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FINNBARR WEBSTER/GETTY

Resident doctors vote for more action

England's resident doctors have voted overwhelmingly to extend their mandate for industrial action over pay and jobs for another six months.

In a ballot 93% voted in favour of further action (26 696 of 28 598). Turnout was 53% of the 54 432 eligible to vote.

After the result the BMA's Resident Doctors Committee (RDC) urged the government to act immediately to prevent further strikes.

RDC chair Jack Fletcher said, "Ministers cannot be shocked that 93% of doctors have voted to strike after being recommended a pay cut this year by the same health secretary who promised a journey to fair pay.

"Without thousands more training posts the bottlenecks in training are going to continue to rob brilliant young doctors of their careers. Doctors have today clearly said that is not acceptable."

Emphasising that "none of this needs to mean more strikes," Fletcher added, "In recent weeks the government has shown an improved approach in tone compared with the name calling we saw late last year. A deal is there to be done: a new jobs package and an offer raising pay fairly over several years can be worked out through goodwill on both sides.

"And now that the mandate for strike action is confirmed for six months, the government has nowhere to run and no means of running out the clock."

A Department for Health and Social Care spokesperson said the government was continuing to work with the BMA, including fast tracking legislation to prioritise UK graduates for specialty training places.

They added, "The government has been in intensive discussions with the BMA Resident Doctors Committee since the start of the year to try to bring an end to the damaging cycle of strikes and avoid further disruption for patients and NHS staff. We hope these talks result in an agreement that works for everyone, so that there is not any more strike action by resident doctors in 2026."

Matthew Taylor, interim chief executive of the NHS Confederation and NHS Providers, said the continuation of industrial action was "bitterly disappointing."

"We cannot let these strikes roll through 2026, using up yet more scarce resources and impeding the progress the NHS needs to make in reducing waiting lists," he said.

"Health leaders need to see the government and BMA resume talks—through mediation if needed—to find a long term solution to this dispute."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2026;392:s218

The ballot will give health secretary Wes Streeting (above) "no means of running out the clock," says Jack Fletcher, RDC chair

LATEST ONLINE

- "Alarming" rise in emergency pneumonia admissions in England
- RFK Jr nominates antivaccine members to federal autism committee
- Gaza: Israel to ban MSF after charity's U turn on sharing staff details

MEDICAL NEWS

UK loses its measles elimination status

The UK has lost its measles elimination certification after the disease circulated continuously for more than a year. Outbreaks began in late 2023 and intensified through 2024, with 2911 laboratory confirmed measles cases recorded in England.

On the basis of the 2024 data both WHO and the UK Health Security Agency said endemic transmission of the virus was re-established, meaning the UK lost its measles elimination status. This is the second time measles has become re-established in the UK in the past decade.

Although measles cases fell to 957 in England in 2025, this still indicates transmission continued. In April to June (the latest data available) 96.4% of people infected had not received a single dose of the MMR vaccine.

Ben Kasstan-Dabush, assistant professor of global health and development at the London School of Hygiene and Tropical Medicine, said, "Sustained measles transmission reflects the persistent failure in the UK to reach the 95% measles vaccine coverage threshold recommended by WHO."

In 2024 only 84.4% of UK children received both doses of the MMR vaccine, but coverage is as low as 61% in some areas.

Luke Taylor, Rio de Janeiro Cite this as: *BMJ* 2026;392:s172

Vaccination

Falling rates are "national disgrace"

England's child vaccination strategy is failing, and the fact so many children are at risk of life threatening diseases is a "national disgrace," a damning report concluded. MPs on the Health and Social Care Committee warned a catalogue of problems had left England with some of the worst health outcomes in Europe among young children. The report looked at the period from conception to 2 years, highlighting that preschool vaccination rates in England have declined since 2012-13.

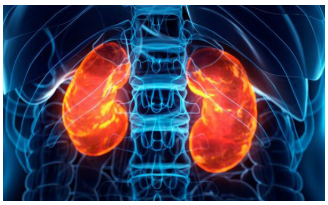
US medical groups challenge RFK's changes

A coalition of medical and public health groups filed a legal motion to cancel changes to the childhood vaccine schedule overseen by the US health secretary, Robert F Kennedy Jr. The group, led by the American Academy of Pediatrics, filed a preliminary injunction on 13 January asking a federal district court in Massachusetts to block changes Kennedy announced on 5 January. In a statement the academy's president, Andrew Racine, said, "Children's health depends on vaccine recommendations based on rigorous, transparent science."

Lupus

Treatment that restores kidney function approved

NICE has approved a treatment that restores normal kidney function in almost half of patients with lupus nephritis. Obinutuzumab (Gazyvaro) is a twice yearly intravenous infusion that, when combined with daily immunosuppressant tablets,



"significantly outperforms" current treatments, said NICE. Around 60 000 people in England and Wales have the autoimmune disease systemic lupus erythematosus, and as many as 60% of them will develop inflammation of the kidneys—lupus nephritis. The condition disproportionally affects women and people from Asian and black African or Caribbean backgrounds.

Social media

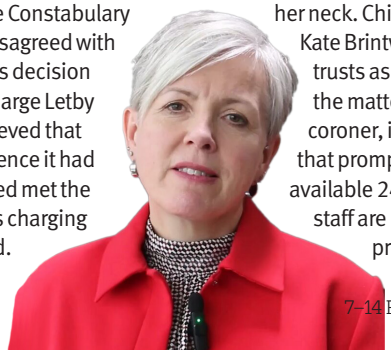
France votes to ban children's access

French MPs voted by 116 to 23 to ban social media access for people under 15. The bill will next go to the Senate for approval. If the bill is passed young teenagers will not be able to use apps such as TikTok, Snapchat, and Instagram. President Emmanuel Macron called the vote a "major step" and said "our children's brains are not for sale." The measure could come into force at the start of the next school year in September.

Lucy Letby

Former nurse faces no further murder charges

Lucy Letby will face no further charges of murder or attempted murder, said the Crown Prosecution Service. The former neonatal nurse is serving life in prison after being convicted of the murder of seven babies and the attempted murder of another seven at the Countess of Chester Hospital in 2015 and 2016. She had been under investigation by police over further deaths and collapses of babies at the Countess of Chester and one death at the Liverpool Women's Hospital, where she trained. Cheshire Constabulary said it disagreed with the CPS's decision not to charge Letby and believed that the evidence it had submitted met the service's charging standard.



ADHD

Medicine use rises 20-fold in UK women aged over 25

The use of drugs to treat attention deficit/hyperactivity disorder has spiked "dramatically" among UK adults, particularly women, research showed. ADHD drug use had increased overall in the five European countries studied, with prevalence in the UK more than tripling from 0.12% to 0.39%. The most pronounced rises were in people aged over 25. From 2010 to 2023 use of ADHD drugs by UK women over 25 rose more than 20-fold, from 0.01% to 0.2%.

Home births

NHS trusts told to urgently review services

NHS England has told hospitals to "urgently review" safety of home birth services, after a coroner's report on the deaths of a mother and baby in Manchester. Jennifer Cahill died after a haemorrhage during labour, and Agnes had the umbilical cord wrapped around her neck. Chief midwifery officer, Kate Brintworth (left) wrote to trusts asking them to consider the matters identified by the coroner, including ensuring that prompt midwifery care is available 24 hours a day and staff are properly trained to provide home births.

IN BRIEF

Pollution

Potential health warnings for wood burning stoves

Wood burning stoves could carry health warnings like those on cigarettes or alcohol, under new government plans. Ministers are also considering imposing stricter limits on the emissions produced by new stoves, which would reduce the current cap by 80%. But because the plans apply only to new models, campaigners said they "fall well short" of protecting the public against the health risks. Wood burning has been linked to increased risks of heart and lung disease, lung cancer, strokes, and adverse pregnancy conditions and is one of the main sources of fine particulate matter ($PM_{2.5}$).

Ministers consider cigarette-style health warnings for wood burning stoves

Cancer

Home bowel screening kit threshold to be lowered

NHS England will lower the detection threshold for a home screening kit to trigger bowel cancer screening from February, in a move that it says will lead to

earlier diagnosis and treatment for thousands of people. The faecal immunochemical test is offered to all people aged over 50 years to check for blood in a small stool sample as a possible sign of bowel cancer. The detection threshold that triggers an urgent cancer test will be reduced from 120 µg of blood per gram of stool to 80 µg, in line with the current threshold in Scotland and Wales.

Child patients to have travel expenses paid

Children being treated for cancer will have their travel costs to and from hospital paid for under a new support package worth up to £10m, ministers have announced. The funding, available through the government's National Cancer Plan, will be accessible to all children and adolescents with cancer and their families, regardless of income. The government said over a third of families with a child being treated for cancer must travel more than an hour to reach hospital, creating a "significant" financial burden owing to factors such as petrol costs, train fares, and lost earnings. Health secretary Wes Streeting said, "If your child needs treatment, we will help you get them there. When a child is fighting cancer, their family should never have to fight the system too."

