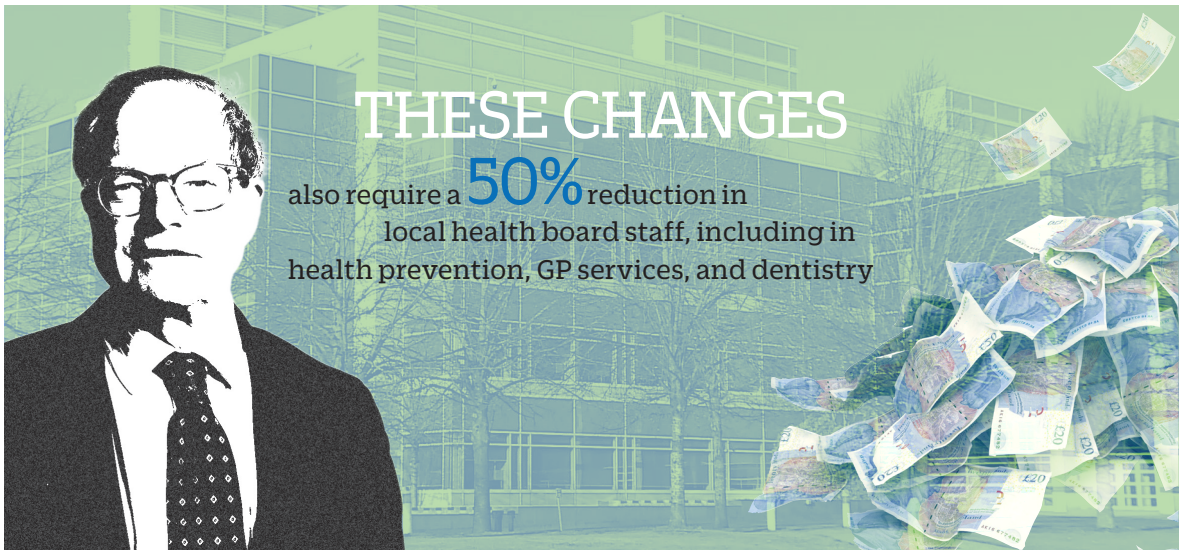
WEIGHTWATCHERS page 171 • **LMCs CONFERENCE** page 172 • **REFORM UK ON HEALTH** page 174



MPs call for NHSE abolition plan clarity

MPs have criticised the lack of a clear plan for the abolition of NHS England and the halving of staff in integrated care boards (ICBs), demanding the government set out how such a major structural change will affect services.

The Public Accounts Committee's report on the Department for Health and Social Care (DHSC) accounts for 2023-24 said the government "lacks a grip of the financial pressures it faces and lacks adequate plans for key areas of spend and activity." It said DHSC's report was late again and contained too little information on plans for social care, the move to ill health prevention, and how to harness technology to improve productivity.

In March the government announced that NHS England will be abolished and its functions taken over by DHSC to reduce duplication and bureaucracy. Staff numbers in both organisations will be halved. On the same day ICBs were told to reduce running costs by 50% by the third quarter of 2025-26.

The committee said the announcements had created high levels of uncertainty, given the lack of a clear plan for how staffing will be cut. It said it was not clear how any savings would help services nor how NHSE's institutional knowledge would be preserved.

"During the restructure it will be essential to maintain and protect the effective local delivery relationships that are so critical to delivering good quality patient care," the report said. "The changes should preserve the place-based approach to retain close and effective working relations with local councils, directors of public health, and GPs."

Committee chair Geoffrey Clifton-Brown said, "It has been two months since the government's decision to remove what up until now has been seen as a key piece of machinery without articulating a clear plan for what comes next, and the future for patients and staff remains hazy.

"These changes also require a 50% reduction in health board staff, including in health prevention, GP services, and dentistry. These services are usually the first interaction a patient has with the NHS, so we will require further reassurance and clarity."

Another concern raised was the "jaw dropping" amounts paid out in clinical negligence claims, with DHSC setting aside £58.2bn a year to cover the potential costs. The report said it was "unacceptable" there was still no plan to manage such costs more effectively and reduce the incidence of harm to patients, despite the issue being raised in the committee's previous report.

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;389:r980

Geoffrey Clifton-Brown, chair of the Public Accounts Committee, said the NHS's future remains hazy

LATEST ONLINE

- Immigration changes are big risk for social and healthcare provision, say sector leaders
- System is failing people with both mental health and substance use problems
- Trump watch: US drug prices to be slashed, attorney who threatened journals is removed, and more

MEDICAL NEWS

Race and Health Observatory to work with NICE to tackle ethnic inequalities

The NHS Race and Health Observatory has agreed to collaborate with NICE to tackle persistent and systemic health inequalities among ethnic groups.

The first tranche of work will look to de-bias clinical guidance across five areas: maternal and neonatal health, mental health, genomics, sickle cell, and hypertension.

The organisations said they will share expertise and evidence based approaches to tackle inequalities and embed processes that ensure any new clinical guidance does not include any potential racial or other bias that could affect treatment, safety, and outcomes among patients. Any new guidance will also include insights from the experiences of patients from diverse communities.

The observatory was set up in 2021 after a special issue of *The BMJ* focused on the continuing problem of racism in medicine. The issue's guest editors, Mala Rao and Victor Adebowale, called for an independent "observatory" to "inform action towards the overarching NHS race equality goals."

Habib Naqvi, its chief executive, said, "Equitable healthcare is not just good for patients and their families, it also improves productivity and saves the NHS money."

Veline L'Esperance, a senior clinical adviser to the observatory, said, "Too often we see how systemic bias in guidance can lead to poorer outcomes for certain groups. It's an important move towards a more inclusive and accountable health system."

Zosia Kmietowicz, *The BMJ* Cite this as: *BMJ* 2025;389:r913

Resident doctors

BMA ballots members on strike action over pay

The BMA's Resident Doctors Committee in England will ballot its members on taking industrial action over pay, stating that "no doctor today is worth less than they were 17 years ago." The BMA said that basic pay for resident doctors had fallen by 22.3% in real terms since 2008-09. The ballot opens on 27 May and closes on 7 July. If members vote for industrial action the mandate will last from July 2025 to January 2026.

Physician associates

GMC formally approves PA training courses

The GMC approved 33 courses to teach physician associates, the first time such degrees have been subject to formal quality assurance by the regulator. However, one course, delivered by the University of East London, was not approved, owing to "concerns about the quality of teaching and course delivery." Its recruitment of new students will be paused until improvements have been made, although some of its graduates are already working in the NHS.

Antibiotics

UKHSA warns of low level resistance to newest drug

Low levels of resistance have been detected against one of the newest antibiotics, ceftazidime-avibactam, which has been used in the NHS since 2017, warned the UK Health Security Agency. In a study published in *Eurosurveillance* researchers analysed resistance to the drug from 2016 to 2020 and found that 6.3% of gram negative bacteria that were tested for ceftazidime-avibactam susceptibility were found to be resistant (4200/66 914; 95% confidence interval 6.1% to 6.4%).

Screening

Consultation on addition to newborn programme

The UK National Screening Committee opened a consultation on evidence relating to screening of newborn babies for metachromatic leucodystrophy. The committee has not previously considered screening for this rare inherited condition that causes progressive nerve damage leading to muscle weakness, with loss of coordination, mobility, and mental processes. The condition worsens over time and affects an estimated one in every 40 000 babies born in the UK. The consultation opened on 6 May and runs for three months.

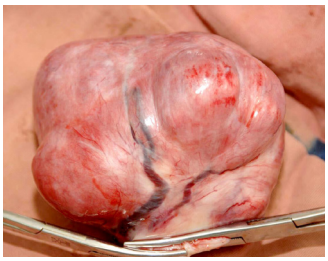
Internet crime

Twelve arrests made in drug trafficking raids

Twelve suspects were arrested in dawn raids across the West Midlands and northwest England as part of the Medicines and Healthcare Products Regulatory Agency's largest criminal investigation into organised trafficking of medicines. Hundreds of thousands of doses were seized, including controlled drugs such as opioid painkillers and anti-anxiety medicines. Andy Morling (left), head of the agency's criminal enforcement unit, urged the public to be extremely cautious when buying medicines online and to obtain them only from a registered pharmacy against a prescription issued by a healthcare professional.

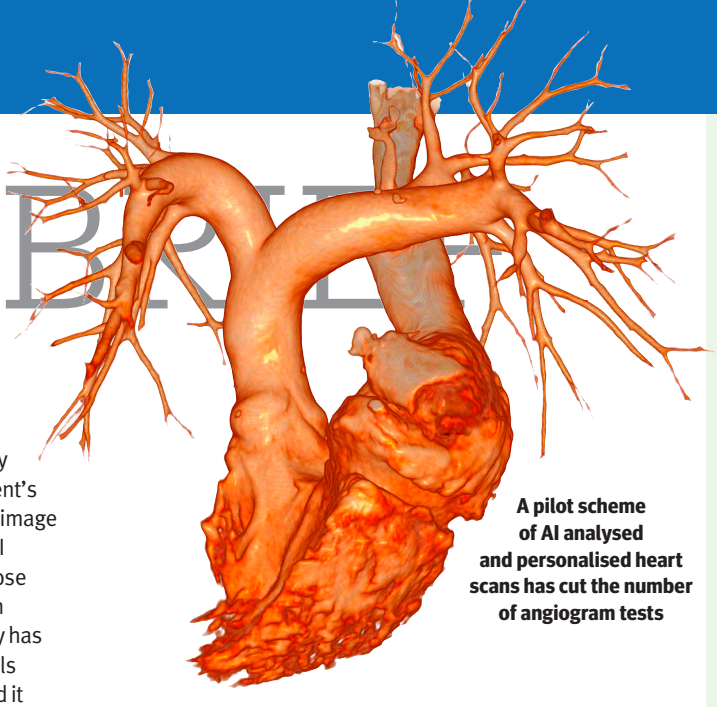
Endometriosis

NICE approves linzagolix with hormone treatment



A once daily tablet approved last year for uterine fibroids is now available for patients of reproductive age who have previously had medical or surgical treatment for endometriosis. In final draft guidance NICE has recommended linzagolix (Yselty) with hormonal add-back therapy for symptoms of endometriosis in this group. The gonadotropin releasing hormone (GnRH) antagonist works by blocking specific hormones that contribute to the symptoms of endometriosis, and the addition of hormonal therapy helps to manage potential side effects.

