: Manin's Bombshell:

> **'In the very opening paragraph**

[of Bernard Manin's *The Principles of Representative Government* (1)] Manin remarks "Contemporary democratic governments have evolved from a political system that was conceived by its founders as opposed to democracy".'

Not surprising then that: 'A system based on electoral representation is no longer – if it ever was – capable of delivering either democratic or good governance'.

'Bringing the Shy People Out'; under this first sub-heading in the first chapter Landemore comments this is something she has appreciated only recently and elaborates here for the first time. 'Bringing the Shy People Out' is also the title of Chapter 8. Interestingly the book is dedicated 'To my younger self, and all the other shy people out there'. 'Shyness' it seems is something Helene Landemore knows from personal experience. 'Bringing the Shy People Out' in a world where deliberative democracy prevails is of utmost importance.

"It's time for a Copernican revolution – one that places ordinary citizens back at the centre of the democratic universe. If this vision of politics resonates with you, there is much work ahead."

Reclaiming Populism:

'Before I launch into my critique of politicians let me address a suspicion that may already be forming in your mind. Am I some radical populist plotting to dismantle decent government and replace it with socialist totalitarianism under the banner of "real democracy"? And doesn't it concern me that my book's thesis could be twisted into a justification for anti-parliamentarianism – even violence against elected officials?'

The parting shot of the introductory chapter:

'As you'll soon find out, I'm an optimist, but I'm no Pollyanna. I see the gulf between the ideal of democratic equality and the reality of plutocratic and exclusionary politics in the United States and elsewhere. But I also see that it's not too late for reform.'

Chapter 5: 'The Case for Lot'. Sortition and citizens' assemblies are dealt with in detail. Why Lot (random selection) is preferred to election by Landemore is interestingly highlighted by the first three of eight sub-headings: Liberty, Equality and Fraternity.

'Collective Intelligence' the 5th and crucial sub-heading in chapter 5 and perhaps the central reason I am reviewing *Politics without Politicians* because it draws our attention to the myriad small and large teams that constitute our NHS within which collective intelligence remains alive and kicking but under the duress of an ever increasingly tyrannical strangling structure:

'A second, much less intuitive instrumental argument for lot, is that it plays a key role, via deliberation, in the capacity of a democracy to produce good results and generate what is sometimes called "collective intelligence". Collective intelligence, defined as a capacity to achieve one's ends and solve problems successfully, is the intelligence of the group, as distinct from, and indeed superior to, the average intelligence of its individual members.'

Landemore at the end of this chapter draws our attention to the work of James Fishkin and the fact that 'Deliberation educates, depolarises, and additionally aligns fundamental preferences by, for example, transforming narrowly self-interested

preferences into more socially oriented ones'. At 1:18:42 in the Q&A following James Fishkin talk (2), Fishkin makes a crucial observation from his work: that exposure to the facts has little effect on movement of opinion but with the addition of deliberation movement of opinion is dramatic.

Chapter 7, 'The Power of Love' brought tears to my eyes; no spoiler, I'll just mention it's about the French 'Citizens Convention on the End of Life'. Helene Landemore was part of the governance committee for a citizens' assembly on this notoriously difficult and sensitive subject.

The final Chapter 11 'The Future of Democracy and How to Get there Fast' analyses a range of possibilities under nine subheadings. Under the final subheading, 'To Earth', the final paragraphs read:

> **'Democracy as it stands, has long been defined by elections, parties, and elites. But it's time for a Copernican revolution – one that places ordinary citizens back at the centre of the democratic universe. If this vision of politics resonates with you, there is much work ahead. We need to reimagine democracy not as a system confined to the ballot box, but as a daily practice – a way of living, thinking, and engaging with others and with the world.**
>
> **'The most critical step toward a politics with fewer politicians and more active citizens is to empower new generations to experience democracy as something they do not something they watch. Teaching people to live democratically, deliberating, sharing power, caring for one another – and modelling that way of life at home, in the office, and in our daily encounters is how democracy not only survives but thrives.'**

This book is a work of scholarship but it is not a dry work of scholarship. It is full of passion and background detail of her own childhood and development including triumphs and setbacks (or failures) relevant to how Helene Landemore has become one of the foremost scholars helping us find our way to living together in this frighteningly troubled world.

