comment

"We live in toxic times; the NHS has a chance to show commitment to equality" **PARTHA KAR**
"As doctors embrace career polygamy, we must remain cautious" **MATT MORGAN**
PLUS Exception reporting; the conveyor belt of medicine

PRIMARY COLOUR Helen Salisbury

GPs v hairdressers? Streeting has no idea

The row about online access to GP services continues. In April it was agreed that GPs would keep online portals open in their core hours, but a six month delay was put in place. This was so NHS England could develop measures to prevent surgeries being overwhelmed—and, most importantly, to ensure that clinically urgent cases weren't missed.

Wes Streeting, the health secretary, last week claimed that safeguards were now in place to prevent urgent and emergency requests coming via this online route. This is not true. There are no safeguards. Simply putting a disclaimer on your website is not effective: even if patients read it, they can be poor judges of what's urgent. People with a stubbed toe turn up at the emergency department, while others with hours of chest pain ask for a routine appointment.

A newspaper reported a bizarre statement from Streeting comparing the ease of booking a haircut with the difficulty of booking an NHS appointment, which triggered a lot of comment. Some highlighted the differences between safety critical medical work and the need for a cut and blow dry, while noting that £164 a year—the upper limit of estimates of annual funding per patient—won't buy you many haircuts. But behind the humour there is real hurt, as Streeting's insensitive comments seem to show the value he places on general practice and his lack of understanding of how we work. This is not disrespect for hairdressers—rather, a criticism of sloppy and inappropriate comparisons.

The lack of understanding is a real problem, resulting in internal inconsistencies in NHS England's diktats, making it difficult or impossible to follow the rules. On the one hand we're mandated to provide online bookable appointments; on the other we're encouraged to triage all requests. The latest hoop we must jump through to claim some payments is one aimed at providing equity between phone, online, and walk-in requests for appointments, asking for standardised information to be collected, whatever route is used.

This equity is already negated by the existence of directly bookable appointments that don't involve triage. But it also makes no sense in many situations. The online form we use asks, "How long has this been going on?" and "What have you tried already?"—questions that are clearly nonsensical if the patient telephones to ask for an appointment to discuss their latest letter from a cardiology clinic.

We need to trust our sensible reception staff to collect relevant and appropriate information, and the government and NHS England need to trust GPs when we say this online access proposal isn't safe. This isn't about money: it's about how we can provide the best and safest service while struggling with too few doctors and growing demand. No matter how many times we reiterate that tinkering with access doesn't increase capacity, it seems no one is listening.

It's hard not to conclude the main aim of these changes to online access was to generate favourable tabloid headlines. Trust has been squandered in the process, and the government can wave goodbye to the goodwill and engagement it needs from the profession to make progress with the10 year plan.

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Bluesky @helensalisbury.bsky.social

Cite this as: *BMJ* 2025;391:r2103

Ministers and NHS England need to trust GPs when we say this online access plan isn't safe

THE BOTTOM LINE Partha Kar

MWRES five years on—an opportunity for antiracist action in the NHS

Looking at the state of the world, it seems fitting to say that we're living through fractious times, and the UK is no exception. Far right marches and racist abuse and violence are surging once again. Dangerous anti-immigrant sentiment and false narratives are taking hold.

Against this backdrop, the *Medical Workforce Race Equality Standard (MWRES) Five Years On* report comes at a pivotal moment. It would be naive to believe that NHS staff are immune to many prevalent views and narratives, and the report once again highlights concerns about discrimination and equality in the NHS and the medical workforce.

The publication of the dataset for *MWRES Five Years On* was warmly welcomed by NHS England's interim chief executive, Jim Mackey.

The new data show interesting areas of development. A standout improvement has been the progress shown in the General Medical Council's data on referrals. The proportion of designated bodies (organisations providing doctors with regular appraisals and revalidation support) with disproportionate referrals of ethnic minority doctors continues to decrease, as does the ethnicity gap in referral rates.

Beyond that, and beyond some improvement in representation on royal college councils, the data continue to show problems with admission to medical schools and harassment and bullying faced by ethnic minority doctors.

Progress for specialist, associate specialist, and specialty (SAS) doctors—most of whom are from ethnic minority populations—has been glacial.

Reinstatement of roles

Induction of international medical graduates into the NHS workforce has improved but is patchy in its implementation. And the data mask the growing fractious debate around international medical graduates and their role and presence in the healthcare system.

The fact remains that, irrespective of someone's place of medical qualification, international doctors still face barriers to career

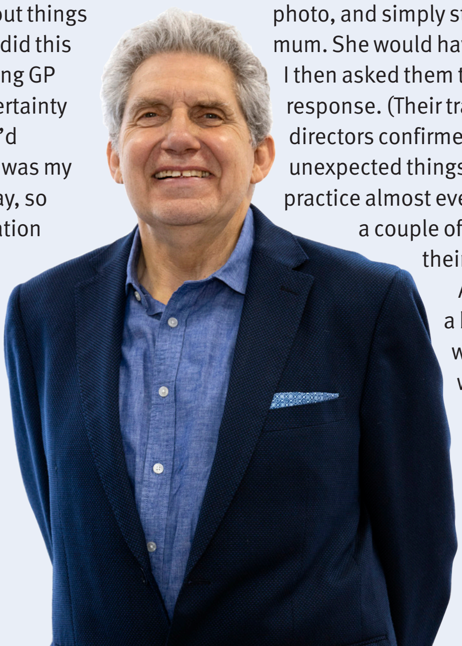
The NHS has an opportunity to show its commitment to equality

TALKING POINT John Launer

The pluripotent consultation

Every time I teach, I try to introduce an exercise I've never done before. I hope this ensures that people are less likely to be bored if they've already been to one of my workshops, but it also keeps me on my toes.

Occasionally I try out things that are quite risky. I did this recently when teaching GP residents about uncertainty in the consultation. I'd realised that the day was my late mother's birthday, so I started my presentation by putting up a slide of her in her 50s, looking rather thoughtful. I explained who she was and gave the residents a question to answer.



Many encounters in general practice can go in countless directions

Suppose, I said, that a man like me walked into your consulting room, produced this photo, and simply stated, "This was my mum. She would have been 106 today." I then asked them to write down their response. (Their training programme directors confirmed that such strange and unexpected things do happen in general practice almost every day.) I gave the group a couple of minutes to think about their answers.

