



XR activists cleared of criminal damage

Six doctors and nurses who cracked windows at JP Morgan's headquarters in London in protest against the bank's funding of fossil fuels have been unanimously acquitted of criminal damage by a jury.

Jury members at Snaresbrook Crown Court delivered their not guilty verdicts after a retrial, following a 2024 trial when a jury was unable to reach a verdict.

The four doctors—GPs Patrick Hart and David McKelvey, consultant obstetrician Alice Clack, and consultant psychiatrist Juliette Brown—and two nurses are all members of Health for XR, a group of health workers supporting the environmentalist movement Extinction Rebellion.

In July 2022, during a record heatwave, the group broke windows at the financial services firm JP Morgan, causing nearly £200 000 worth of damage. Two days later the UK recorded its hottest day ever at 40.3°C.

Hart said in his closing speech at the retrial, "You will be aware from our evidence that a lot has changed in just the three and a half years since that day of deadly heat in July 2022. You've heard that overheating has accelerated and that we have, during 2023, 2024, and 2025, crashed through the 1.5 degree safety limit that governments around the world had committed to protecting."

In her closing statement Brown told the jury, "We have never lived in these conditions before. You are the ones who can see what's important here. What is important is a matter for your judgment."

At the end of a criminal trial the judge sums up the case to the jury to help them reach a verdict, but jurors are free to come to their own conclusions. Juries are not required to give reasons for their decisions and are free to return a verdict of not guilty even if they think a defendant has broken the law—a process known as jury nullification or jury equity.

After the verdict McKelvey said, "We stepped up as health professionals to take this action. We are delighted the jury acquitted us unanimously; it effectively vindicates the message that life should come before profit."

Maggie Fay, a dementia specialist nurse who was one of the defendants, added, "It's really important that doctors, nurses, and all healthcare professionals take a stand for the most vulnerable in our society, because they're going to be the most affected by this climate emergency and we need to take their protection seriously."

● NEWS, page 173

Clare Dyer, *The BMJ*

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Ali Rowe, a CAHM specialist, during the 2022 protest. She was one of six health workers found not guilty after a retrial

LATEST ONLINE

- Intermittent fasting not worth the hype, review suggests
- Alcohol ad restrictions sunk after lobbying
- Government plans new vaping restrictions



MEDICAL NEWS

Surgeon who sexually harassed colleagues can work again, appeal judges rule



James Gilbert (left), a transplant surgeon who sexually harassed junior colleagues for more than a decade, can work again after a second attempt to have him struck off failed.

A medical practitioners tribunal ruled in August 2024 that Gilbert should be suspended for eight months. But four women harassed by Gilbert protested this was too lenient and urged regulators to appeal.

Both the GMC and the Professional Standards Authority for Health and Social Care (PSA) took the case to the High Court, arguing that Gilbert—who was sacked from his consultant post at the Oxford Transplant Centre in May 2022—should be struck off. The judge agreed that eight months' suspension was too lenient but only increased it to 12 months.

The GMC and the PSA then took the case to the Court of Appeal. Three appeal court judges have now ruled that the High Court ruling was correct. With the appeal failing, there are no longer any restrictions on Gilbert working.

Vivien Lees, senior vice president of the Royal College of Surgeons of England, said, "Erasure from the medical register must always remain a potential outcome for unacceptable behaviours, including sexual misconduct."

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2026;392:s258

Scotland

Resident doctors accept pay offer and call off strike

Resident doctors in Scotland voted to accept a government pay offer that the BMA says will equate to a pay uplift of almost 10% a year for the next two years. The deal includes an 8.16% pay rise over two years—4.25% in 2025-26 and 3.75% in 2026-27—plus additional investments that mean doctors will move up the existing pay scale sooner. Over 62% of eligible doctors voted, of whom 97% voted in favour of the deal. As a result, previously postponed strike action has been cancelled.

Medical records

Participants' GP records to be shared with researchers

GP records of over three million patients will be shared with researchers as part of a drive to improve diagnosis, treatment, and prevention of major diseases. Data will be shared with three large national research studies—Genomics England, Our Future Health, and UK Biobank—where



participants have given consent. The move is a new legal direction from the health secretary, Wes Streeting, which hands NHS England responsibility for sharing coded GP data securely and directly with the three approved projects. Patients not participating in any of the three trials will not have their GP data shared.

Drug pricing

NHS to double spending to pay for UK-US deal

The cost of the UK's drug pricing deal with US president Donald Trump's administration will come out of the NHS's budget, science minister Patrick Vallance says. Vallance confirmed the deal—which doubles the UK's spending on branded drugs from 0.3% of GDP to 0.6% by 2035—would cost the NHS an extra £1bn over the remaining three years of the current spending review. This estimate contradicts a widely reported figure of £3.3bn a year previously provided by the Office for Budget Responsibility.

Sickle cell

Same day London pilot for emergency care ends

A same day emergency care unit for patients with sickle cell disease hailed as a success by patients and experts has closed. The unit at

the Royal London Hospital, run by Barts Health NHS Trust, ended at the end of January after a six month pilot. The project was launched after a 2021 report found a government goal for patients to be



given pain relief within 30 minutes of emergency admission was not being met.

Statins

Researchers call for side effects leaflets to change

Information leaflets about statins should be changed because the drug doesn't cause most of the side effects currently listed, said researchers. The University of Oxford's Cholesterol Treatment Trialists' Collaboration found that taking a statin didn't cause a statistically significant excess rise in memory loss, depression, sleep disturbance, erectile dysfunction, weight gain, nausea, fatigue, or headache, when compared with placebo. The meta-analysis in the *Lancet* included 19 trials involving 123 940 participants with a median follow-up of 4.5 years.

Cancer

Four in 10 cases "could be prevented" worldwide

Most new cancer cases are not caused by modifiable risk factors such as tobacco and alcohol, a World Health Organization analysis of data from 185 countries found. Research published in *Nature Medicine* reported that most new cases were instead attributable to inherent factors such as inherited or randomly mutated genes. However, the researchers said that nearly four in 10 cancer cases worldwide could still be prevented through interventions such as reducing exposure to tobacco, some infections, and alcohol.

Study suggests less frequent cervical screening

Women who have been vaccinated against human papillomavirus (HPV) should be screened for cervical cancer less often, a study published in *Annals of Internal Medicine* suggested. Researchers used a mathematical model based on a population of Norwegian women to estimate the long term health and economic results of various strategies. They concluded that screening just two or three times over a lifetime would be cost effective and would reduce unnecessary procedures without compromising cancer prevention.

IN BRIEF

Alcohol

Wales lifts minimum price to cut harmful drinking

Wales is set to raise the minimum price for a unit of alcohol by 30% from 50p to 65p in October, bringing it into line with Scotland. Independent research commissioned by the Welsh government claims the change could prevent more than 900 alcohol related deaths over 20 years and cut the number of harmful drinkers by nearly 5000. Wales's minister for mental health and wellbeing, Sarah Murphy, said, "Cheap, high strength alcohol disproportionately affects hazardous and harmful drinkers. The evidence is clear: minimum unit pricing works."

Gaza

Israel accepts 70000 Palestinian death toll

Israel reportedly acknowledged that at least 70 000 Gazans had been killed in Israeli attacks since 7 October 2023, but experts



warned that the true number was likely to be much higher. Several sources reported that an Israeli security official had anonymously briefed journalists last week and had accepted the Gazan Ministry of Health's estimated death toll. Israeli officials have repeatedly questioned and dismissed the ministry's numbers, calling them " Hamas propaganda," despite the UN noting that the numbers had been broadly accurate.

Patient harm

Hospital leaders told to be "more curious"

NHS trust leaders need to be more



The Welsh government hopes a 65p minimum price per unit will prevent 900 alcohol related deaths over 20 years

"curious" about standards of care in their hospitals to rapidly identify rogue surgeons, said NHS England's chief executive, Jim Mackey. The comments followed the news that nearly 100 children had been harmed by the consultant orthopaedic surgeon Yaser Jabbar at Great Ormond Street Hospital from 2017 to 2022. Mackey said that NHS boards were too willing to trust what he described as unreliable performance data and that executive teams needed to be more "willing to challenge" surgeons and practitioners when patient harm was suspected.

Cardiovascular health

Wireless monitor approved for heart failure patients

NICE has recommended a wireless sensor that allows patients with chronic heart failure to be monitored from home. The CardioMEMS HF System—the size of a paperclip and costing around £9500—is implanted into a pulmonary artery and allows patients to take daily pressure measurements at home by lying on a special pillow and pressing a button. These readings are sent wirelessly to the patient's hospital team. NICE said that trial evidence showed the system to be associated with 34% lower hospital admissions for heart failure than usual care.

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SIXTY SECONDS ON... HEADING BALLS



GIVE ME THE HEADS-UP

The Professional Footballers' Association (PFA) has launched the first "comprehensive protocol" for preventing the neurodegenerative disease chronic traumatic encephalopathy (CTE), which has been linked to repeated injuries and blows to the head.

AND THE HEADLINE IS?

The guidelines recommend that professional footballers shouldn't head the ball more than 10 times a week, including during training. Children under 12 shouldn't head the ball at all. "It is the principles of less heading, less force, less often, and later in life that matter," Adam White, PFA's director of brain health, told the Associated Press.

ALL SOUNDS A BIT FAMILIAR

CTE was studied in boxers more than a century ago when it was known as "punch drunk syndrome." It has since become a concern in a number of sports. In 2022 the PFA brought in a phased ban on deliberate heading of the ball for anyone under 12.

