Call for new regulator to replace GMC

Philip Banfield, head of the BMA, has called for a new independent regulator of doctors, calling the GMC "clueless" about how medicine is delivered and "contemptuous of safety concerns."

The BMA's chair of council said the GMC's "abject failure" to regulate physician associates (PAs) and anaesthesia associates (AAs) showed it could not protect the public and it had lost the confidence of most doctors.

Speaking to the BMA's annual representative meeting in Liverpool on 23 June, Banfield warned that the GMC's approach had led to a blurring of professional boundaries and accused it of a "dangerous obsession with substituting doctors at the expense of patient safety." He also announced the launch of a BMA register solely for doctors, saying the BMA was in a "fight for the soul of our profession."

He said most doctors backed a new regulator that could command confidence, with a clear statutory duty to protect the public, setting a clear distinction between uniquely qualified doctors and non-doctors.

A GMC spokesperson said, "We take our role working with doctors to support good, safe patient care very seriously. Our aim is to deliver effective, relevant, and compassionate regulation. A critical part of how we do this is by gathering feedback from doctors and patients about their experiences and using this to change and improve our processes.

"This year, we also welcomed the announcement of much needed reform of the regulatory framework we operate to. Making further changes to the way we work will benefit patient safety and ensure the public has confidence in the doctors we regulate."

Results from a BMA survey of more than 1400 doctors showed that 82% supported the creation of a new watchdog solely focused on doctors. More than 60% believed the GMC was failing to keep patients safe.

Banfield said the BMA had collected more than 600 "shocking examples" of unsafe practice by PAs, including widespread prescribing, inappropriate referrals for ionising radiation, and cases of avoidable patient harm and death. He added that the GMC had argued that doctors supervising a PA should first check with the PA's former employers what they were capable of doing. "What world is the GMC living in?" he asked. "Clueless about how medicine is delivered. Condescending of the working lives of doctors. Contemptuous of safety concerns. I'm afraid it feels they have lost the plot."

Matthew Limb, London

Cite this as: *BMJ* 2025;384:r1304

Philip Banfield, chair of the BMA council, said the GMC had a "dangerous obsession with substituting doctors"

LATEST ONLINE

- Health secretary announces national investigation into NHS maternity services
- Psychiatrists and paediatricians warn care is at risk, as services are overstretched and staff burnt out
- E-cigarettes risk "renormalising" smoking, says WHO

MEDICAL NEWS

NHS staff raise concerns about patients streaming hospital videos on social media

A growing trend of patients filming themselves receiving medical care and uploading the videos to social media sites is causing unease among healthcare staff, the Society of Radiographers has warned.

It said it was concerned that people were filming their own treatment or the treatment of a relative without permission, which was compromising the privacy of other patients and undermining the patient's treatment by making staff uncomfortable and anxious.

Dean Rogers (left), the society's director of industrial strategy and member relations, urged NHS hospitals to ensure that patients were aware they shouldn't be filming without staff knowledge and permission. "There are hospital trusts that have good policies. But this is something all trusts need to have in place," he said.

One example cited was a radiology department assistant from the south of England who was inserting a cannula into a patient when the patient's 19 year old daughter started filming. "She wanted to record the cannulation because she thought it would be entertaining on social media," the assistant said. "She didn't ask permission."

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2025;389:r1258**

Industrial action

Senior doctors will be balloted on pay offer

The BMA has announced indicative ballots of senior doctors in England, asking whether they are willing to take industrial action over their recent 4% pay offer. The BMA said the offer was an "insult" and urged the government to negotiate. The ballots of consultants—including those from public health and medical academia—and specialist, associate specialist, and specialty (SAS) doctors will run from 21 July to 1 September.

Sickle cell

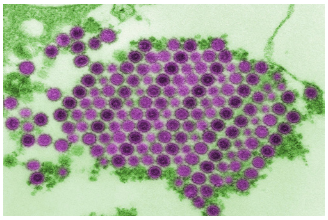
Call for urgent action on "starkly" inequitable care

Persistent neglect of sickle cell disorder has led to a "breakdown in trust" among UK patients, who continue to experience racism and substandard treatment, said Imperial College London research commissioned by the NHS Race and Health Observatory. When compared with cystic fibrosis or haemophilia, patients with sickle cell disorder faced "stark disparities" in areas such as funding, treatment options, research grants, clinical trials, and the healthcare workforce. The researchers called for action to improve sickle cell outcomes, including greater investment.

Chikungunya virus

Vaccine is restricted, pending safety review

The UK's Commission on Human Medicines has temporarily restricted the use of the IXCHIQ chikungunya vaccine in people aged over 65 after very rare fatal reactions were reported worldwide. Chikungunya virus is a potentially life threatening viral infection found in subtropical regions. The commission said the restriction was precautionary, pending a "full safety review" by the Medicines and Healthcare Products Regulatory Agency in response to 23 cases of serious adverse reactions, including two cases reporting a fatal outcome.



Cancer

Breakthrough myeloma treatment gets UK approval

Patients in England with multiple myeloma will become the first in the world to access a new treatment that combines belantamab mafodotin (brand name Blenrep) with bortezomib and dexamethasone, after its approval by NICE. Draft guidance recommends the treatment for adults with multiple myeloma who have had previous treatment containing lenalidomide and who either cannot tolerate lenalidomide or whose cancer has become resistant to it. Around 1500 patients are expected to benefit from the treatment.

GP pancreatic screening pilot is launched

NHS England launched a £2m initiative to catch people most at risk of pancreatic cancer. In the pilot scheme more than 300 general practices will scour online patient records to identify people aged over 60 who have key early warning signs, including recent diagnosis of diabetes and sudden weight loss. The health minister Karin Smyth (below) said, "This targeted approach to identify people at risk of one of the most lethal cancers could give more people a fighting chance."

Patients warned over weight loss drugs

People with cancer should consult their GP before taking weight loss drugs, said Macmillan Cancer Support, which has launched information on its website about cancer and the drugs Ozempic, Wegovy, and Mounjaro. This follows a recent increase in calls from the public, including people asking about safety and those who want to manage their weight before or after treatment for cancer. Owen Carter, the charity's national clinical adviser, said, "We simply do not know enough about the long term impact of these medications to recommend them if they're not prescribed by a specialist."

Clinical trials

NHS App plan to boost participation in research

The National Institute for Health and Care Research (NIHR) launched a UK-wide recruitment drive for clinical trials to get millions more people involved in research and join trials suited to their interests and needs. Under-represented groups, including young people, black people, and people of South Asian heritage, are particularly encouraged to sign up for the NIHR's Be Part of Research service on the NHS App. Vin Diwakar, NHS England's clinical transformation director, said that the initiative would give patients access to new treatments and technologies earlier, improving the quality of their care.

IN BRIEF

Environment

Polluters face jail term in Dominican Republic

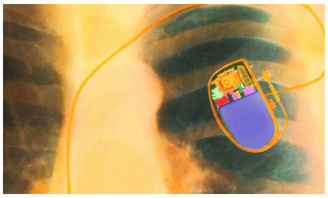
Environmental polluters responsible for severe or irreversible damage could face 20 years in prison under plans to criminalise the act of ecocide in the Dominican Republic. A bill put forward by the congresswoman Llaniris Espina would give courts the power to penalise senior policy makers and corporate executives for illegal acts causing serious, widespread, and longlasting damage to ecosystems. Offenders could also be forced to restore the environments they had damaged.

Company executives in the Dominican Republic could be jailed for ecocide

Medical devices

New reporting rules aim to beef up patient safety

A major reform of regulation of medical devices in England, Wales, and Scotland took effect on 16 June, intended to help identify potential safety concerns earlier and strengthen protection for patients. Under new post-market surveillance regulations, manufacturers of devices such as in vitro diagnostics and implantable pacemakers will have to actively track the safety and performance of products already in use and respond more quickly to incidents and emerging risks. Lawrence Tallon, MHRA chief executive, said the change marked an "important milestone in our work in building a modern, responsive regulatory system."



Maternity care

Leeds trust is warned over safety breaches

The CQC called for immediate improvements to services at Leeds Teaching Hospitals NHS Trust, including safe staffing levels, to protect people using maternity and neonatal services. This follows inspections at Leeds General Infirmary and St James's University Hospital and concerns raised by staff and service users. The CQC's warning notice highlights unsafe and dirty facilities, insufficient qualified staff to care for babies with complex needs, and breaches of maternity service regulations.

Respiratory

WHO criticises poor care of chronic respiratory disease

A World Health Organization Europe and European Respiratory Society report states that chronic respiratory diseases—including asthma and COPD—are vastly underdiagnosed, poorly managed, and significantly underestimated in their impact on health systems in Europe. Diagnostic capacity and tools such as spirometry remain limited, primary services often misdiagnose or delay referrals, and health professionals lack sufficient training to identify chronic respiratory diseases early, it said.

Blood scandal

Victims to get bespoke psychological care

Patients and relatives affected by the contaminated blood scandal in England will be able to self-refer for psychological treatment from the new NHS Infected Blood Psychological Service. The service will include access to talking therapies and peer support.

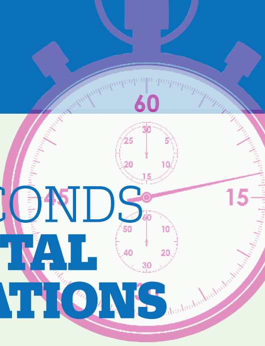
Cite this as: *BMJ* 2025;389:r1290

GENETIC TESTING

The Information Commissioner's Office has fined the genetic testing company 23andMe

£2.31m

for failing to put in place appropriate security measures to protect users' personal data, after a cyberattack in 2023



SIXTY SECONDS ON . . . RECTAL EXAMINATIONS

THE PUNCHLINE TO MANY A JOKE

Perhaps no longer. Leading urologists have called for an end to the routine use of the digital rectal examination (DRE), stating it is no longer a useful test for prostate cancer.

THAT'S A BUMMER

In a joint statement the British Association of Urological Surgeons (BAUS) and Prostate Cancer UK said, "The way prostate cancer is diagnosed has improved vastly in recent years with the introduction of magnetic resonance imaging and new biopsy techniques."

