GPs warn online access rules are unsafe

The BMA has entered into formal dispute with ministers over new online consultation rules, warning that the volume of requests received by GPs is unsustainable and unsafe.

As of 1 October all general practices in England are required to keep online consultation tools open from 8 am to 6.30 pm, Monday to Friday. The government says this will free up phone lines and "end the 8 am scramble" for appointments. But the BMA warned of a barrage of urgent and non-urgent online consultation requests, with no additional staff to manage the extra activity, which could lead to potentially serious and life threatening problems being delayed or missed entirely.

Katie Bramall, chair of the BMA's General Practice Committee in England, said, "Despite repeated warnings of the potentially significant risks, the government has refused to act over GPs' concerns for patient safety.

Steve Taylor, GP co-lead at the Doctors' Association UK, said surgeries risked being stretched to breaking point. Speaking on Sky News, he said, "On the face of it, online access sounds brilliant. But if a message comes through at 6.15 pm, someone has to action it. In a small practice like mine, that means staff staying late with no safeguards.

"The reality is there aren't more GPs—there aren't more appointments."

Taylor also accused the Department of Health and Social Care of "gaslighting" GPs by posting on X an image of the rapper Drake looking distressed about calling a GP at 8 am and then happy about being able to request an appointment at any time. Taylor posted, "This is out of the playbook Trump might use. I am appalled @Wes Streeting, this is not acceptable."

The DHSC was approached for comment.

NHS England data show that more than 96% of practices in England have at least one online consultation system, and in August there were 5.1 million online submissions, an average of 88.9 per 1000 patients.

Oxford GP Helen Salisbury told *The BMJ*, "Our patients are already able to book appointments online: this change has allowed them to submit all manner of other queries to us throughout the day. We have to read them all in case there is something medically urgent. This has resulted in us replacing face-to-face appointments with admin slots for doctors to deal with whatever has come in online."

▶ HELEN SALISBURY, page 27

Jacqui Wise Kent

Cite this as: *BMJ* 2025;391:r2083

GPs Katie Bramall (left), Helen Salisbury, and Steve Taylor have warned the government that online consultation rules will endanger patients

LATEST ONLINE

- Covid-19: Lack of surveillance leaves UK in dark as hospital admissions rise, experts warn
- Trump launches website to help Americans buy cheaper drugs, with Pfizer signing up
- Lecanamab: Alzheimer's drug is approved by Australian drugs regulator after two rejections

MEDICAL NEWS

NHS ONLINE HOSPITAL: **Leaders question where money and staff will come from**

MARK THOMAS

Patients in England will be able to see specialists through an NHS "online hospital" from 2027, the prime minister has said. Keir Starmer said the service would improve patient access and cut NHS waiting lists.

In theory, the service will enable patients to make digital appointments with clinicians throughout the country. Patients needing a scan, test, or procedure can then book these at their local community diagnostic centre or hospital.

NHS England said the service would initially focus on a small number of treatments but estimates the service will deliver the "equivalent of up to 8.5 million appointments and assessments in its first three years—four times more than an average trust."

But health leaders have queried how it will be funded and staffed. The BMA's chair of council, Tom Dolphin, said that doctors were keen to cut waiting lists but added, "We are told that there will be dedicated doctors assigned to this service. We're keen to find out where this extra staffing is going to be sourced from. Doctors are already flat out across the NHS, and there is little spare capacity to go around."

Dolphin also raised concern about groups of patients who "risk being excluded from this digital service," such as older or disabled people and those with limited English or without internet access.

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2025;390:r2058

AI

Commission will "accelerate" use in NHS

A government commission has been launched to accelerate use of artificial intelligence across the NHS. It promises to "immediately review tech that's being held back by regulatory uncertainty," such as AI note taking assistants and tools for radiology and remote monitoring. Interim guidance is expected soon, with a full regulatory "rule book" due in 2026 to supersede the current guidelines. Liz Kendall (below), science and technology secretary, said, "AI has incredible potential to help doctors spot and treat diseases earlier. But we need experts to come together so patients can benefit from these opportunities quickly and safely."

Respiratory viruses

UKHSA starts winter vaccination drive

The UK Health Security Agency is urging eligible groups to come forward for flu, SARS-CoV-2, and RSV vaccines ahead of winter. A national campaign highlights the risks of serious illness. For the first time toddlers can receive the flu nasal spray (below) in community pharmacies. National surveillance figures showed that flu and covid-19 cases had been steadily increasing for several weeks. The UKHSA said that covid-19 positivity had risen from 7.6% to 8.4% in a week, and hospital admissions for covid-19 rose from 2.00 to 2.73 in 100 000 people.

Asthma

Combination inhaler "cuts risk of attacks in children"

A two-in-one inhaler treatment is more effective than salbutamol for preventing asthma attacks in children aged 5-15 and is similarly safe, a randomised controlled trial published in the *Lancet* found. A combined treatment of the inhaled corticosteroid budesonide and the fast acting bronchodilator formoterol reduced children's asthma attacks by an average of 45% more than the commonly used salbutamol inhaler, the study found. Experts said that the results could prompt a change in UK clinical practice.

GP surgeries

Premises in England are "not fit for purpose"

A BMA survey of almost 2000 GPs and practice managers revealed widespread concern about the physical state of surgeries in England. Participating practices reported problems such as mould growing in waiting rooms, cracked walls in treatment rooms, and inadequate space for staff to work in. Only half of respondents (50%) said that their premises were suitable for present use, while 83% believed that their surgery couldn't meet future demand. Over 80% of respondents reported not having enough space for additional staff.

A&E

Over 800 deaths in Scotland linked to long waits

Excess deaths in Scotland linked to delays in admission to an emergency department increased by a third last year, showed an analysis by the Royal College of Emergency Medicine (RCEM). The college estimated that a total of 818 deaths in 2024, averaging 16 a week, were associated with long waits for emergency care. Fiona Hunter, vice president of RCEM Scotland, said, "The fact that the deaths of more than 800 patients have been lost due to a system in crisis is a national tragedy. These are patients who are sick and need further care on a ward."

Coroner's report

Hospital maintenance "contributed to death"

A coroner has warned of risks associated with NHS building maintenance after a patient died after being moved from a main hospital unit for care. Gareth Johnson, 41, died at University Hospital of Wales on 16 October 2024 because of complications from a catheter directed thrombolysis procedure. A prevention of future deaths report from Kerrie Burge, coroner for South Wales Central, said that Johnson had received "suboptimal" postoperative drug management partly because he was cared for outside the main hospital unit. This had "more than minimally, negligibly, or trivially contributed to Johnson's death," the coroner concluded.

IN BRIEF

Puberty blockers

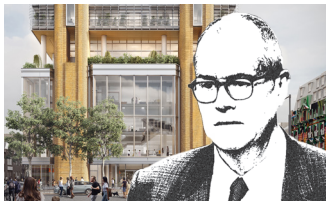
Planned trial shouldn't proceed, say experts

Experts argued that a planned clinical trial to assess the safety of puberty blockers in children posed too many ethical and methodological problems to proceed. At a webinar organised by the Clinical Advisory Network on Sex and Gender (CAN-SG), speakers said the proposed Pathways trial—currently undergoing ethical assessment—should not be approved. But Hilary Cass, who led a landmark review for the NHS into gender identity services, told *The BMJ* that the trial, which is running behind schedule, was still justified.

A planned trial to assess the safety of puberty blockers for children should be abandoned, say experts

Drug pricing

Rises are "necessary" to bring back investment



The science minister Patrick Vallance admitted that the price paid by the NHS for drugs would have to rise to win back industry investment. He added that demands from Donald Trump for international drug price parity were a "big factor" in the dispute. When the US drug giant Merck halted construction on its £1bn London research centre earlier this month it became the latest company to cancel investment in the UK.

Doctor unemployment

First year doctors in England vote to strike

First year resident doctors in England (FY1s) voted resoundingly for strike action over a shortage of jobs. The ballot, which closed at midday on 6 October, saw 97% of resident doctors (3950 of 4057) who voted backing strike action on a turnout of 65%, giving them a mandate for industrial action alongside the linked dispute over eroded pay. Although no strikes are currently planned, the BMA said that ongoing talks with the government would now have to produce a solution on jobs as well as on pay erosion.

Public health

Ban on "buy one, get one free" supermarket deals

The government has banned "buy one, get one free" promotions on unhealthy food and drink in England. The ban, which applies to supermarkets, large businesses, and online retailers, also stops restaurants from offering free drink refills of certain products. The long delayed ban is being implemented three years after originally scheduled. Campaigners welcomed the move but are frustrated that a 9 pm TV watershed on advertising unhealthy food and drink, also due to begin this month, has been pushed back to 2026.

Palantir

King's Fund is urged to cut ties with tech giant

More than 700 health professionals and campaigners urged the King's Fund to cut sponsorship ties with Palantir, a US technology company which works with the Israeli military, the Pentagon, and the NHS. The King's Fund said it would review its ties in line with its usual processes. Palantir defended its record.