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Getting Better. The Policy and Politics of Reducing Health Inequalities
(£12.99 paperback, available free on Kindle)
Clare Bambra, Julia Lynch, and Katherine E. Smith, 2025, Policy Press, 130pp.

"If there is sufficient political desire to reduce health inequalities, it can be done".

This message is what the authors hope the reader will take away from this short and accessible text which should engage all those concerned with the health of the nation. The topic of how government might go about improving the lives of the many by paying serious attention to addressing health inequalities is an important one. Given Micchael Marmot gets only a cursory mention in the '10 year health plan for England', and Alan Milburn has dismissed the social determinants of health as 'outside the the remit of the NHS' the publication is timely. Each chapter is outlined below.

Introduction

There are inequalities, inequities and disparities in health in every country of the world but in recent decades these have been increasing, with life expectancy stalling (or even declining in the most disadvantaged communities). Both the COVID-19 crisis and the post-pandemic rise in cost of living have exacerbated this trend. This book asks what may be learned from countries that have had some measure of success? The authors set out what happens when social safety nets are dismantled, access to care becomes more difficult, poverty and inequality increase, and political civil rights begin to decay. They assert that even within the constraints of unequal societies, the social and behavioural determinants of health are amenable to public policy interventions.

The social determinants of health are largely outside the control of individuals. Political choices that have been made determine why some people do well and others fare badly, raising questions as to where power lies and in whose interest it is exercised. Health inequalities fell from the start of the 20th century, then more quickly during the period of economic growth from the late 1940s to late 1970s, rose steeply during the years of 'market fundamentalism', with further acceleration following the Global Financial Crisis. This pattern demonstrates that the reduction of health inequalities requires large-scale policy action across all aspects of society, but the authors draw out common levelling mechanisms and conclude that given sufficient political will, reducing health inequalities is eminently feasible.

USA

In the United States, the 'Great Society' programmes were enacted from 1964-68. The Democratic Johnson administration pursued a series of policies addressing poverty, malnutrition, housing, education, healthcare, unemployment, racial discrimination and barriers to political representation. Despite rapid economic growth, one fifth of the population and four in ten Black Americans lived in poverty, experienced shorter lives and had much higher infant mortality. The health of rural children was more like those in parts of Africa rather than an economically developed country; 31% of Black families lacked basic in-home sanitation and unemployment rates were double those for Whites. The education system was segregated and unequal, healthcare paid for out of pocket or through insurance, and in some states only a small proportion of Black Americans were registered to vote.

The 'Great Society' targeted the root causes of poverty and of socio-economic and racial inequalities through a wave of legislation. This targeted poverty, poor nutrition, education, housing, employment, access to healthcare, political representation, the environment and sales of health harming products. Inequalities in health substantially narrowed while life expectancy and infant survival rates improved. Most of this can be attributed to concerted action

on the social, economic and political determinants of health rather than expansion of healthcare access. By the mid-1970s the Great Society initiative had been supplanted by neoliberal policy approaches, bringing an end to the brief narrowing of health inequalities.

Brazil

Brazil from 1985-2000 was transitioning from the military dictatorship in place from 1964-84. The coup in 1964 was supported by the USA and justified by the usual spurious claims that progressive reforms would inevitably lead on to a communist revolution. Post coup, relative income declined for all but the top 10%, while housing was neglected in favour of infrastructure projects. The rural poor moved to cities to take up poorly paid and dangerous work. Popular resistance eventually ended the military dictatorship but left Brazil with 'strong hierarchies of gender, race and class, which sustained enormous and persistent social and political inequalities'. However, Brazil's 1988 constitution sought to improve lives and declared that 'health was a right to be enjoyed by all'.