ENOUGH TO GIVE ONE A HEADACHE

More than that. Early symptoms of CTE include depression or suicidal thoughts and behaviour changes such as aggression. As the condition worsens, symptoms include memory loss, confusion, and problems with movement. There is no known cure, and CTE can be diagnosed only with a brain autopsy.

WHAT'S THE EVIDENCE?

A key piece of research, the Field study, was published in the *New England Journal of Medicine* in 2019. It found deaths from neurodegenerative disease were 3.5 times higher among Scottish former professional footballers than among matched controls. And last month a coroner ruled that heading footballs is "likely" to have contributed to the death, aged 70, of former Manchester United defender Gordon McQueen. Willie Stewart, a consultant neuropathologist at Queen Elizabeth Hospital in Glasgow, told the inquest he had found evidence of CTE in McQueen's brain.

WHERE'S THIS HEADING?

The campaign group Head Safe Football has called for more education and stronger safeguards. It says the average 16 year old footballer has headed the ball 15 000 times. It adds that female players are 1.9 times as likely to suffer from concussion as male ones and take an average of two days longer to recover.

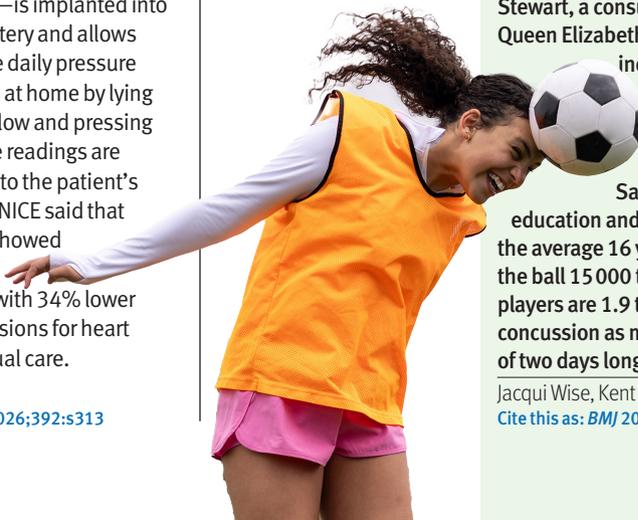
Jacqui Wise, Kent

Cite this as: *BMJ* 2026;392:s310

OBESITY

One in 10 deaths worldwide related to infection are potentially linked to obesity

[*Lancet*]



STREETING-MANDELSON TEXTS: Israeli war crimes, US drug tariffs, and tech companies

I have met with our own medics [in Gaza] who describe the most chilling and distressing scenes

Wes Streeting

Health and social care secretary Wes Streeting said Israel is “committing war crimes before our eyes” and suggested the country should face sanctions over its actions in the occupied Palestinian territories.

The comments were made in private messages to Peter Mandelson—former Labour Party politician, a key influential figure in the party for decades, and longtime friend of convicted sex offender Jeffrey Epstein.

Streeting voluntarily published just over a year of his communications with Mandelson, covering August 2024 to October 2025, telling Sky News he had “nothing to hide.” They show that last July the health secretary messaged Mandelson, who was then

the UK’s ambassador to the US, to discuss the UK’s recognition of a Palestinian state. He wrote: “Morally and politically, I think we need to join France.

“Morally, because Israel is committing war crimes before our eyes. Their government talks the language of ethnic cleansing and I have met with our own medics out there who describe the most chilling and distressing scenes of calculated brutality against women and children.”

Streeting added that while he appreciates “these things are always more complicated than they appear,” the UK needs “to lead, not follow.”

After pushback from Mandelson, who expressed concern that recognising Palestine could jeopardise a two state solution and lead to further annexation of the West Bank, Streeting replied, “Israel is doing it anyway.”

“This is rogue state behaviour. Let them pay the price as pariahs with sanctions applied to the state, not just a few ministers,” he continued.

The UK formally recognised the Palestinian state in September 2025.

Drug tariffs and tech companies

The messages also show Streeting and Mandelson briefly discussing US president Donald Trump considering pharmaceutical tariffs in February

2025. Mandelson wrote, “By [the] way we have a big problem coming down [the track] re pharma tariffs. Trump thinks US pharma not being treated well, wants to put tariffs on EU and UK and force manufacturing to US.”

To this Streeting replied: “Urgh. Yet RFK [Robert Kennedy] hates pharma.”

Last year Trump threatened the UK with up to 250% tariffs on medicines imported to the US as part of a push to get other countries to pay more for drugs. This led to a heavily criticised agreement announced in December that could lead to the NHS paying billions more for drugs.

In June the pair then discussed whether Streeting would visit the US, with Mandelson saying he had “lots of tech companies and people” for the health secretary to speak to. While no tech company was named, the texts come amid growing concern about the involvement of the controversial US tech giant Palantir in the NHS.

Streeting also asked Mandelson for a call to prepare for a last minute meeting with RFK.

The last message Streeting sent was dated 3 September 2025.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2026;392:s269



Read more at [bmj.com/news](https://www.bmj.com/news): Streeting’s links to private health and tech companies under fire in wake of Mandelson texts



New campaign launched as measles outbreak hits London

A large measles outbreak, mostly affecting unvaccinated children, has been confirmed in London, with some patients needing to be admitted to hospital.

The outbreak has prompted renewed calls to boost uptake of childhood vaccinations and the launch of a new campaign.

There have been 96 laboratory confirmed cases of measles in England between 1 January and 9 February 2026, according to the latest figures from the UK Health Security Agency.

More than a third of those cases (34 of 96, 35%) have been in the north London borough of Enfield, an area with one of the country’s lowest vaccination rates. Only 64.3% of 5 year olds in Enfield had received both doses of the MMR vaccine in 2024-25, show UKHSA figures published last August.

A GP surgery in Enfield reported that one in five children who contracted measles had been admitted to hospital and none had been fully immunised.

Enfield’s Ordnance Unity Centre for Health said on its website, “There is a fast spreading measles outbreak in several schools across Enfield. Many children are being hospitalised. Parents should ensure that their children are fully immunised.”

“Unvaccinated children”

Vanessa Saliba, consultant epidemiologist at the UKHSA, said, “Our latest data show we are seeing a big measles outbreak in northeast London, mostly affecting

unvaccinated children under 10 in schools and nurseries, with some being admitted to hospital.

“Measles is a nasty illness for any child, and for some it can lead to long term complications and death, but it is easily preventable with two doses of the MMR vaccine.”

She added, “With Easter holidays fast approaching it is a timely reminder to families travelling overseas to ensure all family members, especially children, are vaccinated, as



MEDIA/UNIC/ALAMY

Trump's repealing of EPA climate change regulations a "rejection of laws of physics"

US president Donald Trump says he has finalised rules to revoke the legal basis for emissions regulations related to climate change. Scientists and environmental lawyers have condemned the move, labelling it a rejection of scientific logic that will harm human health.

US regulations on emissions that cause climate change hinge on a 2009 finding by the US Environmental Protection Agency (EPA) that greenhouse gases endanger human health and welfare. This "endangerment finding" means the EPA must regulate these gases under the rules of the 1970 Clean Air Act.

But on 12 February the EPA announced it had "finalised its rescission of the 2009 Greenhouse Gas Endangerment Finding." The statement reads, "Absent this finding, EPA lacks statutory authority under

section 202(a) of the Clean Air Act to prescribe standards for greenhouse gas emissions.

"Therefore, EPA also finalised the repeal of all subsequent greenhouse gas emission standards from its regulations for light, medium, and heavy duty on-highway vehicles."

A fact sheet published with the announcement claims the move "will make vehicles more affordable for everyday Americans." It adds, "The Trump EPA chooses consumer choice over climate change zealotry every time."

David Doniger, senior attorney and strategist (climate and energy) for the non-profit organisation Natural Resources Defence Council (NRDC), said the arguments for repealing the 2009 finding seem to be based on the assumption that the Clean Air Act only covers breathing pollutants

that have direct toxicity, not those that have an indirect impact on human health. But the act is "not limited in that way," Doniger told *The BMJ*, as indirect effects are within the scope of the law.

In a press conference, Trump called the 2009 finding and subsequent regulations "a disastrous Obama era policy that severely damaged the American auto industry and massively drove up prices for American consumers."

Academic response

Friederike Otto, a climate scientist at Imperial College London, told *Nature* the move "is a rejection of the most basic laws of physics," while Andrew Dessler, director of the Center for Extreme Weather at Texas A&M University, said there was "no legitimate scientific rationale" for the decision.

That climate change fuelled by greenhouse gases is harming human health is "beyond scientific dispute," concluded a 2025 report by the US National Academies of Science, Engineering, and Medicine.

The Environmental Protection Network, a group of former EPA employees, said communities across the country will "bear the brunt" of the administration's decision "through dirtier air, higher health costs, and increased climate harm."

Several organisations, such as the Clean Air Taskforce and the NRDC, are already planning legal challenges to the action.

The question of whether greenhouse gases affect human health has been raised in the US before. In the early 2000s, the EPA, under George W Bush, argued that carbon dioxide and other greenhouse gases did not endanger human health.

The US Supreme Court found in favour of a court challenge brought by the state of Massachusetts in 2007. The decision was sent back to the EPA, which found that the gases affected human health.

Trump's repeal is based on arguments similar to those the Supreme Court rejected in 2007.

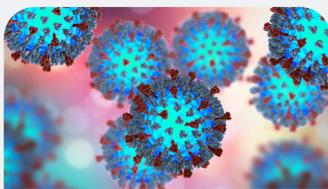
While the Clean Air Act listed air pollutants that affect breathing (nitrogen oxides, ozone, sulphur dioxide, carbon monoxide, and particulates), it requires the EPA to analyse other pollutants that could affect human health. This has included action on lead in gasoline and chlorofluorocarbons thinning the ozone layer.