IN BRIEF



A pilot scheme of AI analysed and personalised heart scans has cut the number of angiogram tests

Digital health

3D heart scans speed up diagnosis

NHS England said technology that turns a CT scan of a patient's heart into a personalised 3D image that is then analysed using AI has helped doctors to diagnose and treat heart disease much more quickly. The technology has been rolled out at 56 hospitals in England. An analysis found it reduced the number of patients needing invasive angiogram tests by 16% in cases where it was later found no further treatment was required and by 7% overall. The number of second heart tests needed by patients within two years has also been cut by 12%.

Health Foundation: £21bn is needed to digitise NHS

Digitising NHS and adult social care services will cost an estimated £21bn, including £14.75bn for England, over the next five years, said research published by the Health Foundation. The costs include putting in place infrastructure such as electronic patient records, cloud storage, cybersecurity, and wi-fi, along with the skills to use these effectively. The research has been published ahead of the spending review and 10 year health plan, which will set out the government's plans to shift the NHS from "analogue to digital."

Waiting lists

No link to rise in benefit claims, study shows

Increases in NHS waiting times and lists for pre-planned hospital treatment and some mental health treatment have not been a major factor behind the large rise in working age adults claiming health related benefits, said a report from the Institute for Fiscal Studies. Areas that experienced larger rises in NHS waits did not, on average, experience larger increases in the number of working age adults receiving health related benefits. The analysis is subject to caveats and did not examine other parts of the NHS such as primary, community, or emergency care.

Cancer

New technology is rolled out

The government said that a groundbreaking new tool called Cancer 360 would be rolled out to all NHS trusts to speed up diagnosis and cut delays. Patient data for tests, appointments, and treatments will be brought into one central system so doctors can prioritise the patients most in need. The real time tool helps teams track a patient's progress, avert delays, and reduce paperwork. Since April 2024, hospitals using the platform have typically performed 70 000 more procedures and have reduced unnecessary hospital stays by almost 19%, said the Department of Health and Social Care.

Social care

Commission's terms of reference are published

The government published the terms of reference for Louise Casey's commission into adult social care. The first phase, reporting in 2026, will focus on making the most of existing resources to improve people's lives in the medium term. The second phase, reporting by 2028, will consider the long term transformation of adult social care. Simon Bottery, of the King's Fund, said the commission "offers a real opportunity to truly reform fundamental issues."

Cite this as: *BMJ* 2025;389:r966

GLOBAL HEALTH

The Gates Foundation said it will invest at least **$200bn** (£151bn) to expand global health programmes and fight extreme poverty over the next two decades, after announcing it will close in 2045

SIXTY SECONDS ON . . . WW

DO YOU MEAN WWE?

No, this has nothing to do with Hulk Hogan and his pals. WW is the slimline name that WeightWatchers adopted in 2018 as it reshaped itself as a wellness brand that wasn't just about helping people lose weight.

I HEAR THEY'VE LOST POUNDS?

Dollars, actually. WeightWatchers filed for bankruptcy in the US last week to help it shift $1.15bn (£860m) of debt. The filing means that the company has its debt written off as it agrees new terms to pay back lenders. While it streamlines its balance sheet WeightWatchers will remain "fully operational" with "no impact" on its 3.4 million members worldwide, said the company in a statement.

DON'T TELL ME, WEGOVY SWALLOWED UP ITS BUSINESS?

You could say that the rise of GLP-1 agonists has forced the business to remodel. WeightWatchers started 62 years ago as a weight loss support group with weigh-ins and a points based approach to food intake. But it has faced stiff competition from the proliferation of weight loss and fitness advice on social media, as well as drugs such as semaglutide (Ozempic, Rybelsus, Wegovy) and tirzepatide (Mounjaro).

IS WW SCALING BACK ITS OPERATIONS?

It doesn't seem to be. In 2023 it acquired a digital health business to help prescribe weight loss drugs. When it rebranded in 2018 it distanced itself from the restrictive diet approach to weight loss with the new tagline "Wellness that Works." The clinical side of the business, which includes weight loss drugs, has expanded massively, with revenue up 57% in the first quarter of 2025, while subscriptions during the same time fell by 9.3%.

CAN I STOP COUNTING POINTS NOW?

A 2011 *BMJ* paper found that commercial weight loss programmes actually work pretty well and are more effective and cheaper than services based in primary care. But weight loss drugs are proving to be even more effective, with people losing an average of 10-20% of their body weight, while lifestyle changes lead to an average loss of 5-10%.

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2025;389:r942

GPs demand review and tougher regulation of online prescribing of weight loss drugs

Regulators must produce clear guidelines for prescribing and monitoring GLP-1 receptor agonists for weight loss, particularly when treatment is initiated online, GP leaders have urged.

Representatives at the annual UK conference of local medical committees (LMCs) in Glasgow passed a motion calling for the BMA's General Practitioners Committee UK to push for the MHRA and the CQC to undertake an "urgent and thorough review" of the online prescribing of GLP-1 weight loss drugs "to ensure that patient safety is not compromised."

The motion also called for "robust national protocols that clearly delineate the responsibilities of online prescribers and GPs" so that GPs are not left with the burden of monitoring and managing these drugs without adequate resources and support.

Do we want to return to doctors telling patients things they can read or watch for themselves? Helena McKeown

Representatives also called for a public awareness campaign to educate patients about the risks associated with obtaining weight loss drugs online.

A separate strand of the motion, passed as a reference, said that the NHS should ensure there was a nationally commissioned obesity management service to ensure equity of provision to the people most clinically at risk, rather than those with the highest perceived need.

Will Denby, of Hampshire and Isle of Wight LMC, proposing the motion, said GPs were bearing the brunt of the "unintended consequences" arising from an "unprecedented" number of patients accessing the drugs off label through private or online providers.

"Patients often return to their NHS GP seeking follow-up care, support for common side effects, or routine monitoring. This is creating additional strain on overstretched resources with no financial support to compensate for the added workload," he said.

Denby added that GPs often receive letters from companies asking if they know of any reason why they should not prescribe a GLP-1, placing practices in an "unenviable position" with regards to clinical risk.

Peter Kenworthy, a GP from

Assisted dying: GPs must not be compelled

Representatives overwhelmingly passed a motion saying that if any assisted dying legislation became law GPs should not be compelled to participate in or initiate discussions, and medical involvement should sit with a separate service and not general practice. They also backed the motion's insistence that doctors who refused to be involved in assisted dying should not risk professional sanction or discrimination. Effective and properly resourced palliative care should be delivered in addition to the option of assisted dying if it became law, they said.

Doctors back AI for transcribing patient notes

GPs voted overwhelmingly for a motion that supported the use of artificial intelligence in general practice in various ways, including transcribing notes. The motion also approved calls for the BMA to advocate for these technologies to receive national assurance in the form of data protection impact assessments; to establish robust data protection and governance frameworks to ensure patient confidentiality and compliance with GDPR and NHS regulations; and regulatory oversight and ongoing evaluation of AI applications in general practice.

Call for more recognition of IMGs' NHS role

A majority of GPs voted for a motion that called for public acknowledgment of the "significant benefit" that international medical graduates brought to the NHS. They said that there should not be any policy that disadvantaged IMGs in applying for jobs and training posts in the NHS and that the Royal College of GPs and relevant health education bodies should offer more educational and practical support to those IMGs who requested it during their GP training.

PSA tests in general practice must be funded

GPs voted overwhelmingly for a motion that called for funding to support the growing expectation for GPs to provide PSA testing, counselling, and ongoing monitoring as well as post-treatment surveillance of discharged prostate cancer patients. They also voted to oppose the transfer of routine PSA monitoring from urology services to general practice without evidence, agreed guidelines, and appropriate funding, while also calling for a national review of PSA screening and monitoring pathways.

Cite this as: *BMJ* 2025;389:r974

Lack of posts is "terrifying" GP registrars, doctors' leader warns

GPs are now struggling to find any jobs—be that partnership, salaried, or locum roles Mark Steggles

The current situation for GP registrars is "frankly terrifying" because of a lack of permanent posts, the co-chair of the BMA's GP registrars committee has warned.

Victoria McKay told the conference, "After years of intense training, dedication, and sacrifice, more and more newly qualified GPs are finding themselves without jobs. This is not a distant problem. It is happening now. And it is affecting the morale, stability, and future of our profession."

McKay said she was deeply concerned for GP registrars who felt disillusioned and cast adrift at the

EDUARDO HENRIQUE

Gateshead and South Tyneside LMC, also backed the motion. "My understanding is that GLP-1s were supposed to be prescribed as part of a wraparound tier 3 service. I've seen no evidence of this in any of the private prescriptions my patients received. I don't believe patients are counselled properly about possible side effects or risks."

Speaking against part of the motion, Helena McKeown, of Dorset LMC, said a public campaign would undermine shared decision making and wasn't needed as patients were already educating themselves about the drugs' risks and benefits. "Do we want an empowered patient population reducing their risk of early death or do we want to return to doctors telling patients things they can read or watch for themselves?" she asked.

But Denby said he and colleagues working in an urgent primary care centre would regularly see patients presenting with abdominal pain or nausea after starting weight loss drugs or increasing the dosage. "It is undoubted this is landing in the system and causing extra workload," he said.

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2025;389:r944

end of their training. "We worry for the sustainability of general practice if we cannot offer a clear and secure path to permanent employment. And we worry for the patients who will ultimately bear the brunt of a system that cannot hold on to its own future workforce. The current situation for GP registrars is, frankly, terrifying."

Facing unemployment

She said that with around 4000 GP registrars training each year there would be "potentially hundreds or even thousands of registrars facing unemployment" in three months' time.

McKay said the situation had arisen because of "sustained underfunding of general practice, combined with a systemic devaluation and even vilification of the GP."

She said members of the GP registrars committee who had recently obtained their certificate of completion of training were contemplating taking jobs as the duty doctor in acute sexual health or taking salaried jobs two hours travel each way from their homes, and some had even considered whether they might need unemployment benefits.

Other registrars have left the NHS or moved to Australia, New Zealand, or Canada because of the lack of opportunities in the UK.

McKay also criticised the dilution of GP registrars' training experience because of blended learning, which had replaced a significant portion of direct patient contact with online e-learning modules. "If this continues, we will lose the expert from expert generalists," she warned.