Cite this as: *BMJ* 2025;391:r2097

CANCER

Annual cancer deaths worldwide are set to rise to **18.6** million in 2050 without urgent action and targeted funding *[Lancet]*

SIXTY SECONDS ON . . . **PROTEIN BARS**

WHAT ARE PROTEIN BARS?

Big business. The global market is worth billions and UK shelves are stacked high. They've hit the headlines after fitness influencer Joe Wicks (below) and ultraprocessed food warrior Chris van Tulleken cooked up a deliberately unhealthy protein bar—"Killer"—to expose the "health halo" that surrounds them. While being marketed as fitness fuel, most bars are in fact ultraprocessed confections packed with sugar, fat, salt, and additives.

ISN'T THIS A BIT OVER THE TOP?

Not really. After the US, the UK is the leading consumer of ultraprocessed food, and research links it to up to 14% of premature deaths in England. And a quarter of British children live with overweight or obesity. Meanwhile, food labelling laws remain flabby, giving shoppers little guidance on what they're biting into.

HOW FAR DID THE FAKE BAR GO?

All the way to the junk aisle. Only one (cacao) of its 96 approved ingredients would be recognisable from your kitchen cupboard. The rest were "bowl after bowl of white powders," van Tulleken said. They included glycerol (found in slushie drinks; in excess, it can intoxicate children), maltodextrin (linked to gut inflammation), maltitol (a sugar alcohol giving bulk that can cause diarrhoea if eaten in large quantities), and aspartame (which WHO classifies as a carcinogen). But, with 19 g of protein, 27 vitamins and minerals, and more than 200 nutritional benefits, the bar can also claim to be healthy, exposing the absurdity of labelling standards.

WHY LAUNCH SUCH A STUNT?

To show how it's possible to create an unhealthy product, full of junk, and sell it as a health food. Van Tulleken and Wicks are calling for the UK to follow Chile's lead and introduce clear front-of-pack warning labels and ban marketing to children of any products that carry warnings.

BUT WE HAVE A TRAFFIC LIGHT SYSTEM

Yes, but it's more misleading than illuminating. A can of Coke, for example, has three green lights—positively saintly. And while new high fat, salt, and sugar marketing limits will come in next year, this protein bar slips through the net. Proof, say campaigners, that the system needs a serious workout.

Rebecca Coombes, *The BMJ*

Cite this as: *BMJ* 2025;391:r2111

HUNTINGTON'S DISEASE
Gene therapy explained

What has happened?

On 24 September the US biotech company uniQure announced results from its phase 1/2 study of AMT-130, a gene therapy for Huntington's disease. The treatment showed a statistically significant 75% slowing of disease progression at 36 months.

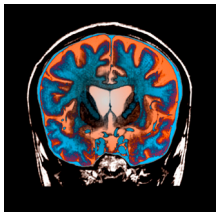
The results were announced in a press release, and the full study data have yet to be peer reviewed and published.

If confirmed, the treatment would be the first disease modifying therapy for Huntington's, a fatal inherited neurological disorder that typically leads to complete disability, with median survival of 24 years from diagnosis. Around 75 000 people in the US, EU, and UK have the disease.

What is AMT-130?

It's a gene therapy delivered directly into the brain through a single neurosurgical procedure. MRI guided surgery is used to administer the treatment in the caudate and putamen. The therapy consists of an adenoassociated viral vector, which delivers genetic material to cut production of the toxic huntington protein responsible for the disease.

What were the results?



Patients showed slower cognitive decline on standard neuropsychological tests. This included an 88% slowing of disease progression in processing speed and a 113% slowing in reading ability compared with the control group.

Most significantly, cerebrospinal fluid concentrations of neurofilament light protein—a marker for neurodegeneration—were reduced by 8.2% below baseline at 36 months. This indicates the therapy may actively protect brain cells from damage rather than simply masking symptoms.

What are the limitations?

The study included only 29 treated patients, with just 12 receiving a high dose therapy evaluated at 36 months. The study also used external controls from natural history databases rather than a concurrent placebo group. Long term efficacy beyond three years also remains unknown.

How does this compare to current practice?

Currently, no treatments exist to slow progression of Huntington's as available therapies only manage symptoms.

What are the next steps?

The company plans to submit a biologicals licence application to US regulators in early 2026, with potential approval that year. In the US it has received breakthrough designation, potentially accelerating review timelines. The European Medicines Agency may require a further trial.

Like other gene therapies, however, the cost is likely to be substantial, possibly exceeding £1m per treatment.

Yemisi Bokinni, London Cite this as: *BMJ* 2025;390:r2029

NHS removes blog on first cousin marriage—but expert says it was factually based

NHS England has removed an article on the subject of first cousin marriage after a public backlash.

A blog published by NHS England's Genomics Education Programme said marriage between first cousins had "various potential benefits," while acknowledging that children of first cousins had an increased chance of being born with a genetic condition.

The blog was removed after criticism, including from Richard Holden, the Conservative MP who has proposed changing UK law to outlaw marriage between first cousins (consanguinity). NHS England said it withdrew the article because it had been published by mistake. It said it was intended for informational and educational purposes and did not represent NHS policy or professional medical advice.

But Sam Oddie, professor and consultant neonatologist at Bradford Teaching Hospitals, who was quoted in the blog, said its content was "extremely uncontentious" and "very substantially factually based" and he did not know why it had been pulled.

"I don't consider that any of the comments that have been made in response to it in the media are in any way reasonable or grounded in fact," Oddie told *The BMJ*.

The private member's bill proposed by Holden, due for its second reading in the House of Commons on 31 October, argues that first cousin marriages significantly increase the

Doctors may have to do volunteer work under new migration rules

Medical leaders are urging ministers to exempt overseas trained NHS doctors from having to do voluntary work as part of new rules designed to reduce net migration.

Last week the government announced proposals for a new contribution based settlement model that includes conditions to gain indefinite leave to remain (ILR) in the UK. Proposed conditions include being in work, making a certain level of national insurance contributions, not taking benefit, learning English to a high standard, having a spotless criminal record, and "giving back" through means such as voluntary work in their local community.

In addition, the standard qualifying period for permanent residence will rise from five years to 10, although some people will be able to qualify earlier.

A Home Office statement did not rule out overseas doctors having to carry out community work, instead it stated it would consult on the changes later this year.

Currently, around a third (57 000) of the 148 000 doctors working in the NHS in England are non-UK nationals.

PROPOSED CONDITIONS INCLUDE "GIVING BACK" THROUGH MEANS SUCH AS VOLUNTARY WORK

BMA council chair Tom Dolphin told *The BMJ* he was concerned the move could deter doctors from coming to work in the UK and be unfair to those already working in the NHS. He said, "We would strongly oppose any suggestion a doctor offering their skills and expertise to the NHS and public services would have to further demonstrate their commitment. Doctors are already stretching themselves so thinly that they are burning out."

Amit Sinha, president of the British International Doctors Association, said, "Working in the NHS is in itself a way of contributing to society's welfare."

Adrian O'Dowd, Kent Cite this as: *BMJ* 2025;391:r2090

THE RISK of children having a genetic condition was around 2-3% in the general population and 4-6% in children of first cousins

risk of health consequences such as cerebral palsy, cystic fibrosis, and increased susceptibility to cancer, hepatitis, birth defects, and cardiovascular conditions.

The NHS blog noted that more babies were born with certain genetic conditions in Bradford—an area with a large British Pakistani population in which first cousin marriage was "fairly common"—than in other areas of the UK. However, it quoted some experts who argued it was an oversimplification to say this was entirely due to first cousin marriage.

In the blog Oddie noted that the cause of certain genetic conditions could be endogamy, where people marry within the limits of their close community but not necessarily to blood relatives. Even if exact family ties cannot be traced, certain genetic variants will occur more often in a tight knit community, leading to a higher chance of both parents having the same affected gene.

The blog added that, although first cousin marriage was linked to a higher risk of a child having a genetic condition, other factors also increased this chance, such as parental age, smoking, alcohol, and assisted reproductive technologies—none of which were banned in the UK. It also noted that the risk of children having a genetic condition was around 2-3% in the general population and 4-6% in children of first cousins.

The British Society for Genetic Medicine said it is unjustified to cite health as a reason to ban first cousin marriage and that focusing on cousin marriage in this way stigmatised certain communities and undermined trust in medical services.

I don't consider the comments in response to the blog are reasonable or grounded in fact Sam Oddie

But Holden argued that first cousin marriage "is hugely damaging to individual freedom and women's rights and has massive health implications."

A spokesperson for NHS England said, "This article should not have been published. The NHS recognises the scientific evidence that there can be increased risk of children having certain conditions when parents are consanguineous, and the health service seeks to advise and inform patients of these risks in a respectful way."