WHAT'S THE BOTTOM LINE?

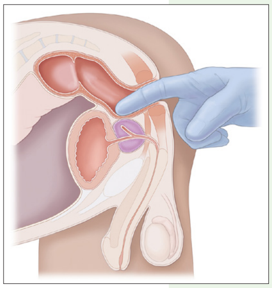
The statement says men can understand their risk of prostate cancer by doing an online questionaire and, if still concerned, talking to a GP about a PSA test. "Our message to GPs is: if a man has raised PSA there is no need to do a physical exam—refer him for an MRI, which will far more accurately identify whether or not he has cancer." Last year the NHS's Getting it Right First Time programme said no DRE is needed if PSA is raised.

BUTT WAIT, THERE'S MORE

Vishwanath Hanchanale, chair of section of oncology at BAUS, said, "DRE is a poor test, with a limited role in both diagnosing and active surveillance of prostate cancer. Its continued presence in referral guidelines is causing confusion and anxiety."

DRE DREAD

A Prostate Cancer UK survey of 2000 men found that 60% were concerned about having a rectal exam. Of those, 37% would not speak to a GP about prostate worries because they feared it. And black men—whose risk is double that of other men—reported they felt an even greater sense of stigma.



DO GPs STILL DO DREs?

Another survey by the charity showed a third of 750 men who said they'd asked for a PSA blood test were offered a DRE as well. And 3% were offered a rectal exam instead of a blood test.

IS THERE STILL A POINT TO DREs?

Royal College of GPs chair Kamila Hawthorne noted that because the PSA test has a false negative rate of about 15% it was sensible to wait for the Transform screening trial results before ditching DRE.

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;389:r1238

Doctors vote to end NHS's "unethical" ties to Palantir

Representatives voted in favour of lobbying against Palantir's involvement in the NHS's data management system and supporting doctors who refuse to use the system.

In 2023 NHS England awarded Palantir a £330m contract to create the Federated Data Platform, which aims to provide "joined up" NHS services.

Maisun Elftise, a Coventry GP, said some of her patients were already facing "marginalisation through privation, language barriers, and immigration status." She said, "Many worry about who has access to their information. So when I hear their data is being handed to a company with deep ties to military surveillance and border enforcement I'm worried, because this is not just about technology, it is about the trust and moral integrity of our NHS."

Call to reimburse GPs for national insurance costs

Representatives voted for the BMA to lobby the government for general practices to be reimbursed for the enhanced national insurance contributions that were introduced last year.

Om Aggarwal, a GP from Cardiff and Vale of Glamorgan, also called for an immediate exemption of general practice from the increases, saying, "This is not just about balance sheets but whether we can continue to offer safe, timely, and continuous care to communities."

Demand for tougher action on sexual harassment

Nearly all representatives (98%) voted in favour of a motion calling on the BMA to lobby for a national reporting structure for sexual harassment in the NHS and to develop better support for victims who act as witnesses in tribunals.

The motion also called for trusts to make active bystander training mandatory and for employers to use trained external investigatorst.

Introducing the motion, consultant perinatal psychiatrist Bhairavi Sapre said, "The majority of perpetrators are doctors, predominantly in consultant positions. That means we must take responsibility."

Cite this as: *BMJ* 2025;389:r1316

GPs who refuse to follow "ludicrous and unsafe" hospital prescribing win support

It's easier for trusts to ask GPs to prescribe than to invest in IT systems

Brian McGregor

The annual representatives meeting strongly voted to support GPs who refuse to prescribe medicines for hospital patients unless the GP has been properly informed and the treatment has been started and stabilised in secondary care.

The meeting also backed GPs who reject initial prescriptions from hospital staff who are not qualified to prescribe, warning that current practices were unsafe and driven by outdated hospital systems.

Brian McGregor, the GP who proposed the motion, called for a UK-wide rollout of electronic prescribing systems linking primary and secondary care, saying this would improve safety and reduce inappropriate workload transfers. Hospital letters could take months to reach general practices, he said, and the chain of people involved in the prescribing process was becoming dangerously long.

BMA guidance states patients started on new drugs in secondary care should be counselled, titrated, and stabilised before any responsibility is passed to primary care. "It's easier for trusts to ask GPs to prescribe than to invest in proper IT systems," said McGregor.

Annie Farrell, a GP partner and hospital clinic lead in Liverpool, said her trust still relied on handwritten prescriptions, using a shared pad that was locked in a cupboard. "My mind has been blown by the totally inadequate computer systems we are expected to use at the trust. There's no auto-population of patient details, the list of other medications the patient is on, or the amount of drugs that come in the box," she said.

"It's mad that we are talking about AI in healthcare, and moving from analogue to digital, when we don't even have the basics of a working IT system in secondary care," Farrell told the conference. "Electronic prescribing from hospital clinics would save endless, inappropriate transfers of work to general practice and make access to medication much better for patients."

The motion also called on the BMA's General Practitioners Committee UK to explore how prescribing data from outpatient clinics could automatically flow back into GP records.

Rebecca Coombes, *The BMJ* Cite this as: *BMJ* 2025;389:r1315

"Assisted dying services need additional funds"

The NHS and social care cannot absorb the costs

Samuel Parker

Representatives called for additional funding to meet the costs of delivering assisted dying services, emphasising that the money should not be drawn from existing health and social care budgets.

Proposing the motion, Samuel Parker, a GP in northeast England, referred to Wes Streeting's claim that "there isn't a budget" for the implementation of the services. Parker told the conference that with 7.4 million patients on NHS waiting lists, the NHS and social care could not absorb the costs of setting up and running services to deliver assisted dying.

The motion also called for funding for assisted dying to be matched by equivalent additional funding for palliative care, mental health, and social care services, stating "assisted dying must never be seen as a cheaper alternative to high quality state funded public services."

Speaking in favour of the motion, Sarah Foot, a registrar in palliative medicine in Essex, said currently only a third of funding for hospices came from government, with the remaining two thirds coming from "things like bake sales at my son's primary school."

A subclause of the motion calling for patients who request assisted dying to be encouraged to attend face-to-face reviews by an independent palliative care doctor was passed separately. Parker said such reviews would ensure that patients' care needs have been met and would protect against coercion.

But James Booth, a GP from north Essex, told the conference that he was "uncomfortable" with the proposal, which he likened to "those practices in America where women requesting termination of pregnancy are mandated to have an ultrasound scan first." Booth said, "This does not respect the autonomy of patients making those decisions."

Ella Hubbard, *The BMJ* Cite this as: *BMJ* 2025;389:r1314

VUK VALCIC/ALAMY

MPs back legalising assisted dying in England and Wales

MPs voted by 314 to 291 to approve a bill that would make assisted dying legal in England and Wales.

The Terminally Ill Adults (End of Life) Bill will now go for further scrutiny to the House of Lords, where commentators have suggested the decision to give it a third reading meant it was almost certain to become law. There is a convention that the Lords will not interfere with the decisions of MPs, although the size of the majority, reduced to 23 from the 55 in the second reading, could influence peers opposed to the bill.

The bill will allow adults in England and Wales who are terminally ill and expected to die within six months to have assistance to end their lives. Two doctors would need to support the application, and it would have to be approved by a panel of three: a senior lawyer, a psychiatrist, and a social worker.

During the third reading debate MPs accepted an amendment designed to stop people from accessing assisted dying services by stopping eating or drinking. The Royal College of Psychiatrists and eating disorder charities had warned that a loophole in the bill risked making people with anorexia eligible for assisted dying.

MPs voting in favour included Keir Starmer, while Kemi Badenoch voted against. Some 20 Conservatives, including Rishi Sunak, voted in favour, along with mostly Labour MPs.

"This vote sends a clear message," said Sarah Wootton (above, centre), chief executive of Dignity in Dying, which has campaigned for years for this legislation. "Parliament stands with the public and change is coming."

Doctors must have to actively opt in, and no doctor should be forced to take part
Andrew Green

But Gordon Macdonald, chief executive of Care Not Killing, said it was a "deeply flawed and dangerous bill that since November has been made considerably worse with important safeguards watered down or scrapped."

The government and the NHS will have four years to implement the legislation if it becomes law.

The BMA is neutral on the issue of assisted dying. Andrew Green, chair of its medical ethics committee, said, "One fundamental principle that we have been clear on is that, if the law does change, doctors must have to actively opt in, and no doctor should be forced to take part in any part of the process.

"We were therefore glad to see MPs pass an amendment, as a direct result of our engagement, that strengthens the comprehensive protection for all healthcare workers to be able to decline to take part.

"As the bill reaches the Lords there are a number of issues we want addressed. These include the need for an official service to provide individual patients with tailored information about the range of options available, which should include access to palliative care, as well as assisted dying."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;389:r1293

Doctor who had relationship with teen patient is suspended

A doctor who met a teenage patient in hospital when he was a medical student, then maintained a messaging relationship with her that became sexual when they met again years later, has been suspended from the medical register for 12 months.

Cian Hughes, who qualified in 2012, met the 13 year old girl, named only as Patient A, in March 2011 while assisting at a confidential operation. He was nine years older and a fourth year medical student. The two became friends during her six week stay.

While in hospital, she asked for copies of her x ray pictures, which he sent from his personal email. She used this address to contact him after her discharge. The two maintained regular email and text correspondence for years, discussing her medical situation, her educational options, and 50 poems that she wrote.

In October 2014, when she was 17, she arranged to meet Hughes in person. Days after that meeting Hughes sent a message asking whether she was interested in a romantic relationship, to which she responded positively.

HUGHES HAD DISCUSSED GUIDELINES ON DOCTOR-PATIENT RELATIONSHIPS

Over the following months she stayed several times at his home, and Hughes stayed twice at hers, while her parents were there, the tribunal heard. Their messages during this period grew more intimate and nature.

Hughes attended Patient A's 18th birthday party at her parents' invitation. The next weekend they met again and this time had sex. But a few weeks later, after a disagreement about marriage, they agreed to take a break.