Mark Steggles, chair of the BMA's sessional GPs committee, said that unemployment was not confined to registrars. "GPs are now struggling to find any jobs—be that partnership, salaried, or locum roles."

Caroline Rodgers, of Cambridgeshire LMC, called for "urgent strategies to prevent the dismantling of general practice as a career."

Jacqui Wise, Kent
Cite this as: *BMJ* 2025;389:r968

Scheme to cut birth brain injuries to be rolled out in England

An NHS programme designed to improve safety in maternity care and help prevent brain injuries during childbirth is set to be rolled out in England.

The government said Avoiding Brain Injuries in Childbirth (ABC) would provide a standardised approach for detecting and responding to fetal deterioration during labour, aiming to reduce "unacceptable inequalities" in maternity outcomes throughout England.

The programme is designed to help maternity staff more easily identify signs that a baby is in distress during labour and to respond more effectively to obstetric emergencies, such as where the baby's head becomes lodged deep in the mother's pelvis during a caesarean birth.

Latest data from the MBRRACE-UK Perinatal Mortality Surveillance Report showed that the UK's extended perinatal mortality rates had decreased in 2023 to 4.84 in 1000 total births, down from 5.04 in 1000 the previous year. This was driven primarily by a reduction in stillbirths.

Ethnic inequalities

However, ethnic inequalities in perinatal outcomes persisted. Stillbirth rates declined in black and white babies but increased by 10% in Asian babies. Black babies remained more than twice as likely to be stillborn as white babies (5.84 *v* 2.71 in 1000). Neonatal mortality rates fell across all ethnicities that were measured but remained higher in Asian babies (falling from 2.5 to 2.35 in 1000) and black babies (down from 2.41 to 2.28 in 1000) than in white babies (down from 1.56 to 1.5 in 1000).

The ABC programme, which will be rolled out from September, has been piloted in nine maternity units and is delivered by the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, and the Healthcare Improvement Studies Institute.

The Department of Health and Social Care did not respond to a request to provide data on the pilot scheme. It had previously said ABC will fill an important training gap by enabling multidisciplinary teams to work more collaboratively, while giving clinicians more confidence to take swift action when managing emergencies.

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2025;389:r982

EXTENDED perinatal mortality rates decreased in 2023 to **4.84** in 1000 total births, down from **5.04** the previous year

APHP-COCHIN-VOISIN / PHANIE / SPL

MPs call for public campaign to warn of gambling health risks

MPs have called for a public information campaign warning of the risks from gambling, such as suicide, and for tougher rules on advertising, promotion, and sponsorship.

The Health and Social Care Committee said the government should review the Gambling Act so the law supports a "total system response" to gambling related harms. In a letter to the Department of Health and Social Care (DHSC) on 8 May the MPs cited the serious financial, physical, and mental harms gambling can cause, including an estimated 117 to 496 suicides every year in England.

Problem gambling was rarely recorded in an individual's medical notes, the MPs said, unlike smoking, alcohol, or drug use. It asked the government to set out steps to raise awareness of gambling related suicide among coroners and others involved in sudden death investigations. In the letter to the DHSC the committee chair, Layla Moran, said, "The evidence we heard emphasised how prevalent and normalised gambling has become in society."

Advertising crackdown

Moran said gambling promotion had become "intrusive and targeted," with 80% of the population exposed to some form of advertising each week, and people receiving offers of free bets in the middle of the night, leading to feelings of "no escape." The MPs recommend limits to advertising before the watershed and to the frequency and types of promotions and incentives used by firms.

The Office for Health Improvement and Disparities should launch a public information campaign targeted at people who participate in gaming because of gambling related content in this medium, it added.

The committee also urged the DHSC to set out how it will monitor the implementation of NICE guidance that recommends that primary care clinicians ask patients about their gambling habits.

New Gambling Commission data show online gambling in Great Britain grew to £1.45bn (gross gambling yield) in January to March, a 7% rise on the same period in 2024.

GambleAware, which commissions the National Gambling Support Network to provide confidential treatment and advice, received over £24m from industry funding in the year to 31 March. Its chief executive, Zoë Osmond, said the network had supported more than 110 000 people since its launch in 2023.

The DHSC said it was committed to protecting everyone from gambling harms and was reviewing the MPs' recommendations before formally responding.

Matthew Limb, London Cite this as: *BMJ* 2025;389:r963

ONLINE GAMBLING in Great Britain grew to £1.45bn (gross gambling yield) in January to March 2025, a 7% rise on the same period in 2024

NEWS ANALYSIS

What does Reform UK mean for healthcare?

The party gained the largest number of English council seats in recent elections. **Adrian O'Dowd** looks at how its policies and priorities may affect the NHS and social care

Should Reform UK be taken as a serious political voice?

Yes. In the recent local government elections Reform UK achieved huge success for such a young party, capturing more than 600 council seats, mostly at the expense of the Conservatives.

Across England, Reform gained control of 10 local authorities and won a byelection and two mayoral seats. Though only 23 council elections were held, out of a total of 317, Reform gained 677 seats, while the Tories lost 674 and Labour lost 187. The Liberal Democrats won 163 more seats.

In a post on X, Reform's leader, Nigel Farage, described the results as unprecedented.

How much power do local councils have over healthcare?

Local authorities control public health budgets that fund services such as smoking cessation, alcohol and drug misuse prevention, tackling obesity, and social care.

But their role also involves creating and maintaining healthy places for people to live and work, while working with the NHS and other partners to ensure that health improves locally.

Councils host Health and Wellbeing Boards, which include representatives of the local authority, integrated care boards, adult social services, children's services, public health, and the advocacy body Healthwatch.

Will Reform tackle overall funding problems in local government?

Local authority finances are often said to be stretched to their limit. A survey published in March by the Local Government Association showed that a quarter of responding councils had already applied for or were very or fairly likely to apply for exceptional financial support to set a balanced budget in 2026-27.

In 2023 Birmingham city, Nottingham city, and Woking borough councils were reported as being "bankrupt," with growing financial problems stemming from rising populations, increasing demand for social care, cuts to government grants, and limited annual increases to council tax.

Reform's chair, Zia Yusuf, said

Inaction on social care is harming country and NHS, say MPs

The government is failing to measure the "true cost of inaction on social care" and the harms caused by a broken system to the country and the NHS, MPs have warned.

The cross party Health and Social Care Committee said that, without changes, any reforms to emerge from a new review of the social care sector commissioned by ministers will be "doomed to fail."

In a report the MPs said that although the adult social care system costs taxpayers £32bn a year (2023-24) it does not meet the needs of the population, adding that the failing system was straining local authorities' budgets and placing huge burdens on the NHS and unpaid carers, who provide care worth £184bn a year.

In an analysis welcomed by health and care leaders and analysts, the committee said that successive governments had "stepped back from reform when faced with the cost."

The MPs said, "Too much emphasis is put on the cost of change and not

recently on the BBC's *Sunday with Laura Kuenssberg* his party intended to "cut waste" in the 10 councils where it has a majority.

What are Reform's plans for healthcare?

Plans outlined in Reform's main policy document *Our Contract with You* include giving NHS patients a voucher for fully funded private treatment if they can't see a GP within three days, can't see a consultant within three weeks, or can't have an operation within nine weeks.

The party has promised to keep the NHS free at the point of use, but Farage said last year the UK might adopt a French style social insurance healthcare system.

The party has also stated its intention to reduce NHS waiting lists to zero in two years, to exempt two million frontline healthcare workers from the basic rate of income tax for three years to encourage staff retention and boost recruitment, to launch public inquiries into excess covid deaths and vaccine harm, to introduce tax relief of 20% on all private healthcare and insurance, and to review all NHS private contracts to "cut waste, bureaucracy, and unnecessary managers."

What are the party's overall political priorities?

Reform UK's policies include freezing "non-essential" immigration, protecting public services, ending housing problems, scrapping energy levies and net zero carbon emission targets to cut energy bills, and reducing crime.

Its policies relating to immigration include a tax on employers who hire foreign employees, leaving the European Convention on Human Rights to cut legal migration, ending illegal immigration, and introducing new visas for international students that bar their dependants.

Reform has stated its intention to have no diversity and inclusion officers at its councils and to fly only Union, St George's, and county flags at Reform controlled councils.

Do Reform councillors intend to change approaches to health?

It's highly likely. In a recently published analysis of public satisfaction with the NHS and social care by the Nuffield Trust and the King's Fund, 20% of Reform supporters said "too much" or "far too much" was spent on the NHS, against 11% of Conservative supporters, 4% of Labour supporters, and 2% of Liberal Democrat supporters.

That level of scepticism over health spending may influence council decisions on how much to allocate to public health.

Mark Dayan, policy analyst at the Nuffield Trust, said, "What we can say is that the voters who [Reform] have relied on were probably voters with a very particular set of views on average about the health service. They're less satisfied with the health service. They also tend to be more financially conservative about it, so they're more likely to believe that it's wasteful with this money and they're less likely to be willing to pay more tax for it."

Will Reform tackle longstanding social care problems?

Social care is a thorny issue that the main political parties—and local councils—have struggled to deal with effectively. Nationally, the latest of several reviews is under way, in the form of the Independent Commission on Adult Social Care. But over the years little has improved despite previous reviews' recommendations.

Reform pledged to create a royal commission to tackle social care if it won the last general election and promised to close a loophole that it claimed enabled larger providers of care home services to avoid tax through offshore structures.

On average Reform voters are less satisfied with the health service
Mark Dayan

Adrian O'Dowd, London

Cite this as: *BMJ* 2025;389:r958

VUK VALCIC/ALAMY

Unless the cost of inaction is known the Casey commission is doomed to fail
Layla Moran

enough consideration is given to the human and financial cost of no or incremental change. This is an active choice that is no longer tenable."

The report said two million people aged 65 or over and 1.5 million people of working age were not getting the care they needed, "leading to lives led at the bare minimum rather than to their fullest." Many paid carers live in poverty and need state support in the form of Universal Credit, while 1.5 million unpaid carers provide over 50 hours of care a week, many of whom withdraw partly or wholly from employment as a result.

Furthermore, people face "unknowable and potentially life changing" charges for care, including one in seven elderly people with lifetime care costs more than £100 000. The report found that every £1 invested in the adult social care sector would generate a £1.75 return to the wider economy and that an extra £1bn spent on social care would create 50 000 jobs.