Adrian O'Dowd, Kent

Cite this as: *BMJ* 2025;391:r2061

SEXUAL MISCONDUCT OF DOCTORS: **New tribunal guidance is welcomed but experts say inconsistencies will remain**

Medical tribunal panels that decide whether doctors guilty of sexual misconduct are fit to continue practising will work under new directions from next month.

The Medical Practitioners Tribunal Service (MPTS) published updated guidance on 1 October that introduces key changes aimed at helping panels improve decision making. The move followed criticism by victims of sexual misconduct and researchers that the current sanctions guidance was not fit for purpose. The guidance applies to all types of allegations, such as poor performance and clinical failings, as well as sexual misconduct.

The guidance, which comes into effect on 24 November, does not change the severity of sanctions but introduces "bandings" to guide panels to issue rulings that are appropriate to the level of risk a doctor is considered to pose: low, medium, or high. It also provides more detailed advice on how to assess the seriousness of allegations, with classifications of low, mid-range, and high, to help ensure greater consistency in the way behaviour is interpreted.

Medium to high risk

Sexual misconduct allegations should be considered serious, and the risk posed by the doctor as medium or high, the guidance says, attracting sanctions of between 12 months' suspension and erasure from the register. Any persistent or repeated behaviour is considered more serious.

The MPTS hopes the guidance will "support consistent and well-reasoned decisions" and help the public better understand what outcomes are likely in different types of cases.

Gill Edelman, interim chair of the MPTS, said, "We recognise the impact tribunal decisions have on doctors and on complainants. It is therefore paramount our tribunals reach fair, proportionate, and transparent decisions and that there is clarity in the range of outcomes that can be expected."

Sexual misconduct in the guidance encompasses uninvited or unwelcome behaviour of a sexual nature—physical, verbal, or visual—that offends, embarrasses, or humiliates an individual.

Frances Dixon, general surgery registrar in the Thames Valley Deanery, and Mei Nortley, consultant surgeon at Oxford University Hospitals Trust, two authors of a recent *BMJ* analysis (*BMJ* 2025;390:e086867), welcomed the "many positive changes" in the guidance, including the recognition that character references have limited value in sexual misconduct cases and that such behaviour is not always sexually motivated.

But they added, "We remain concerned that without formal recognition of aggravating factors such as grooming, and coercion, tribunal outcomes will remain inconsistent and overly lenient."

Adele Waters, London

Cite this as: *BMJ* 2025;391:r2105

ROWENA SHEEHAN

NEWS ANALYSIS

Are more dissatisfied UK doctors really moving abroad?

Amid pay and training disputes, the narrative of an exodus of UK doctors has taken hold—but do the data back this up? **Elisabeth Mahase** investigates

Years of industrial action and numerous surveys have shown widespread dissatisfaction among doctors in the UK, with concerns spanning pay, working conditions, and access to and quality of training.

The BMA has warned that this "toxic cocktail" is making emigration an attractive option for doctors, and a GMC survey over the summer suggested that a third of doctors were looking to leave medicine in the UK.

But while the number of doctors looking to move abroad has almost doubled since 2019, data show that an increasing proportion of these may be opting to stay after all. Figures shared with *The BMJ* show that the GMC issued certificates of good standing (CGSs) to 11 384 doctors in the year to 31 July 2025, up from 6327 in the 12 months to 31 July 2019.

CGSs are used to confirm to regulators in other countries that a doctor is in good standing with the GMC. Although they don't show a doctor has left the country, they do indicate some intention to leave. They remain valid for only three months after being issued.

While the number of CSGs issued is on the rise, the proportion of doctors who were issued one but still registered with a licence to practise in the UK on 6 August 2025—indicating that they had chosen to stay or had left and then returned—has also increased.

Data show a record 74% of doctors who were issued a CGS up to 31 July 2025 were still in the UK on 6 August. This compares with only 53% of such doctors who were issued certificates in 2019 and 58% in 2024.

The total number of doctors issued a CGS who were then no longer registered with a licence to practise—showing that they may have left UK medicine—remained broadly stable from 2019 (2998 doctors) to 2022 (2905 doctors). However, this figure rose to 3375 in 2023 and again to 4246 in 2024. In 2025 it has fallen back to 2920 (graph), but this figure could change.

This is because the data provided on the number of doctors still registered was pulled on 6 August 2025, less than a week after the 2025 application data ended. As certificates are valid for three months, this means doctors who applied for a CGS late in the year (for example, in June or July) may still have gone but wouldn't be in the data.

It should also be noted that a rise in CGSs being issued isn't simply due to the number of doctors in the UK having risen overall. From 2019 to 2025 the GMC register increased by 77 721 to 338 025. This means the proportion of doctors registered who were issued a CGS has increased by one percentage point, from 2.4% to 3.4%, over the past seven years.

Highly mobile workforce

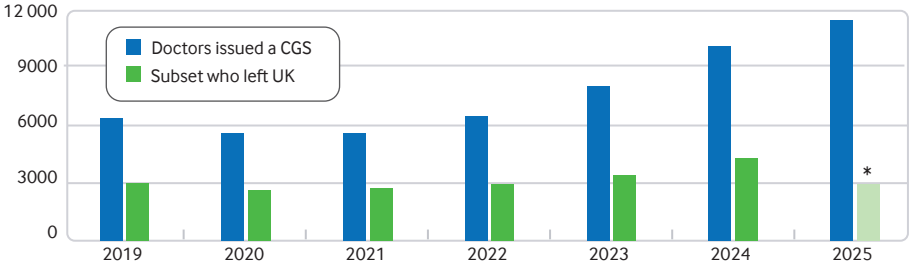
Amit Kochhar, the BMA's representative body chair, said the data pointed to a "worrying exodus of doctors from the UK," with potentially more than 4000 doctors having left in 2024. "While many other doctors are applying for certificates without using them, it should be no comfort to NHS workforce planners that so many are taking this 'insurance policy,'" he said. "These are clearly doctors with eyes fixed on the escape hatch, even if they haven't turned the handle yet.

"We have been raising the alarm on this for years. A confluence of eroded pay, lack of training and job opportunities, burnout in an overstretched NHS, and diminished value of their profession has become a toxic cocktail that is making emigration the only attractive option for far too many doctors."

However, a GMC spokesperson said, "Applying for a CGS can indicate plans to work overseas, but some doctors give up their licence while remaining registered for other reasons, so the data doesn't confirm they have left the UK. We greatly value the doctors delivering excellent care in the UK and want to retain their skills by making this an attractive place to work and stay.

"Doctors are a highly mobile workforce, and while many gain valuable experience

APPLICATIONS FOR CERTIFICATE OF GOOD STANDING (CGS)



* Data period to 31 July each year; data for 2025 may not yet be complete.

abroad—often in countries like Australia and New Zealand—many also return to contribute to our health services."

New Zealand—like NHS but better perks

One popular destination is New Zealand. The Medical Council of New Zealand said that 3349 doctors who had obtained their medical degree in the UK were working in New Zealand as of 30 June 2025, up from 2170 in 2019.

Ruby Abdi, a paediatrics trainee, moved to New Zealand to work after completing her foundation training in the NHS. Speaking to *The BMJ*, Abdi said, "I found foundation training really intense and struggled to find a balance between work and my life outside work, so I really wanted a break from training and to experience new things outside work and medical school."

New Zealand doesn't have the same employment rights, so long shifts can be 15 hours
Ruby Abdi

In New Zealand she was surprised to find that the work felt "very similar" to working in the NHS. "The New Zealand health system is very much modelled after the NHS," said Abdi. "It's just 10 years behind. The first year, I worked in a district general hospital in quite a deprived area, and I found the experience worse, in terms of resources, than the NHS district general hospital I'd worked in."

However, in her second year she then worked in two major hospitals in Auckland. "That was a very different experience. It was incredibly well resourced," she said, when compared with the deprived area she had worked in before.

Abdi also noted that some of the rotas she worked on in New Zealand were "much tougher" than those in the UK. She explained, "They don't have the same employment rights, so long days can be 15 hours—there's no max 13 hour shift—and there's no 11 hours of rest in between shifts. You can finish your shift at 11 pm and be back in at 7 am the next day."

Abdi added that she thought many doctors ventured to New Zealand because they heard it was so much better to work there. "I don't think the work is that different," she said. "I think it's just as busy and can be just as tough. The grass is always greener."

Training opportunities

And, just like the UK, there can be discontent among the medical profession. Just last month 6000 doctors in New Zealand—members of the Association of Salaried Medical Specialists—took part in a 48 hour strike over the government's latest pay offer.

Abdi said that, for many UK doctors, working in New Zealand was about getting a new experience. She described feeling as though you're on holiday, experiencing nice weather and scenic landscapes and making the most of days off. She added that, despite similar working pressures to the NHS, there were positives in New Zealand that the UK could learn from.