Biodiversity

Intelligence chiefs warn of effects of ecosystem loss

The collapse of global ecosystems poses a high risk to the UK's national security and prosperity, government intelligence leaders warned. A report, *Global Biodiversity Loss, Ecosystem Collapse and National Security*, said that the "severe degradation or collapse" of ecosystems presented a series of risks, including food shortages and price rises, global conflict, novel zoonotic diseases, and the loss of drug resources. If ecosystems collapse, it warned, UK food supplies would be at particular risk "without significant increases" in the domestic food system and less reliance on imports.

Cite this as: *BMJ* 2026;392:s201

PREPAY COSTS

Patients in England saved **£883m** last year from more than **3.6** million prescription prepayment certificates being issued

[NHS Business Services Authority]

SIXTY SECONDS ON . . . ENGLAND ON THE WAGON

ANOTHER DRY JANUARY ATTEMPT?

No, this seems to be a year round phenomenon. Latest data from the Health Survey for England (2024) show that almost a quarter of adults don't drink alcohol.

ABSTINENCE MAKES THE HEART GROW FONDER?

Maybe the public health messages are getting through. The survey of 10 000 adults found 24% described themselves as non-drinkers. This is a noticeable rise from data covering 2011-22, when non-drinkers hovered around 19%.

WHAT'S CAUSED THE STAT TO TANK?

Gen Z shunning the booze is a major factor. Almost a third (32%) of 16-24 year olds—including a whopping 36% of men—described themselves as non-drinkers. This compared with only 15% of people aged 55-64 (17% of women, 14% of men).

CAN WE THANK LOVE ISLAND?

There does seem to be a generational shift in how health conscious and body conscious people are, but that's possibly too simplistic. Income is also a factor: 39% of all adults living in more deprived areas said that they were non-drinkers, which compared with 16% in the least deprived neighbourhoods.

ANY OTHER DEMOGRAPHIC DIVERGENCES?

Try saying that after a couple of jars. Overall, a higher proportion of women (25%) than men (22%) reported not having had a tipple in the previous 12 months. But both sexes showed marked differences by age, with far fewer older people abstaining.

ARE WE TALKING DAILY BOOZING?

Older drinkers are more likely than younger people to drink at dangerous levels. Those aged 65-74 were twice as likely to drink over 14 units a week (29%) as people aged 25-34 (14%).

BOTTLING UP PROBLEMS?

Jem Roberts, head of external affairs at the Institute of Alcohol Studies, said that while it was encouraging that fewer people were drinking at a higher risk level, millions still drank at levels "that significantly increase their risk of serious harm, from alcohol related cancers to life changing injuries and long term illness."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2026;392:s207

Pancreatitis warning issued for GLP-1 drugs

Patients and healthcare professionals have been freshly warned of a potentially fatal side effect of glucagon-like peptide-1 (GLP-1) receptors: pancreatitis.

The use of the drugs, sold under brand names such as Ozempic, Wegovy, and Mounjaro, has been linked to a rare risk of the condition, a dangerous inflammation of the pancreas that can prove fatal.

Data published by the MHRA on 29 January show that the agency has received 1296 reports of pancreatitis, including 19 deaths, in people taking GLP-1 agonists or dual GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonists for weight loss or to treat type 2 diabetes.

That tally of 19 is nearly double the number (10) reported in users by last June. At the time, the MHRA announced a study into possible serious side effects of the drugs. Last year it also emerged that, by January 2025, a total of 82 people had died from various causes, including pancreatitis, after taking GLP-1 agonists.

"For the vast majority of patients who are prescribed GLP-1s, they are safe and effective medicines which deliver significant health benefits," said Alison Cave (below), the MHRA's chief safety officer. "The risk of developing these severe side effects is very small, but it is important that patients and healthcare professionals are aware and alert to the associated symptoms."

Around 25.4 million packs of GLP-1 receptor agonists have been dispensed in the UK in the past five years, the MHRA said. Around 200 000 people are estimated to be accessing the drug through the NHS. However, there have been reports of patients purchasing the jabs online, including some drugs only at the clinical trial stage.

The main symptom of pancreatitis is strong pain that develops quickly in the centre of a person's abdomen that does not go away and can radiate to the back. Nausea, vomiting, and a high temperature are also possible.

Patients experiencing such symptoms should seek urgent medical attention, and if pancreatitis is suspected patients should stop taking GLP-1 agonists "immediately," the MHRA added.

Clinicians and patients can report side effects from GLP-1 agonist use through the yellow card scheme.

A spokeswoman for Novo Nordisk, which makes Wegovy and Ozempic, said, "We recommend patients take these medications only for their approved indications and under the strict supervision of a healthcare professional, who can also advise on potential side effects."

The patient information leaflet distributed with Mounjaro notes that acute pancreatitis may affect up to one in 100 people, said a spokesperson for Lily, the brand's manufacturer. "We continue to work with the MHRA to ensure appropriate safety information is available to prescribers," she added.

Chris Baraniuk, Belfast

Cite this as: *BMJ* 2026;392:s204

ICE AND PALANTIR
US agents using health data to hunt suspects

US immigration agents are using an app developed by Palantir that draws on the health records of millions of Americans to find and detain people they deem to have entered the country illegally.

The US's Immigration and Customs Enforcement (ICE) has come under increased scrutiny after the shooting of Alex Pretti, a 37 year old intensive care nurse, by ICE agents in Minneapolis.

It has now emerged that data from the Department of Health and Human Services (HHS) is being fed—along with other commercial and public datasets—into an analytics app developed by Palantir, as found by an investigation by the news outlet 404 Media.

Testimony from an ICE official and internal documents obtained by 404 show that the app, Enhanced Leads Identification and Targeting for Enforcement (Elite), maps areas to help agents decide where to conduct detention raids.

Elite reportedly pulls names, addresses, and photos from health records and works like Google Maps, showing ICE agents which areas have higher densities of people who could be detained. It also generates dossiers on individuals, including their name, photo, and "confidence scores" that they are at home.

An HHS spokesperson contacted by *The BMJ* did not clarify what information was given to ICE but said the information sharing was permitted under law.

Great Ormond Street surgeon harmed 94 children, review finds

Nearly 100 children suffered harm while under the care of a consultant orthopaedic surgeon at Great Ormond Street Hospital, a review has found.

Yaser Jabbar (right), who worked in the limb lengthening and reconstruction service at the children's hospital between 2017 and 2022, harmed 94 of the 789 children he treated, the investigation concluded.

After staff and patients' families raised concerns, the Royal College of Surgeons was asked to review Jabbar's practice and the work of GOSH's paediatric orthopaedic service.

The college recommended an investigation of 200 of his patients, but GOSH decided to look at all 789.

The review, carried out by a team of paediatric orthopaedic surgeons from other UK hospitals, concluded that in 36 of the 94 cases the harm suffered was serious; 39 experienced moderate harm and 19 mild harm.

The report found that Jabbar was "highly inconsistent in his approach to clinical care, with recurrent deficiencies in documentation, assessment, and surgical decision making."

"Several federal laws authorise the Centers for Medicare and Medicaid Services (CMS) to make certain information available to the Department of Homeland Security (DHS)," the spokesperson said. "Under the Immigration and Nationality Act, 'any information in any records kept by any department or agency of the government as to the identity and location of aliens in the US shall be made available' to immigration authorities."

There is no data sharing agreement between CMS and DHS on "US citizens and lawful permanent residents," they added.

In July 2025 it was revealed that a data sharing agreement between the US health department and ICE would see the personal data of 79 million Americans receiving Medicaid assistance handed over to the deportation agency. This includes names, addresses, birth dates, and ethnic and racial information.

Protesters and US federal agents on the streets of Minneapolis, Minnesota, after a man was killed by an ICE agent last month

BRANDON BELL/GETTY

PALANTIR also operates in the UK, where it won a £330m contract to develop data platforms that integrate information held across separate NHS trusts

Palantir, a US tech giant best known for its work with defence and intelligence agencies, also operates in the UK, where it won a £330m contract to develop data platforms that integrate information held across separate NHS trusts.

Doctors and patient advocacy and rights groups, as well as the BMA, have questioned whether it is ethical for a US defence technology firm to handle sensitive health data and if the deal could undermine patient trust.

Contacted by *The BMJ*, a Palantir spokesperson said it "cannot comment on specific data sources used by our customers in their confidential environments. However, Palantir expects data sharing among government agencies to be conducted in accordance with lawful authorities and compliant with applicable data sharing agreements."

John Howard, a specialist in healthcare data privacy at the University of Arizona, said that although the interagency sharing of data from health records is legal, it could damage people's trust in healthcare.