The government has set up an independent commission into adult social care under Louise Casey as part of its steps towards delivering a national care service. The commission is expected to issue a first report next year and a final report with longer term recommendations in 2028.

The committee said that the government had too few data to assess which social care reform interventions would result in the highest returns. It called on ministers to publish annual assessments of the level of unmet care needs for adults and the yearly costs to the NHS of delayed discharges.

"Unless the government measures the true cost of inaction and can make a convincing case to the Treasury, the recommended reforms that come out of the Casey commission will be doomed to fail," said Layla Moran, the committee chair and Liberal Democrat MP.

Matthew Limb, London

Cite this as: *BMJ* 2025;389:r912

CLIMATE CRISIS: **Tony Blair Institute sparks row with call to rethink net zero policy**

The former prime minister last month claimed that green strategies were causing public disengagement and division and were "doomed to fail." **Dominic Murphy** asks if he is on the wrong side of history

FRANK FRANKLIN II/AP/ALAMY

The row over climate emergency policies has intensified after a report from the Tony Blair Institute for Global Change (TBI) called for a radical reset in the way the world tackles global heating. In a headline grabbing line in the foreword Blair said "any strategy based on either 'phasing out' fossil fuels in the short term or limiting consumption is a strategy doomed to fail."

What does the report criticise?

The urgency of the need to tackle climate change is not up for debate. It is an existential threat and a public health emergency, causing death and illness through increasing numbers of heatwaves and floods, helping spread infectious diseases, and more. Nor is there a problem with the idea of achieving net zero greenhouse gas emissions in the UK, where the amount of gas we produce is balanced by the amount we're removing from the atmosphere.

Instead the report takes issue with the UK's policy to get to net zero by 2050. It's wrong, says the TBI, to place so much emphasis on limiting fossil fuel consumption. "Net zero policies, once seen as the pathway to economic transformation," says the report, "are increasingly viewed as unaffordable, ineffective, or politically toxic." Many politicians think this, the TBI claims, but are just too scared to say it.

How should we alter our focus?

The TBI's solutions include putting carbon capture at the "centre of the battle," harnessing technology (including AI), investing in nuclear energy, and finding new ways to unlock climate finance. Nature based solutions, such as planting more forests, should be scaled up. Climate adaptation, from "green cities" to flood defences, need to be a priority. And—taking aim at the COP climate change conferences—the report says that global collective action must be reimagined and "simplified."

The only reason large nations are doing much at all is that they're under public pressure
Doug Parr

A POLL of nearly 6000 people in March found 61% supported the government's commitment to cut carbon emissions to net zero by 2050

Some commentators wonder how all this will be achieved.

Doug Parr, Greenpeace's chief scientist and policy director, said on X, "The Blair 'solution' is that the large nations get together to produce roadmaps for technology deployment that brings down costs, with smaller nations excluded.

"But there's nothing to stop the large nations choosing to do this if they want to. But they don't, and the only reason they're doing much at all, I would say, is because they're feeling public pressure."

What does the report say on renewables?

The report describes renewable energy as "both necessary and cost effective."

However, despite a massive rise in renewables in the past 15 years production of fossil fuels and demand for them have risen, not fallen, says the TBI. In 2024, it says, China began building 95 GW of coal fired energy infrastructure, almost as much as Europe's total energy from coal. India also recently announced it had reached the milestone of one billion tonnes of coal produced in a single year.

The world needs to be realistic, says the TBI, about the surging demand for energy from developing economies, which will continue to drive a demand for fossil fuels. "We need to recognise that without turning some of the emerging technologies into financially viable options, the world will choose the cheapest option," says the report.

What about carbon capture?

Prioritising "global investment in carbon capture" is the TBI's number one recommendation, putting it "at the centre of the battle."

Blair writes in the foreword to the report, "The disdain for this technology in favour of the purist solution of stopping fossil fuel production is totally misguided."

Carbon capture and storage (CCS) is a process that stops greenhouse gas emissions at source, then stores them underground in empty oil and gas wells or other geological formations. Last year chancellor Rachel Reeves announced she would invest £22bn in CCS, and the government is hoping the technology will come good. However, critics say the technology is unproved and expensive and could justify more use of fossil fuels.

What's the TBI line on nuclear power?

Nuclear power is also an essential part of the answer, says the report, which says, "The confusion of this with nuclear weapons and consequently the irrational fear of it, intensified by hyperbolic campaigning, has led the world to an egregious policy error with many countries turning their back on it from the 1980s onwards, when embracing it would have significantly changed the trajectory of emissions."

Critics again point out that current nuclear power capacity is not delivering at the level that it promised and that the costs are enormous.

Where does the UK public stand on net zero?

Polls consistently show high levels of support for tackling climate change and for net zero. A YouGov poll of nearly 6000 people in March found 61% supported the government's commitment to cut carbon emissions to net zero by 2050.

How has the government responded to the TBI report?

Asked about the report at prime minister's questions on 30 April, Keir Starmer said, "If you look at the detail of what Tony Blair said, he's absolutely aligned with what we're doing here." But Downing Street said Starmer did not agree with Blair about there being too much "hysteria" in debates about the climate emergency.

The media also reported that No 10 insiders were furious about the report's timing, which they claimed gifted votes to the climate sceptic Reform party on the eve of local elections.

Blair's intervention was also criticised by Dan McGrail, chief executive of government owned GB Energy. "Resets, stops, massive changes, or 180 degree changes in strategy are deeply unhelpful," he told the Innovation Zero conference in London on 29 April.

The row has been enough for the TBI to issue a statement saying that it "supports the government's 2050 net zero targets" and that Labour's approach is the "right one."

How is the TBI funded?

TBI and Blair's funding is controversial. Since leaving office Blair has lobbied on behalf of fossil fuel companies. In 2014 he was hired as an adviser by a BP led consortium looking to build a gas pipeline from Azerbaijan to Europe. The TBI had a turnover of $145.3m (£114m) in 2023 and had net assets of $37.4m, its financial statement showed.

The institute has taken money from the Saudi government, and its largest donor is Larry Ellison, a US tech billionaire who has hosted fundraisers for Donald Trump, whose administration is currently dismantling policies aimed at protecting the environment and limiting the use of fossil fuels.

A TBI spokesperson said, "We maintain intellectual independence over our policy work. The Larry Ellison Foundation's donations are publicly available. The $271m sum [to TBI] is for a five year period and for the work TBI does around the world, particularly in Africa, on a not-for-profit basis, helping governments with reform and change programmes."

On the Saudi connection, the spokesperson added, "TBI works in over 40 countries advising governments. Some are oil and gas producers. Some aren't. All are impacted by climate change."

But Patrick Galey, head of fossil fuel investigations at the campaign group Global Witness, told the *Guardian*, "Blair's well documented links to petrostates and oil and gas companies ought alone to be enough to disqualify this man as an independent and reliable arbiter of what's possible or commonsense in the energy transition."

Dominic Murphy, Bath

Cite this as: *BMJ* 2025;389:r955

UK is "unprepared for rising deaths and health disruption"

The UK is not prepared for the likely effects of a heating climate, such as escalating deaths and health system disruption, independent advisers have warned the government.

In its 2025 report to MPs published on 30 April the Climate Change Committee (CCC) said that, without adequate action, heat related mortality could "rise several times over" to exceed 10 000 deaths a year by 2050. Last year 1311 heat related deaths were reported in England during four heat episodes.

The UK is also likely to see increases in malaria and tickborne diseases and more overheating and flooding of NHS buildings, which the report said could be harmful to staff and disrupt surgery, laboratories, and IT systems. But the CCC said the Labour government had so far not made improving resilience a priority, despite having pledged at the last general election to take mitigating action across central government, local authorities, local communities, and emergency services.

If unchecked, the committee warned, climate change could damage UK economic output by as much as 7% of GDP by 2050, with consequences for key infrastructure such as agriculture, railways, and water.

We are not ready—in many areas we are not even planning to be ready Julia King

"No evidence of change in pace"

When assessing progress made towards achieving the goals set out in the government's 2023 climate change adaptation plan, the committee found that most policy and plan scores had not changed since its previous progress report two years ago, with "no evidence of a step-change in the pace of policy development since the 2024 general election."

In terms of adaptation delivery, the CCC said it was unable to score a single outcome as "good," grading 12 of 46 outcomes as insufficient. It also found that, beyond the NHS, no routinely collected data covered climate adaptation in other healthcare settings such as care homes, domiciliary care, and GP surgeries or documented extreme weather disruption.

"We have seen in the last couple of years that the country is not prepared for the impacts of climate change," said Julia King, the committee chair. "We know there is worse to come, and we are not ready—indeed in many areas we are not even planning to be ready. The threat is greatest for the most vulnerable: we do not have resilient hospitals, schools, or care homes."

Responding to the findings, Emma Hardy (left), minister for water and flooding, told BBC News that the government was "really committed" to preparing for the changing climate and accepted that more needed to done.

Matthew Limb, London

Cite this as: *BMJ* 2025;389:r873

THE BIG PICTURE

MSF's innovative 3D printer helps Syrian refugee burns patients

After more than 13 years of war in Syria and the fall of the Assad regime, more than 7.2 million people remain internally displaced, living in camps without basic services, such as heating and electricity.