Last year was the third warmest since the US National Oceanic and Atmospheric Administration began keeping records in 1850.

Carolyn Brown, Ottawa

Mun-Keat Looi, *The BMJ*

[Cite this as: *BMJ* 2026;392:s324](#)



Most measles cases confirmed in the UK so far this year were in children aged 10 and under (74 of 96, **77%**). Some **64%** of cases have been in London, **26%** in the West Midlands, and 4% in the East Midlands

measles is widespread in some countries with close links to the UK and there are ongoing outbreaks in parts of Europe."

Enfield councillor Alev Cazimoglu said the council was working to manage the situation and limit further spread. "The outbreak has mainly affected children and some have needed additional care with a short stay in hospital."

Last month the World Health Organization stripped the UK of its measles elimination status after the disease was found to have circulated continuously for more than a year.

MMR jab uptake has been falling gradually year on year for the past 12 years. In the UK 84.4% of children have received both doses of MMR vaccine by their fifth birthday, much lower than the 95% herd immunity target.

On 16 February the government launched a national campaign to encourage parents to get their children vaccinated. The "Stay Strong, Get Vaccinated" campaign will include a TV advert, social media content, and digital display advertising. Zubir Ahmed, health innovation and safety minister, said, "With vaccination rates falling

and the UK losing its measles elimination status, it's vital we act now. Our campaign will help parents get clear and trusted information about vaccines and the protection they offer."

Since 1 January 2026 children have been offered a combined MMR and varicella vaccine instead of the MMR as part of the childhood routine vaccination schedule. The first dose is offered at 12 months of age, and the second will be brought forward from 3 years 4 months to the new 18 month appointment.

Jacqui Wise, Kent

[Cite this as: *BMJ* 2026;392:s316](#)

GP DESERTS Fears for patient safety in regions facing chronic shortages of family doctors

Leaders call for more investment in general practice as patient ratios in some areas rise above 2700 per doctor. **Stephanie Santos Paulo** reports

EXCLUSIVE Four fifths of England's integrated care boards would need to at least double their number of GPs to meet staffing standards considered safe for patients, a *BMJ* analysis of NHS workforce data finds.

The BMA says that, by 2040, England should have one full time equivalent (FTE) GP for every 1000 patients, to ensure manageable workloads and patient safety.

But new data released in January show every one of England's 42 ICBs is operating way above this threshold. Nationally, there is one FTE GP for every 2220 patients, but ICB level data show some regions face a far more severe doctor drought.

The highest reported patient to doctor ratios are in London and in Bedfordshire, Luton, and Milton Keynes (BLMK), where there are more than 2700 patients for every GP. These figures are based on the FTE counts of fully qualified GPs, which more accurately reflect actual workforce capacity than simple headcount data, which count doctors who work part time as equivalent to FTE GPs.

"No matter where a patient lives in England, the safe limit for patients is being exceeded, with patient demand far outstripping GP capacity," said Katie Bramall, chair of the BMA's GP Committee.

Victoria Tzortziou Brown, chair

The pressures on general practice are clearly far beyond what is safe or sustainable

Victoria Tzortziou Brown

of the Royal College of GPs, added that the findings demonstrated the "troubling picture" of growing strain. "The pressures on general practice are clearly far beyond what is safe or sustainable," she said.

But a Department of Health and Social Care (DHSC) spokesperson defended the government's record on GP numbers, telling *The BMJ*, "We currently have the highest number of fully qualified GPs since at least 2015 thanks to actions taken by this government."

While it is true that England now has 648 more FTE GPs than six years ago, since then 3.69 million more patients have registered at practices. This represents a 6.1% rise in patient numbers, against a 2.3% increase in GPs, leaving practices more thinly spread.

Regional disparities in patient ratios

However, the pressure is not felt equally across all regions. North West London ICB records the highest ratio, with one FTE GP for every 2746 patients.

BLMK had the second highest ratio at 2706 patients per FTE GP. This ICB has consistently been among those with the highest ratios in England, with 2640 patients per GP as far back as December 2019.

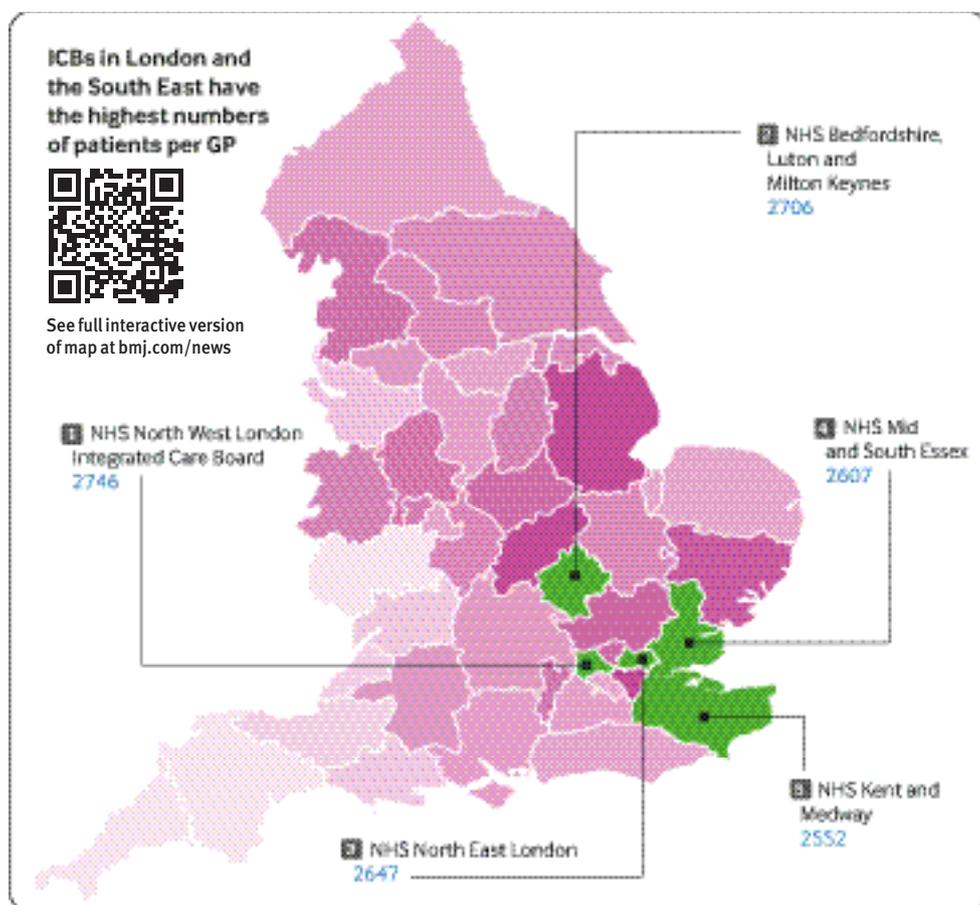
A spokesperson for the ICB told *The BMJ*, "The population in our area continues to grow roughly twice as fast as that of England as a whole.

"We presently have over 140 GPs in training roles, many of whom we expect to contribute to improving our GP to patient ratio when they qualify."

However, they acknowledged that a low number of GP vacancies could make it difficult for trainees to secure posts once they have qualified.

Since 2019 the gap between the most and least stretched ICBs has hardly changed. In December 2019 there were 862 more patients per doctor in the most overstretched areas than in the least. In December 2025 the difference had risen slightly to 875, suggesting that these workforce shortages are chronic.

Tzortziou Brown said the "stark disparities" between ICBs were worrying. "We know that areas facing





2025, a 15% increase (around 220 000 more appointments) on the same period the previous year.

A spokesperson said practices have been expanding roles for physiotherapists, clinical pharmacists, paramedics, health coaches, and social prescribers.

The same is true of North West London ICB, where expansion of non-GP roles through the additional roles reimbursement scheme (ARRS) has helped free up GPs' time.

From 2023 to 2024 the patient population in North West London ICB increased by 3.5%, while GP numbers rose by only 3.2%. However, a spokesperson for the ICB explained that in this time they increased ARRS roles by 3.5%—a boost in general practice capacity that is not reflected in NHS GP workforce data.

GP to patient ratios aren't just an issue in primary care. They have a knock-on effect on other parts of the NHS, experts warn.

"Without sustained and targeted investment in staff, practices, and

higher deprivation often have the highest ratios of patients to GPs, as well as the most difficulty recruiting and retaining GPs," she said. "This risks fuelling health inequalities and preventing those in the most deprived communities—who often have more complex health needs—from accessing the care they need."

In North West London, the ICB area with England's highest ratio, GPs' workload is intensified because several boroughs in the area have high levels of deprivation and associated long term conditions, an ICB spokesperson told *The BMJ*.

They added that GP capacity is limited by infrastructure, with some practices operating in buildings that are difficult to expand.

Newly qualified GPs without jobs

The data underline what GP leaders describe as a paradox in the workforce crisis, with qualified GPs unable to find work while their employed counterparts struggle to keep pace with growing patient lists.

"Patients urgently need more GPs, yet we risk losing them altogether if there are no jobs or practices available," said Bramall.

"Newly qualified GPs are struggling to secure NHS roles, while practices lack the funding to recruit, as government investment in patient care has failed to keep pace with inflation."

This is despite the government placing primary care at the forefront of its promises to transform the NHS, with its 10 year plan promising a shift of care from hospitals to the community.