A few responses included a brief acknowledgment of what the man had said but were mainly designed to prompt him to focus on the problem he wanted the doctor to deal with. Other replies were more personal, such as asking whether he'd been close to his mother. Some of the residents, quite appropriately, said that they might remain silent until he spoke again. Mercifully, no one volunteered that they might launch straight into a dementia screening questionnaire. The response that moved me the most was from a woman who offered, "She was very beautiful."

My purpose in creating the exercise was to illustrate what I call the pluripotent consultation—like a stem cell that can develop in various ways. Many encounters in general practice can go in countless directions, often leading to somewhere neither the doctor nor the patient expected. Although residents initially learn formulaic ways of consulting, they find with experience that good consultations are less like line dancing and more like freeform jazz. There's rarely just one right thing to say at any moment, so any choice of words will take the conversation somewhere different but perhaps equally creative.

progression and endure xenophobic attitudes and overt racism in the NHS. The publication of the latest MWRES report opens the possibility of racism being challenged and discussed more openly in the NHS. But it needs more than a warm welcome from the NHS chief executive.

We live in toxic times, and the NHS has an opportunity to show its commitment to equality. My recommendations would be to reinstate the national role dedicated to confronting racism in the NHS; regular publication of datasets; and a process to act on reported variations that links up with the work on health inequalities. After many false starts, the new report provides yet another opportunity to challenge racism in the NHS workforce. Acting on its recommendations is the responsibility of NHS leadership.

Partha Kar, consultant diabetes and endocrinology, Portsmouth Hospitals NHS Trust
drparthakar@gmail.com

Cite this as: *BMJ* 2025;390:r2041

Once they discover this, they'll hopefully shed two misconceptions. The first is that you'll miss essential medical information by improvising or going with the flow. The opposite is often true. If someone asked to know more about my mother, for example, they might discover very quickly how my life was affected by her experiences as a refugee—or how I inherited the thrombophilia she died from but (unlike her) was put on anticoagulants in time.

The second misconception is that trusting the narrative will waste time. It usually doesn't. It instead saves the huge amount of time we often waste by going down the wrong track, meaning that patients keep coming back or seeking a second opinion. Understanding that consultations are pluripotent can be clinically effective as well as exhilarating.

John Launer, GP educator and writer, London
johnlauner@aol.com

Cite this as: *BMJ* 2025;391:r2001

DISSECTING HEALTH Scarlett McNally

Why I love our new operating theatres

My trust has opened a brand new operating theatre complex. I'm pleasantly surprised by how much an updated environment and a fresh start have created new ways of working. It feels as though the new physical building has enabled pathways of care to be clarified and teams to flourish.

I admit that I was sceptical. I thought that it would have been better to install some pre- and postoperative areas closer to the old operating theatres. But I was wrong. It's helpful that the new operating building, with its integral assessment, admission, and recovery and day ward areas, is on the same site as the acute hospital, so patients can get medical support in an emergency and we can retain our excellent, experienced staff. This co-location is beneficial, and I've written before about how offsite "standalone" units for surgery can reinforce inequalities and potentially contribute to worse outcomes in maternity services.

Distributed leadership

People feel energised if they're included. In my hospital, our changed environment has prompted us to update our ways of working and allowed everyone to challenge existing systems and suggest improvements. Each surgeon has had to review their list of preferences and equipment requirements for each type of surgery. This helps with standardisation and team discussion of how we're meeting safety and sustainability objectives in accordance with initiatives. Aligning our work with helping people and the planet seems like an effective antidote to moral injury. Surgeons have historically been in charge, and egotistical personas and presenteeism have often flourished.

The new operating theatres have subtly challenged this hierarchy. Our surgical centre's shake-up means that surgeons are no longer visibly in charge. Surgeons now just need to remember to bring our shoes and hat, trusting that our team has made all the arrangements—with our input as needed.

Change is difficult, especially with staff shortages, overwork, and unachievable expectations, but in our hospital it's been worth it. Hospitals without a new surgical centre can still glean lessons from our experience. I suggest setting up a meeting with your wider teams—including clinical, administrative, assessment, therapy, and other staff, as well as those involved in equipment and processes—to understand how each role contributes and what information or resources they need in order to excel.

All perioperative staff should feel part of the team and should contribute to designing pathways and helping patients through them. Clinical staff should initiate meetings and discussions with other staff about aiming for day case surgery rather than overnight admission, along with health optimisation, early screening, shared decision making, standardised processes, and preparing for discharge. The rest of the team, and those designing services, need to be valued and ready to work together to deliver all of this. New buildings aren't always necessary to make substantial change.

Scarlett McNally, professor, Eastbourne
scarlettmcnally@cantab.net

Cite this as: *BMJ* 2025;391:r2064

All perioperative staff should feel part of the team

OPINION Alexander Mafi

Resident doctors shouldn’t depend on exception reporting

The recent reforms to exception reporting agreed between the BMA and the government are a win for resident doctors working in NHS hospitals.

The new policy will help to ensure that resident doctors are promptly and fairly compensated for additional hours worked above their contracted hours. Although these reforms will streamline processes and increase accountability among trusts, they also represent another step towards cementing a culture of shift work into UK medical practice.

Exception reporting is a valuable tool, but it’s one that is best used to flag a consistent problem with ward staffing, high workloads, or personal challenges, not as a mechanism to compensate doctors for every extra minute worked. We should reflect on whether we’re sacrificing too much professional autonomy and workplace support mechanisms for a small financial benefit.

The new exception reporting agreement with the government has multiple strands. It states that employers are accountable for onboarding residents to reporting systems and reimbursing trainees quickly, with financial penalties for non-compliance. It also removes the need for clinical supervisors to sign off on additional work and prompts investigations into safe staffing if a doctor reports they’ve worked more than two hours beyond their contracted end time in a single shift.

We must not tie ourselves into becoming expendable shift workers

It’s easy to learn a mentality of “do nothing for free” early in our careers. This is a justifiable response to a system that has historically taken advantage of doctors’ commitment to their patients while simultaneously eroding their pay. On the current trajectory of changes, however, it’s not a far flung idea that we will soon be punching timecards in and out at every shift.

It is healthy to be able to disconnect from work between shifts and ensure that we are taking appropriate rest, but a mentality of turning up to work primarily to complete contracted hours—and not one of turning up to take on responsibility for patients—could undermine our own feelings of professional purpose and value. Resident doctors’ dwindling feelings of professional value are challenges largely driven by variable resident doctor rota patterns and lack of continuity of care and teams. An overemphasis on exception reporting, rather than confronting these challenges, may serve only to exacerbate the problem.