She said that many NHS foundation doctors felt as though they were being used just for service provision, whereas in New Zealand she was given "lots of training opportunities," even as a non-trainee. Other perks she cited included free meals for staff, exams being paid for, and relocation costs being covered for doctors who had to move for training—which she said could make a difference if the NHS adopted them.

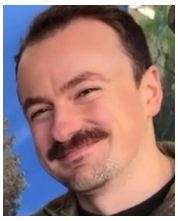
"Even though I don't think the pay is too different, those are big incentives. It makes doctors feel appreciated," she told *The BMJ*.

Abdi has now moved back to the UK and has just started paediatrics training. She considered staying in New Zealand to train but said that she wasn't ready to commit to staying there for the next decade.

Australia's "focus on balance"

Another hotspot for UK doctors is Australia. The Australian Medical Council says that more than 1500 UK qualified doctors applied for registration in 2023-24, up from 995 in 2018-19.

Adam Jones, a psychiatry registrar, moved from Wales to Melbourne in September 2021 during the covid pandemic, just after finishing his foundation training. "I made the decision while working in a covid ICU," he told *The BMJ*. "I wanted a 'light at the end of the tunnel.' I came alone, with no fixed plan, and I felt that my 20s were the right time for an adventure."



In Australia I have more autonomy to plan my life. I'm a human first, a doctor second
Adam Jones

Jones said his experience had been "really positive" and that he felt more settled since meeting his Australian partner and starting a relationship. After working in emergency medicine when he first arrived, he secured a place in a psychiatry training programme.

"The NHS gave me an amazing foundation, and I'll always be proud to have trained there," he said. But in Australia, "Rosters tend to be more predictable, annual leave is encouraged, and there's a stronger focus on maintaining balance outside work."

Jones said that he heard countless stories from friends working in the NHS about "struggling to get leave for important life events like weddings, honeymoons, and family milestones. Here I feel like I have a bit more autonomy to plan my life. At the end of the day, I'm a human first and a doctor second."

Culture and structure

Reflecting on how the NHS could learn from the Australian healthcare system, Jones said, "One thing that stood out to me in Australia is that every two weeks all the training doctors meet to discuss any issues we're facing." He said that the Australian system also placed "more emphasis on protected teaching time, proper cover on shifts, and encouraging people to take breaks."

On top of this, doctors can "apply directly to the hospitals" they want to work in. "These sound like small things, but they go a long way in creating a positive working environment and make me not dread going into work," he said.

While different lifestyles, travel opportunities, and better pay and working hours could attract doctors to working abroad, Jones also admitted that it had its challenges. "I've missed two close friends' weddings, and when my dad had emergency surgery I was on the other side of the world," he said. "Visas can also be tricky to navigate, and it can feel destabilising when your whole life depends on paperwork."

He said that many British doctors he had worked with in Australia went abroad after foundation training and later returned to the UK to continue their training. He explained, "Ultimately, family and friends pull people home. It feels right to live here currently, but I'm not saying I don't miss the UK an awful lot, and I would definitely consider moving back in the future.

"No health system is perfect, including here in Australia. However, small changes to culture and structure could make a big difference in helping people see a long term future in the NHS."

Elisabeth Mahase, *The BMJ*

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“Abortion reversal” pill is back in the news—is it being pushed in the UK?

New evidence that progesterone is being prescribed off label to women to “reverse” medical abortion is concerning doctors and charities. **Jacqui Wise** reports

How has this come to light?

An investigation by the *Times*, published on 23 September, exposed the ways in which US inspired Christian activists are pushing medical, counselling, and mental health services on vulnerable women.

An undercover journalist posed as a woman in early pregnancy who had taken the first of two sets of prescribed abortion pills and was having doubts. She called a helpline run by an anti-abortion charity called Rachel’s Vineyard, founded in the US but now in many countries, including the UK.

The journalist was immediately recommended the “abortion reversal pill” and given the mobile phone number of Dermot Kearney, a cardiologist and past president of the Catholic Medical Association (UK), who boasts of having “saved” dozens of babies. She also says she was discouraged from seeking “secular” mental health support.

Janet Barter, president of the College of Sexual and Reproductive Healthcare, told *The BMJ*, “We are deeply concerned by reports that an unethical and frankly dangerous intervention is being suggested to women at an incredibly vulnerable moment in their lives.

“Women should always feel that they are able to choose if and when they wish to be pregnant, and such practice as reported directly contradicts that. We call on regulators and health authorities to ensure women can always access safe and impartial medical support when they need it most.”

In a statement, Rachel Mackenzie from Rachel’s Vineyard said, “Rachel’s Vineyard UK offers non-judgmental support to women and men who contact us because they are struggling with grief or trauma after abortion. The feedback from those who attend our retreats is overwhelmingly positive.

Mothers continue to request it when they want to try to save their babies Dermot Kearney

“We are openly pro-life and Christian, and these values shape the caring support we’re proud to offer. Our conversations with service users are confidential and grounded in trust and good faith, therefore we do not comment on them.”

Mackenzie said that Rachel’s Vineyard does not offer medical advice, adding, “When women have asked about their options after taking the first abortion pill, we have signposted them to Dr Dermot Kearney so they can make their own informed choices.”

We are openly pro-life and Christian, and these values shape the caring support we’re proud to offer Rachel Mackenzie

What is the abortion reversal pill?

A medical abortion involves taking mifepristone and then misoprostol 24 to 48 hours later. Mifepristone works by blocking the hormone progesterone so that the lining of the uterus breaks down. Misoprostol causes the uterus to contract and the pregnancy tissue to pass, similar to a miscarriage.

During the covid pandemic there was a change in legislation so that the pills could be sent by post, and this practice was made permanent in 2022.

The so-called reversal treatment involves prescribing progesterone off label to be taken after a woman has taken the mifepristone.

Does it work?

A joint statement from the Royal College of Obstetricians and Gynaecologists (RCOG), the Faculty of Sexual and Reproductive Healthcare, the Royal College of Midwives, and the British Society of Abortion Care Providers states there are no reputable national or international clinical guidelines that recommend the use of progesterone to reverse the effect of mifepristone and no evidence that it increases the likelihood of continuing pregnancy, compared with expectant management alone.

The American College of Obstetricians and Gynecology does not support the use of progesterone for the purpose of reversing an abortion, stating it is “unproven and unethical.”

A randomised controlled trial to assess the effectiveness of progesterone in reversing the effects of mifepristone was published in 2020. However, when three of the 12 participants had “severe bleeding requiring ambulance transport to an emergency department” the trial was stopped early.

A systematic review published in 2023 found that the ongoing pregnancy rate in women treated with progesterone after mifepristone was not significantly higher than that in women receiving mifepristone alone. It also found that women who did not receive misoprostol after mifepristone may be at an increased risk of bleeding. But the study authors noted their conclusion was based mostly on poor quality data.

Jonathan Lord, consultant gynaecologist and RCOG spokesperson, said, “The RCOG does not recommend the use of any medication marketed as ‘abortion reversal,’ as this term is misleading and such treatment is not offered by NHS services.” He added, “Anti-choice websites that advertise abortion reversal are providing unlicensed drugs without any evidence of benefit and using a drug that often causes unpleasant side effects and is only available to buy privately.”

Can progesterone be prescribed legally?

Progesterone is used widely in

gynaecology and is a part of in vitro fertilisation treatment. NICE also recommends progesterone to women who experience bleeding in early pregnancy and have previously had a miscarriage. Progesterone can be obtained through private providers, and it is not illegal to prescribe progesterone off label.

Kearney was previously investigated by the GMC for prescribing the "reversal pill," but temporary restrictions that prevented him from prescribing it were dropped by the regulator in 2022.

The GMC told *The BMJ* that Kearney is currently registered with a licence to practise with no restrictions on his registration. A GMC spokesperson added the regulator's guidance is clear that doctors must keep up to date with relevant clinical guidance from bodies such as the royal colleges and NICE.

Is the practice gaining traction in the UK?

Abortion reversal is widely promoted by anti-abortion groups in the US. It is not clear how many doctors in the UK, other than Kearney, are prescribing progesterone.

Lord told *The BMJ* he didn't believe that the practice is increasing in the UK and he has not heard any further complaints since a cluster in 2021 that led the GMC to launch an investigation.

But he added, "We are concerned that this is a major problem in the US, where anti-abortion politicians have attempted to introduce legislation to compel clinicians to offer this untested treatment, which has significant side effects. And with increasing involvement and funding of anti-abortion activities by US groups in the UK it would not be surprising if this were pushed more."

Lord added, "We believe that referrals to clinicians in the UK who prescribe this drug commonly come from US websites run by anti-abortion activists."

Kearney told *The BMJ* he is still providing the abortion pill "reversal" service. "My rationale is first that mothers continue to request it when they want to try to save their babies. Second, it is often, not always, effective in saving lives.