They met a few times over the next two years but did not resume the relationship.

Last contact

Their last contact was a 2018 message from A asking to meet up, to which Hughes did not reply. In 2020 Patient A reported the relationship to the police, who interviewed Hughes but took no further action.

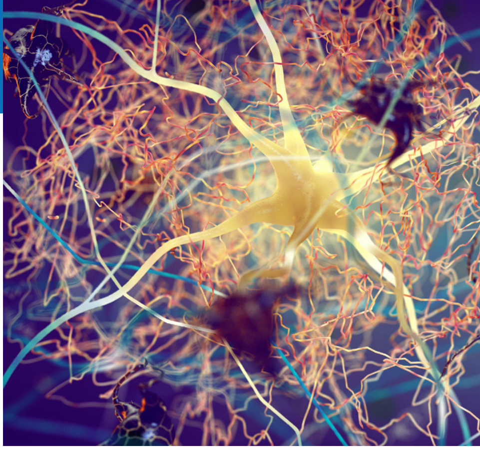
In a case that was "finely balanced" between suspension and erasure, said tribunal chairman Duncan Ritchie, one factor in sparing Hughes the harsher penalty was that he had discussed guidelines on doctor-patient relationships with a colleague and A and concluded he wasn't breaching them.

The panel rejected the GMC's call for erasure, agreeing with Hughes's lawyer that he had not "blatantly disregarded" the guidelines and that his case "could be distinguished from other cases of sexual misconduct."

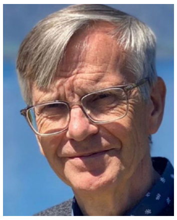
The tribunal imposed a 12 month suspension. Hughes no longer practices as a doctor and has no immediate plans to return, the tribunal heard. He has 28 days to appeal against the ruling.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;389:r1221



Benefits of Alzheimer’s drugs “still too small to justify costs”



NHS should sit this one out and wait for the arrival of a clinically effective treatment
Rob Howard

In final draft guidance NICE has recommended donanemab and lecanemab should not be provided on the NHS for treating mild cognitive impairment or mild dementia caused by Alzheimer’s disease, as they are not good value for money.

Both drugs are monoclonal antibodies that bind to aggregate forms of amyloid β proteins and, by doing so, reduce β plaques in the brain.

NICE has previously rejected both treatments in draft guidelines because of a lack of cost effectiveness. An independent NICE committee has now reappraised the evidence after the manufacturers submitted new information.

Final draft guidance published on 19 June said that, although the drugs have been shown to delay progression from mild to moderate Alzheimer’s by 4-6 months, the overall costs of purchasing and administering them—including monthly infusions in hospital and intensive monitoring for side effects—remain high and the benefits too small.

Helen Knight (left), NICE’s director of medicines evaluation, said, “While we recognise the hope these treatments offer, the evidence shows they only provide modest benefits at best, and substantial resources would be needed to enable access to them.

“The committee concluded that the small benefits shown in the clinical trials and the lack of long term evidence of effectiveness, together with the substantial resources the NHS would need to commit to the treatments, means if they were approved they could displace other essential treatments and services that deliver significant benefits to patients.”

Minimal benefits

Rob Howard, professor of old age psychiatry at UCL, told *The BMJ* the drugs were “never going to be cost effective” for the NHS. “Their absolute effects on cognitive and functional outcomes in the pivotal trials were about 50% of conventionally agreed minimum clinically important differences and not noticeable in an individual patient,” he said.

“We were warned there would be no new NHS funding for their introduction and, with annual costs of drug supply, infusions, and safety monitoring for each patient close to the cost of a full time nurse, NICE approval would have devastated the dementia healthcare economy.

“NICE have made the right decision, and the NHS should sit this one out and wait for the arrival of a clinically effective treatment for people with dementia.”

Tom Dening, professor of dementia research at Nottingham University, said, “The benefits of these two expensive and unwieldy drugs are minimal and probably overstated by their advocates. They have side effects that require monitoring with magnetic resonance imaging.”

UK deviates from US and EU

Paresh Malhotra, head of the division of neurology at Imperial College London, said that, while not unexpected, NICE’s decision created a “large gap between what is done in other countries as well as the private sector, and what will be done for NHS patients.”

The US Food and Drug Administration has approved both drugs for mild cognitive impairment or mild dementia, with black box

MPs vote to end legal prosecution for pregnancy termination

MPs have voted decisively to abolish the possibility of prosecuting any woman in England or Wales for terminating her own pregnancy at any stage, in a move described as the biggest change to UK abortion law in nearly 60 years.

The change could come into force within months, after MPs voted by 379 to 137 for the Labour MP Tonia Antoniazzi’s amendment to the Crime and Policing Bill. The bill will still have to go through the remaining Commons stages and all stages in the Lords before it can become law.

The legal framework for obtaining an abortion, including the existing time limits, will remain the same. But there would no longer be the possibility of prosecuting the woman under the Offences Against the Persons Act 1861 for ending or attempting to end her pregnancy, which carries a maximum penalty of life imprisonment.

Laws passed during the covid pandemic allow abortion pills to be sent to a woman up to 10 weeks pregnant, after a telephone consultation. The new law led to a surge in police investigations and prosecutions, and more than 100 women are thought to have been investigated for suspected illegal abortions over the past five years. Six women have appeared in court in the past three years charged with terminating or attempting to terminate their own pregnancy.

Recent police guidance told officers how—in cases involving sudden unexpected pregnancy loss—to search women’s homes for abortifacient drugs and to seize phones to look for period trackers.

Ranee Thakar, president of the Royal College of Obstetricians and Gynaecologists, called the vote a “victory for women and for their essential reproductive rights.”

She added, “The college has been campaigning to see this achieved for many years, and the decision reflects the voices of over 50 medical, legal, and public health organisations. It also reflects the views of the

warnings of safety risks such as brain swelling and bleeding. The European Commission formally granted authorisation in April for lecanemab to treat mild cognitive impairment in the early stages of Alzheimer's under "strict conditions," a decision criticised by expert advisers. Donenamb does not have European approval.

Hilary Evans-Newton, chief executive at Alzheimer's Research UK, described NICE's decision as a "painful setback" for people with Alzheimer's disease. "While these drugs are not a cure and do come with potentially serious side effects, they represent an important first step in changing the course of Alzheimer's," she said.

Registered stakeholders have until 8 July to appeal against NICE's decision. Lilly said it would appeal the decision. Eisai called for an overhaul of the NICE appraisal process for drugs for early Alzheimer's disease, which it said had serious flaws that tipped "the balance so heavily towards costs and away from treatment benefits."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;389:r1270

MORE than 100 women are thought to have been investigated for suspected illegal abortions over the past five years

public, who overwhelmingly support the right of women to access abortion care safely, confidentially, and without fear of investigation and prosecution."

Antoniazzi described the women affected as "often acutely vulnerable victims of domestic abuse and violence, human trafficking, and sexual exploitation, girls under the age of 18, and women who have suffered miscarriage."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;389:r1261

BMA raises concerns over unsafe PA working practices at Plymouth hospital

The BMA has accused University Hospitals Plymouth NHS Trust of unsafe and unprofessional practice and raised "serious concerns" about the trust's working arrangements between resident doctors and physician associates.

Writing to the trust, BMA chair of council Philip Banfield criticised a leaked departmental email, in which doctors were told to "prescribe all necessary medications" for PAs, as well as requesting imaging and other investigations on their behalf.

This is an issue across the board, not just the ward the email was sent to
Resident doctor

In the email to a ward medical team from a senior figure at Derriford Hospital, resident doctors were told to organise an informal rota for signing off a PA's prescriptions and imaging requests. The email said residents should be proactive in asking the permanent PA for requests, adding that PAs couldn't prescribe, owing to a "variety of issues."

PAs are not authorised under UK law to prescribe prescription only drugs, something clearly stated in GMC guidance. The BMA said the directions issued to residents were highly inappropriate and, if followed, would cause doctors to breach GMC guidance, risk their professional indemnity, and put patients at risk. The BMA demanded they be urgently rescinded.

GMC guidance states that, if prescribing on the recommendation of another professional, doctors must be confident they have enough information to safely proceed. But the BMA said the trust's directions failed to make this clear.

Royal College of Physicians interim guidance says responsibility for prescribing and requesting ionising radiation for PAs lies with the supervising consultant. It says resident doctors must not be responsible for clinical supervision of PAs.

A resident doctor at Derriford Hospital, speaking to *The BMJ* on condition of anonymity, said management had not clearly acknowledged the RCP guidance. "This is an issue across the board, not just the ward this email was sent to," they said.

Anjula Mehta, the trust's joint chief medical officer, said, "We are clarifying our position urgently with all our resident and senior doctors as well as our PAs. We apologise for any confusion."

Elgan Manton-Roseblade, *The BMJ*

Cite this as: *BMJ* 2025;389:r1291

"Addictive phone use" is important in predicting suicidal thoughts in children

Children who develop addictive use of digital technology have up to twice the risk of developing suicidal behaviour within four years than those who may spend longer on their phones but don't develop addictive behaviour, a study has found.

Over four years 4285 US adolescents who were 10 years old at the start of the study were regularly screened for addictive symptoms, including compulsive use, difficulty in disengaging, and distress when denied access. It is the first study to "show that addictive screen use, not total screen time, is linked to suicidal ideation and behaviour and mental health problems in US teens," said lead author Yunyu Xiao, an assistant professor of psychiatry and population health sciences at Weill Cornell Medical School.

The results, published in *JAMA*, showed that nearly a third of participants had an increasingly addictive use trajectory for social media or mobile phones, which started at age 11. More than two fifths (41%) experienced a high addictive use trajectory for video games. The study found that high addictive use for all screen types was associated with suicide related outcomes.

Children who had a high video game addiction trajectory had the largest relative difference in internalising symptoms, while those who reported rising addictive use of social media had the highest trajectory for externalising symptoms. High and increasing addictive use trajectories for all screen types were associated with suicide related outcomes.