From 1985, multiple social, heath and economic policies saw infant mortality rate fall from 69 to 11 deaths/1000 and life expectancy increase from 62.5 to 76.8 years. Key policy areas included the establishment of a largely tax-funded health system providing comprehensive care for everyone. Pro-poor cash transfers included grants to low-income families on condition that their children attend school; this helped reduce poverty and improve education. Impoverished families were then awarded a fixed monthly stipend, leading to significant reductions in poverty and income inequality, improvements in educational outcomes and health care access, a reduction in malnutrition and infant deaths. Financial support was also associated with reductions in premature all-cause and cardiovascular disease mortality. A minimum wage was implemented. Precarious employment was reduced.

Citizen stakeholder participation helped people to determine investment priorities in their communities, bolstered democracy and increased accountability. Public policy councils were established to promote dialogue and decision making on health, education and social development. The commercial determinants of health were addressed through successful tobacco control measures and (limited) restrictions on alcohol and ultra-processed food. One of the world's largest government housing programmes was launched. The transition to democracy appears to have been a fundamental factor in reducing health inequalities. Conversely, lack of progress on human rights, failures implementing the housing programme, low levels of student learning, workplace safety, and weakening of environmental protections are identified as areas of policy that fell short in terms of outcomes.

Germany

Disparities in post-reunification life expectancy between East and West Germany fell rapidly (largely through falling death rates in pensioners). East Germany lagged behind the West in terms of economic development, healthcare provision, living and environmental standards and public health, although basic foods and rent were very cheap. Industry took a heavy toll on the environment and housing stock was poor; workplace accidents and occupational health issues were also rife. State funded and provided healthcare delivered similar outcomes until the late 1970s but then fell behind due to lack of investment, with the gap in life expectancy opening out. The East German system prioritised care for working age men and women, including maternity provisions. Smoking rates and alcohol consumption in the East were higher while infant mortality rates were the same between the two countries.

Factors implicated in rapid reduction in health gaps included economic reunification improving the economy of the East. The wages of East Germans improved significantly. De-industrialisation of state-owned East German enterprises proceeded apace with many women losing their jobs and childcare

support, and unemployment among women then remaining high. Pensions and unemployment benefits increased and relative poverty rates fell. East German diets improved, with high obesity rates falling together with alcohol consumption. Hospitals were modernised including updating equipment, coming up to the standards of the West in just a few years. Peri- and neonatal mortality fell in the East as did the number of deaths from preventable conditions including cardiovascular and cerebrovascular disease.

The democratisation of the German Democratic Republic probably also played a role in improving public health and reducing inequalities. Contrast with the Soviet Union and Eastern Bloc where rapid deindustrialisation and massive privatisation in the absence of public policy support drove an increase in poverty, psychosocial stress, increased alcohol consumption and rising mortality. Above all else, the German experience shows that if there is sufficient political desire to reduce health inequalities, it can be done.

England

This section explores the positive impact of England's National Health Inequalities strategy, 2000-2010. The rise of neoliberal economics had gone hand in hand with dismantling and restructuring the welfare state, privatisation and marketisation of services, benefit cuts, deregulation of the economy, flexible labour markets and the subordination of social policy to the demands of the market. Ensuring the efficient functioning of markets now became regarded as the primary function of the state. Thatcherism in the 1970s explained the crisis of British capitalism as a crisis of the welfare state, high wages and low productivity, together with the 'undemocratic' power of the unions. Income inequality increased steeply and poverty rates doubled as did unemployment.'Giving power back to the people' led to the radical de-democratisation of the power industry and other utilities. An ambition to create 'a nation of home owners' produced mushrooming homelessness from lack of affordable social housing. Thatcher's government kick-started the dismantling of the welfare state, privatisation of the NHS and created the conditions for the banking and finance crisis.

Inequalities in both educational outcomes and access to healthcare increased. The housing 'right to buy' scheme contributed to growing wealth inequalities and sowed the seeds of the 1989 housing crash. In health, a quasi-market centred around competition and choice was introduced; outsourcing of cleaning, catering and laundry services opened up the NHS to market forces. Trade union rights were curtailed and jobs became more flexible and precarious; unemployment grew while benefits shrank.