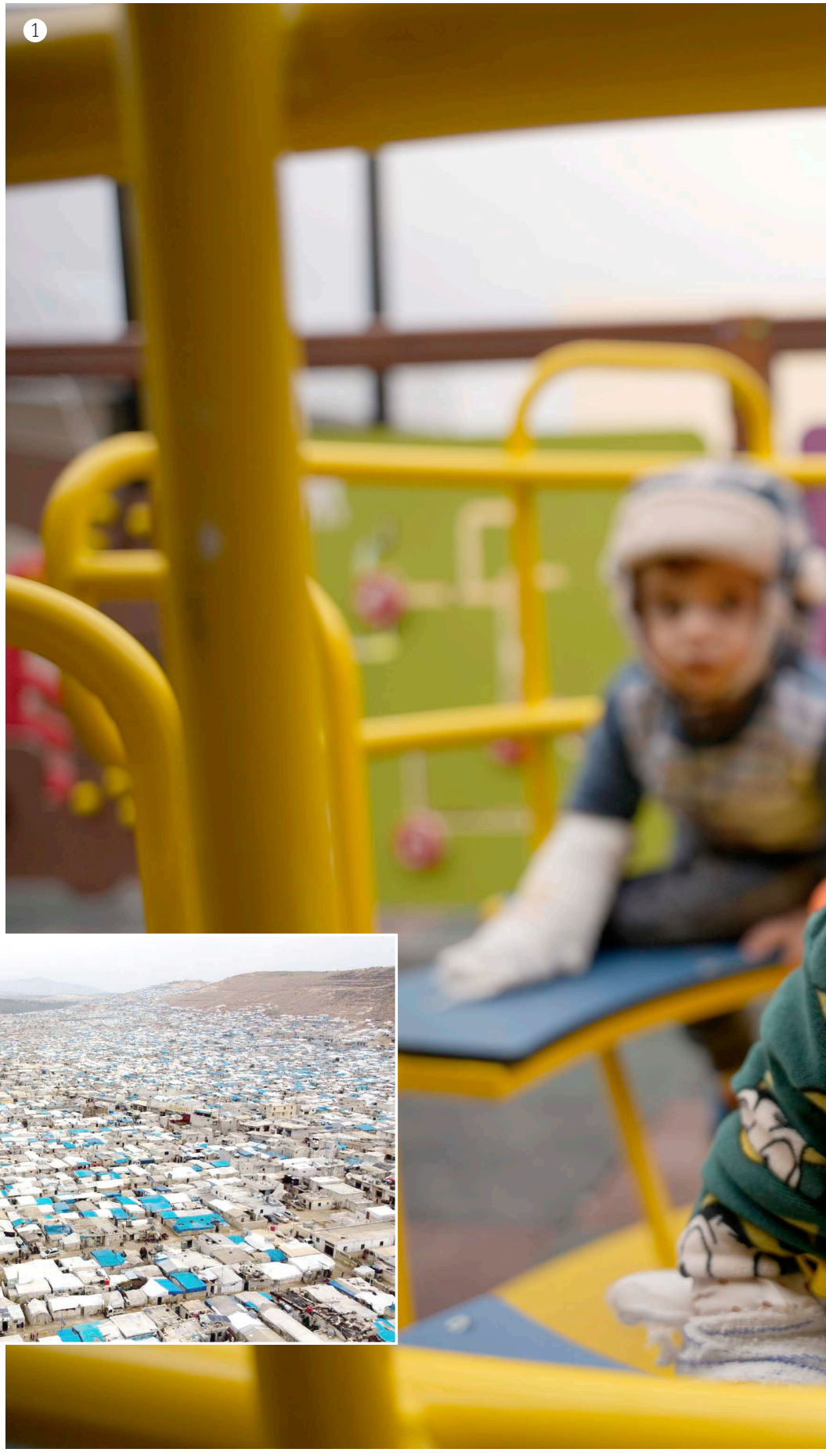
As a result, burn injuries from unsafe heating methods are increasingly common: the healthcare charity Médecins Sans Frontières treated 8340 cases last year —a 6% rise on 2023—at its hospital in Atmeh, Idlib, in northwest Syria.

A 27 bed burns unit was opened in the hospital in October, and in March an innovative 3D printing programme was launched. The first of its kind in Syria, the system creates 3D printed compressive masks for severe facial burns, which treat scarring and swelling and enhance patients' movement and recovery.

The burns team also offers essential and holistic rehabilitation services, including surgery, physiotherapy, mental health, patient education, and ambulatory outpatient services.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2025;389:r971



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1 A child with burns plays in the MSF hospital in Atmeh, Idlib

2 The Al-Karama camp for internally displaced people in northwest Syria

ABDULRAHMAN SADEQ/MSF; JUMA MUHAMMAD/IMAGESLIVE/ALAMY

EDITORIAL

Achieving equitable maternal health

A lifelong approach is needed for safe and personalised care in the UK

Achieving safe, personalised, and equitable maternal health services with a lifelong focus is not a new vision,[1] yet data suggest we are still far off achieving this goal.[2 3] Maternal mortality, now 12.8 deaths per 100 000 women giving birth in the UK,[4] is higher than in most countries with comparable surveillance systems.[5] Variation in extended perinatal mortality rates between different maternity units is wide,[2] ranging from 3.4/1000 births to 8.4/1000 with an overall UK rate of 4.8/1000. Equitable outcomes are still a long way off, with maternal mortality rates of 12.2 per 100 000 for white women compared with 16.7 for Asian women and 28.2 for black women and a wide gap between women in the most and least deprived areas (18.8/100 000 *v* 10.3/100 000).[4] Investigations continue to show that women's and families' voices are not listened to.[6 7]

How then, do we escape from this spiral of concerns and develop our maternal health services to be fit for the future? Recognising that pregnancy health services form only one part of a woman's healthcare over the life course, integral connection with services before and after pregnancy is essential. Yet policy teams retain a largely siloed focus on maternity and neonatal services. Improving maternal health needs to begin before pregnancy, incorporating both public health actions to address risk factors such as obesity and smoking as well as care for pre-existing health conditions. The latest data in England show that around 27% of women are obese in early pregnancy.[8] Around 16-18% of women enter pregnancy with two or more comorbidities.

Analysis suggests that 90% of women of reproductive age could benefit from pre-pregnancy advice[9] yet the service provision for such

Coordinated multi-disciplinary care in pregnancy is uncommon

advice is inconsistent.[10] In England, networked maternal medicine services have been established to provide pre-pregnancy advice for women with the most complex medical conditions, but ring fenced funding has now ceased,[11] raising uncertainty about their future. Pre-pregnancy advice for women with mental health conditions is even harder to obtain.[12]

Coordinated and timely care

A second key change is to ensure genuinely coordinated, multidisciplinary care in pregnancy, which is currently uncommon. A few notable examples of integrated models exist, such as the Lambeth Early Action Partnership, which has shown benefits for parental mental health and longer term child development.[13] But too often women are required to attend multiple visits with different clinical teams. Women with multiple and complex needs lack a single trusted relationship with a care navigator.[14] Research suggests benefits of different continuity models, including midwife or nurse led approaches and using peers or other trained providers.[14] However, little robust evidence is available on the impact of redesigned services because evaluations of service changes are rarely planned or conducted. Ensuring that robust evaluations of all policy and service changes are conducted, perhaps through existing National Institute for Health and Care Research (NIHR) infrastructures, will ensure that developments are evidence led.[15]

The expanding potential of electronic data systems offers opportunities for using real time data to drive continuous improvement and empower women. However, such developments rely on motivated research teams rather than being strategically commissioned by policy teams. There is a reliance on multiple external inspection systems to drive quality improvement,[16] and individual hospitals are not incentivised to continually respond to their own data. Better use of electronic data systems and real time monitoring and response has the potential to transform maternal and perinatal health services. All maternity units in the UK have access to the MBRRACE-UK real time data monitoring tool, which allows hospitals to identify when four or more babies have died within an unusually short period,[17] but it requires training and staff resources to interpret and respond to the findings.

A similar tool incorporated into the MBRRACE-UK programme to monitor maternal morbidity would allow a correspondingly early response to concerning rates of maternal complications. Tools to detect and escalate management of deterioration are currently being developed as part of research programmes.[18]

Finally, the NHS needs to move to a system of no-fault compensation (compensation without requirement to prove fault or negligence)[19] to enable open and transparent learning based on human factors approaches when things go wrong. Facilitating a just learning culture is essential to break out of the vicious cycle of maternity service decline and build a maternal and child health system fit for the future.

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EDITORIAL

End nuclear weapons, before they end us

WHO's mandate to provide evidence on health effects must be restored

In May 2025 the World Health Assembly (WHA) will vote on re-establishing a mandate for the World Health Organization (WHO) to address the health consequences of nuclear weapons and war.[1] Health professionals and their associations should urge their governments to support such a mandate and support the new UN comprehensive study on the effects of nuclear war.

The first atomic bomb exploded in the New Mexico desert 80 years ago, in July 1945. Three weeks later, two relatively small (by today's standards), tactical size nuclear weapons unleashed a cataclysm of radioactive incineration on Hiroshima and Nagasaki. By the end of 1945, about 213 000 people were dead.[2] Tens of thousands more have died from late effects of the bombings.

Last December, Nihon Hidankyo, a movement that brings together atomic bomb survivors, was awarded the Nobel peace prize for its "efforts to achieve a world free of nuclear weapons and for demonstrating through witness testimony that nuclear weapons must never be used again."[3] For the Norwegian Nobel committee, the award validated the most fundamental human right: the right to live. The committee warned that the menace of nuclear weapons is now more urgent than ever before. In the words of committee chair, Jørgen Watne Frydnes, "It is naive to believe our civilisation can survive a world order in which global security depends on nuclear weapons. The world is not meant to be a prison in which we await collective annihilation."[4]

While the numbers of nuclear weapons are down to 12 331 now, from their 1986 peak of 70 300,[8] this is still equivalent to 146 605 Hiroshima bombs[9] and does not mean humanity is any safer.[10] Even a fraction of the current arsenal could decimate the biosphere in a severe mass extinction event. The global climate disruption caused by the smoke pouring from cities ignited by just 2% of the current arsenal could result in over two billion people starving.[11]

GUY CORBISHLEY /ALAMY

The world desperately needs leaders to freeze their arsenals, and end further modernisation of nuclear technology

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Kamran Abbasi, editor in chief, *The BMJ*, London

Parveen Ali, editor in chief, *International Nursing Review*

and others, see bmj.com

Growing global risk of nuclear weapons

A worldwide nuclear arms race is underway. Deployed nuclear weapons are increasing again, and China, India, North Korea, Pakistan, Russia, and UK are all enlarging their arsenals. An estimated 2100 nuclear warheads in France, Russia, UK, US, and, for the first time, in China, are on high alert, ready for launch within minutes.[8] With disarmament in reverse, extensive nuclear modernisations underway, multiple arms control treaties abrogated without replacement, no disarmament negotiations in evidence, nuclear armed Russia and Israel engaged in active wars involving repeated nuclear threats, Russia and the US deploying nuclear weapons to additional states, and widespread use of cyberwarfare, the risk of nuclear war is widely assessed to be greater than ever. This year the Doomsday clock was moved the closest to midnight since the clock's founding in 1947.[10]

Led by Ireland and New Zealand, in late 2024, the United Nations General Assembly voted overwhelmingly to establish a 21 member independent scientific panel to undertake a new comprehensive study on the effects of nuclear war,[12] with its final report due in 2027. Noting that "removing the threat of a nuclear war is the most acute and urgent task of the present day," the panel has been tasked with examining the physical effects and societal consequences of a nuclear war on a local, regional and planetary scale. The last such report dates from 1989. It is shameful that France, UK, and Russia opposed this resolution.[13]

Our joint editorial in 2023[16] on reducing the risks of nuclear war and the role of health professionals, published in over 150 health journals worldwide, urged three immediate steps by nuclear armed states and their allies: adopt a "no first use" policy, take their nuclear weapons off hair trigger alert, and pledge unequivocally that they will not use nuclear weapons in any current conflicts they are involved in.