Of those reporting addictive phone use, nearly half said the problem had started from the age of 11, with another 25% beginning with low addictive use which then increased steeply.

The authors said, "A key finding is that total screen time was not associated with suicide related or mental health outcomes, underscoring the importance of treating time spent and addictive use as separate constructs."

The study also found higher levels of addictive use of social media, video games, and mobile phones among adolescents from ethnic minority groups, those from poorer households, and those with parents who were unmarried or without a college education.

Jane Feinmann, London **Cite this as: *BMJ* 2025;389:r1289**

Too many children are missed in healthcare settings, says review of child sexual abuse

The medical profession and NHS leaders need to tackle “ambivalence” concerning the sharing of information on children at risk of sexual exploitation, the independent review into grooming gangs has said.

The crossbench peer Louise Casey, who conducted the review, said that there was “no shortage” of reviews, recommendations, and strategies to deal with child sexual exploitation since the government first defined this in 2009 but that “collaboration and grip has been lacking,” letting down victims and the public.

The review, which covered England and Wales, found that no official figures on group based child exploitation were collected, but data showed that around 500 000 children a year were subject to sexual abuse of some kind, and 100 000 offences of child sexual abuse and exploitation were recorded by police in 2024. Casey wrote that, throughout the many reports and initiatives of the past 15 years, “health services are relentlessly cited as a key safeguarding partner that does not share information as easily and frequently as it should.”

Casey quoted the 2022 Telford review of child exploitation, which found that health services often turned a blind eye to abuse. The chair of that review said of health services, “Many witnesses I heard from were looking for a ‘way out’ and wanted someone to uncover what they were going through, without having to make an official complaint.” That inquiry, said Casey, had “heard evidence from witnesses that health services did not help them.”

The Telford inquiry also heard repeatedly how underage children had sought medical help for sexually transmitted infections and abortions from GPs, sexual health clinics, and pharmacies without any questions being asked about “familiar faces.” It reported, for example, that one child “repeatedly visited the same GP practice for the morning-after pill. No one ever asked any questions about her age or why she needed the morning-after pill; the witness said it felt like no one really cared. She was 14 years old.”

Casey said in her review, “We should not be putting professionals in a situation where they worry about sharing information that might affect the safety of a child, but it seems clear that many practitioners fear just that. Some in the medical profession and the leadership of the health service should step in to end this ‘ambivalence.’

“In too many circumstances, identified in too many inquiries and reviews, too many children are not identified and helped, even when they are in healthcare settings.”

RCPCH’S REQUIREMENTS FOR MANDATORY REPORTING

In February this year the Royal College of Paediatrics and Child Health, along with the Royal College of General Practitioners, said that five issues needed to be tackled before reporting of child abuse is made mandatory:

- Include all types of child abuse in the policy
- Follow a children’s rights based approach
- Carry out a government systems impact assessment
- Build measurable outcomes for children into any plans, and
- Provide clear definitions before further consultation

In too many circumstances children are not identified and helped
Louise Casey

Mandatory reporting

Casey welcomed a proposed new information sharing duty related to safeguarding in the Children’s Wellbeing and Schools Bill that will apply to integrated care boards and trusts. She said that this and the Policing and Crime Bill’s new mandatory duty to report child abuse concerns were opportunities for improvement. However, the reluctance to share information “will need to be addressed if these provisions are to have the transformative impact that is needed,” she added.

Casey’s report made 12 recommendations, including mandatory sharing of information between all statutory safeguarding partners in cases of child sexual abuse and exploitation, with compliance monitored by inspectorates and overseen by the proposed Child Protection Authority.

In response to the Casey review the Royal College of Paediatrics and Child Health (RCPCH) said that training in safeguarding was part of the paediatric curriculum. But in February the college, along with the Royal College of General Practitioners (RCGP), said that it could not support mandatory reporting of child abuse without five issues first being tackled (box).

At that time Andrew Rowland,

In 2024 police recorded 100 000 offences of child sexual abuse and exploitation

How to age-proof your life
Matthew Parris on defying the odds
The new It bag (that we can all afford) Times2
andal of the 1,400 lost girl
failed to stop grooming by gangs amid racism fear

BETRAYAL
Huge paedophile gang left free to rape and abuse 57 children
Police and social workers knew what the 97 men were doing but didn’t stop them
Eight of them went on to rape and abuse other girls
Carers knew one victim, Victoria Agoglia, 15, was being injected with heroin by man aged 50 – but did nothing and she died
Top inquiry blasts police, council and coroner for letting down vulnerable children
FULL STORY: PAGES 2,3,4,5,6&7

‘WORST E
CHILD AB
SCANDAL
EXPOSED
Hundreds of young girls raped, beaten, sold for sex and some even killed over 40 years, as authorities fail to act

HORRIFIC
BETRAYAL
OF 1,400
CHILDREN
n gangs’ appalling sexual abuse of young girls
d 16 YEARS because people in authority were
ed of being labelled racist if they tackled it

nspiracy of
on UK sex gangs
ers of Pakistani heritage ● Pattern of abuse across

RCPCH officer for child protection, said the college was concerned that the government had not considered evidence on mandatory reporting that repeatedly showed that outcomes for children were not improved in terms of protection from future abuse, access to support, and health outcomes.

Rowland said, “The government’s own impact assessment predicts that a maximum of nine offenders would be given a custodial sentence at Crown Court as a result of the implementation of this duty. When over 500 000 children are estimated to be sexually abused each year, this figure simply isn’t good enough.”

Confusing for GPs

Rowland added, “The limited resource allocated in this area must be done with precision if we are to maximise improved outcomes for victims of child sexual abuse and to prevent future victims. The currently proposed resource allocation is mistargeted, and in all the above circumstances the government should stop, rethink, and not introduce this policy until and unless the five points are addressed.”

Kamila Hawthorne, RCGP chair, said, “We have raised concerns that introducing two different requirements to share information at the same time, with different processes and different thresholds, will be confusing for GPs without the proper support. We also need to make sure that consideration is given to how we can ensure that younger teenagers are not put off accessing GP care and sexual health services and that professionals have the confidence to ask the difficult questions needed for safeguarding.”

Hawthorne said that the RCGP was engaging with the government as the bills progressed through parliament.

The government has accepted all the Casey review’s recommendations, including setting up a statutory inquiry into repeated failures in England and Wales and tightening the law so that anyone who sexually penetrates a child under 16 is charged with rape.

The Department of Health and Social Care did not respond to a request for comment.

Zosia Kmietowicz, *The BMJ*

Cite this as: ***BMJ*** **2025;389:r1265**

Independent US vaccine body is planned after RFK Jr’s mass firing

EXCLUSIVE “High level” discussions are under way to establish an independent US vaccine committee after Robert F Kennedy Jr dismissed 17 members of the CDC’s advisory committee on immunisation practices (ACIP).

In an interview with *The BMJ*, Noel Brewer, a public health professor at the University of North Carolina and one of the recently ousted ACIP members, said he had heard “more than rumours” that an independent vaccine advisory group separate from ACIP was being “discussed by people at a high level.”

“The abrupt changes have dramatically undermined trust in ACIP recommendations among healthcare providers,” he said. “If the actions of the new committee do not build credibility quickly among providers, some alternative is going to be needed.”

Brewer said the question now was whether vaccine policy should be set by a body funded by the US government or handled independently by the professional organisations representing those who administer vaccines to patients.

So far eight new ACIP members have been announced. “They are the new ACIP,” Brewer said. “We’re going to have to hope they can do a fantastic job. All of them are critical thinkers, and some think in non-traditional ways.”

“Severe consequences”

Brewer said the consequences of the mass dismissal, a shock to him, may be severe. “Half of childhood vaccines in America are provided through the vaccines for children programme, paid for by the US government. For private insurance, the Affordable Care Act requires first dollar coverage for vaccines approved by ACIP.”

“If ACIP doesn’t recommend a vaccine, insurance coverage could be denied. That could be one of the levers for increasing health disparities,” he said. It could be that only people with private health insurance will be able to access certain vaccinations, Brewer explained.

Brewer had no idea his dismissal was coming before reading about it in the newspapers. “I was fired in an editorial in the *Wall Street Journal*,” he said, referring to an article written by Kennedy that announced the action before any official communication, even to ACIP members.

“At 4 pm the article was published and at 4 02 pm I had journalists sending me copies of it,” he told *The BMJ*. He said he did not receive an official termination notice until 5 48 pm.

It’s the first time I’ve been fired in an op-ed
Noel Brewer

TOM WILLIAMS/CQ ROLL CALL/SIPA/ALAMY

“It’s the first time I’ve been fired in an op-ed,” he added, pointing out that the CDC was not currently able to handle all its own communication, given the mass layoffs at federal agencies. The CDC has also been without a permanent director since January, with the acting director position having to be filled twice.

Brewer said the new committee’s abrupt formation, announced by Kennedy just days later, risks damaging trust among healthcare providers and clinicians. In normal circumstances it takes over a year to confirm and bring new members—who are meant to join on a rolling basis to preserve institutional memory—up to speed. Brewer said it had taken him 18 months from first application to being in post.

Uncertainty and instability

“It takes time to understand the complex data that CDC staff present,” he said. Yet the new ACIP members seem set to start almost immediately, with an existing meeting on 25-27 June already in the diary to discuss new recommendations for covid-19, flu, and HPV vaccines.

“It’s unclear how the new members will be brought up to speed on the work that’s been done to date and whether they will just start again,” Brewer said. He was three years into his four year term and was puzzled as to why some members had been removed so swiftly when their terms were expiring at the end of June.

Asked about conflicts of interest (one reason Kennedy gave for the sweeping changes), Brewer said, “ACIP has one of the most rigorous conflicts of interest policies of any federal advisory committee.” He also expressed concern over the politicisation of vaccine guidance. “We are in a bad place if ACIP becomes a blue thing under a Democratic administration and a red thing under a Republican one.

“We can’t keep toggling back and forth over the next 50 years. It will create instability that will make it harder for insurers to know what to pay for, for healthcare providers to deliver vaccines effectively, and for the public to know what to trust.”