This overemphasis could also undermine doctors’ professional judgment and time management. If resident doctors consistently demand extra pay for every 15 minutes worked over their shift, trusts will be increasingly justified in pushing back if, when safe to do so, we leave work early during a quiet day. In medicine, no week is ever the same and workloads continuously fluctuate. By setting this standard, we may be sacrificing our own autonomy to manage our workloads and balance our working weeks as we see fit.

OPINION Stephanie Santos Paulo

There’s no shame in stepping off the conveyor belt of medicine

After two years working as a foundation doctor, I took a year out to move abroad and explore life outside medicine. I’d ridden the conveyor belt non-stop since applying to medical school and had doubts about whether a choice I’d made at age 17 still made me happy.

I wasn’t alone in feeling as though I needed a break. The latest General Medical Council (GMC) barometer survey of 4967 doctors in the UK found that 19% were considering leaving the UK profession permanently, with 15% taking hard steps towards doing so.

Respondents to the GMC survey who were considering leaving the NHS were more likely to have had experience of compromised patient safety or care, or dissatisfaction with career progression, including competition for training posts. Among doctors who were considering moving abroad, the most common reasons were better working conditions or better pay.

Whatever your reasons may be, leaving medicine is a hard decision to make, not least because of the fear of what other people will think. For all the praise you receive from family and friends when you sign up to join the noble profession, there’s an equal and opposite feeling of guilt associated with abandoning it. People’s reactions will range from supportive to bewildered to clearly disapproving, and it can be hard to trust that you made the right call. It doesn’t help when you’re the biggest critic of all, judging yourself for leaving an understaffed NHS or for wasting all that time at medical school.

At times it felt like a tumultuous break-up, with feelings of regret and nostalgia when I saw my colleagues progressing through the next stages of their careers.

Time to reflect

The default route to qualifying as a consultant is through a specialty training programme, which thousands of applicants miss out on every year because of ever increasing competition. Anyone who veers from this traditional career path (voluntarily or not) can probably relate to the feeling of being left behind in medicine. Even if you continue to work as a doctor, your progress towards consultancy is usually paused if you’re not in a training role. This places undue emphasis on time spent in a training programme rather than developing your competence. When the struggle to secure a

The new changes may further undermine our own support networks within hospitals. Patterns of resident doctors consistently staying late may reflect not only systemic challenges in wards or departments but also that a trainee's educational needs aren't being met. It's true that having the full process of exception reporting bypass clinical supervisors will relieve supervisors and resident doctors of an administrative burden. But externalising this process may have the unintended consequence of eroding supervisors' responsibility for our training, development, and wellbeing. This bypass risks missing any extra training or support that resident doctors may require to do their work effectively.

We must not tie ourselves into becoming expendable shift workers who are paid by the minute. Instead, we must campaign for improvements that will preserve our professionalism. These should include more responsive local feedback mechanisms for resident doctors, a stronger and more consistent voice in departmental and senior hospital management, and advocating for working patterns that foster continuity in patient care and teams. In doing so we may have a better chance of reviving the autonomy, support networks, and sense of professional responsibility that make medicine a satisfying career.

Alexander Mafi, internal medicine trainee, Guy's and St Thomas' NHS Foundation Trust, London, UK

Cite this as: *BMJ* 2025;391:r2052

Stepping away from medicine shouldn't feel like giving up

training post is compounded by pay erosion and low workforce morale, it's no wonder that a fifth of NHS doctors are losing steam—some of us early on in our careers.

Taking a break was the right decision for me. I took time to reflect on what I wanted, reconnected with my non-medical interests, and came away with a renewed enthusiasm for medicine that I thought had been extinguished.

Stepping away from medicine shouldn't feel like selling out, giving up, or failing to beat the competition. Whether it's a brief clinical hiatus or a complete career change, there is value in stepping off the treadmill and taking a moment to check whether it still makes sense to keep running.

Stephanie Santos Paulo, editorial registrar, *The BMJ*

Cite this as: *BMJ* 2025;390:r1924

CRITICAL THINKING Matt Morgan

Embracing career polygamy

Two hours into a beautiful drive through mid-Wales, my friend James and I got onto a serious topic of conversation—diaries. While James has stuck to his faithful leatherbound journal, my life is coordinated with multiple coloured events and recurring reminders in an ever more complex digital diary. I need this level of integration because I'm one of those annoying people with a "portfolio career": I teach, I write, and I sometimes even work as a full time doctor.

Medicine has never really been a straight line. Even the Victorian physician John Snow embraced this. He was not only an anaesthetist but also an epidemiologist who mapped London's cholera outbreaks, laying the foundations of public health. He was also a public advocate, a teacher, and a writer. Medicine has long thrived through people with multifaceted careers.

Snow exemplified what today might be called career polygamy: having multiple professional identities and roles simultaneously. Today, more of us are following his model and abandoning the traditional career path with its single, lifelong clinical role. Doctors increasingly combine clinical practice with writing, research, innovation, advocacy, media roles, or even entrepreneurial ventures.

Health systems accustomed to defined roles and linear career trajectories face a real threat if they resist this inevitable shift. If they fail to adapt they will breed frustration and burnout, pushing talented individuals away from clinical practice entirely. This isn't merely hypothetical: medicine already struggles with poor retention, low morale, and exhaustion. Ignoring the shift towards career plurality risks exacerbating these problems.

Medicine has never really been a straight line

Embracing this evolution offers immense opportunity. Health systems can foster environments that support flexible career portfolios. This approach would not only retain talent but would also nurture the diverse skill sets vital for tackling modern healthcare's complex challenges.

Imagine if systems treated careers like personalised portfolios, with modular training and flexible contracts. These could be supported by micro-credentialing. Clinicians could regularly recalibrate their commitments depending on evolving interests and life stages, creating fulfilled professionals who deliver better patient care. Such environments would attract the brightest and most creative minds to healthcare.

Yet, as we embrace career polygamy, we must remain cautious. Fragmented roles could dilute clinical expertise if managed poorly. Systems must safeguard standards and continuity of care. I could never return to a paper diary. And while I deeply admire those who dedicate their whole lives to bedside care, I find fulfilment in variety.

Ultimately, the "death" of the traditional medical career is not an ending but more a return to our roots—back to the rich professional lives exemplified by figures such as Snow. By adapting thoughtfully, our health systems can turn this transition into a renaissance, benefiting clinicians, patients, and society alike.