"If a population does not trust a health system to protect it and its information there could be a loss in trust of that system," he told *The BMJ*. "Eroding this trust can cause public health problems if we have sick or injured people who forgo seeking care."

Dave Maass, investigations director at the non-profit Electronic Frontier Foundation, said, "In the wake of the Watergate and COINTELPRO scandals of the 1970s, US Congress enacted laws to protect private information from government misuse. Data grabs like the DHS's reported use of healthcare data for immigration enforcement are exactly why."

Maass told *The BMJ*, "Government agencies necessarily collect information to provide essential services, but when governments begin pooling data and using it for purposes unrelated to why it was originally collected, it provides them with enormous power that can be abused. The misuse of healthcare data is particularly insidious."

Luke Taylor, Rio de Janeiro

Cite this as: *BMJ* 2026;392:s168

There were "instances of premature removal of fixture devices, inadequate counselling on fracture risk, and an over-reliance on junior staff," the review found. "Some serious problems [were] found, including poor planning before surgery, not making the area stable enough, unclear or incomplete notes, and putting implants in the wrong place," it said.

"Other issues were making cuts in the bone at the wrong level or using the wrong method, making decisions that didn't match what was seen in the scans during surgery, problems with how frames and pins were used, and not involving the wider team when dealing with infections," it added.

The report did not highlight individual cases, but some families and patients have spoken to the media about their experiences.

One girl, born with a rare bone disease, had several procedures and eventually had to have her lower leg amputated. Other children suffered chronic pain or nerve damage or were left with legs of different lengths.

Jabbar qualified at St George's Hospital Medical School in London in 2004 and worked privately at the Portland Hospital as well as at GOSH. After leaving GOSH he moved to Dubai. He has not been licensed to practise in the UK since January 2024, when he voluntarily relinquished his licence.

The BMJ attempted to contact Jabbar but received no response.

Matthew Shaw, GOSH's chief executive officer, said the trust was "profoundly sorry" to all affected patients and their families.

He said, "We have made significant changes to both the orthopaedic service and across the hospital to minimise the chance of something like this happening again."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2026;392:s198

Jabbar was highly inconsistent in his approach to clinical care with recurrent deficiencies in documentation, assessment, and surgical decision making
Investigation report

NEWS ANALYSIS

PHYSICIAN ASSISTANTS: **Six months on from Leng review, where does the profession stand?**

Gillian Leng's investigation into the safety and scope of PAs set out recommendations last July for how they should be used in the NHS. **Matthew Limb** examines how much progress has been made

What was the Leng review?

In autumn 2024 health and social care secretary Wes Streeting asked Gillian Leng, president of the Royal Society of Medicine and a former chief executive of NICE, to carry out a rapid independent review into the safety and scope of the roles of physician associate (PA) and anaesthesia associate (AA).

The review was an attempt to "reset the hostility" after the long and bitter debate in the NHS over the safety and effectiveness of the roles.

Leng was tasked with assessing how effectively PA and AA roles were currently deployed in the NHS and how any new roles should work in the future.

What did Leng recommend?

Leng's report, published in July 2025, made 18 recommendations, all of which were accepted by the government (box).

How was the review received?

Many stakeholders praised Leng's constructive, pragmatic, and balanced approach, but there were critics on both sides.

Some said the measures did not go far enough to protect patients. The BMA said an opportunity had been missed to "end the postcode lottery of what PAs can and can't do" and the review left patients at the mercy of local employers' decisions.

The Doctors Association UK said the recommendations placed workforce convenience above the need for safety.

On the flip side, United Medical Associate Professionals (UMAPs), the union representing PAs, warned that implementing Leng's review would have a terrible effect on PAs and AAs, patients, and doctors and would limit access to care.

UMAPs has since launched a legal challenge against Streeting, NHS England, and Leng to question several aspects of the review, including that the government failed to consult it as the recognised trade union for PAs and AAs before taking a decision "it knew would result in mass redundancies."

Who is responsible for implementing Leng's recommendations?

The Department of Health and Social Care was tasked with delivering all the changes "as soon as practically possible."

But other bodies have key roles, including NHS England, medical royal colleges, the General Medical Council (GMC)—as the regulator responsible for PAs and AAs—and NHS trusts.

The government accepted Leng's recommendation to implement a name change "immediately" to give clarity to patients and staff. But this requires parliamentary time for legislation to legally enact it.

The GMC is responsible for making any necessary changes to the curriculum and training provided to PAs and AAs and for revising the text in *Good Medical Practice* to provide distinct categories for PAs and AAs.

What has happened since the review was published?

PA and AA roles remain legally known as physician associates and anaesthesia associates—and will do so until any name change is formally consulted on and agreed by parliament.

The BMA said the government has "dragged its feet" on bringing forward legislation, leaving "misleading and unhelpful titles" in place across the UK.

NHS England has told employers to make changes to the way PA and AA roles are referred to in the workplace, "to ensure that patients are not under the misapprehension that they have seen a doctor." It said trusts should have proper regard to employment law and involve affected members of staff and local trade unions.

But the BMA said NHS hospitals and trusts have been "very slow in making any changes to remove confusion for patients and other healthcare workers." The union added that the GMC had yet to publish how it will take forward Leng's recommendation to "provide much needed distinction between doctors and assistants in *Good Medical Practice* or make changes to the curriculum and training provided to PAs and AAs."

"With little urgency coming from the NHS and regulators, we can't see any evidence that patient safety has benefited in the six months since Leng published," BMA council chair Tom Dolphin said.

Mumtaz Patel, president of the Royal College of Physicians, told *The BMJ*,

LENG'S KEY RECOMMENDATIONS (OF 18)

- PAs should be renamed physician assistants, and AAs renamed physician assistants in anaesthesia, to avoid confusing patients
- PAs should not see undifferentiated patients except within clearly defined national clinical protocols
- Newly qualified PAs should gain at least two years' experience in secondary care before taking a role in primary care or a mental health trust
- A set scope of practice was not recommended, but Leng said there should be defined national initial job descriptions for PAs in primary and secondary care and for AAs when they first qualify
- A named doctor should take overall responsibility for each PA as their formal line manager
- Standardised measures, including clothing, lanyards, badges, and staff information, should be used to distinguish PAs from doctors
- PAs should have the opportunity for ongoing training and development within a formal certification and credentialling programme
- A permanent faculty should be established to provide provisional leadership, with standards for training set by relevant medical royal colleges or the Academy of Medical Royal Colleges
- GMC requirements for regulation and reaccreditation of PAs and AAs within its *Good Medical Practice* should be set out separately from those for doctors

"Unfortunately, too much still depends on local interpretation. It is disappointing that nationally agreed scope and supervision standards are not yet in place, and there has been no legal move to enforce a name change."

Luke Mordecai, a consultant anaesthetist at University College London Hospital, is co-director of Anaesthetists United, a campaign group that last year lost a legal challenge it mounted against the GMC on the grounds that the regulator had failed to introduce a scope of practice for PAs and AAs.

Reflecting on what has happened since Leng's review, Mordecai said, "Streeting said he would implement Leng in full. In policy terms nothing has happened."

Mordecai said associate roles were still being advertised as before.

He told *The BMJ*, "AAs continue to work as they were. The name was a source of confusion and harm to patients and still is. Supervision is variable, and safety remains an issue. Trusts have been relying on local scope, which was what we argued against."

Mordecai emphasised he had no knowledge that AAs were being used inappropriately in his own trust.

UMAP said its fears about the impact of the review on PAs were borne out by its latest survey of 459 PAs, which it carried out in December 2025 and January 2026. Three quarters (76%, 348) said their scope of practice had been restricted since the Leng review was published, while two in five (184) reported worsening patient waiting times in their departments since the review.

What does the government say?

Asked to outline what action it has taken in response to Leng's review, a Department of Health and Social Care spokesperson said, "We have brought together senior NHS leaders and government officials as part of a new oversight group to deliver the recommendations and a panel of clinical experts to develop clear protocols on how and when PAs can see patients.

"Patient safety is our absolute priority. We're implementing all the recommendations of the Leng review to ensure physician assistants and physician assistants in anaesthesia can work safely and effectively.

The department said it will begin the consultation on new legal job titles "in the coming weeks and meanwhile encourage professionals and employers to adopt the new titles in day-to-day use, consistent with NHS England guidance."

What action has the GMC taken?

Appearing before the health and social care select committee on 21 January, GMC chief executive Charles Massey was asked why the regulator hadn't already scrapped the old "nomenclature," given the review's recommendations.

Massey told MPs, "We took the view that there would be quite considerable confusion as a result of adopting new titles that were not the titles set in legislation."

The GMC said it has been talking with royal colleges and the PA Schools Council about Leng's recommendation on PAs not seeing undifferentiated patients and to what degree that might need to be reflected in changes to the curriculum and training.