"We are making progress to reverse more than a decade of neglect of primary care, with patient satisfaction with GP services rising and more than 2000 extra GPs

recruited in the past year," the DHSC spokesperson said.

Health and social care secretary Wes Streeting has also pledged to expand training numbers further.

But expansion of GP training places would need to be considerable to keep up with growing demand. In 2025 there were 20995 applications for 4726 GP specialty training posts, a ratio of 4.91 applicants per post. This competition ratio has more than tripled since 2019, when there were just 1.34 applications per post.

On 13 January the government introduced a bill promising to prioritise UK medical graduates over international medical graduates for specialty recruitment. Tzortziou Brown said that retention measures were urgently needed to keep experienced GPs in post.

More appointments, GP access is harder

Despite workforce pressures, GPs are delivering more appointments than ever. The monthly number rose by more than 10 million between December 2018 and December 2025, reaching a record high last year.

"Ministers frequently talk about doing more with less, but general practice is already delivering around 1.7 million appointments every day," Bramall noted.

Much of this increase has been driven by a more diverse primary care workforce, with more appointments at GP surgeries being delivered by health professionals other than doctors, such as nurses and physiotherapists.

Between 2018 and 2025 the proportion of appointments actually being delivered by GPs fell from 53% to 45%, show NHS data comparing equivalent months.

In BLMK, patients were able to access 1.65 million primary care appointments from June to August

Victoria Tzortziou Brown (left), RCGP chair, and Katie Bramall, chair of BMA's GP Committee

NATIONALLY there is one
FTE GP for every **2220** patients

premises, the foundations of the NHS will continue to weaken," says Bramall. "More and more patients will present in far more costly urgent and emergency care settings."

The DHSC spokesperson said that GPs are "at the heart" of the government's "historic shift" from hospital to community and will benefit from a growing share of NHS funding.

The question of whether this shift in governmental priorities will translate to safer GP workloads remains to be seen. Tzortziou Brown said the health secretary's promises to support general practice and deliver "thousands more GPs" must be backed by a clear and robust 10 year workforce plan.

"General practice is the bedrock of the NHS. With the right investment and meaningful initiatives to recruit and retain GPs we can turn this around and ensure patients get the care they need, when they need it, wherever they live."

Stephanie Santos Paulo, *The BMJ*
Cite this as: *BMJ* 2026;392:s301

Without sustained investment more patients will present in far more costly urgent and emergency care settings
Katie Bramall

NEWS ANALYSIS

Plan to double medical school places in England at risk

The NHS workforce plan pledged a rapid rise in medicine students, but two years on progress has stalled. **Alison Moore** reports

A planned doubling of medical school places in England to 15 000 by 2031-32 is in jeopardy, with the government refusing to commit to the goal.

The *BMJ* can reveal that the number of students admitted in 2025-26 and for 2026-27 falls far below the planned trajectory for the increase unless an expanded number of international students are included.

A failure to expand medical student places is also putting some medical schools—which opened in anticipation of an increased number of students—at risk of collapse.

The goal of 15 000 medical school places by 2031-32 was set by the then prime minister, Rishi Sunak, in the *NHS Long Term Workforce Plan* in 2023.

But two years on experts have told *The BMJ* they believe it is now unlikely the new Labour government will stick to the 15 000 target—and that this spring’s new NHS 10 year workforce plan will quietly aim for a reduced number of students.

Katie Petty-Saphon, chief executive of the Medical Schools Council, said, “We think that, if there are going to be new places, they will be focused on widening participation and under-doctored areas. Given the state’s finances, it’s probably unlikely to be as many as proposed in the previous workforce plan.”

Another commentator who has closely examined government workforce figures over time, who wished to remain anonymous, said, “If I was to speculate, I think they will scale back.”

They pointed to work by the Institute of Financial Studies in August 2023, which said the workforce plan had not considered

the medium term implications of increasing NHS staff numbers and the need for greater productivity to help fund this. The 2023 workforce plan was about getting extra Treasury investment, they added.

The Department of Health and Social Care (DHSC) refused to commit to the 15 000 target when asked to by *The BMJ*. Instead a spokesperson said, “This government is committed to developing more of our own homegrown talent and training thousands more doctors.

“We are working with partners including medical royal colleges, NHS England, and the university sector to ensure a person’s background is not a barrier to them being able to study medicine.

“Through our 10 year workforce plan, we will make sure we train the staff we need so we have the right people with the right skills in the right place, when and where patients need them.”

Increase in student numbers stalling

There are already signs that student numbers have flatlined. This year (2026-27) English medical schools will receive funding for only up to 8126 students—the same as 2025-26.

And targets are being met only by including a higher number of international students for which medical schools are given special exemption to recruit if they request it.

In 2025-26 medical schools were given special exemptions to take an extra 670 international students, above the normal maximum fundable limit (MFL) of 7.5% of each school’s total intake (see box). This brought the total number of medical students enrolled in England that year to 8775.

Without the additional 670, the medical school intake was slightly below the 8200 trajectory set out in the 2023 workforce plan.

The 2026-27 trajectory is 8700, but the number of medical school places funded under the MFL for autumn 2026 entry will be the same as that in 2025.

The Office for Students, which is responsible for distributing places among medical schools, has confirmed the government has not informed it of any increases for the 2026-27 intake, meaning the 2026-27 trajectory will also only be achieved if additional international students are included.

What happens beyond that is uncertain: the trajectory published at the time of the 2023 NHS workforce plan showed planned increases in England to 9350 in 2027-28 and 10 000 in 2028-29. There was then to be an uncharted jump to 15 000 by 2031-32. This now seems unlikely.

Medical apprenticeships, which offer the chance to gain a medical degree while working within an organisation and being paid, were meant to be a significant area of growth (up to 2000 places by 2031-32) but were indefinitely paused in 2025.

What will this mean for medical schools? The promise of growing numbers came with announcements of increased funded intakes for some of the newer medical schools. But these increased numbers have still left some medical schools with



If there are going to be new places, they will be focused on widening participation and under-doctored areas

Katie Petty-Saphon



HOW FUNDING OF MEDICAL SCHOOLS WORKS

Medical schools have an allocation of funded places that is decided each year by the Office for Students, with an overall maximum set by the government. The number allocated to each medical school is called the maximum fundable limit (MFL). Schools then get extra funding additional to standard tuition fees, reflecting the high cost of training medical students, and NHS trusts also get funding for providing clinical placements.

The MFL includes home students (UK graduates) and some overseas students, who pay higher fees. Overseas students are a maximum of 7.5% of each school’s intake, but schools don’t get funding from the Office for Students for these overseas students.

relatively low student intakes, with several taking only 45-65 UK students a year.

The graduate only Three Counties Medical School at the University of Worcester has a handful of international students. It opened in 2024 with 50 places allocated, with the number increasing to 62 in 2025.

Sandra Nicholson, dean of the school, said that “62 medical students isn’t really a viable number.” She added, “We have the capacity to take more, and we meet requirements for widening participation and being an underdoctored area. If someone suddenly offered us another 50 students we would not turn them down.”

The extra places allocated nationally in 2025 were widely spread across medical schools, meaning many only got a handful.

But Nicholson questions whether that was the right approach: while 10 extra students may not mean much to a university with a yearly intake of 350, smaller medical schools might have benefited from a region’s increases being clumped together and awarded to one school.

“We feel we are not being supported to deliver the NHS workforce because we have not been given the numbers to do it,” she said.

Despite the low numbers, Three Counties should “break even” in 2027 if the combined number of UK and international students currently being enrolled is maintained, Nicholson said.

But she added, “That’s not a healthy place

to be—we want to be sufficiently financially viable so that we can expand and support staff development.”

John Cookson, who has helped establish several medical schools in the past few years as a dean, including Portsmouth, Three Counties, Hull and York, and Aston, said, “The new medical schools are all relatively small, and it’s clear that the economics don’t stack up very well.”

He called for any increase in student numbers to go to these newer schools, “otherwise we run the risk of some of them getting into serious problems.”

Cookson added that some of the new schools have been good at widening

THIS YEAR (2026-27) English medical schools will receive funding for only up to **8126** students—the same as 2025-26

participation and also developing placements in a wider range of settings, outside teaching hospitals.

Some medical schools are predominantly taking students who fall outside the MFL. The University of Lancaster, for example, has 210 places exempt out of 265 and Brunel University has 105 out of 155.

The University of Greater Manchester (formerly the University of Bolton) opened



It’s clear that the economics don’t stack up very well
John Cookson

a medical school with 40 international students in 2025. It had hoped to get funding for some UK students through the MFL this autumn, but that has not happened.

Financially it is still viable and is looking whether it could take a few UK students, utilising its own resources.

But Iqbal Singh, pro-vice chancellor for medicine at the university’s Institute of Medicine, points out that the area it serves ticks all the boxes in terms of factors such as deprivation.

“There is always a fallback in that we [the NHS] can get international doctors,” he says. “That means the urgency [to increase UK medical student numbers] is no longer there.”

Enrolling overseas students helps to keep some medical schools financially viable—although it is far from clear whether those students will work as doctors in the UK in the long term. But schools with very low numbers and that rely on taking UK students may be wondering what their future holds.

In 2024 the Office for Students pointed out that some schools had said future capital investment required “larger numbers of new students to reach critical mass to make innovation in ways of teaching financially viable and sustainable.”

The BMA says that expanding student numbers needs both investment in medical academics, whose numbers have been falling, and jobs for newly qualified doctors.

In a joint statement the BMA’s medical academic staff committee co-chair David Strain and BMA medical students committee co-chair Elgan Manton-Roseblade said, “We cannot and must not be expanding medical school places without first making sure there will be sufficient teaching and other key resources in place to provide the quality of education required.