Matt Morgan, consultant in intensive care medicine, Cardiff
mmorgan@bmj.com

Cite this as: *BMJ* 2025;391:r1969

LETTERS Selected from rapid responses on bmj.com

MEASLES VACCINE INFORMATION

Vaccine confidence in the digital age


JIM WEST/SPL

Jha and Psaki outline supply side breakdowns and demand side erosion in vaccination efforts, advocating for public health to reclaim digital spaces (Editorial, 12–19 July). Their recommended strategies are sound, but we also need to target the root causes of mistrust in our evolving digital landscape.

The traditional vaccine "trust deficit" reflects broader institutional disillusionment, not merely knowledge gaps. Expert driven, top-down communication increasingly fails in a world where trust is local, relational, and experiential. Rather than simply "delivering trust alongside vaccines," we must co-create vaccine narratives with communities. This requires embedding public health professionals in digital communities as peers engaging in dialogue, not authorities delivering monologues, involving not only religious leaders and influencers but authentic community voices.

The authors highlight the outsized influence of the "disinformation dozen" and amplification by foreign actors. Beyond partnerships with technology platforms, we need more ambitious solutions: incentivising platforms to use AI driven tools that identify and neutralise misinformation through real time, credible, locally relevant counter messaging rather than censorship. This demands open collaboration between public health, civil society, and technology companies with clear accountability metrics.

The editorial underplays economic incentives driving mistrust. Many communities perceive—sometimes accurately—that drug companies and governments profit while their health needs are neglected. We must explore benefit sharing models, such as local health equity funds or participatory budgeting for public health initiatives.

Although a digital focus is timely, we must tackle offline mistrust drivers. Vaccine hesitancy often proxies deeper anxieties about social exclusion, economic insecurity, and autonomy loss. Public health must evolve from messenger to partner in dealing with these systemic issues.

Restoring vaccine confidence requires more than reclaiming digital spaces—it demands reimagining public health as a collaborative, community driven enterprise tackling modern society's full spectrum of anxieties and aspirations.

Y Tony Yang, endowed professor and associate dean, Washington, DC

Cite this as: *BMJ* 2025;390:r1955

SUPPORTING DEAF COLLEAGUES

Occupational health guidance

Mahase quotes her colleague's experience at work related to their hearing impairment (Careers clinic, 14-21 June). We have supported many trainee healthcare professionals and NHS employees with deafness or hearing impairments in training programmes and the workplace.

We have designed, from an occupational health perspective, a practical toolkit of guidance and support for both employees and employers with hearing disabilities. It looks at the whole process of employment, providing a better foundation while waiting for the government's Access to Work programme.

The toolkit seeks to encourage employees and employers to start with available resources and information like using clear signage; turning off background noises when communicating with a deaf colleague; and directing to deaf awareness training. Employees can be pointed to the local audiometry unit that provides structured lipreading training (if available).

Chibueze David Nwosu, specialist registrar, occupational medicine; Harj K Kaul, consultant occupational health physician, Leicester

Cite this as: *BMJ* 2025;390:r1910

Learn British Sign Language

Over the past year I have studied for my level 3 British Sign Language (BSL) qualification, which has significantly increased my understanding of Deaf history, identity, and culture.

Not all Deaf people sign. Much of the difficulty stems from the institutional suppression of sign languages, notably since the Milan Conference of 1880, which declared that oral education was superior and passed resolutions banning sign language in schools.

UK health and educational policy continues to privilege oral methods—prioritising cochlear implants, hearing aids, and speech therapy. These are valuable tools for many, but when policy neglects exposure to native signers, free sign language education, and Deaf community networks, it creates disadvantage.

The revival of the Welsh language offers hope. Now that BSL is recognised by an act of parliament as a native language of the UK, we have a chance to apply similar commitments.

Simon Braybrook, GP partner, Cardiff

Cite this as: *BMJ* 2025;390:r2020

WIDENING ACCESS TO MEDICAL SCHOOL

King's College London is committed to widening participation

We welcome Simpson and colleagues' call for greater clarity and collaboration around the national widening participation strategy for medicine (Editorial, 19-26 April). But we'd like to provide some clarification about King's College London.

King's Extended Medical Degree Programme (EMDP) is the UK's flagship widening access to medicine programme, established in 2001 and recognised by the government and regulatory bodies as a model of good practice. Since 2017, applications have been accepted from across the UK.

King's uses a highly sophisticated contextualised admissions process, ensuring that the most deserving candidates are admitted. King's contribution to widening participation in medicine is substantial, with 100% of the EMDP's 77 student annual intake, and 28% of students on King's standard medical degree, coming from widening participation backgrounds.

As the programme approaches its 25th year, close to 1000 doctors have qualified through the EMDP. We are immensely proud of their achievements, and of the support King's has provided.

Graham Lord, senior vice president; Kim Piper, academic lead; Ajay Shah, executive dean; Nicki Cohen, dean; Michael Bennett, associate director; Steve Thompson, co-director EMDP; Jane Valentine, co-director EMDP, King's College London; Amy Moore, chief of staff, King's Health Partners

Cite this as: *BMJ* 2025;390:r2016

REGULATION OF AI SCRIBES IN CLINICAL PRACTICE

Focus on the basics first

Shemtob and colleagues discuss artificial intelligence (AI) tools that transcribe consultations (Editorial, 28 June – 5 July). This feels like putting the cart before the horse.

Anyone working in the NHS is no stranger to poor IT infrastructure. I cannot imagine the computers we have, many of which struggle with Microsoft Word, coping with layered AI tools. Central London hospitals often have computers that work fairly well, but concentrating AI efforts there risks widening the infrastructure inequity between the capital and the rest of the country.

When I hear about the AI revolution in the NHS, I think of the computers that won't load, the systems that freeze, and the desks missing a mouse. We should stop wasting money on flashy tools and focus first on getting the basics right. When we have a nationwide, reliable NHS IT system across both primary and secondary care, we can start to indulge in future tech.

Yrina Ghrabigi, masters of public health student, London

Cite this as: *BMJ* 2025;390:r1968

Bloundary between admin and clinical work

Shemtob and colleagues flag the regulatory uncertainty around AI scribes. Yet new UK guidance treats transcription of GP consultations as administrative, separate from clinical work.

This framing neglects three interconnected areas. First, GPs think while they write, which helps them surface hunches, weigh alternatives, and negotiate risk. Second, the record is a clinical artefact whereby future clinicians, decision support systems, and others will act on what is captured (or omitted). Third, when AI models filter, summarise, or rephrase encounters, they shape current and downstream clinical reasoning.

Should AI enabled ambient scribes be regulated in the same way as other clinical decision support tools? What regulatory standards are needed to ensure human review of notes focuses on how they affect clinicians' thinking, not just whether the words are accurate? And how can AI systems provide clear audit trails?