"At the moment, I think our view is that there probably does not need to be any significant change to curricula on the back of it," Massey told MPs, describing talks as a "work in progress."

He said, "We actually think that, even in a world where PAs and AAs are seeing differentiated patients, the curricula would still want them to look at the totality of the patient in front of them and to be able to use the wide set of diagnostic skills and experiences that they would have built up through their education."

Massey said the question of differentiation was "a matter for employers and how they deploy PAs, and the way in which doctors operate in their supervisory role with PAs."

Leng recommended that the GMC should be clearer in differentiating on its website and in some of the materials associated with *Good Medical Practice* about where that relates to PAs, AAs, and doctors.

Massey said the work was under way, telling MPs, "We have thousands of pages and hundreds of different guidance documents that we need to update. That is not a trivial task."

He confirmed that as of the end of December 2025 the GMC had registered about 3900 PAs and nearly 200 AAs—estimated to be around 80% of those currently in practice. They must register with the regulator by the end of 2026.

"I'm absolutely confident that we will deliver all of the recommendations we're responsible for that came out of the Leng review," Massey said. "There are a number of things that still remain unresolved in terms of implementation—those aren't issues the GMC owns."

What do other bodies say?

The Royal College of Anaesthetists said several recommendations from Leng's review were directed to the college and carried significant implications for the specialty and its members.

The college said it supports the recommendations relating to nomenclature and scope of practice, workforce planning, and safety monitoring.

Its president, Claire Shannon, said, "We have recently updated the PAA [physician assistants in anaesthesia] Scope of Practice to reflect the change in name, and it continues to provide a safe framework for PAAs to contribute to the provision of high quality anaesthetic care for patients.

"We are actively engaging with all parties as we work to identify the best route forward for our specialty and for patients."

NHS Employers was asked to give an employers' perspective on progress in implementing Leng's recommendations but it declined to comment.

We can't see any evidence that patient safety has benefited in the past six months
Tom Dolphin

Matthew Limb, London

Cite this as: *BMJ* 2026;392:s205

Two more royal colleges join the X exodus—why medical leaders are refusing to tweet

The RCP and the RCGP are stepping back from Elon Musk's social media platform, citing abuse and hatred. Three other medical organisations have left, and two are reviewing their activity. **Chris Stokel-Walker** reports

First it was the Royal College of Nursing, which left X in November 2024, saying the social media site was "at odds with our organisational values." Last month the Royal College of Surgeons of England announced it was also departing the platform formerly known as Twitter, soon followed by the Royal College of Anaesthetists.

Since *The BMJ* reported on those three departures, two other royal colleges have chosen to dial down their presence on X. After being contacted by *The BMJ* the Royal College of Physicians said it too was leaving.

"We cannot overlook the normalisation of unacceptable online behaviour," said the college's president, Mumtaz Patel, in a statement. "Council members agreed that we should stop posting on X with immediate effect."

It was quickly followed by the Royal College of General Practitioners, which told *The BMJ*, "We've temporarily paused our posting on X due to concerns around the AI bot Grok, and discussions are ongoing about our future use of the channel. Meanwhile, we are using other social media platforms to engage with our members."

Two other professional bodies—the Royal College of Psychiatrists and the Royal College of Emergency Medicine—are reviewing their use of social media channels, including X.

Twitter becomes platform of politicians and journalists

The story of individuals and organisations abandoning X can't be told without outlining its history. Founded in 2006, the shortform online forum Twitter, founded by Jack Dorsey, became popular as a place different from other social media such as Facebook and MySpace because of the calibre of its users.

On Twitter all users were equally accessible, whether presidents, prime ministers, or members of the public. Its adoption by the political and media classes meant it became a key place to be informed about what was going on in the world.

That was why royal medical colleges and other organisations adopted the platform so eagerly. "It was a way for people to find researchers who worked there, so it automatically created a directory that was more accessible than a website," says Carolina Are, a social media researcher at the London School of Economics.

Twitter retained that position for the best part of a decade, being the place where decision makers congregated and where the public went to hear from them. "A lot of colleges originally joined X many, many years ago, because X tended to be quite news focused and a bit more about discussing policy and political issues," says Patrick Leahy, director of communications at the Royal College of Surgeons of England, which left the platform in mid-January.

"There have traditionally been a lot of journalists and politicians on X," he explains—which proved useful for royal colleges in getting their message out to the public.

But after the 2022 takeover of

We cannot overlook the normalisation of unacceptable online behaviour
Mumtaz Patel

Xand van Tulleken (far right) says Elon Musk has made X a toxic site

Twitter by the billionaire Elon Musk—and his avowed attempt to turn the platform into a more politically right wing space, promoting free speech at the expense of offending—the thinking has changed.

Grok, the AI image generator, brings concerns to a head

Once Musk had taken over Twitter and then renamed it X in 2023, he reshaped it by removing guardrails and firing the trust and safety staff who were meant to monitor users' behaviour and the content posted, to help keep the app a pleasant place. As a result, abuse and harmful content thrived.

Things came to a head over Christmas 2025 when users began weaponising X's AI image generator, Grok, to harass women by posting nude or scantily clothed images of them. Ofcom, the UK's communications regulator, opened an investigation into the platform after the technology minister, Liz Kendall, raised concerns in parliament.

Matt Navarra, a social media expert, says, "I think the royal colleges, operating in tightly regulated sectors like healthcare, can't afford to be seen sharing space with platforms that are under investigation for failing to prevent harm. And that's a compliance risk, not just a PR risk."

The top-down decisions by royal colleges are being echoed by a bottom-up approach, including some of the sector's most public faces.

"I post almost nothing on X now," says Xand van Tulleken, a doctor and TV presenter. "I occasionally retweet if a colleague or a friend asked me to, or there's something I think is worth retweeting—but essentially, I don't think it's appropriate."

The rationale is simple, says van Tulleken: the direction that X has taken under Musk has made it a toxic place.

He adds, "I'm on children's television, I'm a medical broadcaster, and I don't think it's appropriate for anyone who wants to know about my stuff to have to go on X to find it out, in the same way that I wouldn't publish my thoughts in a pornographic magazine."

Falling engagement eases leaving

Professional bodies are using similar reasoning, says Navarra. "I think if you're a professional institution tied to public trust, you can't justify staying in that mess," he says.

Many are coming to the same conclusion. "I still circulate my thoughts into the world," says Are, who has left X. "But it doesn't have to necessarily be only through something that's shaped by the affordances of a tech bro owned platform."

X is a fundamentally less interesting place than it used to be—a consequence of chasing so many users away with its general tone. "My experience of going on X is that it's full of pornography, snuff videos, and very extreme violence and racism," says van Tulleken. "It's also full of a lot of lies and misinformation." His comments echo those of many others who are either leaving or dialling down their activity on the platform.

That mass departure of users helped make the decision easier for the Royal College of Surgeons of England, says Leahy. "We had concerns about X for a while anyway, because there had been quite a lot of bot accounts," he says. Engagement on the college's posts began to dwindle, particularly in comparison with other platforms. So, when things turned even more toxic, the college made the decision to leave.

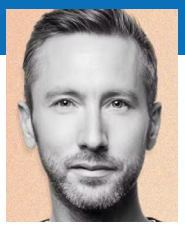
"So far, we're not really seeing any detrimental impact on our ability to reach people," says Leahy. He adds that the Royal College of Nursing, for instance, is active on Instagram, Facebook, YouTube, and Bluesky, while the Royal College of Surgeons is increasingly using email newsletters.

At the same time, says Navarra, audiences are migrating to Bluesky, Threads, and LinkedIn. He says, "They might not replace X's reach overnight, but they do offer safer spaces for professional engagement."

A clue as to why X hasn't been a big miss for royal colleges may come from van Tulleken, who says that he spends "increasingly little time there—I don't think it's a place where the discourse is sincere, good faith, or honest any more."

Chris Stokel-Walker, freelance journalist, Newcastle upon Tyne

Cite this as: *BMJ* 2026;392:s206



The royal colleges can't afford to be seen on platforms under investigation for failing to prevent harm
Matt Navarra

We are not really seeing any detrimental impact on our ability to reach people
Patrick Leahy

Lords vote for ban on social media for under 16s

The House of Lords has voted in favour of an amendment to a bill that would ban the use of social media among young people aged under 16.

The decision is independent of a recently launched government consultation on restricting children's use of social media.

Peers voted on the amendment on 21 January as they examined the Children's Wellbeing and Schools Bill, which is at the report stage.

The proposed legislation is designed to improve child safety and education by strengthening safeguards for children's social care, regulating use of social worker agencies, ensuring that schools offer free breakfast clubs, and introducing a register of children not in school.

Peers considered various amendments to the bill during their debate on 21 January, including banning social media use by under-16s. In the end they voted 261 for the amendment and 150 against—a 64% vote in favour.