"Third, it is entirely safe for mothers and their babies and likely reduces the risk of serious maternal haemorrhage. The evidence in favour of abortion pill reversal is convincing."

Is there a need for "abortion reversal"?

The RCOG says most women requesting an abortion are clear about their decision and want treatment as soon as possible.

The college points to research stating that there is no evidence of emerging regret after an abortion, with 97.5% of women believing that their decision was the right one after eight days, increasing to 99% after five years.

It says that on the rare occasions that a woman changes her mind during treatment she should be offered non-directive, neutral counselling that states the benefits and risks of each option. This could be through their local NHS service or providers such as the British Society of Abortion Care Providers or MSI Reproductive Choices.

Sarah Salkeld, deputy medical director at MSI Reproductive Choices UK, said, "Anyone who decides to have an abortion thinks deeply about their decision. It can be a complex decision, and it's concerning that anti-abortion groups are taking advantage of that complexity to make women feel shamed and stigmatised."

She added, "Women deserve advice and support they can trust. The administration of 'abortion reversal' pills is not an endorsed medical practice, and it's difficult to see how doctors promoting medicines without evidence wouldn't come into conflict with guidelines on medical ethics. No one should have to experience this level of medically misleading advice when looking for emotional support."

Lord said, "Our concern is twofold. Firstly that non-specialists are offering a treatment that has no evidence base, and secondly that they are doing so owing to their belief that all abortion is wrong and women need 'rescuing.'

"This can fuel guilt, shame, and stigma in this highly vulnerable group and means they then re-present to us later in gestation even more distressed and when the risks of an abortion are higher."

Jacqui Wise, Kent

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We are deeply concerned by reports that an unethical and frankly dangerous intervention is being suggested
Janet Barter

RESEARCH states there is no evidence of emerging regret after an abortion, with 97.5% of women believing their decision was the right one after eight days, increasing to 99% after five years

THE BIG PICTURE

Memorial unveiled as aid worker deaths rise

A memorial to humanitarian aid workers was unveiled in Gunnersbury Park, west London, last week, as record high numbers of aid workers continue to be targeted and killed.

The unveiling event included speeches from William, prince of Wales, and the UN emergency relief coordinator, Tom Fletcher, and was attended by humanitarian workers from the UN's Palestine agency, UNRWA.

The memorial, created by British artist Michael Landy, features a circle of 15 human sized steel figures that are painted green and grouped in fives. On each figure is a story of someone who either received humanitarian assistance or provided it. Spaces in the circle allow visitors to join hands to complete the circle.

Last year was by far the deadliest year since records began for aid workers, with at least 383 recorded deaths across 27 countries. So far this year an estimated 270 have already been killed. Many more aid workers have been injured, kidnapped, or arbitrarily detained. In Gaza alone 543 aid workers have been killed since 7 October 2023. Fletcher said, "Gaza is now the deadliest place on earth to be a humanitarian."

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2 Tom Fletcher, the UN's emergency relief coordinator, said that for aid workers Gaza is now the "deadliest place on earth"

1 Prince William speaks at the unveiling of the London memorial

CHRIS JACKSON/AFP/GETTY

EDITORIAL

Once weekly insulin in type 2 diabetes

A technical advance in search of its clinical place

Insulin remains a cornerstone of treatment for many people with type 2 diabetes whose blood glucose levels are not adequately controlled with oral therapies. NICE recommends insulin as the optimal treatment in these circumstances[1] but is reviewing this guidance and considering refining advice for population subgroups.[2]

Delivery of steady levels between meals and at night currently requires once or twice daily regimens of basal insulins such as insulin glargine or insulin degludec. Although effective, these regimens can present barriers to adherence and quality of life because of the burden of daily injections, titration challenges, and patient concerns about hypoglycaemia.

The recent development of once weekly, ultralong acting insulin analogues is potentially an important step forward. Several studies have shown that the ultralong acting insulin icodec is non-inferior to insulin glargine and insulin degludec but raise concerns about risk of hypoglycaemia, especially for people with type 1 diabetes.[3 4] Several jurisdictions have approved icodec for use in adults with diabetes, including the EU and Canada, but the US Food and Drug Administration has rejected it.

Two large randomised controlled trials published in the *Lancet* (QWINT-3 and QWINT-4) have shown promising results for a second once weekly analogue, efsitora alfa, in patients with type 2 diabetes.[5 6]

In the QWINT-3 trial, 986 participants with type 2 diabetes already using basal insulin were randomised to receive either efsitora or insulin degludec. Glycaemic control, measured by glycated haemoglobin, was non-inferior in the weekly insulin group, and rates of hypoglycaemia were similar. QWINT-4, a trial of 730 participants using basal and bolus insulin, found efsitora to be non-inferior to glargine U100, both used in combination with insulin lispro, again with no clinically meaningful difference in hypoglycaemia.

Once weekly insulins may complement, and not merely compete with, existing therapies

The populations in both trials were broadly representative of people with longstanding type 2 diabetes. The unblinded design introduces a degree of bias, particularly in assessing patient satisfaction, but participants expressed a clear preference for weekly dosing. Importantly, there were no new safety signals, and the rates of levels 2 and 3 hypoglycaemia (moderate to severe) were not significantly different between groups.

Reasons for caution

Interpretation of these findings should be cautious. Titration of weekly insulin could take 8 to 12 weeks, sometimes longer for patients with insulin resistance,[7] and its safety in frail patients or those with renal impairment, both common in advanced type 2 diabetes, remains uncertain. The data on using large doses of insulin, common for people with type 2 diabetes, are also limited. These trials were conducted in largely white populations, raising questions about generalisability to different settings.

For people at high risk of recurrent diabetic ketoacidosis related to missed insulin doses, weekly regimens may help reduce these serious events. Weekly dosing may also allow for more structured management of missed or delayed doses. Once weekly insulin may also be useful for patients with less aggressive glycaemic targets (for example, those with comorbidity) and those whose injections are administered by a caregiver or in community healthcare.

Simplification, where safe and effective, is desirable. The therapeutic landscape for type 2 diabetes is evolving rapidly.[8-11] Although GLP-1 receptor agonists may offer additional benefits, they are not suitable for all. Among people with lower body mass index, such as those in the efsitora trials, the comparative benefit of GLP-1 drugs over insulin remains uncertain.

Neither insulin efsitora nor insulin icodec is authorised for use in the UK. These formulations represent a substantial technical innovation, and the data supporting their efficacy and safety are encouraging. However, before widespread adoption, their place in the NHS treatment pathway must be carefully established.

This includes evaluating not only clinical outcomes, but also real world acceptability in different settings, long term safety, training needs for clinical teams, and potential system-wide benefits. Identifying the subgroups of people with type 2 diabetes most likely to benefit, whether because of adherence difficulties, recurrent ketoacidosis, psychosocial barriers, or specific comorbidities, will be key to guiding equitable and effective implementation.

As NICE revises its guidance, it should consider how once weekly insulins may complement, not merely compete with, existing therapies. The goal is not simply convenience, but improved outcomes. Whether that goal is met will depend on much more than injection frequency.

Andrew Farmer, professor of primary care, University of Oxford
andrew.farmer@phc.ox.ac.uk
Kashyap Patel, consultant, University of Exeter Medical School
Hajira Dambha-Miller, general practitioner, University of Southampton

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EDITORIAL

UK clinical trials are under pressure

Reducing administrative and regulatory hurdles could restore momentum

The number of industry clinical trials conducted in the UK has fallen substantially in recent years, both in absolute terms and relative to other countries.[1]

Setting aside the exceptional covid-19 pandemic period, data from the Association for the British Pharmaceutical Industry (ABPI) show annual recruitment fell from 58 280 in 2018 to 44 564 by 2023 (24% decline).[1] Phase 1 studies seem to be particularly affected with only 58 in 2023 versus around 100 annually in the preceding decade.[2] The decrease affects the NHS, which receives around £30 000 per participant for industry trials, as well as the wider economy: in 2022 UK commercial trials supported 65 000 roles, with an estimated economic value of £7.4bn.[3]

The UK should be well placed to deliver clinical trials given its unified healthcare system, prominent research universities, and active biotech and pharmaceutical industries. The scale, quality, and global impact of UK led covid-19 clinical trials were widely recognised and admired by the international research community. However, fewer industry phase 3 trials started in 2023 in the UK (212 trials) than in Canada, Germany, Italy, and Spain (217-241).[1]

Many factors seem to have contributed. These include the move of the European Medicines Agency away from the UK post Brexit, along with the loss of automatic access to the EU market when a drug or medical device is approved in the UK. Competing European countries such as Spain and Poland have made strides to improve processes and develop competencies (eg, reducing costing and contracting time).[2 4] UK regulatory approval and set-up times have become increasingly slow and unpredictable.[5] Decline in clinical researchers, driven by institutional financial pressures, and the increasing demands of pursuing clinical and research careers, will have also contributed.[6]