Only by acknowledging that note taking bridges administrative routines and clinical reasoning can regulation ensure that AI scribes add value without compromising care.

Duncan J Reynolds, research associate, London

Cite this as: *BMJ* 2025;390:r1978

Keeping the human touch

AI scribes have the potential to transform clinical practice but must be accompanied by clarity in roles and responsibilities.

The gap between responsibility and capacity to oversee AI generated documentation is concerning. In TB care, for example, errors in documentation can delay diagnosis or compromise preventive treatment. If clinicians are expected to verify AI outputs without adequate time, training, or institutional support, benefits may become liabilities.

The discussion around cognitive over-reliance on AI is also important. In TB detection, clinical judgment, pattern recognition, and contextual understanding remain irreplaceable. Over-trusting AI systems in high pressure environments must not be underestimated.

Whether tackling TB in Indonesia or in broader health systems worldwide, AI tools must serve to enhance, not complicate, the human relationships at the core of healthcare.

Aulia Rizkia Herawati, medical doctor, masters student, London

Cite this as: *BMJ* 2025;390:r1999

Digital colonialism

The unchecked diffusion of AI scribes into low and middle income countries (LMICs) risks repeating patterns of digital colonialism, where technologies designed in high income contexts are introduced into different linguistic, legal, and clinical ecosystems, often with harmful consequences.

Digital health interventions intended to bridge infrastructure gaps have displaced local expertise or introduced inappropriate decision making frameworks. Without contextual adaptation or co-design, AI scribes risk delivering efficiency while disregarding cultural nuance, data sovereignty, or patient autonomy.

A global regulatory void persists. Many LMICs lack robust AI governance or medical device frameworks, allowing unvalidated models to escape scrutiny or be piloted where oversight is weakest. This echoes troubling precedents in pharmaceutical history. International collaboration is essential to avoid two tiered safety standards.

The solution is to embed global health equity into AI governance. Multilateral bodies such as WHO and international donors should support LMIC regulators to develop transparent evaluation protocols.

Kynthia Ravikumar, medical student, London

Cite this as: *BMJ* 2025;390:r2005

IMPACT OF RETRACTED TRIALS

Tackling the contamination chain of flawed evidence

Xu and colleagues quantify the impact of retracted clinical trials on systematic reviews and clinical practice guidelines (Research, 3-10 May). They also highlight a critical gap: the need to tackle contamination beyond formally retracted studies.

Clinical consequences can be profound. The Women's Health Initiative trial's initial misinterpretations—associating menopausal hormone therapy with breast cancer—led to dramatic worldwide declines in the use of hormone therapy, altering the health behaviours of millions of people before subsequent analyses clarified benefits in appropriate subgroups.

We propose four actions: strengthen systematic reviews and guideline methodology through mandatory disclosure of retracted studies and validated quality appraisal tools; implement automated alert systems linking citation databases with retraction tracking; require proactive reanalysis and correction of guidance based on flawed evidence; and educate clinicians to critically appraise emerging evidence and avoid overinterpreting exploratory findings.

We call on journals, publishers, and guideline developers to adopt these proactive safeguards.

Zeev Shoham, professor, Jerusalem; Rong Li, professor, Beijing; Tommaso Simoncini, professor, Pisa; Maria do Carmo Borges de Souza, adjunct professor, Rio de Janeiro; Gurkan Bozdag, professor, Ankara; Asher Bashiri, professor, Beer-Sheva

Cite this as: *BMJ* 2025;390:r2014

ANALYSIS

Delivering on the 10 year health plan for England

Members of the The BMJ Commission on the Future of the NHS consider the difficulties of implementing the health plan and what is needed for success

The 10 year health plan for England[1] isn't so much a plan as an ambition. Setting a view for a reshaped NHS through the lens of three shifts, its 168 pages are full of ideas. Many are interesting and sometimes exciting, but the quality of the evidence behind them is variable and some ideas have been tried before and are being presented again under a different guise.[2] To date there is little articulation in the plan of how these changes will actually happen: a clear theory of change is notably lacking,[3] and a delivery chapter was reported to have been omitted.[4] Also striking is some rather technocratic, top-down, and paternalistic thinking that does not sufficiently recognise the importance of those who use and work in the NHS having agency—a sense of control and ability to make choices that will be so critical to actually making things happen.[5]

What is clear is that many tensions and contradictions need to be addressed

KEY MESSAGES

- The government's 10 year plan gives few details on how it will be achieved
- Delivery of the plan should focus on the top priorities, ideally in ways that engage patients, the public, and the workforce in determining them
- How the many ambitious goals of the plan will be delivered and financed has to be addressed, and a clear theory of change needs to be developed and consistently applied
- Implementation should not be about politicians, but about the millions of people inside and outside the NHS who, if they feel agency to act, are best placed to make things improve
- Wider structural determinants of health are crucial to success, and we need a strategically led, committed, cross sector approach to tackling them

Neighbourhood health and shift from hospital to community

Central to the new plan are bold aims to move care from hospitals to the community. Although the aspiration seems right for many well described reasons, the strikingly confident expectation that the shift to the community will save money is unsupported by evidence[6] and fraught with logistical complexity. Clarity on resourcing is critically important, but the plan lacks operational detail on funding flows.

One basic problem is that relocating care will, of necessity, quickly run into the realities of the current configuration and state of NHS estates, including the limitations of primary care buildings and facilities. Nor is it clear how some of the time of the current workforce employed in hospitals will be moved to and managed in the community. It is not safe to close hospital provision before alternatives are built and operational, yet the "double running" required to move hospital care into the community, and to provide estate, is not accounted for.

This shift provides an opportunity to think differently about how people in the NHS work in a more connected way across the wide interface between primary and secondary care.[7,8] Encouragingly, the recent invitation to integrated care boards, primary care, and local authorities to get involved in the national neighbourhood health implementation programme recognises the need for shifts in culture, allocation, and ways of working.[9] The response to this invitation has been positive, but little of it is likely to be easy.

What is clear is that many tensions and contradictions need to be addressed. One of these relates to how to get the best out of practice level autonomy at the same time as enabling wider scale collaborative arrangements. Although the plan accepts that when traditional general practitioner GP partnerships are working well they should continue, and that the number of GPs in training should be increased, it also proposes a model (supported by new contracts) of GPs working over larger areas covering 50 000 or more people and convening teams of professionals.