“We need to know that there will be employment for graduates at the end of their degree course. There needs to be a guarantee of a foundation training post, both foundation and specialty training posts, and the necessary financial commitments to create these posts.”

Alison Moore, Oxford
Cite this as: *BMJ* 2026;392:s312



Sandra Nicholson (left), dean of Three Counties at Worcester University; the BMA’s David Strain (centre) and Elgan Manton-Roseblade



THE BIG PICTURE

Ukraine's home front

As the war in Ukraine reaches its fourth anniversary, the charity Médecins Sans Frontières is marking the Russian invasion with a series of pictures taken by the award winning Ukrainian photographer Julia Kochetova.

With more than four million people internally displaced, MSF teams consistently see that the last to leave their homes are often the most vulnerable—elderly people, young families, and people with illnesses. Kochetova has captured portraits of these people, such as Zinaida Babisheva and her dog Toshyk, forced to survive in strange towns after being evacuated from their homes.

Alison Shepherd, *The BMJ*

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JULIA KOCHETOVA/MSF

UK medical workforce needs urgent reform

Evidence from University Hospitals Birmingham exposes deep flaws in the current approach

The exploitation of international medical graduates (IMGs)¹ and the financial irregularities in the international training fellowship programme uncovered at the University Hospitals Birmingham NHS Foundation Trust are deeply concerning.²

IMGs were recruited to work under poor employment conditions by using a “student loophole.” The funding of the fellowship programme, totalling around £40.5m, was routed through a third party company registered to a home address, with additional expenditure on overseas recruitment trips.³ Furthermore, most of the fellows were recruited from Pakistan, a country on the World Health Organization’s health recruitment “red list,” and many did not return to their countries as intended.^{2,3}

This scandal should be viewed in the broader national context, as symptomatic of a healthcare system with severe failings in workforce planning. Instead of a quick fix, we need bold action to overhaul medical workforce planning in the UK.

The UK’s shortage of doctors remains a persistent reality resulting in continuing reliance on IMGs.^{4,5} Yet the recent fierce competition for medical specialty training posts^{6,9} means that UK medical graduates fear unemployment.¹⁰ On the other hand, demand for healthcare services have expanded beyond the capacity of traditional consultant, SAS (specialist, associate specialist, and specialty), and specialty training roles.

This service gap has led NHS employers to develop locally employed doctor (LED) posts, whose numbers have surged over the past three decades.^{11,12} Unlike others, LED posts lack uniformity in standards and scope of practice, with substantial variations in employment contracts, pay, supervision, and career support.¹³ In 2024, there were 38 394 locally employed doctors in England and



A standardised national contract for LEDs is needed

Wales, of whom 69% were IMGs.¹²

Myriad pathways have evolved to facilitate the entry of IMGs to fill LED posts.¹⁴ Many follow the traditional Professional and Linguistic Assessment Board (PLAB) exam route. Others seek registration by sponsorship in one of over 100 schemes approved by the GMC.¹⁵ These schemes, lacking aligned standards in terms of format and quality assurance, promise doctors a confusing mix of service delivery roles and training opportunities, as highlighted by the GMC.¹²

For example, in Birmingham’s fellowship programme, IMGs were offered training but were exploited financially and used as cheap and disposable labour. Their contractual arrangements may have breached UK employment law and tax requirements.² Furthermore, the lack of standard pre-employment checks may have put patient care in jeopardy.³

Systemic overhaul is urgently required

We reiterate our call⁹ for urgent multipronged action to address these systemic workforce planning and governance failures, the perfect storm which led to the Birmingham situation. We must learn from our mistakes and acknowledge that fixing one workforce problem in isolation will only lead to the creation of new ones.

NHS employers should not be permitted to develop LED posts to fix the problem of service delivery only to create another—that is, training bottlenecks. Alongside the

GMC¹² and others,^{13,18} we advocate for a standardised national contract for LEDs, analogous to those held by consultants, SAS, and resident doctors.

With the introduction of the Medical Training (Prioritisation) Bill in 2026,⁷ which seeks to limit IMGs’ access to training posts, careful planning and standardisation is even more critical. This will mitigate the risk of IMGs having to choose between repeated applications for LED posts or leaving the UK, only to be replaced by another batch of IMGs through a “cycle of brain gain, waste, and drain.”¹⁹

A UK-wide strategy that takes a multidimensional approach to medical workforce planning will leave no room for IMG sponsorship programmes like Birmingham’s international fellowship programme, and all such programmes must therefore be abolished. The GMC must review and simplify the pathways for IMGs to enter UK practice, as the current complex system is not working.

Finally, accountability must be enforced when financial governance, employment law, and global recruitment codes of practice have been breached. Senior IMGs—including those currently leading IMG sponsorship programmes¹⁵—must uphold the highest ethical and professional standards and financial accountability. They must ensure the wellbeing of IMG fellows, appropriate use of public funding and safe patient care, and avoid potential reputational damage to all IMGs in the UK.

It is time to start tackling the UK’s medical workforce issues in a cohesive manner and stop exploiting IMGs and shattering their career aspirations. Birmingham’s failings must trigger bold and tangible actions to protect the NHS, deliver safe patient care, and ensure fair working conditions for all its medical workforce.

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Ambition versus reality in the training review

Postgraduate medical training review highlights key issues but stops short of the structural reform needed

Phase 1 of NHS England's medical training review is the most comprehensive assessment of postgraduate medical training in over a decade.¹ Based on more than 8000 responses, it brings overdue candour to longstanding clinical concerns. Despite large shifts in healthcare demand, the review finds that training structures have changed little over the past two decades. It identifies systemic problems, including rising competition for training posts, misalignment between service delivery and learning, and inflexible training pathways.¹

Severe bottlenecks now constrain training progression, particularly after foundation training, with record numbers taking career breaks;² in 2023, over 77% of doctors completing foundation year 2 in England did not, or could not, progress directly into core training.¹ As competition intensifies, many move into non-training roles, fuelling growth in the locally employed doctor workforce.³ These posts often offer inconsistent access to supervision, professional development, and career progression, creating inequity.⁴⁻⁶

Addressing the challenge

The review provides an evidence based diagnosis and sets out four promising recommendations: increasing flexibility, removing bottlenecks, recognising training outside traditional numbered posts, and rebuilding team structures.¹

A strengthened focus on flexibility is timely. Competency based training offers promising flexibility,^{14 15} but its effect on retention, wellbeing, and skill acquisition will need robust evaluation as reforms are implemented. Critics caution that moving beyond fixed time models requires stronger assessment practices and clearer evaluation frameworks to ensure competency based approaches are effective.^{16 17}



LES GIBBON/LAMY

Increasing trainee numbers without protecting training capacity risks lowering educational quality

Tackling training bottlenecks is another crucial area. There is now a bill before Parliament to prioritise the appointment of UK graduates to foundation programmes, which will address one aspect.¹⁸ Increasing training numbers is attractive, but doing this without safeguarding training capacity and quality risks exacerbating educator burnout and diminishing educational value.¹⁹ Structural measures to protect training time and strengthen supervision are therefore essential. One potential opportunity is to increase the training value of service work—for example, through improved feedback when trainees are working in supervised outpatient clinics. A 2012 systematic review found that clinical supervision of trainees is associated with better educational and patient outcomes.²⁰ More recent evidence links high quality supervision to positive organisational outcomes, including reduced staff burnout and improved retention, while highlighting limited evidence on scalable implementation.^{21 22}

From diagnosis to delivery

The limitations of the phase 1 recommendations lie not in their content but in their reliance on guaranteed investment, service redesign, and regulatory alignment across the General Medical Council, royal colleges, and NHS. Phase 2 must now move decisively beyond diagnosis. There are several priorities for action.

The first is to develop a fully costed expansion of training numbers,

explicitly linked to regional need and workforce modelling.²³ International evidence suggests that purposeful redesign of training pathways can improve workforce distribution. In Canada, doctors from the socially accountable, distributed medical training programme—designed to recruit students from rural backgrounds and to provide substantial training in underserved and rural regions—were more likely to practise in those underserved regions after graduation.²⁴ Similarly, in Australia, doctors who undertook longer periods of rural training and had regional ties were more likely to work in the rural region in which they had trained.²⁵ This supports recruitment and training embedded within underserved communities to tackle inequitable workforce distribution. Phase 2 should therefore pursue bolder recruitment and retention measures in underserved areas, including enhanced financial incentives, housing support, educational loan relief, and investment in training infrastructure.

A second priority is to address rota gaps and service pressures that erode protected training time. We also need to apply the same educational standards to locally employed roles as to training posts, including defined supervision arrangements, access to professional development, and recognised pathways for progression. In addition, digital and artificial intelligence (AI) competencies should be embedded across all curriculums, as these will soon be core clinical skills.²⁶

This review represents a rare opportunity to reshape medical training for the next generation. Whether it succeeds will depend on the willingness of policymakers, the profession, and regulators to confront structural constraints beyond training design.

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Unpaid overtime in the NHS is falling—what this means for the workforce

In 2024 NHS staff reported working unpaid overtime equivalent to at least 49 000 full time employees. Such discretionary effort has long underpinned NHS service delivery, but recent data show it is declining, find **Jack Elliott** and **Elaine Kelly**, raising questions for workforce planning

NHS Staff Survey

The NHS Staff Survey is an annual survey designed to collect views of staff on their experiences of working in their organisation. It invites staff directly employed by the NHS to participate, including doctors, nurses, allied health professionals, ambulance staff, administrative staff, and estates and facilities staff. In recent years the survey has had a response rate of around 50%.