The share of UK wealth held by the top 1% increased by more than 50% from 1977-97. The new Labour government of 1997 was keen to emphasise the Conservative's 'failure to address health inequalities', and following the Acheson report, adopted targets for reducing infant mortality and the gap in life expectancy, and lowering mortality rates from heart disease, stroke and cancer. There were also targets related to employment rates, education, crime, housing, child poverty and deaths from traffic accidents. Strikingly, the NHS was awarded above historical average budget increases (up from 3.7% to 5.7%) to meet need. Other initiatives included Sure Start (support for children age 0-4 years and their families), tax credits, pension boost, Health Action Zones, New Deal for Communities, tobacco control, and a health inequality weighting in the allocation of NHS funding.

Despite doubts expressed that targets would be met, English health inequalities targets were largely achieved, with notable reductions in geographical health inequalities between 2000-2010. Inequalities in life expectancy for men fell by one year. Inequalities in infant mortality rate also reduced, probably related to a reduction in child poverty. Inequalities in mortality amenable to healthcare fell, likely due to the increase in proportion of NHS funding allocated to deprived areas. Pension improvements were linked to improved mental

well-being for men in the most deprived areas. Sure Start's impacts included positive effects on child development and the mental health and well-being of parents, as well as reducing the chance of hospital admission for children.

While the overall strategy at first focused on the social determinants of health, it then drifted towards trying to change individual health behaviours, potentially limiting greater gains that might have been made. There was little redistribution of income between rich and poor people and the influence of the alcohol industry remained unconstrained. Income inequalities continued to rise while benefits for lone parents and the disabled were cut. In wider economic policy, New Labour continued the neoliberal approach of Thatcherism including further marketisation and privatisation of the NHS.

Waxing and waning

In the historical case studies presented, the waxing/growth of efforts to reduce inequalities occurred at times when tackling inequality more broadly was high on the political agenda. The waning/shrinking was prompted by the victory of neoliberal economic and social policy ideas, persistent structural inequalities, power struggles and erosion of democratic gains. The final section of the book considers that there is not a single best approach to reducing health inequalities, and the determinants that shape health inequalities require effective action across multiple policy areas. Key levellers of inequality from across the countries examined included expanding social protection and the welfare state, reducing economic inequality, increasing access to healthcare, and political incorporation – the right to be heard and having a political voice is good for health!

The Global Financial Crisis of 2007-8 was followed in 2010 by a coalition government of Conservatives and Liberal Democrats, then by majority Conservative governments. There ensued large-scale cuts to local government budgets, underfunding of the NHS and reductions in welfare services and benefits; most of the schemes that had started to reduce health inequalities were ended. Public expenditure on social care decreased, the largest cuts falling on the most deprived areas. Cuts in welfare services and benefits were also felt more keenly in the poorest regions, disproportionately affecting low-income households. Correspondingly, health inequalities have increased, for example in life expectancy. As child poverty increased so did inequalities in infant mortality, while benefit cuts impacted negatively on mental health. Austerity was accompanied by adverse effects on health. England entered the COVID-19 pandemic with stalling life expectancy, increased regional and deprivation-based health inequalities and worsening health for the poorest in society.

Conclusions

The authors demonstrate that by targeting policies, health inequalities can be reduced, and this can happen quite quickly. Continung progress clearly cannot be taken for granted and the current period is characaterised not only by increasing inequalities but a weakening of democracy in the West. Social movements pushing for progressive policies, ambitious political leaders advancing a progressive agenda, and an electorate fuelled by hope and optimism are the antidote to neoliberal proposals for a small state, free markets and trickle-down economics, all of which generate anti-equality sentiment. Perhaps the most important task at present is collective action to make the case for progressive policy reform and counter the ideas and interests that advocate policies likely to increase health inequalities – to the detriment of the many.