However, this is likely to be rejected by the government when the bill returns to the House of Commons

for consideration of amendments as part of its final stage.

During the debate in the House of Lords the Conservative peer John Nash said the UK was facing a "health emergency" over the issue. He said, "We face nothing short of a societal catastrophe caused by the fact that so many of our children are addicted to social media."

Adrian O'Dowd, Kent

Cite this as: *BMJ* 2026;392:s147

THE BIG PICTURE

Exhibition puts female surgeons in the spotlight

A new photographic exhibition brings into focus female surgeons from different specialities, career stages, and regions of the UK.

All the photographs are of members of the Women in Surgery Network (WinS), an initiative dedicated to encouraging, enabling, and inspiring women to fulfil their surgical career ambitions.

The exhibition lays bare the contrast between progress and persistent inequality in the surgical specialty: while over half of doctors in the UK are now women, they form only about 17% of consultant surgeons.

The majority of the portraits were taken by NHS trust staff, including photographers from the hospitals' medical photography departments.

The exhibition runs until 18 April at the Hunterian Museum, London.

Alison Shepherd, *The BMJ* Cite this as: *BMJ* 2026;392:s210

Anusha Edwards, kidney transplant surgeon. Photograph taken by Rebecca Sellick, senior medical photographer, and Dawn White, North Bristol NHS Trust

Evelyn Ong, consultant paediatric hepatobiliary and transplant surgeon. Taken by Bethany Stanley, senior clinical photographer, Birmingham Women's and Children's Hospitals NHS Foundation Trust

Felicity Meyer, chair of Women in Surgery Forum RCS England, and consultant vascular surgeon. Taken by Wayne Fysh, senior multimedia designer, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Sarah Farmer, consultant ENT surgeon. Taken by Lorna Jones, clinical photographer, Aneurin Bevan Univerity Health Board, Gwent

EDITORIAL

Politics trump science in US diet rules

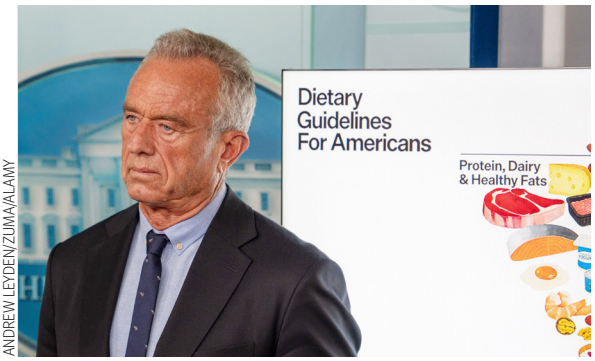
Evidence takes a backseat to conflicting interests in the latest health mandates

The new dietary guidelines[1] and food pyramid[2] issued by the US Departments of Health and Human Services and Agriculture have been met with great fanfare and furore.[3 4] Under the aegis of "make America healthy again," their overall message is the sensible, "Eat real food." Among the actual guidelines, three repeat longstanding advice: "Eat the right amount for you," "Focus on whole grains," and "Eat vegetables and fruits throughout the day." The guidelines reiterate longstanding recommendations to limit sugars and saturated fat to 10% of calories, and sodium to 2300 mg/day. But for the first time, they also include food processing: "Limit highly processed foods, added sugars, and refined carbohydrates." Although this guideline does not use the term "ultraprocessed," that is what it means; it calls for limits on petroleum based dyes and artificial sweeteners, flavours, and preservatives.[5] So far, so good.

But then come four additional guidelines: "Prioritise protein foods at every meal," "Consume dairy," "Incorporate healthy fats," and "Limit alcoholic beverages." These redefine protein to favour meat rather than plant consumption, prioritise full fat rather than low fat dairy foods, specify butter and beef tallow as examples of healthy fats, and omit warnings about alcohol as a cancer risk. This reverses decades of heart health advocacy.

Questionable provenance

Most troubling is the lack of due process, dismissal of scientific consensus, and overt conflicts of interests in producing these guidelines, despite stated promises that they would reflect "gold standard science" and would not reflect corporate interests.[6] Since 1980, the production of the guidelines has followed a two to three year process: a scientific report is written by the Dietary Guidelines Advisory Committee, the report is used to develop the guidelines, and a food guide is based on the guidelines. When I was a member of the committee in 1995, we set the research questions, reviewed the research, wrote the scientific report, and wrote the guidelines. Later, the departments of health and agriculture jointly took over all stages except the research review, allowing politics to overpower the science.



ANDREW LEYDEN/ZUMA/ALAMY

Who wrote the guidelines remains undisclosed

For these new guidelines, the agencies rejected the scientific report commissioned during the Biden presidency[7] and appointed their own committee, giving it only three months to produce its 90 page report and 418 page appendix.[8 9] Although the agencies insisted that these guidelines would not reflect industry influence and would be free of conflicts of interest, they kept neither promise. Most members of the research committee reported financial ties to food companies with vested interests in dietary advice; four members, for example, reported financial relationships with beef, pork, and dairy trade associations.[9 10]

One lawsuit is already charging the agencies with disregarding congressionally mandated processes for preparing the guidelines and, instead, relying on the recommendations of a "hastily assembled ... panel of meat, dairy, and fat diet industry insiders,"[11] whose names were revealed only on publication of their report. Who wrote the guidelines and designed the pyramid remains undisclosed.

Previous guidelines emphasised the benefits of diets based on lean meats, low fat dairy products, and plant sources of protein.[12] These do the opposite. Although they say, "Every meal must prioritize high-quality, nutrient-dense protein from both animal and plant sources," animal sources clearly come first, making protein seem a euphemism for meat. The guidelines recommend increasing protein intake from 0.8 g/kg body weight to 1.2 to 1.6 g/kg, despite current US consumption levels already being close to 1.2 g/kg, two thirds of which comes from meat.[13] Furthermore, there is scarce evidence that exceeding current levels provides additional benefit.[14] Adhering to higher protein goals while keeping saturated fat to 10% of calories will be challenging.

The idea behind these messages is that eating real food and avoiding ultraprocessed food will achieve satiety and promote health, which they well might.[5-19] But largely plant based diets benefit health—and the environment.[20 21] In contrast, meat and dairy production pollute the environment, release greenhouse gases, and raise issues of animal welfare and worker safety.[22 23] These guidelines ignore such issues.

Also omitted is any discussion of the resources needed to follow such advice. Real food is more expensive than ultraprocessed foods and requires cooking skills, kitchens, equipment, and time. Not everyone has such things, but the agencies explicitly reject equity as a consideration.[7] These guidelines also must be understood within the context of the current dismantling of the US public health system. We need public health to support diets that really can promote human and environmental health.

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EDITORIAL

Fossil fuel pollution and health inequalities

Harms from oil and gas development disproportionately affect marginalised communities

Exposure to air pollution is associated with cardiopulmonary disease, respiratory illness, cancer, adverse birth outcomes, and premature death.[1] Emissions from oil and gas extraction, processing, and distribution are a major contributor to air pollution, in addition to combustion during energy generation.

Large scale analyses of over 68 million US older adults showed that even low levels of $PM_{2.5}$ and ozone exposure significantly increase the risk of death. These analyses also show ethnic and income based inequalities.[4] Pollution from oil and gas development in the US accounts for around 91 000 premature deaths every year, along with over 200 000 new childhood asthma cases and 10 000 preterm births, disproportionately affecting black, Hispanic, Native American, and low income populations.[5]

Contributing factors include the siting of industrial facilities in communities historically marginalised through underinvestment and "redlining" (discriminatory practices that block access to financial products or services). Other factors include differential enforcement of environmental regulations (stemming from weaker monitoring and slower response to violations in low income and minority areas) and structural inequities from historical segregation.

Compared with several European countries and Canada, the US has weaker rules on siting fossil fuel facilities, less stringent minimum setback distances from residential areas, and more fragmented regulation of oil and gas development. The Environmental Protection Agency (EPA) has finalised nationwide standards for methane and volatile organic compounds from both new and existing sources, which would affect state plan timelines and signal tighter controls across the sector.[10] But progress towards equitable enforcement and reducing emissions remains uneven and vulnerable to shifts in political priorities. For example, when the EPA weakened enforcement of air quality standards during the covid-19 pandemic, counties with oil refineries did not experience the $PM_{2.5}$ falls seen elsewhere because of reduced population activity.[11]

Monitoring, reform, and enforcement must integrate environmental justice considerations

More recently, the EPA announced it would no longer consider human health in its cost-benefit calculations on $PM_{2.5}$ and ozone, which may further obscure inequitable effects of oil and gas development facilities and weaken the rationale for protective siting, monitoring, and enforcement.