It is an alarming failure of leadership that no progress has been made on these needed measures, nor on many other feasible steps away from the brink, acting on the obligation of all states to achieve nuclear disarmament. Nine states jeopardise all humanity and the biosphere by claiming an exclusive right to wield the most destructive and inhumane weapons ever created. The world desperately needs the leaders of these states to freeze their arsenals, end the modernisation and development of new, more dangerous nuclear weapons, and ensure that new technology such as artificial intelligence can never trigger the launch of nuclear weapons.

The UN scientific panel and a renewed mandate for WHO's work in this area can provide vital authoritative and up-to-date evidence for health and public education, evidence based advocacy and policies, and the mobilised public concern needed to trigger decisive political leadership. This is a core health imperative for all of us.

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"Ambient scribe" tools that listen to and summarise your consultations with patients

New AI tools that record and summarise doctor-patient conversations are becoming increasingly common. But what are they, and can they be trusted? **Chris Stokel-Walker** reports

Heidi is listening. Nearly half a million patients are registered with Modality Partnership, the NHS's largest GP partnership. Hundreds of doctors across more than 50 sites in England see these patients daily. Since November, Heidi, an artificial intelligence tool, has been listening to these consultations and transcribing them.

Heidi allows GPs to spend less time inputting a patient's clinical history into a computer and more time focusing on the patient. "The feedback from colleagues has been very positive," says Tom Ratcliffe, digital transformation clinical lead at the partnership, who has been overseeing the testing of Heidi.

"As a GP, the main thing I've noticed is that I'm able to focus entirely on the patient when they're in the room with me," says Ratcliffe.

Every doctor knows that a lot of patient communication is non-verbal. By having Heidi running in the background, Ratcliffe says, "I can listen more intently and pick up non-verbal cues, which are important in the GP setting. The patient encounter is much more relaxed and there's a better connection because I'm not having to make notes as we go along."

So-called ambient scribing tools—which transcribe but don't record a patient consultation—have been presented as a boon for the NHS. Dominic Cushnan, deputy director for AI at NHS England, called them a "particularly exciting development" at a conference organised by the Royal College of Radiologists in early February.

The patient encounter is much more relaxed
Tom Ratcliffe

It allows clinicians to focus fully on their patients
Dominic Cushnan

"Ambient scribing technology uses AI to automatically transcribe doctor-patient conversations during consultations, reducing the need for manual note taking," Cushnan explained. "This allows clinicians to focus fully on their patients without worrying about documentation."

Jaron Chong, chair of the AI standing committee at the Canadian Association of Radiology, told the same conference that ambient scribes are technology that "clinicians are super-enthusiastic about." Anything that can free doctors from the tyranny of manually updating patient records, reduce form filling, and increase the time seeing patients is seen as a benefit, Chong said.

Write that down

AI scribing is a big business: more than 90 companies market AI medical scribes or similar software, according to an analysis by Northeastern University in the US.

And they are popular. One in 20 UK GPs surveyed for a *BMJ Health & Care Informatics* study said they use AI to generate most appointment documentation. Hannah Allen, chief medical officer in the UK for Heidi's creators, Heidi Health, tells *The BMJ* that one in five NHS GPs have used their scribe. The company did not say how many continue to use it.

"What we've said is that we're using AI to make your consultation more human," says Shankar Sridharan, a consultant cardiologist at Great Ormond Street Hospital, who is overseeing a trial of an AI scribing system called Tortus across London hospitals in his role as chief clinical information officer.

Human in the loop

Sridharan says that Tortus summarises 95% of a doctor's notes and writes 95% of the patient letter. "Why 95%? Because it's my professional responsibility as a clinician to check the notes," he adds.

Putting that check in place is critical because of the risk of hallucination or misinterpretation by AI scribes.

Hallucination, sometimes called confabulation, is when an AI system makes up information because of glitches in its training data or how it produces its output.

This might mean that a medical note could, for example, include suggestions that a frail patient has family who care for them, when they don't, or add a non-existent condition to a patient's medical history. Hallucination is a thorny problem that exists in AI systems across multiple fields: a recent study by the BBC of AI chatbots' ability to summarise its news reporting found more than half of the answers it produced had "significant issues," which could include making up or getting key bits of a story wrong.

Misinterpretation is a different, but similar, problem and occurs when the AI system doesn't fully or correctly hear what a patient is saying.

AI scribing is "a double edged sword," says Ameera AlHasan, a consultant colorectal and general surgeon at the Chelsea and Westminster Hospital, who has previously published a paper on biases in AI. She can see the benefits of speedily produced and standardised notes but also recognises the risks.

"AI does not come up with new information. It depends on what you feed it," she says. "Let's say you've programmed it through information from English speakers. If you try to speak a different language, or English that's not really native English, then that's when inaccuracies can pop up."

MALCOLM WILLETT

Regulation

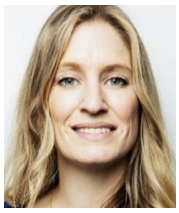
Interpreting patients who don't have English as their first language isn't a new area, but doctors are often able to make sense of missing or misspoken words when taking notes directly. With an AI system, catching those errors relies on double checking.

A GMC spokesperson told *The BMJ*, "As with other medical devices, we expect doctors to use their professional judgment to apply the principles in our guidance to the use of innovative technologies."

They noted the GMC does not regulate or approve new medical devices, but said it has published guidance on the use of new tools in healthcare and the standards medical professionals should follow. They directed *The BMJ* to the GMC's advice on raising and acting on concerns around patient safety.

"The product has to be built with real care—and the way that you manage it has to be built into the product," says Allen. She points out that hallucinations are "almost never encountered in practice," but when they are, the errors are picked up by doctors.

Clinicians are super-enthusiastic
Jaron Chong



We take real care in how we build these tools
Hannah Allen

"We take real care in how we build these tools and how we work with our clinicians. We make sure they understand the risks and benefits through a collaborative training programme," she says. Allen also says that Heidi was piloted in several different geographical areas with a range of accents, and it "performed really, really well."

Mixed trial results

A 2024 study looking at around 3500 US doctors who took up the offer of an AI scribing tool (out of 10 000 who were given the chance) found largely positive outcomes.

On a 50 point scale, the AI transcripts scored 48 for accuracy and other quality metrics. Where they did slip up, however, the changes were troubling. The AI system said one patient who discussed problems with their hands, feet, and mouth had hand, foot, and mouth disease; another patient was described as having had a prostate exam, when the meeting was to schedule the exam.

Ratcliffe has a verbal tic where he says "right" to confirm he's heard what patients are saying—he's seen that folded into AI summaries of his conversations with patients as their describing problems with the right hand side of their body.

Training in the use of these systems, and in how to interpret their outputs, is therefore front of mind for those overseeing trials and tests across healthcare systems around the world.

"There is the occasional hallucination or slightly unusual thing that it throws out, but we've done a lot of work with our clinicians to train in this potential risk," says Ratcliffe. "Everything has to be checked before being copied and pasted into the medical record."

Overall, doctors say they find AI scribes beneficial. Four in five Canadian doctors in a trial of a system provided by Well Health Technologies said they wanted to continue using it. Three quarters said the benefits of the system—including a three and a half minute reduction in administrative tasks for each patient encounter—outweighed the inconveniences.

The London Tortus trial is ongoing, but, says Sridharan, the interim results show a 12% increase in direct care per appointment. "In addition to direct care, doctors are much more efficient at using their electronic patient record," he adds, because they spend less time writing up their notes.

Advocates say that it doesn't just help them to treat patients more deliberately, it also reduces the bits of the job that prevent doctors from being doctors. A Canadian study found doctors who used AI scribes saved three hours a week on administrative tasks carried out after hours—which could help reduce the stress and burnout plaguing healthcare systems worldwide.

"Heidi helps to improve that intra-consultation experience, and remove that unseen work element of being a doctor today," says Allen.

"It's not meant to replace my clinical acumen," says Sridharan. "It's not meant to replace my logic, my reasoning, my empathy.

"It's a bit like a cape. But the human is the superhero."

Chris Stokel-Walker, freelance journalist, Newcastle upon Tyne stokel@gmail.com

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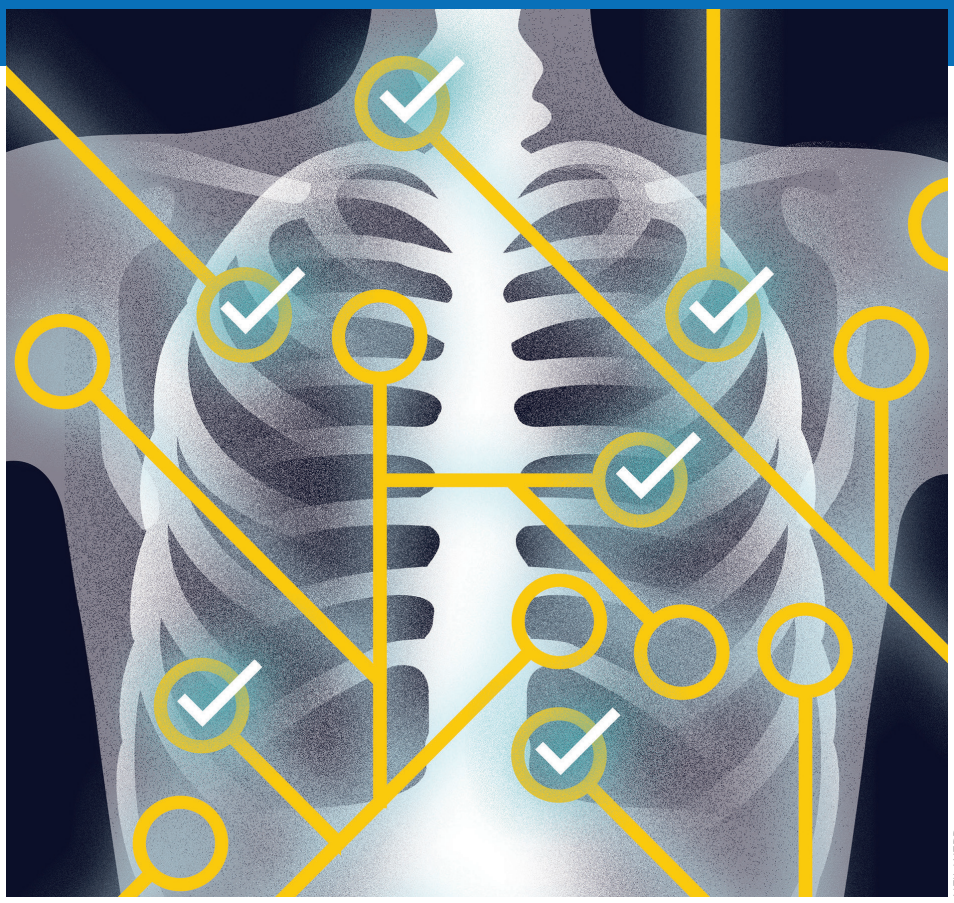
AI depends on what you feed it
Ameera AlHasan

It's not meant to replace my clinical acumen
Shankar Sridharan



NEIL WEBB

Can AI teach medicine?