Mun-Keat Looi, *The BMJ*

Cite this as: ***BMJ*** **2025;389:r1231**

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THE BIG PICTURE

New perspectives on world health

A new exhibition features 25 of the best images submitted to the Wellcome photography prize, now in its 28th year. The photographs brings together stories of health, science, and human experience.

The images, submitted from more than 100 countries, combine powerful personal narratives with scientific imaging to explore human health in all aspects of life.

The exhibition runs at the Francis Crick Institute, London NW1 1AT, from 17 July to 18 October

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2025;389:r1301

1. **"A Thousand Cuts" (2023), by Sujata Setia, depicts the trauma caused by domestic abuse in South Asian culture**
2. **"Stereo EEG Self-Portrait" (2023), by UK based Muir Vidler, taken after electrodes were implanted in his brain to control epilepsy**
3. **"Musa" (2024), by Marijn Fidder. Musa, from Jinja, Uganda, is disabled by polio**
4. **"I spend 150 hours alone each week" (2022), by Madeleine Waller, one of a series of pictures of the photographer's mother in Victoria, Australia**

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EDITORIAL

Abortion law reform in the UK

Decriminalisation needed to protect women from persecution

Abortion is still a criminal offence in England and Wales, with access to abortion permitted under specific circumstances defined in the Abortion Act 1967. One of us (Nicola Packer) was recently acquitted after standing trial in England having been accused of an illegal abortion.[1] The high profile case has highlighted deficiencies in the current legal framework, underscoring the need for decriminalisation.[2]

Packer was the sixth woman to have appeared in court since December 2022 charged with ending her own pregnancy, although around 100 have endured the trauma of criminal investigation in the past five years.[3,4] In November 2020 she took abortion medication (mifepristone and misoprostol), prescribed over the phone during covid-19 lockdown.

The gestation limit for most abortions in England is up to 24 weeks of pregnancy, and 10 weeks for self-administered medical abortion at home. Packer delivered the fetus at home unaware that she had been beyond 10 weeks' gestation, with the head circumference and an examination by an obstetrician suggesting it was 22-24 weeks.

She first attended Charing Cross Hospital from where she was redirected to Chelsea and Westminster Hospital. Despite both emergency departments noting she was tachycardic, which in the context of a retained placenta should warrant immediate action to address a potential concealed haemorrhage, staff seemed distracted by the stillborn fetus and exploring the circumstances of the delivery.[5]

After Packer had surgery to remove the placenta, the head of midwifery called the police.[6]

ALISHIA ABODUNDE/GETTYIMAGES

Women in England have been investigated after experiencing miscarriage and premature labour

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Nicola Packer, patient representative

Tonia Antoniazzi, MP, House of Commons, London,

Janet Barter, president, Faculty of Sexual and Reproductive Healthcare, London

Lesley Regan, chair, Wellbeing of Women, London

Reforms required to abortion law

Although taking a case to trial is on the extreme end of proceedings, women in England have been investigated after experiencing miscarriage and premature labour,[9] had contact with their children barred (in some cases forcing immediate cessation of breastfeeding), and needed panic alarms installed after receiving death threats; three have served prison sentences.[3]

The harm that criminalising abortion causes to women and health systems is well described.[11] In South America women presenting with miscarriage risk long prison sentences.[12] Evidence of rising harm to women has been described in the US.[13] Conversely Canada, where abortion has been completely decriminalised since 1988, has not seen the rise in abortion rates recorded in most other countries.[14] New Zealand also removed abortion from criminal law in 2020,[15] as have all Australian states.[16]

Opponents raise two main objections. First, they suggest the later gestation cases are the result of permitting remote consultation and prescribing ("telemedicine"), even though all four women who have been convicted obtained medication through the internet (one also obtained a second set from an abortion provider).[17]

One of the major advantages of telemedicine is that it enables the most vulnerable to access regulated healthcare, meaning they can be identified and safeguarded.[18,19] The rate of women seeking abortion medication illicitly substantially reduced in the UK after telemedicine was introduced.[18]

The legal reform would apply only to England and Wales and would mean women no longer face the threat of prosecution for any abortion of their own pregnancy. This would give women the same protections as they have in countries such as Northern Ireland, Ireland, France, Canada, Australia, and New Zealand.[10]

Harrowing circumstances

Second, therefore, opponents will allege this permits "abortion up to birth." It is exceptionally rare for women to reach a later gestation and need an abortion—cases occur in the most harrowing of circumstances, such as in the context of abusive relationships,[20] which as the Court of Appeal stated need "compassion, not punishment."[21] The current law will not deter these cases, but it may deter others, including those who have miscarried naturally but are fearful of falling under suspicion, from seeking medical help.[4] In Canada, after 30 years of decriminalisation there has been no detectable increase in later gestation abortions.[14,22]

The main reason so many individuals and organisations acted with suspicion toward Packer—and in other similar cases—is that the law itself directs and encourages such responses. On 17 June members of parliament passed by a large majority (379 *v* 137) an amendment to the Crime and Policing Bill 2025 to remove women from the threat of prosecution for ending their own pregnancy.[23] In the UK parliamentary system amendments are limited in scope, so this will not deliver the reform that has been achieved in other countries.[15-24]

However, it would prevent other women from enduring Packer's horrific experience, which is why we, along with more than 50 organisations,[25] welcome "Nikki's law."[23]

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Find the full version with references at http://dx.doi.org/10.1136/bmj.r1243

EDITORIAL

Rethinking approaches to clinical trials

Choice of statistical models and data integrity are vital

A BMJ investigation by Doshi (see p 350)[1] raises concerns about the integrity of two randomised trials with surrogate endpoints that supported the regulatory approval of ticagrelor.[2,3] If data integrity is compromised, inferences from these studies are unreliable. Additional concerns are the study populations had stable coronary disease and not the acute coronary syndromes ticagrelor is mainly used to treat,[2,3] and the clinical value of the surrogate marker, inhibition of platelet aggregation, remains uncertain.

The statistical model is not a passive, trivial entity

Regulatory agencies do not usually accept surrogate endpoints trials alone for approval, but these studies may still influence decision making by providing plausible mechanisms that make clinical endpoint results seem more credible. Ensuring data integrity in these studies is therefore crucial.

Data quality is vital in multinational randomised controlled trials of clinical endpoints used for drug approval as the decision is often based on a single pivotal phase 3 trial.[6] A controversial example is the PLATO clinical endpoint trial, which was the pivotal study for ticagrelor approval.[7] The data integrity issues, including selection bias in dropouts and possible biased adjudication, have been discussed in *The BMJ* previously.[8]

Influence of statistical models

The operational difficulties in performing global randomised trials are mammoth. What is less obvious is the important role that statistical models have in the integrity of study inferences. Statistical models codify scientific decision making and motivate more careful experimental design and data collection. However, although statistical methods are often presented as neutral tools to summarise data, they quietly encode strong—often unstated, unrealised, and unreasonable—assumptions that can decisively shape conclusions.

PLATO was analysed under a pooled model that assumed constant baseline risks and constant treatment effects across centres, countries, and regions, an implausible assumption given that ancillary care after myocardial infarction certainly varies across the 43 participating countries. Ignoring any systematic centre level and country level factors will lead to falsely precise confidence intervals and increased risk of spurious claims of benefit. On the other hand, a statistical model examining each regional subgroup as distinct separate entities, an unpooled model, such as the US subgroup (HR=1.27, 95% CI 0.92 to 1.75), is wasteful as it excludes most of the randomised patient data. This is the difficulty that bedevilled the FDA, which initially rejected and then approved ticagrelor without any change in the database. Unknown is the role that the previously mentioned surrogate studies may have had in subtlety influencing the regulators to change their initial opposition.

However, there is a third statistical model that offers a sortie from this quandary of being a "lumper" or "splitter." Hierarchical regression is a compromise between unpooled and completely pooled models and indeed includes those two alternatives as special cases, with the amount of pooling estimated from the data in the multicentre trial.[9]

In the bayesian hierarchical meta-analysis with partial pooling, estimated effects for individual studies are shrunk towards the global mean with improved precision or, more generally, to a prediction based on centre and country level characteristics.

The PLATO hierarchical meta-analysis yields a summary estimate (HR=0.90, 0.72 to 1.10) with enough uncertainty that a reasonable interpretation is the ticagrelor signal needs confirmation in further studies, especially for US patients. A second US study has not been done. Moreover, later randomised ticagrelor trials have shown no benefit.[12-14] This newer evidence provides more support for the cautious interpretation of the PLATO hierarchical model and less support for the confident claim of ticagrelor superiority from the pooled model.

The statistical model is not a passive, trivial entity but rather an important element that mediates how data are transformed into regulatory approval, guideline endorsement, and clinical decisions. We believe hierarchical regressions offer more robust estimates and provide a more complete and open accounting of uncertainty. Hence, we recommend they become standard in multicentre randomised trials, especially when data are aggregated across heterogeneous healthcare systems.

In an era where global trials shape global practice, assuring both data integrity and their accompanying statistical models are trustworthy is essential. Statistical models must be critically examined with the same thoroughness as the data they seek to summarise.

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INVESTIGATION

Ticagrelor doubts—inaccuracies are uncovered in key studies of AstraZeneca’s billion dollar drug

As generic versions of the blockbuster drug prepare to enter the market, The BMJ raises fresh concerns over the integrity of the clinical trials that underpinned its approval. **Peter Doshi** reports

For more than a decade ticagrelor (marketed as Brilinta in the US and Brilique in Europe) has been recommended in the treatment of patients with acute coronary syndrome.

As generic versions of the multibillion dollar antiplatelet drug prepare to launch this year, *The BMJ* has investigated the evidence underpinning its approval and continued use. In our first investigation (*BMJ* 2024;387:q2550) we revealed serious data integrity problems in the PLATO study, the 18 000 patient randomised trial that brought ticagrelor to market.