Fewer industry phase 3 trials started in the UK in 2023 than in Canada, Germany, Italy, and Spain

Concerns over the decline of the UK industry clinical trials led to the government initiated review by former health minister James O'Shaughnessy in 2023.[7] This stimulated new targets, particularly to speed up commercial studies for regulatory approval (90% of studies opening recruitment within 60 days of the approval decision and having first recruit within 30 days of opening).[8 9] Other initiatives include the Clinical Trials Delivery Accelerators (eg, UK vaccine innovation pathway) and the creation of NHS commercial delivery centres to increase capacity and infrastructure.[8 10]

Pan UK studies

The UK clinical research delivery programme replaced an earlier UK-wide programme,[11] bringing together representatives of the home nations to make pan UK studies simpler and the devolved nations more attractive hosts for commercial research. Performance indicators have been clarified, targets set, and data are being released more quickly, with some progress in approval.[12]

In April 2025, the prime minister announced a target of 150 days for setting up clinical trials (from regulatory submission to first recruit) by March 2026, modestly building on the existing targets.[13]

Despite some progress, several areas still require attention. Aligning of trial processes and terminology across the whole of the UK can and should go further. Differences in legislation and governance make recruiting participants in Scotland (and to an extent Wales and Northern Ireland) more difficult for some trials than in England. Legislative adjustments should be made to standardise processes (such as consent[17]) across the UK.

In addition, a programme to remove barriers to accessing NHS patients (and related data) is needed to aid the conduct and delivery of commercial and non-commercial clinical trials. New UK clinical trials legislation for drugs needs careful implementation to avoid burdening researchers and the system with additional expectations about conduct and monitoring trials that are not conducted for drug marketing authorisation.[18]

More generally, higher educational investment and NHS infrastructure[19] and related pressures should not be allowed to prevent important trials from being conducted—for example, waiting times affecting surgical trials.[20] Increasing clinical research and clinical trials capacity requires the infrastructure, especially clinical trial units, to support, mentor, and partner with clinicians and industry partners; existing trials groups need increased investment to grow and, in turn, support more investigators.[21 22]

There are signs of progress in speeding up the set-up of and recruitment to clinical trials, although it is too soon to say if the welcome aspirations are achieved and sustained.[6] Further decline in the US clinical trials infrastructure seems likely over the next few years, which presents opportunities for the UK but also a stark warning that the current position cannot be taken for granted.

Jonathan Alistair Cook, professor of clinical trials and medical statistics, University of Oxford
jonathan.cook@ndorms.ox.ac.uk

Matthew Lee Costa, professor of orthopaedic trauma surgery, University of Oxford

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JANE BARLOW/PA/ALAMY

FACT CHECK

What is the evidence for school smartphone bans?

Across the world headteachers are prohibiting mobiles in classrooms. **Chris Stokel-Walker** investigates which studies, if any, support the move

There are certain health maxims we know and trust that have become entrenched over time and with the weight of overwhelming scientific evidence. Too much sugar and salt is bad for your health. Not getting enough exercise can harm you. Brush your teeth twice a day.

But another maxim—that smartphones are dangerous and ought not to be given to children—is inching its way into popular discourse without much evidence.

Certainly, bans in schools are popular. Manos Antoninis, director of Unesco's global education monitoring report, says that between July 2023 and December 2024—18 months after publication of the report—"the percentage of countries that introduced a ban on phones in schools increased from 24% to 40%, which was quite spectacular."

Some media coverage suggested that Unesco had called for a ban on phones in schools, but the reality is more nuanced, Antoninis says. The official guidance of the UK government, for instance, doesn't go as far as banning smartphones in schools but encourages them to restrict access.

Banning phones in school doesn't mean the phone isn't continuing to impact people's lives at other times
Manos Antoninis

But whether those bans are effective is another question, says Antoninis. "It's a difficult question to answer and to research," he says.

"The ubiquity of use means that banning phones for a few hours in school doesn't mean the phone isn't continuing to impact people's lives in the other hours," he says.

Some researchers suggest that bans are blunt instruments to tackle a nuanced challenge.

Early indications are that phone use has a detrimental effect on children's learning abilities. Antoninis points to the Pisa (programme for international student assessment) study of schoolchildren and their performance in classrooms.

"The latest assessment, from 2022, had more extensive questions on the use and the exposure of young people to phones, and this showed that the increasing use of phones for non-pedagogical purposes had a negative impact on learning outcomes," he says.

Once a ban gets into the public consciousness it sticks
Marilyn Campbell

But that's just one report—and other experts say that what evidence there is for a ban is lacking.

Paucity of evidence

"The evidence is very, very, very limited," says Victoria Goodyear, a researcher at the University of Birmingham. "In reference to smartphone bans in schools, and in terms of bans on social media and phones for under 16s, there's limited to no evidence that I'm aware of."

Goodyear wrote a recent analysis for *The BMJ* suggesting that tackling purported problems with smartphone and social media use needed to go beyond bans. She led a cross sectional, peer reviewed study of 1227 students from 30 schools across England that she says was the first to empirically look at the data.

"We found that restricting phone use during the school day can positively impact behaviour during school," she says. "It can minimise bullying [a finding supported by other studies], and it can increase physical activity levels during breaks and lunch times. But when we look at health and educational outcomes and mental health outcomes the evidence is less consistent," she adds.

Some studies, including one in Spain, saw children in regions that banned phones achieve better scores in maths and science subjects equivalent to between 0.6 and 0.8 years of learning, although it wasn't clear whether phones were the only contributory factor.

Goodyear says, "The data tend to show that there are no benefits to

There's no evidence of harm of allowing phones
Victoria Goodyear

restrictive school phone policies, and there's also no evidence of harm from allowing phones in schools."

Politically driven

One criticism of the push towards banning phones is that it has been driven more by campaigning and those who shout loudest, rather than a careful consideration of evidence.

"It seems to be politically driven," says Marilyn Campbell, professor in the school of early childhood at Queensland University of Technology, who studies anxiety disorders in children and adolescents.

Campbell points to research by Jean Twenge and to *The Anxious Generation*, a book by Jonathan Haidt that has been criticised by some for misrepresenting academic research, as driving some of the movement in favour of a ban before the evidence base has formed.

Campbell says Twenge's work correctly found correlation between phone use and mental health harm among young people, but never causation. "But Haidt says that, actually, using social media and mobile phones is causing young people's mental health problems," she says. And once that idea gets into the public consciousness, it sticks.

Shaky foundations

Part of the challenge of establishing a firm evidence base is that phone bans mean different things to different people and can be implemented differently across schools. Some schools take devices away from their pupils as soon as they enter school grounds, while others say that pupils can keep devices on them but shouldn't have them out in classes.

"How a phone ban is put into place in schools is not clear cut, which poses challenges for evaluating and giving evidence," says Goodyear. It's not also clear that bans work at achieving their initial intention: getting devices off children.

Across countries that are members of the Organisation for Economic Co-operation and Development 29% of children attending schools operating phone bans say they still use their devices "several times a day." And the Birmingham study led by Goodyear found that pupils at schools with bans used their phones only 40 minutes less a day than those in schools that didn't ban phones, probably because when they got home they still scrolled away.

However, just because there's no evidence yet, there is what Goodyear describes as a "direction of evidence" showing cause for concern about the effects of phone access on children. But Goodyear believes that limiting investigation and action to schools isn't enough to tackle what could become a major problem.

Taking risks on evidence

"Evidence is incomplete and evolving," says Amy Orben, who leads the digital mental health programme at the University of Cambridge. Fixing that paucity of evidence is a challenge. "We need to understand what the risks of acting on incomplete evidence are versus the risks of not acting in order to wait for more evidence," she adds.

We need to understand the risks of acting on incomplete evidence
Amy Orben

She points out that the initial evidence indicates that something is going on. "If four kids choke on a toy, we would probably see quite a large scale recall," explains Orben. "But for technology we don't have that type of system."

The way to solve that is an uncomfortable one, Orben admits. "Policy choices inherently need to be made, not on perfect evidence but on evolving evidence," she says.

Campbell worries about the risk of taking phones away because of their harms while overlooking the good they can do. "Looking at your phone could be a solitary activity, but it could also be communicating with someone," she says.

She also worries that, although we have correctly diagnosed a mental health crisis among teenagers and young people, we have misdiagnosed the root cause—it's possible that mobile phone use isn't the sole or major contributor to the problem.

Chris Stokel-Walker, freelance journalist, Newcastle upon Tyne
stokel@gmail.com
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Seven reasons why GP consultations are becoming more complex

General practice has become more clinically complicated, alongside the diminishing workforce and increasing demand. **Jo Best** explores the causes—and possible solutions

Steve Taylor has been a GP for almost 30 years, first as a partner and now as a locum. "When I started, 20% of my patients were on some sort of medication; now it's 50%," says the Manchester based GP.