Reducing the risks

To tackle the associated health inequities is crucial to preserving public health. A key step is to strengthen monitoring of air quality, both ambient (background level) and source specific (at the point of emissions), and to increase research in regions of intensive development. The EPA highlights the role of advanced modelling frameworks such as the community multiscale air quality model in linking emissions sources to ambient concentrations.[12] But although the adverse effects of pollution are well established, sustained funding is still needed for cohort and panel studies (which track health and exposure among the same participants over time) to quantify cumulative, long term, and community specific burdens from oil and gas development and to guide equitable policy interventions.

Regulatory monitoring, reform, and enforcement must integrate environmental justice considerations, ensuring that regulatory decisions explicitly consider cumulative exposures and historical inequities in environmental risk. Decisions about new oil and gas facilities should require health impact assessments and local stakeholder engagement to ensure that communities facing disproportionate burdens have a voice in decision making.

Prioritising resources such as improved indoor air filtration, healthcare access, and localised exposure alerts in overburdened "fenceline" communities can help reduce health inequities. Studies show that portable high efficiency particulate air (HEPA) filtration can reduce indoor $PM_{2.5}$ concentrations by 50–80% during pollution episodes,[15] and localised alerts have improved community preparedness in wildfire prone regions.[16]

Expanding renewable energy capacity can directly reduce oil and gas dependence and emissions, and equitable energy transition policies can ensure benefits flow to historically burdened communities.[17]

Evidence now supports moving beyond monitoring towards enforceable cumulative impact standards, mandatory health impact assessments, and federal enforcement mechanisms that prioritise overburdened neighbourhoods when violations occur. Without sustained enforcement, transparent data, and accountability across political cycles, the 2024 strengthening of air quality standards[18 19] risks falling short of protecting the communities that have historically borne the greatest harms.

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Francesca Dominici, director, Harvard Data Science Initiative, Harvard T H Chan School of Public Health, Boston, Massachusetts

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WORKLOAD

“Technostress”—how the NHS is overloading doctors with devices

Doctors are carrying more and more hardware. Each device is designed to do a job, but together they are giving clinicians “alarm fatigue”—to the detriment of patient safety. **Chris Stokel-Walker** reports

Too many pings can result in people turning off their brains

NHS obstetrician Clare Tower spends her day toting around what sound like props from different eras of healthcare: a cordless phone, a bleep, a smartphone that Tower says functions only as an alert system, and a voice activated Vocera smart badge that allows staff to communicate quickly with one another.

Each gadget was given to Tower with a purpose, often tied to safety. Combined, however, they add up to what digital health expert Elizabeth Michels, from the Else Kröner Fresenius Center for Digital Health at the Dresden University of Technology, calls “technostress.”

The addition of new devices is an indication of how the NHS is responding to sicker patients. When an early warning score for deteriorating patients needs a faster response, the solution is often to add another piece of kit, rather than using or replacing what’s already there.

The result, Tower tells *The BMJ*, is “an overwhelming volume of hardware to carry and software to deal with.” Furthermore, they produce “constant interruptions” that can end up distracting clinicians from the work the tech is meant to support.

The alarms and alerts are especially corrosive, Tower says, because they train staff to tune out. Her smartphone warning system “constantly buzzes,” she says, but “response rates have fallen because people can’t cope with the constant interruptions. It’s just too much.”

While the intention is to help patients stay safe, Tower says, “It’s not improved anything, it’s just overwhelmed the system.” She doesn’t believe the NHS is anti-tech, but she thinks it keeps trying to patch problems quickly, piling new tools onto old ones.

“It’s fundamentally constrained by finances and what you’ve already got in place,” she says. “There tend to be workarounds and bolt-ons rather than anyone looking at what the problem is and how we fix it.”

A cycle of layering

The problem of tech overload isn't a surprise to Pritesh Mistry, a fellow in digital technologies at the King's Fund. But "usually it's software," he says. The scale of the software problem, as new systems are installed by IT departments, is something *The BMJ* has previously covered (*BMJ* 2026;392:r2471); devices are no different.

One difficulty is understanding the scale of the problem. "There are no data on what that device duplication looks like," Mistry says. Without a clear picture of what tools exist, what overlaps, and what can be retired, a cycle of layering becomes easier to justify—and harder to reverse.

Why it happens is clearer, and it stems from the way the NHS works. Funding can appear in bursts, creating pressure to buy and deploy quickly. Budgets can also be fragmented. "Procurement and funding happen in silos, and so the money will be for a piece of kit without consideration of what it needs to plug into," says Mistry.

He argues there's often "an overemphasis on the thing, the widget," rather than how it will sit in existing systems and workflows. Tower says that there's a "governance debt" in the NHS, which she describes as "the cost of implementing governance systems that actually create more blockages in the system." She adds, "These things are well meaning, but they don't retire the old systems and don't streamline properly."

The problem feels farcical; Tower calls it "bonkers" to be carrying around so many devices, saying she puts some down then loses them. "I get two thirds of the way around the ward round and realise that I left one of the alert systems in a room somewhere," she says.

Tiring times

What begins as a practical problem of overlapping systems can quickly evolve into something deeper: an overload of attention. The more devices and alerts clinicians must manage, the harder it becomes to tune into what really matters—a phenomenon that has a name in clinical research: alarm fatigue.

Studies show links with frustration, chronic stress, and burnout
Elizabeth Michels

There are no data on what that device duplication looks like
Pritesh Mistry

The problem isn't limited to the NHS. A systematic review found that "over the past 20 years clinicians have faced an increasing communication burden, due in part to the proliferation of devices such as pagers, smartphones, and tablets." That led, the review concluded, to increased frustration among clinical staff. Some 82% of Malaysian healthcare workers said they have experienced moderate or high technostress. And in a German study of general practitioners 73% said IT hardware had caused them additional stress.

But it's not just the annoyance of staff that needs to be tackled; too many pings can result in people turning off their brains, if not their devices.

"Studies show that alarm overload and alarm fatigue are associated with frequent workflow interruptions and impaired performance in healthcare professionals, including distraction, reduced concentration, and compromised communication and decision making," warns Michels. "The literature shows links to longer term outcomes such as frustration, chronic stress, and burnout, as well as safety critical behaviours like delayed responses and alarm related coping strategies."

Michels was behind a recent scoping review of alarm fatigue published in *BMC Nursing* that recognised it as a "significant risk to both patient safety and the wellbeing of healthcare professionals."

"There are many different devices that give off alarms, which makes it even more complicated to locate the alarms, increasing the load on staff," Michels says.

There's an overwhelming volume of hardware to carry and to deal with
Clare Tower

Finding a solution

A piecemeal approach to adding new tech to the toolkit isn't the way forward, Michels says. "Introducing additional standalone technologies may inadvertently increase the number of alarm sources and further complicate clinical workflows."

The need for each item should be carefully assessed before it is rolled out—with the goal of removing duplication of devices and their purpose. A study conducted in a US paediatric hospital found that it is possible to halve alarm notifications without harming patient safety.

"Integrated systems that consolidate alarms from multiple devices into a single (preferably mobile) platform may better align with the highly dynamic and mobile working patterns of healthcare professionals," says Michels, who worries that if staff are handed devices without a clear explanation of what they do and why they're necessary they "may underutilise new systems or develop workarounds that undermine their intended benefits."

The gulf between finding utility in devices and them becoming a hindrance is down to a divide between those operating on NHS frontlines and those making the decisions about IT rollouts, says Tower.

"The people who make the decisions are not on the shop floor," she says, and aren't "spending enough time with patient facing clinical staff to understand the problem properly." The "knee jerk reaction" is to add another fix "as quickly and as cheaply as possible," only to create the next distraction.

Chris Stokel-Walker, freelance journalist, Newcastle upon Tyne stokel@gmail.com
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GPs raise alarm over harms to health and strain on services as families are rehoused hundreds of miles from home

As the housing crisis deepens, homeless people are being moved many miles away by local authorities, affecting their mental health, continuity of care, medication access, and safeguarding

The only answer is more and better social housing
Laura Neilson

We'd like to see homelessness treated as a safeguarding risk
Sam Pratt

Paediatrician Laura Neilson was working a shift at North Manchester General Hospital when a family of seven arrived in the emergency department carrying bags. Several of the family members presented with a rash that turned out to be scabies.

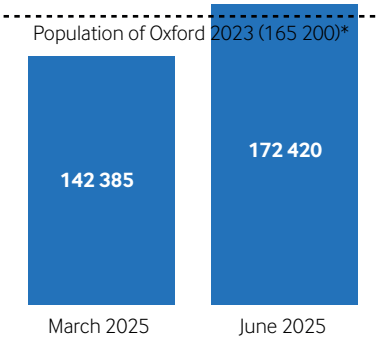
The family were from London and had been relocated 220 miles north by Camden Council. "They had arrived in Manchester with their suitcases and an address on a piece of paper," Neilson says. "They knew no one here, no one had met them on their arrival, and they didn't have school places," she says. "They were overwhelmed."