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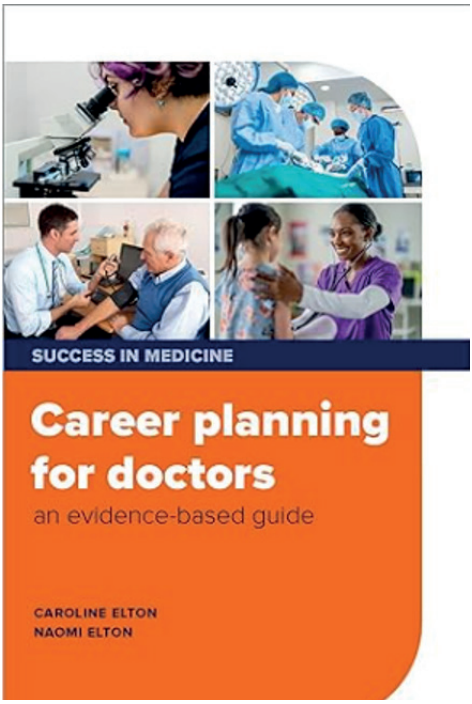
Career Planning for Doctors: an evidenced-based guide
(£22.99, paperback)
Caroline Elton and Naomi Elton, 2025, Oxford University Press, 200 pp.

Planning, luck and opportunity are the three pillars underlining the progress of our medical careers, and this excellent book deals with all three and much more.

It encourages us to move away from the often haphazard approach to career progression and instead boost self-exploration and look at the balance between 'decision hygiene' and intuition. Both are important but active decision-making needs to be promoted much more. The book emphasises aspects such as interviewing prospective consultants and colleagues and where possible visiting the hospital department. My personal advice was always to telephone and if possible visit the department's secretary and through them get a measure of the well-being of the department and by repeating your own name hope it will be ringing in the ears of those on the interview board. Perhaps that is old-fashioned but it works!

As well as the standard path up the slippery and unpredictable career ladder, the book encourages a closer look at alternative pathways including the mis-named and often maligned 'non-training posts' and diploma pathways. It is so wrong that posts are still designated training or non-training. Medical training is gleaned from patients rather than from lectures so the title 'non-training post' is a nonsense. Paracelsus in the 15th century knew this emphasising that our 'Patients are our textbook and their sickbed our study'; this as true today as ever. But there we are, the educationalists have won that battle.

There are excellent and informative chapters for international medical graduates thinking of coming to the UK as well as UK doctors thinking of having time abroad, although it is a shame that there is only one short paragraph on the Medical Training Initiative scheme for international graduates. Perhaps we should also be encouraged to think of the ethical dilemma of the greater needs of



the donor country versus the over-medicalised country to which international graduates are applying and encourage UK graduates to contribute more to global medical needs and their own education by working overseas.

The book looks at the quality of decision-making in general and touches on so many aspects of relevance to doctors of all grades including their well-being, and the pull of family life and outside activities versus the needs of the patient. This is important. We should actively decide on the balance we want to achieve between medicine and 'not-medicine' this, on the one hand to prevent burnout, and on the other to prevent medicine transitioning from a rewarding profession to 'just a job'.

There are good examples throughout the book and I enjoyed learning about Fredkin's paradox: 'The more equally attractive two alternatives seem, the harder it can be to choose between – no matter that to the same degree the choice can only matter less'. In other words overthinking results in decision paralysis.

One important piece of advice that should be mentioned. Do not bring up HR issues at the interview – eg can I take holiday on …; or how are the extra duties payments calculated. Get the job first and then enquire. Lastly, the book puts in a plea to warn aspiring doctors and medical students that the way can be hard, sometimes brutal, but if you persevere and are forewarned it will lead to a uniquely rewarding career.

At less than £25, this is an excellent generic source for those in the UK or thinking of coming to the UK. Buy it now. You may think you know it all, but you won't and it could be a game changer.

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NOTICE

Pam Zinkin, an EC member for many years and tirelss campaigner, died in November just after the last issue of this newsletter went to print. Since then obituaries for Pam have appeared in the Guardian, the BMJ and her local paper, the Camden New Journal.

We will be publishing our own tribute to Pam and her campaign work in the next issue of the newsletter.

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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Fifty Years...

'The National Health Service is safe with us' – Margaret Thatcher

'When we started to introduce private providers, that was when we started to get falls in waiting [lists]' – Tony Blair

'[The NHS] should remain in public hands…not just for the next 70 years, but forever' – Theresa May

'The NHS is safe in my hands' – David Cameron

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