In ordinary language, a neighbourhood is somewhere you can walk around and that has been traditionally served by a general practice. The plan, however, seems predicated on large conurbations. The commitment to "bringing back the family doctor" may mean little if such a role cannot be accommodated in a model where the emphasis is on supply of interchangeable appointments rather than longitudinal relationships. At 50 000 or more people, the scale

of neighbourhoods risks making care more remote and difficult to access, especially for those more disadvantaged (for example, in terms of transport and mobility) and those in more rural areas.[10]

With the contracts for neighbourhood level providers potentially held by hospital trusts (vertical integration) or by federations of general practices (horizontal integration), managing the impact on access, fragmentation, and patient centred care must be a priority. Given the overwhelming evidence that, where adequately resourced, continuity of care with a GP saves money and lives,[11] these new approaches will need rigorous co-design, planning, and evaluation.

Shift from analogue to digital

Envisaging the NHS as a future global leader in technology, the plan features an energetic chapter on digital technologies and data. For patients and the public, the NHS App is reimagined as a "doctor in their pocket," to provide 24/7 advice and guidance and be the front door to the NHS, including communicating with clinicians and specialists. "My choices" will offer patients the ability to shop around for providers with best outcomes, but for many patients the priority is likely to remain having a local provider rather than travelling around the country for an operation. The new single patient record is welcome, if it truly can ensure that patient information derived from different providers is meaningfully available to any clinician. Again, the technological logistics of how these potentially exciting developments will be achieved from the current fragmented starting position remain unclear. Even less clear is how it will all be funded.

Equity and digital inclusion are also not sufficiently addressed. The plan describes how people who have not been able to access and use healthcare on their own terms will, through digital technology, be enabled. But the positioning of the NHS App as the "single front door," where genomics data and insights from wearables define care, and where AI algorithms do the triage, is, as others have pointed out, a long way from what is needed to make a digital-by-default health service equitable.[12]

For NHS staff, the plan envisages AI freeing up clinician time through task automation, generating care plans, supporting clinical documentation (eg, through ambient voice technology), and supporting clinical decision making. Many clinicians are already enthusiastic about such technologies, but the purported productivity gains may be optimistic given the current mixed evidence.[13]

Similarly, the plan rightly assumes that better data (eg, on outcomes) is essential, and that new digital tools, and the processes that sit behind them, will have a key role in driving improvements to quality, but it says nothing about either the workforce or the digital infrastructure that is needed to implement these ideas. The investments needed in people and infrastructure, linked to the benefits that will actually be realised, need to be more rationally and specifically articulated.

Shift from sickness to prevention

The plan's measures to improve vaccination uptake, support a smoke-free generation, take a "moonshot" at obesity, expand free school meals, and reinvigorate Healthy Start are genuine aspirations to move the NHS beyond being just a repair shop. There are, however, missed opportunities around food pricing and alcohol regulation, where England could have emulated the success of minimum unit pricing in Scotland.[14] Evidence shows that some of the most important achievements on prevention in recent history have their origins in law and regulation—for example, the ban of smoking in public spaces—while others are policy led, such as the NHS diabetes prevention programme. Clarification of which initiatives in the plan will be universal, which will be targeted, and which will opportunistically make every contact count will enable the NHS to ensure that prevention and health creation have adequate priority, money, and workforce to deliver them. Preserving a focus on prevention is clearly difficult when general practices and hospital emergency departments are overwhelmed with demand. How this aspect of the plan survives contact with reality is a key question.

Shifting beyond prevention and into health creation also seems like a key opportunity. There are thousands of people living and working in communities who could make an enormous difference to creation and maintenance of health with only a little support and encouragement.[15]

Greater focus on quality

The prime minister's foreword emphasises the principle that all people deserve the same quality treatment. However, variations in quality and outcomes of care have been remarkably persistent since the founding of the NHS.[16] The plan doesn't offer much new on how to address this. It discusses the data—fashioned from metrics like length of wait, patient reported outcomes, and experience. However, it does not adequately acknowledge that collecting, reporting, and analysing data, and making them the basis of improvement, is an expensive and skilled endeavour.[17] To work, this strategy requires not only substantial funding and a recognition of the opportunity costs; it also has to be based on a sound theory of change, given the evidence that audit and feedback often shift the dial only a little.[18] In its use of incentives (both reputational, like league tables, and financial), the plan again revives some 2000s-era performance management thinking [19] with added prominence given to patient ratings. Nevertheless, it does not consider the evidence that important unintended consequences tend to follow even the most well intentioned schemes of this nature.[20]

The hope seems to be that implementing a rules based system, with earnt autonomy, run by a smaller "centre" that pushes power out to different types of providers, will achieve what is needed. If that is the case, that perhaps misses an understanding of the human psychology of change[21] and the things that motivate people. Health and care are all about people—relationships, trust, compassion, and professionalism—yet the plan is dominated by rather outdated economic thinking and financial incentives. If health professionals are motivated and feel they are achieving something, they will bring enormous energy and passion to their work—going that extra mile that money can't buy.

The proposal to refresh and renew the National Quality Board makes a lot of sense, particularly if it can rationalise "priority thickets" (multiple, densely packed goals that may compete, conflict, or fail to cohere). These priority thickets result from having a large number of bodies and agencies without sufficient coordination,[22] and overwhelm the system and undermine the strategic focus of organisations. Crucial to the success of this approach, however, will be finding ways of identifying the priorities. These should be both evidence based and co-designed with clinicians, patients, and other stakeholders—and cannot be simply imposed from above.[23]

Also crucial will be the development of a clear strategy for improvement and the design and operation of the mooted regional improvement fund. The evidence on what works in improvement is still evolving.[24] Some things are reasonably clear, however, and include the role of interorganisational collaboration, the importance of psychological safety for high performing teams, the value of high quality operations, people management, and infrastructures for designing and testing solutions with patients and staff.[25] Given this evidence, there are good reasons to be cautious about what currently sounds like a rather top-down and potentially punitive approach.

Patient and public voice and agency

Various commentators have pointed out that the plan contains many ideas, and it can be hard to see how they all connect in a logical way. Nowhere is this more apparent than in the arguments about patient and public choice, voice, and agency.

On the one hand, the elevation of patient experience and outcomes to the ultimate measure of quality is welcome. Healthcare only works if it works for the people who need it. In this vein, it is great to see a commitment to bringing patient experience, accountability, and leadership to the highest level of the Department of Health and Social Care. A move to collect data about experiences and outcomes more routinely is also positive, and the NHS App is a good vehicle to make this happen. As ever, the trick will be not just to measure “customer satisfaction” (eg, was my experience punctual, hygienic, and kind?), but also real health and self-care outcomes (eg, do I know what I need to do now, do I know who is in charge of my care, do I know what to do if I get worse?).