Neilson runs Hope Citadel, a network of inclusion general practices in Greater Manchester, and is chief executive officer of Shared Health Foundation, a charity that campaigns to reduce the impact of poverty on health. Although the family from Camden were, she says, an "extreme example," it's a problem that GPs are seeing with more frequency owing to the rising number of homeless households being relocated out of area (box).

Why homeless families are being relocated

Councils across England are struggling with a chronic lack of social housing. There were 172 420 children living in temporary accommodation in England in June 2025, according to homelessness charity Shelter, a record high.

Soaring demand and the crippling costs of temporary housing for councils, who have a statutory duty to house homeless residents in their borough, have led many London councils as well as Birmingham and Manchester city councils to relocate residents to more affordable private rentals or temporary accommodation elsewhere – either buying this property themselves, or arranging rentals through the private rented sector in cheaper regions for rentals.



Sources: Ministry of Housing, Communities and Local Government, Shelter
*(ONS mid-year estimate)

The number of children living in temporary accommodation in England is now larger than the entire population of Oxford

A January 2025 report from the Public Accounts Committee found that in the period 2018-19 to 2023-24 the number of homeless households placed out of area increased 42%, with around 39 000 households placed out of area in England as of June 2024. Research from the University of Nottingham, published in 2024 and based on responses to freedom of information requests sent to councils in England, found that 91% of local authorities placed homeless households out of area in 2022-23, with 75% of local authorities placing households more than 20 miles out of area.

"We see people who have been moved from Rochdale to Oldham, Oldham to Trafford, and Trafford to Chester: it's a merry-go-round," Neilson says. "These families turn up at GP surgeries because primary care is a safe space for people, isn't it? But often primary care doesn't have the right personnel to be able to support families with quite complex social issues that are worse when home connections are lost."

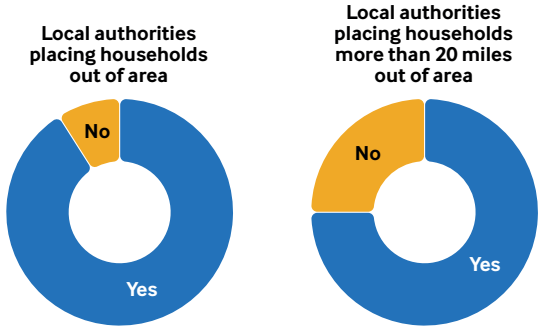
The Ministry of Housing, Communities, and Local Government does not currently require authorities to notify local schools or general practices in receiving areas about a relocated family. Councils are legally required to notify receiving councils about an out-of-area placement within 14 days of families' resettlement, but many councils are failing to do so, says Sam Pratt of Shared Health Foundation. "Councils operate independently, leading to a lack of coordination and communication—and the ridiculous situation where many councils are placing homeless families into a local authority that is in turn sending its own residents elsewhere," Pratt tells *The BMJ*. He cites cases he has seen of homeless families being relocated to Manchester from London boroughs when Manchester rehouses its own homeless residents out of area in Oldham.

Life, interrupted

The Housing Act 1996 states that councils have a legal obligation to house and support homeless families but must only do so within the local area "as far as reasonably practicable." If residents offered a placement elsewhere in the country refuse this offer, councils can legally end their duty of care to them through the Localism Act 2011.

Homeless families face disproportionately high rates of serious physical and mental health problems, increased mortality, and higher use of emergency healthcare services than the general population. Poor nutrition, difficulty accessing consistent medical care, and the cycle of homelessness, whereby health problems can both cause and

PAUL GLENDELL/ALAMY



Source: University of Nottingham

Three quarters of local authorities are placing homeless households more than 20 miles out of their local area

Cultural isolation has big knock-on effects for minority families
Rachel Belton

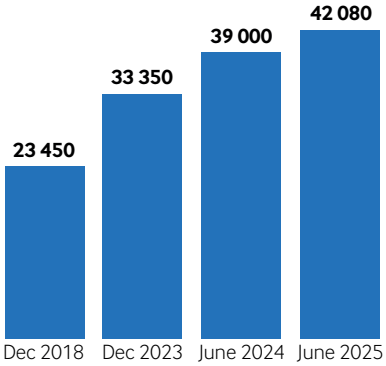
worsen housing instability, are major factors contributing to negative health outcomes. The conditions of temporary accommodation were a contributing factor to the deaths of 74 children between 2019 and 2024, 58 of whom were under the age of 1.

Relocation interrupts secondary care and social care referrals, leading to poorer outcomes than for patients who are rehoused locally and continue in the care of their home area GP. "Babies are more likely to miss the immunisations, mums are more likely to miss their eight week checks," Neilson explains. "In toddlers, we see delayed milestones such as crawling, walking, and potty training in cramped conditions. In older children we see mental health presentations of anxiety; they tend to get quite isolated in school."

Safeguarding concerns

Rachel Belton is a GP at a surgery in Manchester that sees patients in a former office block that's used for temporary accommodation for homeless families. Many of the residents are vulnerable single mothers and have been rehoused from as far afield as Northumberland. "A typical resident will be a 20 year old woman with a baby who is fleeing domestic violence," she says. "Often they don't speak much English."

Belton sees problems accessing medication for relocated patients who want to stay registered with their home GP or who have been removed from their list. She also sees problems with safeguarding. "You'll get a family, for example, who are on their fifth GP in three years [owing to multiple moves] and, when a safeguarding issue is flagged, such as domestic violence risk, they move on, and the social services referral gets lost."



Source: Public Accounts Committee

The number of homeless households in England placed out of their local area has risen by 79% in less than seven years

When families with a disabled member are rehoused, adaptations that facilitated family life are often lost. "We had a family who in their former rented accommodation had a hoist for their disabled child and were then moved into accommodation with no hoist so the child could not be bathed," Neilson says. "The family tried to carry the child to the bath, and the child fell over and ended up with a femur fracture."

Josh Meek, a GP in a deprived area of Sheffield, says that he is regularly in the position of trying to provide remote care for homeless families who have been moved out of the area and are not registered with a local GP while also providing emergency care for homeless families who have relocated into the area but are not yet registered with his practice.

"In one case, a family was getting a service available to us locally that wasn't available in their new area," he says. "We did our best, and kept the family on for as long as we practically could, but in the end it became untenable."

The government does not currently require local authorities to notify schools or GP practices in receiving areas about a relocated family

DAN KITWOOD/GETTYIMAGES

Social effects boost demand

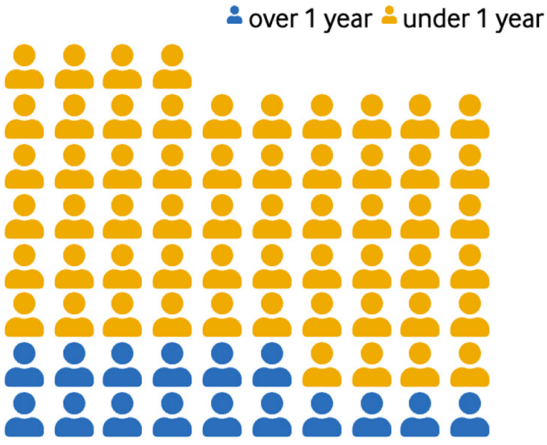
A GP who wants to be known only as Dr Singh recently took early retirement after a "gruelling" few years working at a practice in Medway, Kent, where the workload was exacerbated by high numbers of out-of-area placements.

"The demand was already very high at our practice due to having many patients in poverty with complex medical issues who were awaiting referrals to secondary care," Singh says.

Thames estuary towns are a key region for out-of-area placements of homeless families by London boroughs, including in repurposed shops and office blocks.

These arriving families "would come to us with requests for letters for social issues that would help them to get rehoused," Singh says, "such as complaints of drug dealers trying to groom their children or issues with mould or damp in inappropriate housing. It placed a high burden on the practice, even though we had a social prescriber on staff."

Julie Hammond, a GP in Medway with a special interest in maternal healthcare inequalities, says: "We see councils relocating young mothers who have no social connections to the area, are often from black and minority ethnic backgrounds, and have high levels of mental struggles in the postnatal period. This makes sense if you think how essential existing social structures such as family and friends can be for young mothers."



The conditions of temporary accommodation were a contributing factor to the deaths of 74 children between 2019 and 2024

"Cultural isolation is a huge issue and has big knock-on effects for minority families," Belton adds. A GP from Belton's Manchester surgery visits homeless residents in temporary accommodation alongside a clinical psychologist to let them know about mother and toddlers' groups and places of worship.

Existing social structures such as family and friends are essential for young mothers
Julie Hammond

Better outcomes?