The number of unpaid hours worked by NHS staff in England has fallen steadily since the covid-19 pandemic, show figures reported in the 2024 NHS Staff Survey.

In 2019 just over half (56.2%) of staff reported working unpaid overtime (fig 1). The proportion rose slightly during the pandemic, peaking at 57.4% in 2021, but by 2024 had dropped to 50.3%, below the pre-pandemic level in 2019. The proportion of staff working six or more unpaid hours a week also fell, from 14.3% in 2021 to 11% in 2024.

One cited explanation is lower motivation after the stress of the pandemic

More granular results from the staff survey show that the proportion of staff reporting at least some unpaid hours fell across all occupational groups, clinical and non-clinical.

The survey also provides some evidence for possible causes of this decline. One often cited explanation is staff disillusionment and lower motivation after the stress and exhaustion of the pandemic. The proportion of staff who believe their work to be valued fell from 48.3% in 2019 to 42% at the height of the pandemic, recovering only to 44.4% by 2024 (fig 2). Such a sentiment may affect staff members' willingness to work additional hours.

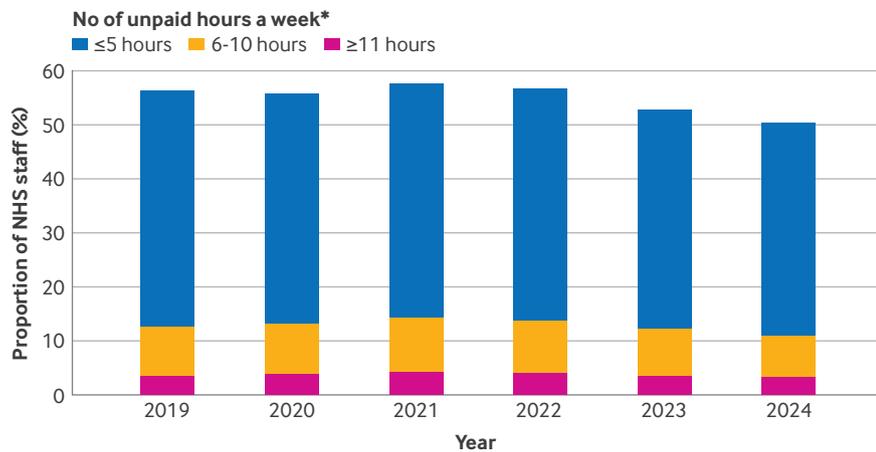
Another potential explanation is that the increasing size of the workforce since the pandemic has helped close rota gaps, which might lessen the need or demand to work additional hours.

Figure 2 shows that the proportion of staff agreeing there are enough staff to do their job properly has returned to pre-pandemic levels: 32.5% in 2019, falling to 26.2% in 2022, and rising to 34% in 2024.

It is likely that both explanations play some role, which may vary across occupations.

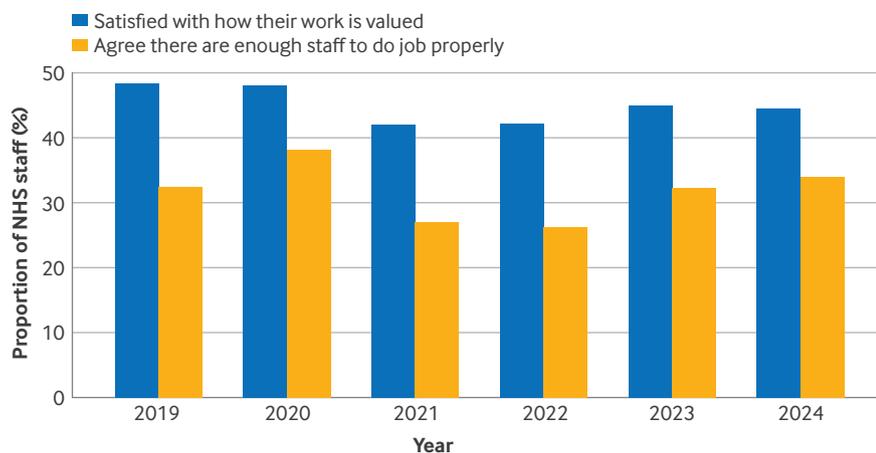
From survey responses and NHS headcount data the total unpaid hours in terms of full time equivalent (FTE) staff can be estimated (fig 3). These estimates, because they rely on assumptions about the number of additional hours worked within each response category and the assumption that survey respondents are representative of the wider NHS workforce, should be interpreted





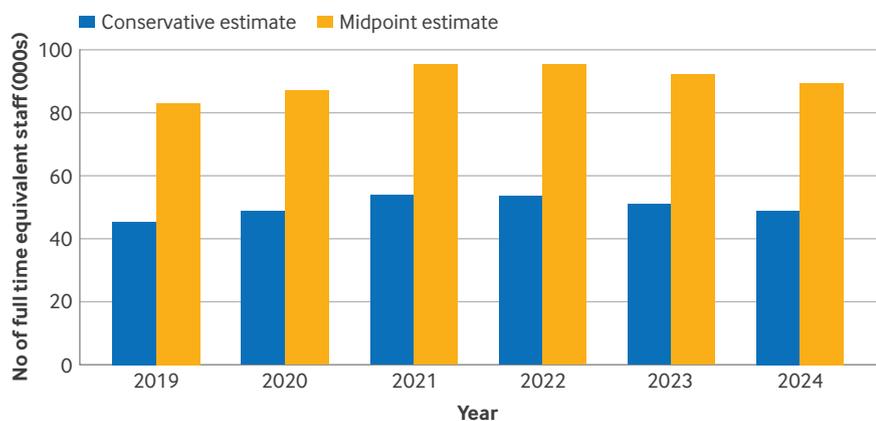
Source: NHS Staff Survey¹
 *Numbers of hours are the original response options in the NHS Staff Survey. Respondents reporting 0 hours are not included.

Fig 1 | Proportion of NHS staff working unpaid overtime



Source: NHS Staff Survey¹
 Data show percentage of NHS staff who responded "satisfied" or "very satisfied" to the question "How satisfied are you with the extent to which your work is valued by your organisation?" and "agree" or "strongly agree" to the statement "There are enough staff for me to do my job properly." Data for 2019 are unweighted as these data are no longer publicly available. Weighting for 2020, the only year with both weight and unweighted results, changed reported percentages by <0.5 percentage points

Fig 2 | Proportion of NHS staff agreeing that they are satisfied with how their work is valued and that there are enough staff to do job properly



Source: NHS Staff Survey¹, NHS workforce statistics³
 Conservative estimates are the minimum reported hours: 0, 1 (≤5), 6 (6-10), and 11 (≥11). Midpoint estimates are 0, 3 (≤5), 8 (6-10), and 13 (≥11), with 13 as an approximate value

Fig 3 | Total unpaid hours worked expressed as number of full time equivalent staff

Workforce planning assumes an implicit, continuing level of unpaid working hours

as indicative rather than exact. A conservative estimate, based on minimum hours worked per category, is that unpaid work in 2021 equated to 54 000 FTEs, falling to 49 000 in 2024. A midpoint estimate puts the figures higher: 96 000 FTEs in 2021 and 90 000 in 2024.

However, the total NHS workforce has grown by over a fifth since 2019, with increases across all staff groups. This complicates interpretation: more staff may mean more unpaid hours overall, even if individual effort declines. The combined effect of a larger workforce and lower rates of discretionary effort (as shown in fig 1) led to an indicative increase in overall unpaid hours from 2019 to 2024, equivalent to around 3000 additional FTEs under our conservative scenario. This is despite a smaller proportion of staff reporting working unpaid hours in 2024.

The higher total unpaid hours are therefore reflective of the larger workforce. It is unknown whether reported rates of unpaid hours were affected by the growth in the size of the workforce and a reduced need to fill gaps in rotas.

The forthcoming NHS 10 year workforce plan will be built on assumptions about how much care will be delivered across staff groups, including clinical and non-clinical roles. Historically, such assumptions were based on an implicit, continuing level of unpaid hours. Given recent declines in discretionary effort and the 10 year plan's commitments to improve working conditions, planners should assess how resilient their strategies are to changes in staff willingness to work beyond contracted hours.

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DOM MCKENZIE

HEALTHCARE APPS

MyChart: doctors are left frustrated and patients panic as NHS trusts roll out hospital records app

Amid poor integration with the NHS App and low user literacy, users say the US tech giant Epic's application is causing as many problems as it solves. **Sally Howard** reports

In September 2025 a patient sent a digital inquiry to the GP Rachel James's surgery in south London. The patient had presented at an emergency department the night before, had been discharged, and was asking for an urgent referral to a specialist. James was able to access the emergency department's notes stating the diagnosis and advice for the patient to contact their GP for a routine referral if symptoms worsened.

James messaged the department back, saying she and the patient could talk about the issue at an appointment the patient had booked on the surgery's system for the following month. Two days later, however, the patient submitted another inquiry through the Accurx digital communication tool, begging the GP for a referral because of abnormal results from their hospital blood test.

The patient's concern and persistence stemmed from them being able to see



It's a mistake to believe NHS patients will interact with these apps as US patients do
Carolyn Hodgman

their blood results on MyChart, a patient facing digital hospital record portal that has been rolled out in some NHS trusts. James recalls, "[The patient] could see on MyChart that their blood results were red flagged as outside normal range, when in fact they were only marginally out of range. There's no explanatory material on the app about this, and [the patient] had jumped to conclusions." The GP picked up the phone to find the patient "quite antagonistic," says James, as they believed that they shouldn't "feel responsible" for understanding and taking action over the abnormal results.