The plan downgrades the role of the community sector in curating, highlighting, and channelling people’s experiences

Worryingly, the plan downgrades the role of the community sector in curating, highlighting, and channelling people’s experiences. The abolition of Healthwatch is a concerning decision that risks setting back, yet again, the systematisation of community insight both locally and nationally.

In addition, many people will not give feedback on their care through the NHS App, particularly those who are already marginalised. An overly generic, numbers driven approach to insight gathering will not work for harder questions. For example, the experience of people with long covid where clinics have closed or never been properly established, or for people living with severe mental illness who miss out on physical healthcare. For the system and its leaders to hear these important insights, you need people who feel passionately about making life better for their communities to ask questions, listen hard to people’s experiences, and campaign for them to be heard.

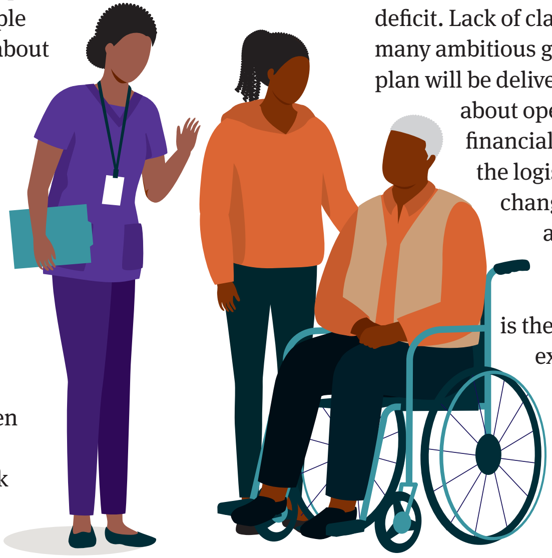
If amplifying tougher experiences makes politicians and system leaders uncomfortable, it is even more reason to do it. The plan seems to think of people solely as individual consumers, choosing care providers by interrogating league tables, and not as members of communities who can hold and support each other, including by arguing that they should be actively involved in the design and delivery of services.

It will be incumbent upon those of us rooted in community activism, as we move to implementation, to use the genuinely positive aspects of the plan to strengthen its understanding of collective approaches to improving health and healthcare.

What needs to happen now

History can be instructive. Just over 25 years ago, on 1 July 2000, the last Labour government published its NHS plan.[26,27] The 200 or so targets for improvement were ruthlessly prioritised after publication, and some were quietly dropped over time. The delivery of the 10 year plan will similarly benefit from being focused on the top priorities, ideally in ways that engage patients, the public, and the workforce in determining them.

Second, a critically important feature of the 2000 plan was its implementation. Numerous NHS leaders at all levels bought into it and made it happen. Clear accountability for actions and outcomes was critical—but so too was a large injection of cash. All these things are more difficult now. There is some new money, but NHS organisations are under great financial pressure, linked to a serious infrastructure deficit. Lack of clarity about how the many ambitious goals of the 10 year plan will be delivered and financed, about operating models and financial flows, and about the logistics of achieving change, all need to be addressed.



Also important this time round is the somewhat exhausted and demoralised workforce,[28] including many people whose jobs are at risk. Compounding this, the plan is dominated by expressions like “We will” and “We will ensure that.” Much more can be achieved by recognising that implementation should not be about politicians, but about the millions of people inside and outside the NHS who, if they feel agency to act, can actually make things improve. These community actors, health creators, and service users, and the many motivated staff starting their journeys in the NHS should give us hope for the future. The NHS needs to co-create the future with them, through building agency and real change. The evidence suggests that if we invest the marginal cost of listening and co-design to give citizens and communities agency as we work with them around prevention and give NHS staff agency as we interact with them around change, we can achieve disproportionately big things.[5]

Finally, the focus needs to step up on health inequalities. There is surprisingly little in the plan on this and exactly how the plan will help achieve the government’s key mission to halve the healthy life expectancy gap between England’s richest and poorest regions. Tackling inequities will go far beyond the NHS and indeed way beyond the health sector. There can be no doubt about the importance of the wider structural determinants of health,[29,30] and accordingly of the need for a strategically led, committed, cross sector approach to tackling them.

Bob Klaber, director of strategy, Imperial College Healthcare NHS Trust, London, UK
bob.klaber@nhs.net

Mary Dixon-Woods, director, THIS Institute, University of Cambridge, Cambridge, UK

Charlotte Augst, non-executive director, Innovation Unit, UK

Helen Salisbury, honorary researcher, University of Oxford Nuffield Department of Primary Care Health Sciences, Oxford, UK

Kiran Patel, chief medical officer, University Hospitals Birmingham NHS Foundation Trust, UK

Chaand Nagpaul, general practitioner partner, London, UK

Nigel Crisp, member, House of Lords, London, UK, on behalf of the BMJ Commission on the Future of the NHS

Cite this as: *BMJ* 2025;390:r1980

ACUTE PERSPECTIVE David Oliver

League tables are no solution to the problems in NHS hospitals

On 9 September NHS England published its first quarterly league tables of NHS provider trusts' performance, as promised in the NHS 10 year plan. There are scores, tables, and rankings covering specialised and general acute hospital trusts, as well as community healthcare, ambulance, and mental health and learning disability trusts. All trusts have been allocated a segment—from 1 for the best performing trusts down to 4 for the worst—and have an overall ranking in the table. The higher performers have the lowest overall score, with 1.0 the lowest and 4.0 the highest possible.

Only a fifth of general acute trusts are in segment 1 or 2, as opposed to two thirds of specialised acute trusts. Trusts of all types have seen a big fall in the numbers rated highly since previous versions of the NHS oversight framework. A big reason for this is that any trust in financial deficit can't be any higher than segment 3, no matter how well it does on all other performance domains—which immediately puts several excellent providers well down the table despite "good" ratings from the Care Quality Commission (CQC) and high patient and staff satisfaction. This makes the table look like a governmental instrument of control and blame rather than a sincere attempt to help the public understand the quality of care and access to services in their local area.

In acute trusts, the metrics used to construct the league table fall under six domains: waiting time metrics for elective care, cancer referral and treatment, and urgent care; effectiveness and experience of care (including the results of the CQC's inpatient satisfaction survey); patient safety (including the CQC's safe inspection score); workforce wellbeing and engagement (including satisfaction scores from the national education and training survey); finance and productivity; and improving health and reducing inequality (including elective waiting list growth for under 18s). There are separate metrics for other types of trusts and for integrated care boards.