Artificial intelligence is making significant inroads into healthcare, diagnostics, workflows, and even medical education. But can it truly take on the role of a teacher, asks **Mun-Keat Looi**

"Can AI do the teaching?" asked Nick Woznitza, consultant radiographer and clinical academic at University College Hospital London. "No. But…"

This was the subject of a panel session in February, at the Royal College of Radiologists' conference on the future of AI in healthcare and the NHS. Medical education has long been built on a foundation of mentorship and hands-on learning—and there are still things that only a human teacher would pick up on, Woznitza told the audience.

"I have been a trainee," he said. "Sometimes I didn't even say, 'I don't understand': it was the quizzical look on my face that told the tutor I needed help. AI can't recognise that."

Artificial intelligence may excel at pattern recognition and data processing, but it lacks the intuition and empathy that a skilled educator brings to the table, said Woznitza.

"If we look at [diagnostic AI that examines images pixel by pixel], it can draw a line around a lesion, but it can't explain why [that lesion is there]," he said. "It might give a probability score, but it definitely can't explain it in another way if you don't understand." The ability to frame a concept differently depending on the learner's needs is a skill that remains uniquely human.

James Wang, consultant oncologist at University College Hospital London, echoed this concern. "[You want the AI to be drawing around] an organ, not just colouring numbers," he said. "As clinicians we have to think about, 'What is the radiation dose doing to the organs that we're trying to detect, and how does my delineation affect that?' And some of that gets lost if the trainees aren't guided through the fact that [the AI drawing this line] is not just a shortcut.

"You have to understand why you're doing the work you're doing,

what the AI is trying to do to help you, and where that's failing. Otherwise, you risk missing things."

Protecting expertise

Despite its limitations AI has valuable applications in medical education, particularly in providing real time feedback and reinforcing pattern recognition.

"We have the ability for AI to give immediate trainee decision feedback," Woznitza told the conference. In radiology, for example, AI driven systems for decision support can highlight missed abnormalities in scans, allowing trainees to correct their errors instantly rather than waiting for supervisor feedback, which can sometimes be late, shallow, or unhelpful simply because the consultant is overworked.

Conference panellists also pointed out the possibilities of AI coming up with useful teaching examples, at least in radiology, to help trainees gain exposure to a wider variety of cases than they might see in their clinical placements alone or which simply aren't available, owing to the low probability of seeing rare or specific examples in a placement.

Still, a concern raised by many educators, including Woznitza, is the potential for AI to de-skill trainees. If AI is flagging abnormalities before a trainee radiologist has a chance to assess an image independently, will they develop the expertise needed for real world practice? "If your training consists of only abnormal cases flagged by AI, how do you maintain the ability to recognise normal?" Woznitza asked.

Wang has observed similar patterns in clinical oncology, where auto-contouring software (which automatically adds outlines of tumours, organs, etc, to scans) is becoming widespread in radiotherapy planning. He said, "Even though it's not perfect, it does save time. But in order to deploy these systems and make the best use out of them, you need technical staff, AI literate support staff, and infrastructure."

He warned that while AI can reduce repetitive workloads it may contribute to automation bias, where users over-rely on AI generated results without critically evaluating them. "Trainees and even consultants are accepting AI generated images without any change," he said. "We need to make sure they're not just colouring in numbers but actually understanding what they're looking at."

Bias and burnout

AI models are only as good as the data they're trained on, and Woznitza highlighted the potential risks of this. He told the conference, "AI can detect race on a chest x ray. We can't. And if we don't know what element of race influences the AI's predictions, we risk entrenching existing health disparities." He pointed to studies that had found that AI algorithms performed worse for certain demographic groups, particularly non-white patients, women, and individuals on low incomes.

Wang extended this concern to broader healthcare applications that use AI. "The assumption is that AI will improve workforce efficiency, but its actual effect is hard to isolate because it depends on the use case, the culture, the infrastructure, the staffing, and the technical expertise available," he said.

He cited a Chinese study of 6000 radiologists that found that AI increased burnout—but this was primarily among those who were unfamiliar with the technology. "If a system is telling you that you made a mistake and you don't understand how it works, you're going to spend even more time and effort trying to work that out," he said.

The automation offered by AI sounds great. But it could also eliminate the "simple" cases, leaving doctors to deal with only the complex, abnormal ones that take a lot of effort to diagnose.

Woznitza explained, "If you're constantly making complex decisions, you will experience fatigue. Are we in danger of burning out our trainees because all they're doing is the abnormal cases? Or do they go against protocol and actually have 100 normal chest x rays and see [the well]" patient?"

And some studies have indicated that AI assistance can have an adverse effect if you have a greater level of expertise.

Woznitza added, "If we start looking at some of the older studies, [we see that] less experienced readers, trainees, get better [at their job] by learning from easier cases, using AI as a clinical decision support. But actually, it can decrease sensitivity for hard cases in already expert readers."

Are we in danger of burning out trainees?
Nick Woznitza

You need technical staff, AI literate support staff, and infrastructure
James Wang

Future of medical training

Woznitza told the conference, "We need to thoughtfully and proactively adapt our teaching to make sure we have experts, not just AI assisted practitioners. Teaching and education is more than knowledge: communication and compassion are central to healthcare." So, AI may support learning, but it can't replicate the mentorship, intuition, and ethical considerations that human teachers provide.

Yet Woznitza and others on the panel accepted that AI could enhance the efficiency of training. By automating repetitive tasks, synthesising vast amounts of medical literature, and generating fictional cases for rare conditions, AI can enrich the learning experience.

It's an environment many at the conference were preparing for. As an audience member pointed out, people nowadays don't think twice about using calculators. Or, in an example given by the panel, "We trust point-of-care biochemical testing and blood tests to work out how many red cells you've got, how many white cells you've got. We don't have anyone going, 'Well, I'd better check and start counting.'"

Similarly, delegating some tasks to AI will be the norm for the doctors of tomorrow.

Wang concluded, "It's about making sure we integrate AI in a way that helps, rather than hinders, our ability to train the best clinicians for the future."

Or, as Woznitza put it: "AI can't replace teaching, but it can help us teach better—if we use it wisely."

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AI therapy tools: what are the risks and benefits?
BMJ 2025;389:r821

Mun-Keat Looi, international features editor, *The BMJ* mlooi@bmj.com

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MALCOLM WILLET

What NHS patients think about AI use for their care

At a recent conference in London patients gave an insight into their thoughts on artificial intelligence tools. **Mun-Keat Looi** reports

Artificial intelligence is rapidly becoming a part of our everyday lives, including the healthcare sector. But as with any technological advance in healthcare its integration comes with its own set of challenges and considerations.

Speaking at an NHS conference on AI in February organised by the Royal College of Radiologists, Nell Thornton, improvement fellow at the Health Foundation, presented data, published in July 2024, from a survey of more than 8000 members of the public and 1200 NHS staff members asking how they perceive AI in healthcare.

Over half (54%) of the public and 76% of staff supported the use of AI. The level of support rose when it came to using AI for administrative purposes, such as appointment notes. But a majority of the public, especially those aged 65 and over, want to be told when AI has been used, even for tasks such as generating appointment letters.

However, significant concerns remain. Women, for instance, were consistently less supportive of AI in healthcare, with only 48% expressing support (against 61% of men). Thornton said this could be linked to a lower level of trust among women in the safety and accuracy of AI.

There was also concern over AI's potential effects on the human aspects of care. Over half of the public and two thirds of the NHS staff respondents worried that AI systems could put distance between patients and care professionals. And when asked about various scenarios involving AI, the public's support for AI drastically declined if there was no human oversight. "When you take a human out of the loop, the support for AI completely flips on its head," Thornton said.

The research also delved into public attitudes towards data sharing for AI development. While many said they were willing to share some of their health data, a sizeable proportion (25%) were not comfortable with any data sharing. The type of data matters, Thornton pointed out, with sensitivity increasing in the case of sexual health information, social media activity, and data collected from wearable devices.

Although healthcare staff were generally supportive of AI, responses varied across different professional groups. Doctors and dentists were the most enthusiastic, while nurses, midwives, and administrative staff were less so. "When you're looking at integrating AI into services, think about how it's going to impact different staff differently," Thornton advised.

"Use My Data . . . and get on with it"

Richard Stephens, a patients' advocate and chair of the organisation Use My Data, decried assumptions that patients don't know about AI. "We all know about AI. We all use Amazon, for goodness' sake."

Speaking at the AI conference, he said he believed AI was now routinely used to send appointment reminders and interpret results but also pointed out the challenges of navigating a complex healthcare system with multiple appointments and fragmented data. But it was in communication that he saw a clear immediate opportunity.

"If you showed people the four pages of gibberish that comes out [of hospital] departments and compared it with what a chatbot could write, there is a massive difference. It's possible to understand one version, as opposed to misunderstand the other version, and go to the wrong clinic . . . Little things like that maybe AI might improve." He said he was "fascinated" by indications "GP letters can actually be made clearer and more sympathetic by using chatbots."

That would be better than endless telephone conversations, he said. "Please, can I talk to a chatbot? They might actually be more logical . . . more helpful. The one on Amazon is. 'What is it you are trying to do?' it asks. And it starts from there."