Patients presenting "in a tizzy" owing to confusion and anxiety over data logged on MyChart has, says James, been a frequent occurrence at her surgery since the trust she refers to for secondary care, King's College Hospital NHS Trust, rolled out the product in 2023.

Tech giant wins over trusts

MyChart is part of Epic Systems, a major US healthcare technology company that provides proprietary electronic health record software, known as Epic or Epic EMR, to hospitals and health systems. Some NHS trusts—including King's College Hospital, Guy's and St Thomas', University College London Hospitals, Cambridgeshire and Peterborough, Manchester University, and Torbay and South Devon—have given the Wisconsin headquartered company contracts worth £1.6bn for the use of Epic's digital products in their hospitals.

In August the *Health Service Journal* reported that Epic was on course to earn more than £3m a year from downloads of the MyChart app, which operates as MyMFT in Manchester University NHS Foundation Trust and as MyCare in University College London Hospitals.

Patients told *The BMJ* they had battled with inaccurate data on their MyChart record, as well as problems with the two factor authentication required to log in, multiple MyChart identities generated across trusts, and problems getting through to helpdesks run by the NHS trusts that license Epic's systems.

And GPs have told *The BMJ* the IT product is increasing anxiety among their patients amid low literacy around the product,

access to medical charts that are confusing to the lay reader, and fragmented access to secondary care. An Epic spokesperson says that “access to the medical record helps patients understand and manage their health” and that “MyChart helps trusts make healthcare more efficient and accessible” (see box overleaf).

Patient left frustrated

George Johansen-Berg, 46, a trans man based in south London, tells *The BMJ* that his recent diagnosis with acute myeloid leukaemia was made “more traumatic” by MyChart. Johansen-Berg is under the care of King’s College Hospital NHS Trust and Guy’s and St Thomas’ NHS Trust, both of which have licensed Epic products.

“MyChart has multiple versions of my name, my former name, and gender, over multiple accounts,” says Johansen-Berg. “One has the wrong name; one doesn’t have access to the data; and one allows healthcare professionals to view my data but not me, despite several unanswered calls to the helpdesks to attempt to resolve it all.”

On 19 September 2025 a bone marrow biopsy confirmed Johansen-Berg’s leukaemia diagnosis after blood tests had shown that he was anaemic and neutropenic. He had to manually download his test results at the point of diagnosis on site at the King’s College Hospital, as they weren’t visible to a doctor.

Sharing his treatment plan with his GP, who couldn’t see his records through Epic, required Johansen-Berg to generate an access code over the phone so his GP could log in. “You need a new code each time, and you have to really know what you’re doing and talk your GP through inputting your details, your date of birth, and code,” he says. “This is not what I should be spending energy on, with a cancer battle ahead of me.”

A joint statement from the King’s College Hospital and Guy’s and St Thomas’ NHS trusts said, “We’re very sorry to hear that George has experienced these issues. We are actively looking into these concerns to improve for the future.”

Access, with caveats

Advocates for digital patient record portals argue for data access on the grounds of patient empowerment and improved outcomes, including access to complex



The main issues are around patients’ anxiety
Jennie Button

records and charts. NHS England has said such products “improve citizens’ engagement in their own care and adherence to medication and care plans.”

Guy’s and St Thomas’ says MyChart gives patients “control over [their] care,” and Manchester University NHS Foundation Trust describes it as a “greener way to access your appointment details.” University College London Hospitals NHS Foundation Trust tells *The BMJ* that the MyChart app and the Epic site “empower patients” through secure access to their health records, appointments, and test results.

Studies in the US have found that digital record access through patient portals such as MyChart can improve patient outcomes by increasing adherence to medicines, improving blood pressure and sugar control in chronic conditions, and reducing hospital admissions, although results depend on patient engagement and how the tools are integrated into clinical practice.

Carolyn Hodgman, head of digital learning and knowledge systems at the South London and Maudsley NHS Foundation Trust, which has a contract with Epic’s competitor Oracle, says that there are “opportunities and risks” in the inexorable push towards digitisation and patient data access. The key questions, she says, are: “What is the cognitive load we are demanding of the user; will the user need education in the technology and how to understand and process the results they see; and who does the burden of explanation fall to? GPs?”

It’s a mistake, says Hodgman, to believe that NHS patients will interact with these digital products as US patients do. “In the US, patients act more like consumers,” she says. “Patients in the UK have a more paternalistic relationship with the NHS, and they don’t necessarily want the same level of autonomy over their care.”

Jennie Button, a Devon GP partner, says there’s a line to tread between these two positions. “There’s a tension between offering a less paternalistic style of medicine and expecting patients to be expert medics,” she says. “It’s a fine balance, but I believe



Clinically insignificant “abnormal” flags on results create extra GP workload
Sophie Newton

in giving timely information that is patient centred and enables patients to make good choices about their future treatment while avoiding unnecessary anxiety.”

Balance not struck

As currently deployed, MyChart isn’t achieving that balance, Button believes. She says, “The main issues are around patients’ anxiety when trying to interpret the meaning of their tests or scans before the images have been assessed by the clinician requesting them. I’ve often seen patients who are worried unnecessarily.”

GPs inevitably end up as the inappropriate receiver of that concern, she adds. “GPs are not best placed to interpret specialist investigations or initiate secondary care treatments or care plans. However, we are accessible, usually more so than the hospital [specialists],” she explains. “If there is bad news this needs to be presented to the patient by the specialist, alongside an action plan. Most of us feel better once there’s a plan!”

Sophie Newton, a GP in West Yorkshire, echoes Button’s concerns. While access to digital records is helpful for some patients, says Newton, it also puts a burden of anxiety and interpretation back on primary care, often at short notice.

“Clinically insignificant ‘abnormal’ flags on results create extra workload for GPs, as patients worry and book urgent appointments to go through them,” says Newton. “Also, serious results can appear in apps before clinicians have a chance to review or explain them, meaning that patients may learn something life changing alone—without adequate ‘breaking bad news’ support.” Such cases have hit the news elsewhere, including the 2023 case of a US parent discovering on a digital records portal that her daughter had a terminal brain condition called lissencephaly.

A GP in Greenwich who asked not to be named says that it’s the speed at which results appear on MyChart, in combination with long waits for secondary care, that causes concern for patients—and therefore creates work for GPs. “Patients get their results instantly on the [MyChart] app, then

have to wait months for their follow-up secondary care,” the doctor tells *The BMJ*. “They come to the GP asking us to discuss or action the results requested by the hospital. If trusts are using this technology they need to action follow-ups and prescriptions in the hospital, promptly.”

However, Sam Everington, a GP in Tower Hamlets, welcomes the ability to explain hospital diagnostic results to patients in his surgery. “Twenty per cent of our workload is looking after patients while they’re waiting [for secondary care],” he says. “Patients enormously appreciate me giving them the results because the wait for a diagnosis, which could be cancer, is enormously stressful.”

“Magical thinking”

Some NHS hospitals are working on integrating their Epic based MyChart data with the NHS App. However, the south London GP James says that she’s “gobsmacked” at trusts being allowed to choose software not currently compatible with the NHS App—in that its data and records from secondary care don’t transfer to the app—leaving GPs and patients alike with “myriad bits of software and places to look.”

An Epic spokesperson says, “NHS England, Epic, and trusts using Epic have worked together to integrate the NHS App with MyChart... Guy’s and St Thomas’ and King’s College Hospital[s] are live with this



Around 20% of our workload is looking after patients while they’re waiting for secondary care
Sam Everington

integration today, and additional trusts including Frimley Health, Great Ormond Street Hospital, and the Royal Marsden plan to go live with it by month’s end.”

James’s patients in Lambeth fall into two broad categories: white collar workers “who want to be over the minutiae of everything” and therefore become anxious when presented with records they don’t understand on MyChart; and digitally excluded people, who struggle to download and use the app in the first place.

Issues are compounded, says James, by the NHS conducting “ever higher numbers of tests” at the same time, as it’s not clear whether and when her patients will get routine hospital follow-ups. She accuses serial UK governments of indulging in “magical thinking” that digital technology will “solve everything in healthcare.”

There are also learnings from failures in MyChart’s operability and patient access for users of the NHS App, in terms of the timing of information being relayed to patients. For example, some patients can access documents from secondary care before their

GPs have had a chance to flag the documents as “no action” (not requiring further action from the GP). Hodgman says that to avoid placing the burden of education and explanation onto patients and GPs, the design of all such digital platforms must incorporate patient engagement and focus on audiences and their needs.

King’s College Hospital and Guy’s and St Thomas’ NHS trusts add, “MyChart has 750 000 registered users across King’s, and Guy’s and St Thomas’, and the vast majority of patient feedback has been extremely positive, with more patients actively involved in their own care.”

Meanwhile, Johansen-Berg is currently undergoing chemotherapy as he and his GP juggle multiple MyChart apps: two within one trust under his current and former names, and one under his current name that was set up by a second trust. He tells *The BMJ* it’s a “travesty” that NHS trusts are rolling out “unintegrated” US technology products “on the cheap”—buying in off-the-peg software rather than the NHS designing its own from scratch.

He says, “They are failing to recognise that the way people interact electronically with the service is just as important as how they interact with the healthcare teams looking after them.”