The January 2025 Public Accounts Committee report recommended that the government improve its data on out-of-area placements "as a matter of urgency" and use the data to encourage better coordination between local authorities and to minimise the number of households placed out of area. The Children's Wellbeing and Schools Bill, which is scheduled to come into effect in September 2026, includes measures to improve support for children in temporary accommodation by establishing a notification system whereby local authorities would be required to inform schools and GPs in receiving areas of a child's homelessness status to enable better support and safeguarding. The move is welcomed by GPs, Belton says.

Pratt says that the Shared Health Foundation would also like to see homelessness being treated as a safeguarding risk that triggers safeguarding frameworks, much like domestic abuse and neglect, and would like the duty on local authorities to notify receiving local authorities to be "enforced" through penalties issued by the Ministry of Housing, Communities, and Local Government.

Neilson says that GPs can help by coding families who live in temporary accommodation on their systems and sharing information with children's schools and the local authority where this is appropriate.

The real answer, though, she adds, is beyond GPs' remit: "The only answer is more and better social housing and accessible housing options for families in the long term."

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CAREERS CLINIC

How can I get involved in research as a doctor?

There are many ways doctors can get participate in studies, from assisting with small projects to becoming a clinical academic. **Elisabeth Mahase** asks the experts where they should start

? I'm early in my career. How can I get involved?

"Start by exploring what's available, such as foundation posts with research time, taster programmes, or departmental audit projects," says Rosalind Smyth, vice president (clinical) at the Academy of Medical Sciences.

She highlights structured schemes like the National Institute for Health and Care Research (NIHR) integrated academic training programme, which allocates academic clinical fellowships and clinical lectureships to doctors and dentists looking to pursue clinical academic careers in England.

Smyth says, however, that there isn't one single path doctors have to follow. "What matters isn't following a prescribed path but finding opportunities that align with your interests and developing them systematically."

Find opportunities that align with your interests
Rosalind Smyth

Funders such as NIHR, Wellcome, and the Medical Research Council (MRC) "offer clinical fellowships at all different stages of the research pathway," she says.

One way to get started is by speaking to "clinical academics in your specialty and consider joining events like the Academy of Medical Sciences' clinical academics in training annual conference," Smyth adds. This year the conference will take place on 29 April.

"These connections help you understand different research paths and identify potential mentors before making formal commitments. The Clinical Academic Training and Careers Hub also provides resources for medical and health professionals interested in clinical academia, she says.

Another way to find opportunities is to speak to your colleagues, Azeem Majeed, GP and professor of primary care and public health at Imperial College London, says.

"Identify a clinician or academic in your department or practice who is active in research and ask if they have any ongoing projects that you could help with," he advises. "Joining a collaborative research network, like trainee led groups, is another way to get involved."

? I'm an experienced doctor, is it too late to get involved in research?

"In short, no," says Mrinalini Dey, clinical research fellow and rheumatology and internal medicine registrar at King's College London.

"In fact, being an experienced doctor may be an advantage rather than a barrier."

"It is commonly perceived—incorrectly—that clinical research careers have a narrow entry window—that is, early in training. In reality, academic medicine benefits enormously from clinicians coming to research later, once they have greater clinical experience and a clearer sense of the problems that matter most to patients and health systems."

She stresses that getting involved in research "doesn't mean stepping immediately into a doctorate or completely abandoning clinical work."

Instead, getting involved in research can look like "contributing to existing projects, supervising trainees in their research, or getting involved in clinical trials," Dey says.

Being an experienced doctor may be an advantage rather than a barrier
Mrinalini Dey

All of these "allow gradual skill building while remaining clinically active."

"Instead of asking, 'Am I too late?' perhaps it's best to ask, 'What kind of research role fits my career now?' For some, that may be clinically embedded research, for others it may be formal training such as a doctorate," Dey advises.

? I'm worried I don't have time. How can I carve out protected time for research?

"This is a key obstacle, as clinicians will have busy jobs and may also be studying for professional exams in their spare time," Majeed says. "The most structured way is through NIHR supported integrated academic training pathways like academic clinical fellowships or clinical lectureships in England."

For those not on a formal research training pathway, Majeed suggests trying to "negotiate some research time."

"For example, some GP vocational training schemes will allow trainees to spend a block of time in a local academic department. You can also look for an out of programme period to focus entirely on a project without clinical distractions," he says.

Meanwhile, Mariam Al-Attar, specialty trainee year 6 rheumatology and internal medicine registrar and NIHR doctoral fellow, says there are "ways to carve out protected research time outside of formal pathways, but this will involve getting

creative and being open to unconventional training routes."

One option is to go less than full time in training and get a research grant to make up the salary difference.

Most people don't succeed on their first grant application. Perseverance is key
Mariam Al-Attar

"This is what I did during specialty training in years 4 and 5. I remained in training at 80% whole time equivalent (WTE), while 20% of my WTE was supported by a research grant. Alternatively, the grant could support an out of programme research juncture, such as pausing your training temporarily to undertake a clinical research fellow post."

She says it's important that doctors discuss their options with their clinical supervisors and training programme directors. "They will always need notice to facilitate these changes to your training. You should keep them updated every step of the way, including when you first plan to apply for a particular research grant or post, both out of courtesy and to make the process as smooth as possible for you should you be successful."

Last year the Royal College of Physicians published practical guidance to help doctors advocate for dedicated research time in their job plans and training programmes. This came after the college's survey found that while 41% of UK consultant physicians were actively involved in research, 36% reported being interested but unable to participate, largely because of a lack of dedicated time.

? What kinds of research roles are there?

Smyth says there are four main types of clinical academic roles. These are:

- **Predoctoral roles like academic clinical fellowships.** "These give you protected time during specialty training to develop research skills and gather preliminary data. These typically lead to doctoral programmes"
- **Doctoral positions, such as clinical research training fellowships or similar.** "These fund you to undertake a doctorate, usually during a break from clinical training. This is when you develop deep expertise in your research area"
- **Postdoctoral roles, generally divided into early and late postdoctoral positions.** "These provide the transition to independence. For example, a clinical lecturer is an early postdoctoral position, with around 50% clinical work and the remainder spent developing one's post-doctoral research"
- **Senior positions such as clinical senior lectureships, readerships, and professorships.** "These support you to lead research programmes, supervise the next generation of clinical researchers, and secure major grants"

There are also other ways doctors can get involved in research outside of the traditional roles, says Dey. "Health services research, along with implementation science, may be seen as a branch most closely tied to care delivery in a real world setting. This includes evaluating models of care, access, equity, workforce matters, digital health, and guideline implementation, to name a few," she says.

"Clinicians of all levels may work with professional societies, guideline panels, or health agencies, using their research skills to shape policy and practice. These roles can combine evidence synthesis with real world decision making.

Identify a clinician or academic in your department or practice who is active in research
Azeem Majeed

Majeed also suggests alternative ways to develop research skills, such as getting involved in clinical audits or quality improvement projects. "Although these are not classed as research they require similar skills in areas such as evidence synthesis, data collection, statistical analysis, and writing up the results for publication or presentation at a conference."

? How can I find opportunities and funding?

"Look at major bodies like the NIHR, MRC, or Wellcome, as well as specialty specific charities, such as the British Heart Foundation. Hospitals may also have some internal grants for small pilot projects or short term research fellow roles," Majeed suggests.

Wellcome has specific funding to support healthcare professionals to undertake a doctorate, as well as funding schemes designed for researchers at all career stages. The organisation also has a guide for those looking to apply for its research schemes and awards.

Rachel McKendry, Wellcome's executive director (discovery), is keen for more doctors to get involved in research.

"Doctors have a unique perspective on research because of their patient centred care lens, as well as being at the cutting edge of research. It's a unique skill set and allows doctors to bring an entirely new perspective and to ask those key research questions that drive big changes in patient health outcomes and benefits," she says.

Doctors have a unique perspective on research because of their patient centred care lens
Rachel McKendry

They can also play a key role in fundamental discovery science, she adds.

"Doctors are crucial to developing the big breakthroughs in our understanding of life, and also the impacts on health and humanity."

For doctors looking to get funding McKendry advises looking out for advertisements on the Wellcome website. "There are lots of opportunities for doctors to engage with. Our early career and career development awards are advertised on our website and people can apply three times a year. There's also a list of guidance on there and we host webinars for people to join and ask questions."

Once you've applied, however, it's important not to be discouraged if your first application is unsuccessful, Al-Attar says. "Remember that most people don't succeed on their first research grant application. Although it feels disheartening, perseverance is key—you can always repurpose your proposals for different applications, and you will likely obtain some useful feedback, so it's never time wasted."

Al-Attar adds that, while splitting your time between clinical work and research can bring its own challenges, including with time management, if it's something you're passionate about it can be rewarding.

"It allows you to broaden your knowledge and skills, and ensures that your research remains clinically relevant while your clinical practice is informed by evidence and critical thinking," she says.

Elisabeth Mahase, *The BMJ*

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