Stephens said patients were enthusiastic about AI's potential to accelerate diagnosis and predict risk. He cited examples of AI being used to identify super-responders to radiotherapy and to assess the risk of heart damage in patients taking certain drugs for blood cancer. He said he also saw potential for AI to improve the efficiency of primary care, such as in triaging skin cancer referrals.

But he called for a more streamlined approach to data access and AI development, criticising the slow pace and bureaucratic hurdles that hinder progress. He also emphasised the importance of using patient friendly language and avoiding terms that create fear or distrust.

"AI needs our data. The data is there. AI is the way forward in so many areas. We [patients] want to see AI used wisely, and safely, but used."

Mun-Keat Looi, international features editor, *The BMJ* mlooi@bmj.com

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CHALLENGING ASSUMPTIONS ABOUT YOUNG PEOPLE AND AI

Young people are often assumed to be more tech savvy and inherently comfortable with technology, but Health Foundation data show this age group is most sceptical about use of AI in healthcare.

"When we just look at the 16-24 year olds, only 23% agree that AI is going to make the quality of healthcare better, compared with 33-37% of other age groups," said Nell Thornton, improvement fellow at the Health Foundation. "And we see this consistently in all of our research."

Susan Shelmerdine, a consultant paediatric radiologist at Great Ormond Street Hospital for Children, said previous research had indicated that young people were generally positive about AI, associating it with progress and intelligence. But they were also more likely than older people to feel wary about how their data would be used and less likely to trust the NHS with their data.

Shelmerdine's research exemplifies how to involve children in shaping AI in healthcare. She created a "fracture study steering group" of young people, parents, and carers to guide the development of an AI model for detecting children's fractures in x ray pictures. This showed children prioritise accuracy and safety over speed and efficiency and had a strong desire for human oversight, preferring AI to act as a "double checker" rather than replacing doctors entirely.

WHY I... write crosswords

Neonatal intensive care specialist Ilana Levene tells **Erin Dean** how writing American puzzles distracts her from the emotional and mental load of medicine

Ilana Levene was seeking a diversion while writing up a doctoral thesis when she found that word and number puzzles offered a quick break.

Levene, a neonatal resident doctor at John Radcliffe Hospital, Oxford, found herself hooked on daily crosswords from the *New York Times*. They inspired her to try creating her own.

Eighteen months after she started completing US crosswords, Levene had one published in the *LA Times* and one accepted by the *New York Times*—often seen as the pinnacle of US crossword publishers.

"I was just sitting all day at my desk writing up my thesis," Levene says. "For a bit of procrastination, I enjoyed doing the word puzzle Wordle, and that became my gateway into the world of US crosswords. I completed one every day, and started to think about how they were made."

Crosswords in the US differ from those in the UK, she explains. They don't tend to use cryptic clues, which are popular in the UK, but use clues based on a mix of facts, synonyms, and word play. US versions are also more densely packed with words compared with those in the UK and contain only a few black squares.

"There are lots of complex rules which you only start to discover when you sit down to write one," she says. "US versions tend to have an overall theme, which links a few of the clues, and coming up with and maintaining a good theme is one of the main challenges." The theme of one of Levene's crosswords, for example, is "shifting sands," with the word sand appearing in a number of answers.

Even when using computer programs that help with the creation of the grid, creating a crossword takes hours of work suggesting words that will fit the white squares available. Levene says that crosswords are an extension of her love for games that use logic, such as Sudoku, which she has enjoyed since childhood. Now they help distract her from the emotional and mental load of medicine.

"When writing a crossword you work through hundreds of decisions, so that satisfies my brain, which likes analysing and ticking boxes," she says. "This is definitely a doctor thing and, certainly for me as a neonatal intensive care specialist, I'm somebody who will go over the list 50 times during my shift, making sure that all the information is exactly correct. I get satisfaction from that both at work and when writing a puzzle."

Levene has designed several crosswords, some created in partnership with a more experienced puzzler. There is payment involved when a puzzle is published, and this can be more than $2000 for an experienced setter of the Sunday *New York Times* puzzle. But payments are usually much lower than that. "Per hour, the pay is very low," Levene says. "It is definitely about the challenge and the satisfaction of being in print, rather than the money."

While creating crosswords provided much need light relief during her doctorate, Levene remains committed to crosswords even though her thesis is complete and she is back in clinical practice.

"It's just a bit of fun and really enjoyable," she says. "Completing and creating crosswords gives me another facet of what I get at work: the satisfaction of building up a complete picture gradually, using little pieces of evidence to get to a bigger answer; and then the dopamine hit of ticking it off your list and completing it."

Erin Dean, London

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Creating crosswords gives me a facet of what I get at work: the satisfaction of building up a complete picture

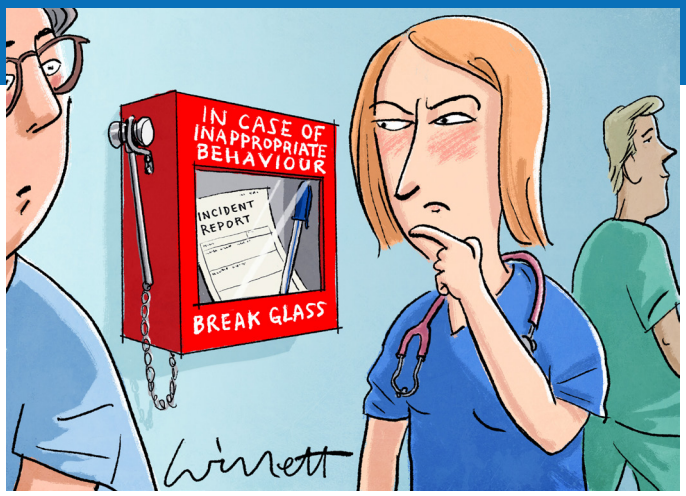
HOW TO GET INTO WRITING CROSSWORDS

- Complete lots of crosswords first to get a good feel of how they work
- If doing US puzzles, start with those published on a Monday as they get harder through the week
- Read the *New York Times* series explaining how to make a crossword (www.nytimes.com/2018/09/14/crosswords/how-to-make-a-crossword-puzzle-the-series.html)
- Join Facebook groups for people new to crossword writing for support and guidance from more experienced creators
- Partner with a more experienced puzzler initially to benefit from their experience
- Competition to get published is high, so expect rejection

CAREERS CLINIC

How do I deal with an inappropriate colleague?

Tom Moberly hears advice on how to tackle unwelcome behaviour from colleagues, including sexual comments and advances



Look after yourself

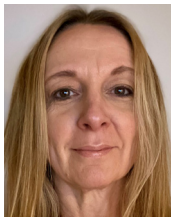
Chelcie Jewitt, cofounder of Surviving in Scrubs

"The first piece of advice I would give to anyone in this situation is to look after yourself. There is an onus on you to speak up when things happen, but in real terms that can feel very scary. You might have concerns about escalating the situation or making things worse for yourself or others.

"If you don't feel safe, recognise this and try to highlight the incident to someone—this can be an educational supervisor, a senior colleague, someone working in HR, or a friend. Ideally, the person you confide in may then be able to support you in navigating the next steps—to support you if you wish to make a formal complaint or just to lend a sympathetic ear if that's all you need.

"The second piece of advice is that there's no rush or pressure to do anything, so if you are OK with not speaking up, you don't have to. Again, this goes back to keeping yourself safe. But please be aware of what support networks are out there. There are support resources online to help you through these difficult situations and to come to a decision that feels right for you.

"Finally, if you do feel safe to say something in the moment, again recognise your feelings and try not to let them influence the interaction. The key to directly calling out someone's inappropriate behaviour is to talk straight with them in a non-inflammatory manner, using simple terms such as, 'I need you to stop that. I am really uncomfortable.' The focus of the statement is on your perception rather than attacking them, which should limit the risk of the situation escalating the perpetrator's behaviour."



Keep good records

Kathryn Leask, medicolegal adviser at the Medical Defence Union

"It can be very distressing if a colleague behaves inappropriately. Sometimes an individual may not feel comfortable speaking out and discussing this with anyone, especially if the person behaving inappropriately is a more senior colleague. However, confiding in a trusted friend, family member, or colleague can be beneficial, as they can offer support and guidance.

"It's important to keep a factual record of any comments or actions, including dates, times, where the incidents occurred, and who else was present. This may help to establish witnesses for any future investigation. The GMC provides guidance on raising and acting on concerns about patient safety. You, or a colleague on your behalf, could raise concerns in line with this guidance and your employer's workplace policy.

"The more details you can include, the better, as this gives you evidence. It's better to do this as soon as possible before recollections fade and to do this on a personal, rather than a work, device.

"If possible, it may also be worth asking a supervisor or another senior colleague whether it would be possible to work on shifts that limit your contact with the individual. If this isn't possible, then try to make sure there is someone else present with you when working or interacting with this colleague.

"If another incident occurs, it's important to try to extract yourself from the situation as best as you can while maintaining your professional integrity. Also, you do have the right to report your concerns to the police, just as anyone else would, if you're comfortable to do so and it's appropriate. Again, taking a trusted friend or colleague with you for support might be helpful."

Report the behaviour

Sue Carr, deputy medical director at the General Medical Council

"Last year, our national training survey revealed that nearly one in 10 female trainee doctors have experienced unwelcome sexual comments or advances causing embarrassment, distress, or offence. Being subject to sexual harassment at work can be devastating. In some cases, such behaviour is criminal. In all cases it is unacceptable, as professional standards make clear.

"The standards now say that doctors 'must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress.' This detail—focusing on behaviour towards colleagues not patients—appeared for the first time in *Good Medical Practice 2024*. It's important there's no room for either inadvertent or wilful misinterpretation of the new duties.

"If a colleague has behaved inappropriately towards you, your best course of action is to report it to your line manager or to a person or organisation who is able to investigate. But of course, it can feel very daunting to raise a complaint against somebody you work with, especially when there's a power imbalance. You can find good advice and signposting to extra sources of support on our ethical hub.

"While the added clarity we've brought to the standards may not resolve all fears around speaking up, I hope it provides assurance of what you can expect. We've set out our expectations of those who witness unacceptable behaviour, and we've been explicit about how doctors with leadership responsibilities should handle any concerns you bring to their door. All doctors have the right to work in a respectful workplace with colleagues who recognise boundaries."

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