The BMJ now turns its attention to two key supporting AstraZeneca studies that convinced doctors of ticagrelor’s ability to rapidly and consistently inhibit platelets—critical for managing patients after percutaneous coronary intervention. Our investigation was based on interviews with trial investigators and platelet experts and on access to the underlying trial data submitted to regulators, as well as readouts from laboratory equipment used in the studies. We found evidence that the trials were inaccurately reported. In one instance AstraZeneca’s trial failed to show statistical significance but was published in a leading cardiology journal as significant. Extraordinarily, most investigators, including the principal investigator and the drug company, were unreachable or declined to be interviewed. The findings raise even deeper questions over the approval and decade long use of the drug.

Victor Serebruany, an adjunct faculty member at Johns Hopkins University, told *The BMJ*, “There are episodes of skyrocketing rebound and profound platelet inhibition after ticagrelor, making patients prone to thrombosis or bleeding. If doctors had known what happened in these trials, they would never have started using ticagrelor.”

Original oddity in the data

Ticagrelor brings in more than a billion dollars in annual sales and is recommended worldwide. Despite this, doubts over the PLATO trial’s reliability have persisted.

But back in 2009, as AstraZeneca sought licensing for its new drug, interventional cardiologists were captivated by the drug’s pharmacodynamics. Shortly after PLATO’s publication in the *New England Journal of Medicine*, two AstraZeneca studies, known as ONSET/OFFSET and RESPOND, were published in *Circulation*, one of cardiology’s leading journals, reporting the drug’s effects on platelet function.

ONSET/OFFSET, a 123 patient, randomised phase 2 trial, reported that ticagrelor provided faster and greater inhibition of platelets than clopidogrel (Plavix), a competitor P2Y12 inhibitor that was nearing patent expiry. Similar results were found in RESPOND, a 98 patient randomised trial that investigated ticagrelor’s platelet inhibition in so called clopidogrel non-responders.

What The BMJ found

Last year a *BMJ* investigation found serious data integrity problems in the landmark 18 000 patient PLATO study, calling into question the drug’s advantage over cheaper rivals. In this follow-up article *The BMJ* has expanded its investigation, looking at two key platelet studies that AstraZeneca claimed explained ticagrelor’s ability to successfully treat patients with acute coronary syndrome. We found evidence of serious misreporting, however, raising doubts over the approval and decade long use of ticagrelor.

Our key findings:

- The primary endpoint results for both clinical trials were inaccurately reported in *Circulation*
- More than 60 of 282 readings from platelet machines used in the trials were not present in US Food and Drug Administration datasets
- One active trial investigator never became a study author, while one author told *The BMJ* he was not involved in the trial. Most investigators, including the principal investigator, could not be contacted or declined to be interviewed.

Doctors would never have started using the drug if they knew what happened in trials
Victor Serebruany

With previous trials of antiplatelet therapy linking early treatment with clinical benefit and with evidence that the greater the platelet inhibition the better the outcome, it stood to reason that use of ticagrelor should lead to fewer fatal thromboses.

“The ONSET/OFFSET study, when it came out, caused incredible interest,” says cardiologist Dan Atar, head of research at Oslo University Hospital. “I remember numerous discussion groups where people were asked to interpret these findings.”

AstraZeneca was also pressing the message. PLATO had demonstrated a cardiovascular mortality benefit over clopidogrel, the company said, and the platelet studies, reporting faster and greater platelet inhibition, explained why. Addressing advisers to the US Food and Drug Administration (FDA), an AstraZeneca vice president said, “We think this is important in the urgent management of patients with acute coronary syndromes.”

But for the FDA doctor leading the review of AstraZeneca’s application, the story was not adding up. Thomas Marciniak’s careful look at PLATO revealed a curious wrinkle in the data: early clinical benefit was not seen. If the platelet trial data were correct, Marciniak reasoned, ticagrelor’s faster and greater inhibition should have led to it beating clopidogrel on clinical outcomes in this population in PLATO—but it hadn't. In his review memo Marciniak noted that "ticagrelor patients undergoing early percutaneous coronary intervention" for secondary prevention, the practice for most patients with acute coronary syndrome, "fare worse than clopidogrel patients."

In his report he wrote, "I would expect that patients with the very early invasive strategy would have the greatest need for good platelet inhibition, but ticagrelor fared worse [in PLATO] for short term outcomes in these patients."

Deepening doubts

While Marciniak's memo left the paradox unresolved, one of his colleagues outside the FDA was also trying to make sense of the discrepancy. Serebruany, who would later become ticagrelor's fiercest critic, originally had a stake in the drug's success.

In early 2010, when the platelet studies were published, he held a patent application related to ticagrelor and was in talks with AstraZeneca about a business relationship. But Serebruany, a pharmacologist with expertise in platelet function tests, thought the pharmacodynamic data were too good to be true. ONSET/OFFSET's study schedule, he reckoned, was almost impossibly intense, including a requirement for six blood tests in an eight hour period.

"6 !!!! blood draws at Day 1 . . . Can you confirm that it was really done with other investigators of the study," he emailed his contact at AstraZeneca in January 2010. Serebruany estimated that, over 24 hours, 210 mL of blood would have to be drawn from study participants, patients with stable coronary artery disease (box, right).

AstraZeneca told Serebruany it looked into his concerns but found nothing. "We remain confident in the integrity and validity of the data." But *The BMJ*'s investigation raises serious questions about data validity.

"It's a lot of blood"

Patients in AstraZeneca's pharmacodynamic studies would have to be unusually committed. Typical platelet studies involve one or two blood draws; AstraZeneca's required up to six per visit.

Trial consent forms seen by *The BMJ* inform patients that up to 429 mL (ONSET/OFFSET) and 604 mL (RESPOND) of blood would be taken across multiple study visits spanning weeks. And, according to the forms, patients would not be paid for enrolling, increasing the difficulty investigators faced in recruiting volunteers.

If I was the subject in a trial taking this much blood, I think I'd probably be saying no
Alan Michelson

Alan Michelson, director emeritus of the Center for Platelet Research Studies at Boston Children's Hospital, who was not involved in either AstraZeneca study, was surprised by the amount of blood taken. "If I was the subject, I think I'd probably be saying no just on that basis—even though I don't think it's a dangerous amount of blood to take. But it's a lot."

The BMJ's analysis found that two of ONSET/OFFSET's 10 study sites failed to recruit any patients. (RESPOND did not publish enrolment by site.) Others described recruitment as a challenge. Drew Purdy, who operated a trial site in Rapid City, South Dakota, told *The BMJ*, "Our site is known for being able to get people to sign up for studies." But because of all the blood draws, he judged that only people living nearby would join. "I could see maybe seven of our best clients probably would have stuck around for it, knowing the importance of the trial."

But Robert Storey, professor of clinical cardiology at the University of Sheffield, who recruited 48 patients across the two studies according to AstraZeneca records, didn't recall participant retention being a problem. He told *The BMJ*, "It is indeed a testament to altruism that patients were willing to have multiple blood tests."

Responses from investigators

The BMJ sought to interview more than 15 investigators from the two AstraZeneca trials, to understand their experience conducting the studies and to verify trial records. But most were unreachable or not willing to be interviewed (see table on bmj.com). Among them was Lars Hvilsted Rasmussen, dean of the faculty of medicine at Aalborg University in Denmark, who emailed a statement: "I have no reason to doubt the proper conduct of the [RESPOND] study in relation to the protocol or the results. If you require further information about the study, please refer to the study's corresponding author Dr Paul A Gurbel or AstraZeneca."

Gurbel, the lead investigator for both ONSET/OFFSET and RESPOND, did not respond to multiple email requests.

One investigator *The BMJ* could reach was Tonny Nielsen, a coauthor of RESPOND and principal investigator in Denmark, according to AstraZeneca documents. But Nielsen told *The BMJ* in a written response, "I did not participate in the RESPOND study"—a statement further substantiated by two of his colleagues. And yet he was listed as an author of the *Circulation* paper.

Meanwhile, *The BMJ* found that one investigator, Alberto Yataco, operated an active study site in Baltimore but never became an author despite enrolling 12 patients and ordering extra test kits. Yataco could not be located for this investigation.

The BMJ also found that several of the named authors of the *Circulation* studies apparently lacked relevant experience. Beyond ONSET/OFFSET and RESPOND, *The BMJ* could not locate any other platelet function study in which Cordel Parris, Vance Wilson, Gary Ledley, Dharmendra Patel, or Georges Sabe-Affaki were named authors.

Data integrity concerns

After *The BMJ* documented discrepancies between study site level records in the PLATO trial and data submitted to the FDA, we asked ONSET/OFFSET and RESPOND investigators to share original data. The three who replied said they had no data.

We did, however, obtain trial datasets submitted to the FDA and documents sent by one of the platelet function test manufacturers to the FDA. One email, sent in response to a request from the FDA, detailed when machines and supplies were shipped to various trial sites. The information presented a confusing picture.

The AstraZeneca dataset shows that one ONSET/OFFSET site apparently began recording platelet levels the morning after a machine was shipped to that investigator. *The BMJ* made multiple unsuccessful attempts to interview the investigator, Cordel Parris, to understand how the machine could have been obtained and put to use so rapidly after shipment.


Ticagrelor quality control at AstraZeneca's factory

At another trial site, the test manufacturer had no record of supplying machines, although other distributors of machines and test kits exist. The manufacturer did supply test cartridges to this site, according to the email seen by *The BMJ*. FDA records indicate, however, that those cartridges were shipped after more than 200 tests had already been performed. *The BMJ* sought to understand where the investigator, Robert Storey, sourced the cartridges used for these 200 tests, but after more than a dozen back-and-forth emails about other aspects of the trial, Storey, without explanation, stopped communicating with *The BMJ*.

Some machines were also returned to the manufacturer for servicing with the most recent platelet activity readings still stored in the machines' memory. *The BMJ* was able to access readouts from machines used at the site of Paul Gurbel, the interventional cardiologist who led the two trials. Our analysis found that more than 60 readings (or around a quarter of the total readings) were not present in either the ONSET/OFFSET or RESPOND datasets submitted to the FDA and that the platelet activity levels not entered were significantly higher than those used in the *Circulation* papers and FDA datasets. It is unclear whose blood was sampled and why those measurements did not contribute to data in either trial. In addition, trial participant numbers—unique identifiers essential for proper record keeping—were not used to identify patients in the machines from Gurbel's lab.