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Issues are compounded by the NHS conducting ever more tests at the same time
Rachel James

Epic responds

In response to the patient and doctor concerns raised in this article, an Epic spokesperson tells *The BMJ*:

- MyChart gives patients direct access to their medical record, allowing the patient and care team to see the same information. This transparency is one of the key benefits of MyChart, and patients who spot inaccuracies can and should contact their care team to correct the medical record held by the trust.
- Two factor authentication helps protect patient information by confirming the user’s identity before granting access. Both the UK Information Commissioner’s Office and the National Cyber Security Centre recommend two factor authentication, and it’s widely used across industries (eg, banking) to keep online services secure.
- To simplify the experience, MyChart offers login options like Face ID, automatically remembers devices so users don’t need to do two factor authentication many times from the same device, and starting next month patients will be able to log into MyChart with their NHS login at trusts live with MyChart-NHS App integration.
- Patients who receive care at several trusts may have separate records at each one. With Epic, trusts can share patient records in real time, and MyChart can bring information from multiple trusts together in one place. Patients with several MyChart accounts can go to “Link My Accounts” in the main MyChart menu to link them, enabling a single view of their health information.

- Patient feedback, along with related research studies, consistently shows that access to the medical record helps patients understand and manage their health. For example:
 - In a study on patient access to clinicians’ notes, 98% of patients thought such access was a good idea, and fewer than 5% said it made them confused or worried.
 - A patient at Manchester University NHS Foundation Trust said, “the time it saves and the worry it saves is fantastic” and “I would recommend everybody to use [MyChart] for peace of mind—for knowledge about your own health, there’s nothing better.”
- MyChart helps trusts make healthcare more efficient and accessible:
 - Last month, UK patients using MyChart were 39% less likely to miss their appointments.
 - Patients on waiting lists can automatically accept earlier appointments as they become available. Last month across UK trusts using Epic, patients were seen an average of 21 days sooner with appointments scheduled this way.
 - In 2025, more than 100 000 hours of UK trust staff time was saved through patients completing check-ins via MyChart.
- For those managing long term conditions or recovering from major procedures, MyChart offers personalised support through reminders, educational content, and progress tracking, with updates instantly visible both to patients and clinicians.

“It brings joy to the working day”—the paediatric doctor boosting morale through baking

Ash Patel, a consultant paediatric nephrologist, tells **Kathy Oxtoby** why he bakes for his team

For Ash Patel, a locum consultant paediatric nephrologist at Leeds Children’s Hospital, baking is more than a hobby—it’s about building connections and bringing joy.

“I use baking as a way of brightening our team’s day,” he says. Bringing treats to work “brings a bit more joy.” And during a busy shift, “having that five minutes to eat a slice of cake improves your mood and keeps you going for the rest of the day.”

Patel has always had “a bit of a sweet tooth.” Growing up in the 1990s in Birmingham, his parents ran a corner shop where he had his pick of penny sweets and chocolates. It wasn’t until his early twenties, however, while doing specialty training in paediatrics, that he discovered a taste for cake. “I was on a night shift when one of my friends brought in a lemon drizzle cake—it was delicious.”

He was inspired to make his own. He followed a recipe, “and it tasted great.”

Soon he was baking for others. When he took a year out from training to be a simulation fellow, part of that role was to deliver regional courses for paediatric trainees. “I set myself a goal of making cake or some sort of baked goods for the faculty and candidates attending the courses,” Patel says.

“People really love baked treats. They’re a nice way of destressing, a break from clinical work, and they bring much needed joy to the day,” he says. On returning

to training, he continued to bring in baked goods for his colleagues. “It’s a way of improving team bonding, morale, and a nice pick-me-up,” he says.

The positive response prompted him to do more; his baking progressed and he shared his experiences on social media. The Royal College of Paediatrics and Child Health (RCPCH) spotted his passion for baking and soon he was writing articles featuring recipes for the college’s *Milestones* magazine. And he now has his own

column—Ash’s Baking School.

He has also shared his interest through baking masterclasses at RCPCH conferences and become a renowned baker within paediatrics. He continues to bake to boost people’s wellbeing and bring joy to colleagues’ special occasions, from birthdays to maternity

Having that five minutes to eat a slice of cake improves your mood and keeps you going for the rest of the day

leave and retirement parties.

While his baking skills have advanced, and he can now create complex cakes, he is not “all about the decoration.”

“If a cake looks great but tastes rubbish then that’s not an enjoyable experience,” he says. “For me it’s about the taste, and what people love to eat.”

He loves to make cinnamon buns and pavlovas, “particularly in the summertime with different fruits,” as well as classics like cookies and brownies. He also enjoys trying recipes he picks up on his travels, such as cardamom buns from a recent trip to Denmark and homemade custard creams from Scotland.

He brings his ability to follow instructions to his baking—“It’s similar to following guidelines and protocols”—and with his renal expertise he finds he is suited to the precision and the attention to detail that sticking to a recipe requires. On a personal level, he loves the homemade taste of baking and finds “the effort, love, and care you put in” rewarding.

Anyone can bake, he says. “There’s a recipe out there for everybody. And it’s a great way of passing the day and sharing occasions with friends and family.”

While he came to baking “later in life, it’s become a huge part of my identity now. From having no baking skills at all I progressed little by little.” And his experience shows “you can take up anything you want, if you put your mind to it.”

Kathy Oxtoby, London
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HOW TO MAKE A CHANGE

- Invest in some basic equipment including scales, wooden spoons or a hand mixer, oven trays, and baking paper
- Look out for recipes on social media
- Start simple—choose something easy to begin with to gain your confidence
- Follow the recipe and be precise
- If at first you don’t succeed, try again

Ramadan: How can I prepare for fasting while working?

From prioritising sleep and hydration to rota planning, Muslim doctors share advice



Agree protected breaks

Salman Waqar, academic GP and former president of the British Islamic Medical Association

“For many doctors, Ramadan fasting is not an added burden but a deeply grounding experience. That said, fasting while working clinically does require preparation. Treating Ramadan as something to simply ‘push through’ is rarely helpful. A better approach is to prepare as you would for a run of demanding shifts: the more you plan, the smoother it’s likely to be.

“Start a couple of weeks before Ramadan. Gradually reducing caffeine can help avoid first week headaches. If you have any new health conditions or major changes to medication, consider speaking to your GP or occupational health early. Temporary adjustments may be practicable if requested in good time.

“Think realistically about your rota. Where possible, avoid stacking long days or heavy on-call commitments at the very start or end of Ramadan, when sleep patterns are most disrupted. Agree protected breaks, particularly for prayer and meals, and have a clear plan for handover if you feel unwell. These are sensible patient safety measures, not special treatment.

“Sleep and hydration are your foundations. Prioritise sleep ruthlessly, even if that means saying no to non-essential commitments. For pre-dawn meals, aim for slow release carbohydrates, fibre, and adequate fluids; after sunset, hydrate deliberately rather than reactively.

“Finally, be attentive to your own signals. If you feel unwell or unable to practise safely, breaking the fast is supported by religious authorities. Approached with planning, self-awareness, and balance, Ramadan can be one of the most rewarding and sustaining periods of the working year.”



Don’t make grand plans

Anisa Jafar, emergency and paediatric emergency medicine consultant

“Preparation is probably the thing we forget. I don’t just mean Ramadan meal planning—although admittedly, with young children and a busy job, that helps a lot over the month. Preparing emotionally and spiritually is key—asking yourself what the month means to you, and how you plan to slow things down and bring yourself back to the deeply important aspects of life which frequently get neglected.

“I’ll often put in my calendar a time where I can force myself to stop and think about this. I try not to have grand plans which are unachievable, but I’ll think about what we can do as a family to reconnect spiritually. I also think about how we’ll realistically weave this around shift work.

“It’s tempting to save days off for the period afterward around Eid. I’ll confess that’s my usual approach, but others say they find that taking time off during the month itself helps them develop the Ramadan ‘frame of mind.’

“Of course, not eating and drinking during daylight hours affects different people in different ways, even those in good health and therefore able to fast. I’m remarkably calm when fasting, usually I’m bouncing around at 100 miles an hour, but during Ramadan something switches.

“What I find tricky is the evening rush with the kids just before breaking fast, where even on a normal day patience is in short supply. Fasting is more than just about eating and drinking, it’s how you handle yourself and consider others—so that’s my pinch point if I’m not paying attention. It’s important to know yourself and plan so that you can get the most from this beautiful month of renewal and reflection.”



Manage your sugar intake

Jihad Malasi, GP and Kent and Medway Integrated Care Board clinical lead in mental health

“In the Islamic tradition, fasting holds a special place for believers throughout the month of Ramadan as one of the five pillars of the faith.

“However, the ‘9-to-5’ poses practical challenges for adherents and colleagues in clinical practice. In addition to the fast throughout the holy month, Muslims engage in deep prayer during the day and particularly during the small hours of the night. In addition to hunger and thirst, tiredness may result. I have developed practical strategies to support a healthy fast and sustainable working arrangements.

“Firstly, preparation is key. Healthy nutrition at break fast and particularly before sunrise is essential. High satiety foods such as pulses and legumes, salads, fibre, and protein may help stave off hunger, keep you full for longer, and support concentration throughout the day.

“Secondly, manage your sugar intake. Dates and traditional pastries are firm favourites at this time of year, for cultural and religious reasons, and although delicious they are high in sugar so avoid consuming too many. Thirdly, hydration throughout the evening is important to keep your kidneys happy.

“Finally, accessing prayer spaces at the appropriate times can be difficult to navigate in the healthcare system. As a GP, I’ve found that an early discussion with the practice manager and clinical colleagues is a good place to start. For most practices, provided the work gets done there can be flexibility in how you arrange your day. Use this to create short prayer breaks but be mindful not to create additional work or drive bottlenecks for colleagues.”

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