"Now, you've got access to more investigations that you wouldn't have had as a GP 20 years ago, and you've got more drugs that you can use.

"There's been a huge increase in complexity. Obviously, there's always been complex cases, but the depth of that has just increased."

He's not alone: ask a GP if their work has become more complex over time, and you'll almost certainly be met with a yes. More patients than ever are registered with GPs, while appointments aren't rising in parallel, leaving GPs' workloads spiralling.

Taylor says, "When I started 30 years ago, I'd do a two hour clinic in the morning and a two hour clinic in the afternoon. I'd do some admin and some visits in the middle, but it was pretty much a 9 to 5 30-ish day. After 30 years in the business I was starting at 8 am, finishing at 7 30 pm, and not stopping for a minute."

But increasing complexity is more than just a side effect of increased demand on primary care: demographic changes and shifts in the nature of GPs' roles have caused an increase in the levels of complexity GPs now see every day.

What is complexity?

Gauging change in complexity comes with challenges. There's little agreement on how to define complexity in primary care and few validated tools for measuring it.

A recent consensus statement attempted to define complex consultations as "those that are more difficult to conduct, challenging, multi-faceted, intensive, or time-consuming than average." It listed factors associated with complex consultations, including those associated with patients—such as chronic pain, homelessness, and drug or alcohol misuse—as well as consultation factors, including those resulting in emergency hospital admission and those needing several separate prescriptions.

So, why are these complex consultations on the rise?

1 Patients' conditions are more serious

Multimorbidity in the UK population has grown in recent years. Research by the University of Birmingham's Institute of Applied Health Research found that, in 2005, 23% of patients were classed as multimorbid (having two or more serious conditions)—and by 2019 this had risen to 32%. Over the same period the percentage of patients with no serious conditions fell, from 52% to 44%.

Multimorbidity is correlated with age, and the UK has an ageing population: the number of people aged over 65 has increased by nearly 60% from 1972 to 2022 and is predicted to carry on rising in the coming decades.

But complexity isn't the sole preserve of the older patient. Children and younger adults are now more likely to present to primary care with chronic and acute conditions that were once almost exclusively seen in older people. The incidence of cancer, for example, grew by almost a quarter from 1995 to 2019 among 25-49 year olds in the UK.

You've got access to more drugs and more investigations
Steve Taylor

Another GP who is based in Manchester, Kirenjeet Bunger, says, "We're seeing lots of younger people with chronic illnesses such as diabetes, which you'd probably think of as more of a condition among those aged 60 and over.

"And with the obesity crisis we're seeing more high blood pressure and obesity related diseases in young people. They're obviously on lots of different medications, and that means more interactions."

2 Guidelines are multiplying

The changing patient population is a significant part of what's propelling the growing complexity in primary care, but changing dynamics in the NHS and in healthcare more broadly are also driving the shift.

Pathways and guidelines for managing particular conditions have become more numerous and complex over time—for example, the National Institute for Health and Care Excellence alone has more than 25 000. This not only intensifies the time GPs have to spend keeping up to date but also increases the work they need to do to manage patients in line with best practice.

3 Prevention programmes are proliferating

Health systems in industrialised countries including the UK are also increasingly interested in preventing disease as well as treating it, with the expectation for GPs to undertake screening and prevention activities.

Minna Johansson, associate professor at the University of Gothenburg, and colleagues recently wrote in *The BMJ* that "primary care is increasingly asked to prevent disease in lower risk populations that, at times, compose the majority of the population. Lower baseline risk leads to higher numbers of patients needed to screen and treat—ranging from the hundreds to infinity . . . Such interventions continue to increase, embedded in a proliferation of guidelines."

They added, "As a result, prevention recommendations for primary care widely exceed available GP capacity. For example, if European guidelines are applied to the general population, over 80% of adults should see their GP to reduce their risk of cardiovascular disease, requiring more GPs than currently practise in any high income country."

4 Waiting lists are growing …

Meanwhile, rising hospital waiting lists mean that patients who would ideally be seen in secondary care are spending longer being managed by their GPs instead.

"The wait times for secondary care make our jobs so much more complex," says Joanne Stewart, a locum GP. "People used to come with hyperthyroidism, and I would just refer them to secondary care—it wasn't a GP job. Now the wait times are a year in some areas to see a secondary care endocrinologist, so I've been starting drugs for hyperthyroid that I would never have started in the past.

"It's the same with rheumatoid arthritis: patients used to be seen [in secondary care] in a couple of weeks and started on disease modifying drugs that I can't start as a GP. But now they aren't and, because I can't start those drugs, I'm sitting with people's pain for a long time."

Omar Hashmi, a London based urgent care GP and GP appraiser, agrees. "It definitely puts pressure on the GP. Some of that is a positive pressure, in that it means you really have to upskill," he tells *The BMJ*—but it's not without risk.

5 … so complications build

Managing patients who are on waiting lists for prolonged periods means that GPs have to expand their skills and the management options they offer into areas that were once dealt with in secondary care. However, as GPs try to manage the symptoms of patients as they wait for referral, the chance of complications can also build up.

"You can't do the arthroscopy, you can't do the knee replacement—but you might be able to do a steroid injection," explains Hashmi. "But you then wonder, am I going to be overdosing this person with more steroids than they need? Am I going to be giving them lots of anti-inflammatories—will there be gastritis or an ulcer?

Prevention guidelines for primary care widely exceed GP capacity
Minna Johansson and colleagues

"At some point, among all the patients you've been giving the naproxen more than you'd like, or giving intra-articular injections more than you'd like, something will go wrong. And that's on you, even though the system has put you in a position where there was no one else to treat that person—it was you or some other GP."

6 Hospital patients are being discharged sooner

GPs are also seeing increasing complexity at the other end of the secondary care pipeline. The amount of time patients spend in hospital has fallen: the average stay in an NHS hospital dropped from 8.4 days in 1998-99 to 4.5 in 2019-20. At the same time, the number of staff available to care for them after discharge has decreased—for example, district nurse numbers fell by 43%, from 7643 in 2009 to 4322 in 2024.

Once more, it's GPs who must work out how to manage patients who would once have been cared for elsewhere. Taylor says, "A&E is so busy, and people are getting shunted home who would have been admitted, because there are no beds. So, you're often having to manage people who are not quite sorted, when they would have been sorted 15 years ago.

"Patients come out of hospital still having quite a few problems, and often their first port of call is to the GP to say, 'Well, what do I do with this?' Even the day-to-day management of people in the community has become more complex."

7 Non-doctor roles in primary care are growing

The rise of non-doctor healthcare staff in primary care is also contributing to GPs' experience of complexity. Over the past few years the number of non-GP healthcare staff seeing patients has increased dramatically under the Additional Roles Reimbursement Scheme (ARRS). In March 2020, 280 full time equivalent staff were in ARRS roles; by March 2023 there were 17 588.

Demographic changes have increased levels of complexity

LANKOWSKY/ALAMY

ARRS staff are typically expected to see more straightforward acute presentations or to review chronic conditions in line with current guidelines. More complex patients, however, remain largely the realm of the GP. For GPs this means that, where once their average day would include a mix of simple presentations that could be handled within 10 minutes alongside more complex ones requiring far more time and resources, now their appointments are largely devoted to the latter.

Andy Brooks, senior visiting fellow at the healthcare think tank the King's Fund, says, "As we move to more of a team based approach in general practice and we have more physiotherapists, pharmacists, physician assistants, paramedics, and other team members, it may well be that those types of roles see fewer of the complex patients than GPs, and it may be that the division of labour within practices is different—GPs are potentially seeing more complicated issues."

The ongoing shortage of appointments also means that when patients do manage to see their GP they often ask for help with multiple problems in a single visit, further extending the complexity the GP has to manage within each short appointment (box).

What are the solutions?

One solution to handling the growing complexity in primary care would be an extension of the standard GP appointment to 15 minutes or more—a call that the BMA first made almost a decade ago and the Royal College of General Practitioners some years later. Patients, too, have backed a move to longer appointments.

Any rise in GP appointment length, however, would likely have an impact elsewhere in primary care: GPs would have to offer fewer appointments each day, when patients are already frustrated at how hard they find it to see a GP—or they would have to extend their clinic hours, at a time when GPs are already doing several hours of unpaid work a day.

Of course, longer slots could be offered without dropping the number of appointments—by increasing the GP head count. However, despite ongoing efforts to bolster GP numbers, the number of full time equivalent GPs has remained stagnant for around a decade, while a considerable number of primary care doctors are deciding to work fewer hours or are thinking about leaving the profession altogether in the face of their increasing workload.

Brooks says, "It would be difficult to say for certain that the reason GPs are leaving is because of the complexity of patients, but clearly GP numbers are still falling. Twenty years ago you were seeing fewer patients in a day, their conditions were less complex then, and it was still a tough job. Now, patients have more complex needs, and you're dealing with more of them, and there are more issues. That makes the job harder and more stressful."