Whether or not data adjustment was reasonable, it absolutely should have been reported
Dan Atar

Through a spokesperson, Sinai Center for Thrombosis Research and Drug Development, which Gurbel leads, stated, "Any allegations of any research misconduct in the RESPOND and ONSET/OFFSET studies are baseless and erroneous." Gurbel declined to be interviewed, as did the chair of his hospital's institutional review board.

Our investigation also included a reanalysis of patient level data obtained under a freedom of information request submitted to the FDA last year. We began by reviewing data from the ONSET/OFFSET trial's primary endpoint: inhibition of platelet aggregation.

The BMJ found that, at three of the study's eight active sites, staff apparently missed conducting the most important test, baseline platelet aggregation—again raising questions about the competence of site operations. Of the 26 patients enrolled at these sites, the dataset shows that tests were not performed at baseline for seven patients—yet blood was subsequently drawn from those same patients an average of 11 times. Why additional blood was taken from these patients is unclear because, owing to the missing baseline measurements, their data were excluded from the analysis.

Then, after removing the patients, authors of the *Circulation* paper labelled the remaining 116 participants the "intention-to-treat" population, a term widely understood to imply analysing all randomised patients.

The BMJ attempted to interview the principal investigators at these sites, to learn whether they knew that their patients had been excluded from the intention-to-treat analysis. Despite multiple attempts, however, none could be reached for comment.

Our analysis also identified more than a dozen patients with baseline platelet aggregation levels recorded as under 50%—lower than what would be expected for stable, non-hospitalised patients. And for some of them platelet aggregation dramatically increased after treatment, an improbable effect for an antiplatelet drug—and one that suggests an incorrect laboratory reading. *The BMJ* analysis determined that the implausible datapoints were incorporated into some analyses. However, for the primary endpoint analysis—a calculation of inhibition of platelet aggregation—they were first transformed through an unpublished data adjustment, obscuring the implausible datapoints.

Dan Atar, editor in chief of *Cardiology*, said that the data adjustment should have been reported in trial publications. "Whether the adjustment was reasonable or not can be debated. But either way it is something that absolutely should have been reported by the authors. Without that transparency, one cannot even evaluate its appropriateness."

The BMJ's review also found that the primary endpoint results specified by the RESPOND protocol were statistically non-significant (P=0.157) but were subsequently reported in *Circulation* as significant (P=0.005) because of an undeclared change in primary endpoint definition. The study had aimed to test whether ticagrelor could convert so called clopidogrel non-responders into responders.

Circulation and AstraZeneca did not respond to a request for comment.

Serebruany told *The BMJ*, "It's been obvious for years that there is something wrong with the data. That the FDA's leadership could look past all these problems—on top of the many problems their own reviewers identified and are now being discovered by *The BMJ*—is unconscionable. We all need to know how and why that happened."

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VACCINATION

NHS inflexibility is behind falling uptake

Vaccine hesitancy may not be as big a factor as poor access, research finds. **Emma Wilkinson** looks at what practices are doing to make it easier for parents to get their children immunised

Evie, keen to get her new baby vaccinated, first called her GP when the baby was 2 weeks old. It's too soon, the receptionist said, phone again at the end of the month. On a Tuesday, when her baby is 6 weeks old, Evie is told the appointment slots haven't opened, call again on Thursday. Later that same day she gets a text reminder urging her to book her baby in for vaccinations. On Thursday she calls, but the slots are already full. The next week she calls on Wednesday. Her baby is now 8 weeks old, so the first vaccinations are due, but again the slots haven't opened. After four phone calls and a written complaint to the practice manager she finally secures an appointment.

Uptake of childhood vaccines in the UK is falling year on year. No vaccines met the 95% coverage target in 2023-24. Last year a measles outbreak was declared a national incident. By the end of 2024 a surge in pertussis cases had led to the deaths of 11 babies. Inequalities in uptake are also growing, with uptake declining more in the most deprived group than in the least.

So far this year there have been more than 400 laboratory confirmed cases of measles. Often vaccine hesitancy is blamed. Yet the barriers the NHS is putting in the way of parents getting their babies protected may well be the bigger issue, experts warn.

Evie (a pseudonym) was interviewed by Georgia Chisnall, a research fellow at the London School of Hygiene and Tropical Medicine who followed 22 parents in Greater Manchester from birth to 1 year old. Nine of the 22 were "supported" in getting the infant vaccines (those due at 8, 12, and 16 weeks), whereby NHS services made it easier for them to book and have all their vaccinations.

Ten of the parents in the study, including Evie, fell into the "struggled" category, where they came up against inflexible booking systems, including appointment times that clashed with the school run or clinics held on only one afternoon of the week. "If I didn't care that much about getting them, I definitely wouldn't have persevered," Evie told Chisnall.

A smaller number of the parents had an experience described as "stalled" (two) or "shunned" (one). When Chisnall revisited the cohort eight months later, in line with the vaccines at 1 year, there was a notable shift towards "struggled," "stalled," and "shunned" experiences, with only four parents getting "supported" vaccination.

Attitudes of practice staff

Kafia, a British-Pakistani mother with two children, was about to leave the house for her baby's 12 week vaccine appointment when the baby soiled her nappy. Dashing to the GP surgery after clearing her up, she was four minutes late and was told she would have to wait another month. Fearful of her child getting sick—Kafia had grown up surrounded by the illnesses that vaccines protect against—she stood her ground. In the end a doctor came out and told her off for being rude, and she had to wait an hour to get the vaccine.

"She did go to the next appointment at 16 weeks, but she felt very uncomfortable," explains Chisnall. When Chisnall visited Kafia eight months later, she found that the baby had not had any of the 1 year vaccines, despite Kafia having emphasised at the 8 weeks vaccines how important vaccination was and advocating for her child.

Staff are often doing their best with constrained resources, Chisnall acknowledges, but it's important to understand parents' experiences to consider how to improve things. Some practices were clearly doing better than others. "Access and attitudes might be far more interconnected than we had realised," she says.

Numerous studies show that very few parents refuse vaccination point blank, even after the covid pandemic. In reviewing the literature, Chisnall found that access as an issue was often overlooked or not clearly defined. "It meant if I was a commissioner or provider I wouldn't really feel supported in knowing how to improve."

She makes eight recommendations, to do with better signposting for parents, more flexible vaccine booking systems, including online forms, and a greater range of appointment times. Also important are training of receptionists and clarity over who is responsible for call and recall. Chisnall urges practices to avoid punitive approaches to parents who are late or miss vaccine appointments.

I was concerned by some of the experiences I came across
Georgia Chisnall

She adds, "The stories were all really powerful and show there are multiple areas of the system that could be improved to make vaccination easier. I was concerned by some of the experiences I came across."

Local knowledge

Shanika Sharma, a GP in the London borough of Barking and Dagenham and its lead for health inequalities, has worked to improve such issues in her own practice, including regular training for receptionists, because of a high staff turnover. The practice now does the newborn baby check and 8 week vaccinations together, giving more time for a conversation.

Sharma says, "A few years ago we did a 16 week project to fund practices to run bespoke MMR catch-up clinics and ended up giving more than 600 vaccinations. It shows what primary care can do when really supported."

She is also involved in health outreach events at local community centres, where GPs and nurses are available to offer information and advice and can book patients into out-of-hours or weekend clinics there and then. "We do need everyone to look at what we can do as a whole system."

Arif Rajpura, Blackpool's director of public health, agrees access is a bigger driver of reduced uptake than vaccine hesitancy. "When families are struggling with the cost of living, working two jobs, and trying to put food on the table, getting vaccinated is not a priority. Anything we can do to improve access is really important."

In response to last year's measles outbreak he commissioned the local out-of-hours GP provider to call families with unvaccinated children, have a conversation, and arrange a home visit.

The team also visited the town's hotel for asylum seekers. They carried out an additional 250 vaccinations of children and teenagers, many on the weekend. Drop-in clinics in children's centres were less successful, because most of the families visiting them had already been vaccinated. This shows the importance of local knowledge, Rajpura notes.

Rajpura is not responsible for commissioning vaccine services but had become frustrated at the lack of action. He later claimed back the funding from NHS England. "We're too quick to jump to [the idea of] people being vaccine deniers and sceptics. People just need a bit of encouragement and information, and they'll have the vaccine."

This sort of approach—one based on local need—was set out in the NHS vaccine strategy published in 2023. But with all the recent structural changes to NHS England and integrated care boards it is unclear how the strategy will now work in practice, Rajpura adds. "The NHS England immunisation team sits very remotely, and often it doesn't use directors of public health as much as it should. I wish I had more of the commissioning budget for this," he says.

Three Cs

Alison Pye, a consultant in public health in Greater Manchester, says it all comes back to three Cs: confidence, convenience, and complacency. In 2024 the schools' immunisation team in her area carried out more than 6000 vaccinations in primary age children and 2700 in secondary schools.

Greater Manchester's immunisation uptake team has also recently been working closely with general practices that have the lowest uptake to tackle issues of appointment availability and flexibility, communication barriers, and active follow-up. Pye says, "We're quite lucky, because we have a unique data architecture [the Greater Manchester care record], so we can develop quite a targeted strategy in terms of barriers and low uptake. From an NHS perspective, sometimes we're not so good at getting that baseline right first: understanding the local situation."

Another public health consultant, who did not want to be named, says funding is a key issue. "The payments are the same for the parents who roll up mid-week with minimal prompting as for those who need evening or weekend appointments, translators, and longer conversations." Local catch-up programmes had reached "hesitant" or "hard to reach" people, the consultant said. "You've just got to be willing to spend more than £10.06 per dose."

An NHS spokesperson says vaccine uptake had recently increased across most childhood immunisation programmes. "NHS England works closely with vaccination teams, schools, and GP services to make it as easy as possible for young people to get their jabs—like hosting vaccine pop-ups in convenient locations like supermarkets, running school immunisation programmes, and organising targeted community outreach events."