Hospitals that struggle often do so because of where they are

Open to scrutiny

So, is any of this problematic? I have no personal objection to the metrics used to construct the table, and they're nearly all well established, routinely collected data points. Plenty of other measures are missing, but the burden of additional data collection and reporting could become overwhelming and distracting. And at least there's a nod to patient and staff experience, not just access and waiting times.

But other authors have made technical critiques of how the data are weighted and aggregated, saying that the process and rankings are "not robust, meaningful or fair." And the methods used to calculate changes in "productivity" over time are opaque and hard to trust as a single point of truth. NHS England seemingly wants a single accepted dataset, not arguments about its validity. The health secretary, Wes Streeting, has dismissed expert health policy think tanks for "elitist nonsense" in caveating the data. But the methods should surely be as open to scrutiny as he wants NHS care providers to be.

There's also no attempt to contextualise performance indicators in relation to the demographics, broader inequalities, or urban-versus-rural nature of local catchment areas. Hospitals that struggle often do so because of where they are. Trusts can find it hard to attract staff to that area because of geography or housing costs, competing employers, or primary and community health services. Indeed, if we look at the percentage of hospitals in each tier by region, the differences are stark. Context matters as a reason for variation—not a "get out of jail" excuse. And hospitals sit in wider local health and social care systems involving numerous agencies, which is perhaps where the performance focus should sit.

Comparing general hospitals with very specialised tertiary providers, which stick to limited lines of service and often don't provide urgent or emergency care, is also deeply unhelpful and gives more heat than light.

Undermining goodwill

We should also ask what the new look league tables are actually for. Plenty of performance data and regulatory ratings were already in the public domain. Any evidence that merely naming and shaming poorer performers—or putting them into some punitive central "performance regime" or threatening executives' jobs—will magically help them to improve is lacking. Indeed, it could further worsen morale, hamper recruitment and retention, and undermine goodwill from the local population.

The argument that this bright new transparency initiative will help patients choose the service they want is a mirage. Most people in England have a maximum of one or two trusts that they use for acute, community, or elective care, as well as one regional tertiary centre. They won't be shopping for care providers.

Finally, these league tables risk recreating a phenomenon seen repeatedly in recent decades: managers being driven to hit certain performance metrics at the expense of all other priorities. Avoiding such distortion was a key lesson of the Mid Staffordshire public inquiry. The former health secretary Jeremy Hunt argued this in a recent article and said that the league tables placed far less emphasis on patient safety than CQC reports.

Given that the league tables will be in place for at least the rest of this parliament, perhaps the best we can do is use any insights and comparisons of similar providers to focus our approaches on local improvement.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com

Cite this as: *BMJ* 2025;391:r2060

EDITORIAL

Bearing witness to genocide

Medical community must play its part in ending atrocities

In 2000, *JAMA* published a commentary by Willis and Levy calling for action to ensure recognition of the public health impact of genocide.[1] The genocide it was reflecting on was in Rwanda, where over the course of roughly 100 days, between 800 000 and one million people, predominantly ethnic Tutsis, were killed by Hutu extremists.[2]

The commentary challenged the notion of medical neutrality and claimed an important role for the medical and public health community in educating the public and policy makers and engaging in advocacy to prevent and stop genocide. Yet a quarter of a century later, we have not been able to prevent or stop the genocide unfolding now in Gaza.

On 16 September 2025, an independent commission operating under the Office of the UN High Commissioner for Human Rights released a report describing the legal framework for determining that a genocide was occurring and finding sufficient evidence that one was happening in Gaza.[3] The report draws on data from UN agencies, news sources, social media, court cases, and non-governmental organisation reports.

The commission's report found that Israel's military offensive in Gaza has resulted in several generations of Palestinian families being killed and that Israeli government blockades of humanitarian aid —including medicines, medical equipment, and food—have contributed to the deaths of more than 60 000 Palestinians, nearly half of whom were women and children. Life expectancy in Gaza decreased from 75.5 to 40.5 years during the first year of the war.[4]

These are just the some of the "factual findings" in the first two sections of the commission's report. Two more sections follow, related to "deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part" and "imposing measures intended to prevent births within the group."

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Fear of speaking out and being seen as partisan persists

Joseph J Amon, Desmond M Tutu professor of health and human rights
joe.amon@jhu.edu
Shatha Elnakib, assistant research professor, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

In reflecting on the Rwandan genocide, Willis and Levy exhort the medical and public health community to document genocide, quantify its public health impact, analyse risk factors and precursors that may lead to genocide, educate others, and conduct advocacy. These are important actions, and since October 2023 many medical and public health professionals have taken some of those steps. But the vision of Willis and Levy is nowhere to be seen.

The reason is simple: the medical and public health community faces the same problems as the public in understanding what constitutes evidence of genocide and how to advocate and press for intervention. One factor is denial. Those responsible for a genocide do not readily admit to their plans. Their allies support their denials. Declassified documents show that US, French, and Belgian officials knew that a genocide was occurring in Rwanda and avoided taking action.[6]

Another factor is intimidation. Healthcare workers treating victims of genocide who speak out may themselves be targeted. Almost 1800 health workers have been killed by Israeli military forces since the start of the conflict.[7] Hundreds more have been detained.[8] Speaking out about genocide in Gaza has led to charges of antisemitism, violent disruption of protests, and restriction of free speech, doxing, and even the politicisation of peer review in public health journals.[9]

Effective action

Responding to the disasters of war, physicians founded the International Committee of the Red Cross (ICRC) in 1863 and advocated for governments to adopt the first Geneva Convention.[10] But fear of speaking out and being seen as partisan persisted.

On Gaza, many medical professionals and professional bodies have kept quiet.[12] So what should our community do in the face of genocide? First, we bear witness: we document abuse, offer testimony, and speak out, issuing clear public statements that condemn violence and call for its cessation. We deploy the tools of our trade—statistics, models, data—to dispassionately quantify the scale of harm inflicted, and we centre and amplify the voices of those affected.

Second, we sharpen our collaborations. Although the medical and public health communities have authority and often respect, our voice alone is insufficient in preventing or stopping genocide. To be effective, we must couple our medical and public health expertise with alliances with human rights organisations, legal experts, grassroots activists, and affected communities. Only then can we overcome the political inertia that hampers the translation of evidence into action.

Medical-legal partnerships are critical in influencing global leaders to intervene, and through international courts, to ensure accountability and justice are realised.

Cite this as: *BMJ* 2025;391:r2101

Find the full version with references at http://dx.doi.org/10.1136/bmj.r2101