For the GPs who remain, there's some consolation in the growing complexity: it remains the area where they excel. "From a professional perspective, for a GP, the concept of dealing with complexity is part of what general practice is all about—that's where you're adding value," says Brooks. "Dealing with complex patients and difficult issues is the most satisfying part of being a GP."

What you really need is a much longer length of time for some patients to address their needs
Azeem Majeed

MORE COMPLEX CONSULTATIONS—BUT NO MORE TIME

While patients' case complexity has grown over time, the average length of a GP appointment hasn't increased in parallel: 10 minute appointments have been the standard in primary care for decades.

Azeem Majeed, professor of primary care and public health at Imperial College London, says, "Typically in a practice, you get 10-15 minutes per patient, which is fine for straightforward problems, but when someone comes in with vague symptoms, or is elderly, frail, or has multiple problems, you really need more time to deal with those problems.

"The model of funding doesn't really support that situation where a GP might need to spend half an hour or even an hour to assess the patient, review their records, come up with a plan, explain it to a patient, and then implement it. The contract GPs have currently isn't really reflecting modern day working."

For patients who need more than their allocated 10 minutes, GPs are faced with the dilemma of accepting that the consultation will run over, meaning that other patients are seen late and that the doctor's breaks are reduced; or bringing that patient back for a second appointment, risking fragmentation of care if they're seen by another doctor or healthcare professional.

"What you really need is a much longer length of time for those patients to address their needs fully," says Majeed. "So, it does mean that GPs are often quite frustrated, because you can't address all their problems in that time, and you have to bring them back again. It does create frustration for GPs, and for patients as well, who are not getting holistic care."

Jo Best, freelance writer and doctor, Brighton
jo@jobest.online

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Dealing with complex patients and difficult issues is the most satisfying part of being a GP

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WHY I...
play football

GP trainee Asif Khapedi tells **Kathy Oxtoby** how playing football helps him stay connected with his community

Asif Khapedi, a GP trainee in London, is a fan of the "beautiful game." He watches and plays football with former school friends and doctor colleagues, finding the twice weekly games "a release" from the pressures of training.

"Being able to switch off, even temporarily, helps me to get my energy back up for when I need to go back into work," he says. "The day after a really hard shift or a block of on-calls, knowing I can just do something for me, without having to take responsibility, helps settle my nerves and the adrenalin I'm feeling after working a large number of hours. Football gets rid of all that stress and tension."

Khapedi has loved football for as long as he can remember. Growing up in east London he became a supporter of his local team, West Ham United, and continues to go to matches.

"Football is exciting and unpredictable; you never really know which way a game is going to go," he says. Then there's the camaraderie and sense of belonging, knowing that thousands of your team's supporters are "in the same boat as you," he says.

It's also important to "support your local community, and supporting your local team is part of that," he believes.

While Khapedi loves watching the beautiful game, playing is his preference. "That buzz you get from playing football and scoring goals—it's up there with your favourite team winning."

At school, he enjoyed playing football with his friends and in matches as part of the school team. Then as an adult, "I wanted to carry on playing, because of the pure enjoyment. And, also, it's a time when I don't think about anything else but the game," he says.

While studying medicine at King's College London, and during his time working as a foundation doctor in Essex, he continued to play. And when he decided to become a GP, his choice of specialty, like his choice of leisure time, had a community focus. "I felt being a GP working in the community was the best way to give back."

He still plays football with old school friends from the area he grew up in, where he is now based as a trainee GP. "After school, people move on and have their own lives. But having a set time where you're all in the same place can help you to stay in contact."

A midfielder as a rule, he plays five, seven, or eight-a-side football typically twice a week, normally in the evenings after work, on his local pitch or at different sports centres across London. He also plays football with people he met at medical school or has worked with during his training.

Five-a-side football, because you need fewer people to play, is "easier to organise" and therefore more accessible to busy doctors, Khapedi explains. "If you have a busy job like a lot of doctors do, you can go for an hour to play a game and not have to think about it too much, whereas with a full eleven-a-side game, normally you have to sign up to play for a team, and you have to train. But working as a doctor where you have a lot of weekend and night work, you don't really have the energy to commit to something like that most of the time."

There are also apps doctors can use to connect with others to meet up and play football. "So that if you're on a busy shift you can still fit playing football around that time and meet new people as well."

Khapedi finds meeting up with other doctors to play football helps him better connect with them. "I feel like when we're working, we don't really have time to speak to each other just as people and it's very much transactional—'you do this, you do that'. Whereas meeting up outside of work to play football helps at work, because you feel as though you're not just colleagues. Sometimes after football we'll go out to eat and chat—it's all part of the experience."

"Staying calm" is one of the biggest skills he brings as a clinician to playing football. "It's important in sports, but also in work and life."

HOW TO GET INTO PLAYING FOOTBALL

- Find a group of friends or colleagues to play with
- Go online to find local leisure facilities
- You will need comfortable sports clothing, football trainers, and shin pads
- Start playing, and try to play without expectations or judgments so that games are beginner friendly

Kathy Oxtoby, London

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CAREERS CLINIC

I think my colleague is struggling, what can I do?

Elisabeth Mahase hears how doctors can support colleagues who are struggling

Take action

Sue Carr, General Medical Council deputy medical director

"In August we published our annual report on workplace experiences, which showed that in the past year almost a quarter (23%) of respondents took time off work because of stress. In such a pressured environment it's almost inevitable that you'll see colleagues struggling at some point.

"The GMC is clear that your first responsibility is to patient safety. If a colleague's health affects, or could affect, their practice, you must act. That could be by encouraging them to seek help, supporting them to step back from duties, or escalating concerns if necessary.

"The professional standards make clear that supporting colleagues is part of that responsibility. That's because doctor wellbeing and patient safety are inseparable. When doctors are supported and able to care for themselves, they are better able to provide care for patients. Showing empathy for colleagues does not conflict with your duty to patients—it helps you fulfil it.

"Practical support in the short term can make the difference between a colleague struggling alone and them being able to practise safely while they get help. And each time you support a struggling colleague, you help to create an environment where others feel able to do the same.

"Good medical practice says you must treat colleagues with kindness and compassion, and be accessible when they ask for support. This means being approachable, ready to listen, and able to point colleagues towards support. Compassion and vigilance must go hand in hand, and both are central to the standards doctors are expected to uphold."

Look, listen, and link

Joanna Bredski, chair of BMA Scotland's Consultants Committee and a consultant psychiatrist

"Supporting our colleagues who are at risk of burnout has never been more important. You are the right person to support your colleague.

"I recently enjoyed reading, and would recommend, *Burnout-Free Working* by Richard Duggins. In the book Duggins outlines a model for responding to a colleague we think is struggling: the 3 Ls of look, listen, and link.

"Look: remember that people may try to hide how they're feeling and fear being judged. If a colleague tells you that they're fine but you spot changes in their behaviour, mood, or the way that they relate to others over the course of a few weeks, be brave and ask if they are really okay.

"Listen: have a conversation with them—or a number of conversations if that's what it takes—in which you truly listen and don't seek to problem solve. Ask them how they feel.

"Link: if they need more support, ask them if being open with their partner, family and friends, other colleagues, or line manager would help. Some colleagues might benefit from professional support such as occupational health or a counselling service. The NHS Practitioner Health service is an excellent source of confidential support and treatment for clinicians experiencing burnout or the mental health sequelae.

"And, finally, don't forget to look after yourself—many of us strive to meet the needs of others and completely neglect our own. We do need to look after ourselves, and we also need organisations that look after our wellbeing so that we can look after each other and ultimately our patients."

Listen and have empathy

Patrice Baptiste, portfolio GP

"It can be hard to know what to do or say if someone seems to be going through a hard time. This may present as a colleague repeatedly being late, making mistakes, or not being as engaged as they used to be.

"Two of the simplest yet most effective things you can do are to listen and to demonstrate empathy.

"Sometimes all a person needs is to feel safe enough to share their thoughts and feelings. When in conversation we may feel we need to respond quickly or to rush in with our opinion, which is not always needed. Just listening to the other person's perspective, without any judgment or critique, can also remove the pressure of thinking about what you can do or say.

"Secondly, we all go through difficult patches and life events. The more I experience life, the easier I find it to empathise deeply with the patients I speak to. In the same way, making connections with your own experiences will enable you to support a colleague who needs help.

"Finally, if someone is not able to open up to you, or you don't feel comfortable speaking in depth with them, you could signpost places where they may be able to find help or people they may want to talk to. This could be NHS Practitioner Health or their supervisor. Reminding them to lean on their immediate support network such as family and friends can also be encouraging."

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If you're struggling, you're not alone. In the UK and Ireland, Samaritans can be contacted on 116 123 or email jo@samaritans.org or jo@samaritans.ie