"Stuck on the fence"

Chisnall has a second analysis on information provision, not yet published, that found that social media messaging competed with official information, which was often lacking. The flow of social media information meant parents had questions and their opinions could fluctuate over time or between appointments. Yet with nowhere to turn for definitive answers they ended up "stuck on the fence."

Parents want to be able to have a conversation without being judged, Chisnall found, and want information earlier, noting that the few weeks after their child was born was a busy and emotional time. "It's the absence of a chance for dialogue that is probably the most critical issue when it comes to parental attitudes," she says.

Helen Bedford, professor of children's health at University College London, was involved with some of the research. She has advised politicians, NICE, and various national reports on vaccine uptake. Chisnall's interview evidence from parents was compelling, she says, because it shows how much onus is put on the parents who are also grappling with a newborn.

"Part of the problem is the way the system works in terms of booking an appointment does differ, and people are automatically expected to know what to do. We have known for a long time the process around vaccination can affect how you feel about it, but this research really brings this to the fore and gives us some very striking examples."

But the findings have to be put in the context of the current difficulties that NHS services face, Bedford says, including a big shortage of health visitors. In NHS England's urgent and emergency care plan, published in June 2025, there is a specific reference to regions working with integrated care boards to "strengthen the childhood vaccination offer," noting that every 1000 vaccinations save four hospital admissions.

At a minimum, the plan says, regions should set out how GPs and immunisation providers will increase vaccination rates, "working with directors of public health," and set up local campaigns. It also says some areas will test the "feasibility and value for money" of the use of health visitors to give flu and other routine vaccines, ahead of national roll out from 2026-27.

We're too quick to jump to the idea of people being vaccine deniers and sceptics
Arif Rajpura

People are automatically expected to know what to do to get children vaccinated
Helen Bedford

Bedford says that more time needs to be awarded to vaccine appointments, so parents can ask questions, and that healthcare professionals need more training to increase their confidence in answering parents' questions.

"I don't know how we rectify this without more resource," she adds.

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ROLE MODEL

Richard Motley

The consultant dermatologist speaks to **Kathy Oxtoby** about how refurbishing a vintage motorbike sparked his interest in skin

Medicine seemed a good choice of career for fixing things and fixing people

For Richard Motley, training to become a dermatologist involves learning a whole new vocabulary—the words and terms that make up the language of skin.

Motley, a consultant in dermatology and cutaneous surgery at the University Hospital of Wales, and an honorary senior lecturer at Cardiff University, is an expert in that language. "Once you've learnt your trade as a dermatologist you can read a patient's skin. It's like reading a book. There's a story—whether it's a familiar one or something new," he says.

"Everything on the skin is by and large visible, and has been given a name, usually described in Latin terms or named after something in nature, such as lichen planus, where the skin surface resembles the mossy changes on trees."

Learning that language takes time. "When you're a trainee you can feel like a fish out of water, more than in other specialties," he says. "Medical school doesn't really train you to describe the subtle changes in the skin. It's completely different from everything else you learn in medicine. With skin you have to look, feel, and use terms unfamiliar to non-dermatologists.

"Once you've had training and experience, you can usually decipher what's going on with a patient. You may even be the first to explain to them what's happening," he says. Skin conditions can also be the first indicators of underlying disease—a specific type of rash, for example, can be a sign of leukaemia.

Since childhood, Motley has enjoyed fixing problems. "I like repairing things and I'm good with my hands. Medicine seemed a good choice of career for fixing things and fixing people."

He grew up in Middlesbrough and went to the local comprehensive school, where in 1974 a visiting lecturer from the University of Cambridge informed pupils about its pre-A level entrance exam. "I took a week off school to read old exam papers, took the exam that year, and was offered a place at Churchill College, Cambridge, where I started my pre-clinical training in 1976."

In 1979 he began his training as a clinical medical student at St Thomas' Hospital Medical School in London. In the evenings he refurbished a vintage motorbike. "I was up to my arms in grease and dirt and scrubbing my hands clean, which gave me hand dermatitis. This was my first encounter with dermatology. It crossed my mind that this was a problem I should learn how to deal with."

After training in internal (general) medicine in Birmingham, London, and Cardiff, he was appointed as a registrar trainee in dermatology at the University Hospital of Wales.

From the start of this training, consultant dermatologist Peter Holt was his role model, sparking his interest in cutaneous surgery and the surgical treatment of skin disease—particularly skin cancers.

Motley then went to Portugal to learn Mohs surgery—a tissue sparing method of skin cancer removal named after Frederick Mohs, the surgeon who developed the technique—and in 1992 he set up a Mohs unit in Cardiff.

In 1994 Motley became a consultant at the hospital and was one of the first dermatologists with a special interest in skin cancer to be appointed in the UK.

He established a postgraduate fellowship programme teaching Mohs surgery in 1995 and has since trained more than 60 doctors in the technique. Two thirds of doctors who practise Mohs surgery in the UK have been trained at the unit, he says.

"There's no greater gift a human being can give another than to teach them," he says. "I want to be remembered as a teacher—it's what I really value."

Motley's role in teaching and training earnt him a fellowship of the Academy of Medical Educators. Other career highlights include establishing the Cardiff teledermatology service in 2005, receiving an NHS Wales award in 2011, and winning the British Society for Dermatological Surgery's Xiphos award for lifetime achievement in 2024.

Outside of work Motley rides horses with his family and plays "anything that's popular, from the Beatles onwards" on his acoustic and electric guitars.

And whether in medicine or around the house, he continues to fix things. "It's my father's influence—he was an engineer. Anything that's broken, I take great pleasure in fixing it."

Kathy Oxtoby, *The BMJ*

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NOMINATED BY SARAH WINTER

"I first met Dr Motley as a foundation trainee, and as if by fate we met again during my oral and maxillofacial surgery rotation in core surgical training. He inspired me to change my career path—I'd planned on becoming a hand surgeon. I was captivated by Mohs surgery, and the complexity and variety in dermatology. The rest is history. I feel fortunate to now be training in dermatology as his registrar."

Sarah Winter is a specialty dermatology trainee year 4 registrar at the University Hospital of Wales.

NOMINATE A ROLE MODEL

To nominate someone who has been a role model during your medical career, send their name, job title, and the reason for your nomination to emahase@bmj.com

CAREERS CLINIC

How should I introduce myself to patients?

Getting your introduction right can make a real difference, **Elisabeth Mahase** hears

Use full names and titles

Anna Harvey Bluemel, academic clinical fellow in obstetrics and gynaecology

"Understanding names, roles, and levels of training in medicine is important—both to resident doctors, who represent a wide range of experience across all specialties, and to patients. The complexities of medical hierarchies and changes to nomenclature mean, however, that communicating exactly what your experience level is can be challenging.

"While somewhat clunky, I've developed an introduction that sets up my role as a junior member of the team—it makes clear that I am a qualified doctor but still learning within my specialty, and therefore may need to ask a senior doctor for a second opinion. So I might say, 'I'm Anna Harvey, one of the doctors on the team today. I'm fully qualified but I am still learning in obstetrics and gynaecology, so if there's anything I'm unsure about I might ask one of my bosses to come in and take a look.'

"This means the patient is primed to see a second professional if needed. I introduce these seniors, typically with their full name and title, even if I'd personally refer to them by their first name. I adopted this approach when I noticed an imbalance between how male and female consultants were introduced by other members of the team.

"I take note, too, of how I'm introduced by seniors. I can remember only a handful of times when I've been referred to as 'Dr Harvey' or even by my first name—generally it's a vague 'this is my team' and a wave of the hand. Perhaps if senior doctors begin to model formal introductions, resident doctors will have the confidence to refer to themselves in the same way."

Adapt to the patient

Fiona Wisniacki, consultant in emergency medicine

"As a doctor, and currently an NHS patient, I've found myself reflecting on this question.

"With adult patients, I use my full title rather than just my first name, as I believe it presents a more professional image. This is exactly how I introduce myself, always with a friendly and approachable demeanour.

"When treating children or patients with a learning disability I use Fiona or Dr Fiona, to put patients at ease. I provide parents and carers with my full title and role to build trust and awareness of my responsibilities. Paula McGowan, who has been campaigning for health and social care equality for intellectually disabled and autistic people since the avoidable death of her teenage son Oliver, told me that getting the introduction right can make a meaningful difference for every patient. She said that if you're using the patient's first name, it's useful to share your own first name too as it creates a sense of mutual respect and connection.

"With older adults, I initially introduce myself by name and point to my badge, especially with those with hearing difficulties or dementia. While working on a ward, patients and families know me as Fiona, which fosters trust over time. First names might not suit everyone, however, and it's important to gauge who you're talking to and what you're comfortable with.

"Introducing yourself in a professional but friendly manner is crucial for establishing initial trust with the patient. It saves the patient from becoming frustrated and mistrusting your abilities."

Explain what your role means

Tim Cook, consultant anaesthetist

"At its simplest, introducing oneself to a patient (or colleague) is simply good manners. A good introduction should leave the recipient in no doubt of who they're dealing with, or why they're there.

"'Hello, I'm Prof Tim Cook, consultant anaesthetist, and I'll be looking after you for your operation. What would you like me to call you, Mrs Smith?' To a colleague I'll add, 'Please call me Tim.'

"Beyond politeness, this introduction makes my professional position and role in the patient's care clear. How I would like them to refer to me is, I hope, inferred. Use of their title and surname provides a respectful, level playing field for communication from which either of us can deviate later, should we wish to.

"But why 'Prof Tim Cook' rather than Dr Tim Cook, Tim Cook, or Tim? In my view there has been an artificial conflation of the need for introductions with two other trends: a desire to flatten hierarchy between colleagues and efforts to make healthcare less intimidating for patients.

"First names are useful once a relationship is established, but professionally a surname is the starting point. What about the title? As the number of healthcare roles and impenetrable titles have increased, exacerbated now by role substitution, explaining what your role means for the patient is a must.

"Everyone needs to devise what works for them, but most especially for their patients. A clear introduction goes a long way to starting a productive, professional relationship."

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