comment

"What things can be done only at national level in our publicly funded system?" **DAVID OLIVER**
"I didn't tell the children 29% of NHS workers are thinking of leaving" **SCARLETT McNALLY**
PLUS MRCP exam disaster and women; placeholder jobs

PRIMARY COLOUR Helen Salisbury

Improved access needs increased capacity

We have a capacity problem in general practice. There are too few GPs for the number of patients who need looking after. This is despite there being GPs unable to find work and practices that would like to employ them but lack the money or space.

Unsurprisingly, capacity and access are a priority for the government—perhaps because nothing says the system is broken quite as effectively as an 8 am queue for appointments snaking around the block. Last year's primary care network contract included extra payments related to this, with a number of boxes that needed to be ticked to earn them.

Unfortunately, the focus was entirely on ease of access (how the patient makes contact with the surgery through new telephone systems and online triage) rather than on increasing capacity (the number of appointments available). This doesn't help patients or doctors, and it often just exacerbates the mismatch between supply and demand.

In this year's contract there's a requirement, although delayed until October, that all practices have online systems open during core hours (8 30 am to 6 30 pm, Monday to Friday), through which patients can submit non-urgent clinical or administrative queries. When online access started some practices left their submission portal open continuously, but they rapidly moved to limit these hours after arriving on Monday mornings to hundreds of patient queries and finding it impossible to respond to them all.

In our practice we have, until now, turned our system off at 4 30 pm so that there's time for submissions to be read on the same day and actioned if necessary. This is because, despite the system advising patients that submissions may not be seen immediately, we're concerned they may send clinical queries that do need an urgent response and that they could come to harm if their question about chest pain or breathlessness isn't seen until the next day. Some online systems (although not all) don't allow submissions if they contain certain trigger phrases, but such safeguards are unlikely to be foolproof.

However, there's a more fundamental problem: making access easier increases demand. Patients message us with questions they would never have booked an appointment to discuss, but we must now read and respond to them. The huge amount of work this creates is of only limited benefit and eats into time we should be using to see patients.

Clearly, we need to make it simple for patients to seek medical care when they need it. But online access is no panacea. It's a mode of access that excludes many patients and may worsen the capacity problem. It reminds me of the town where I grew up, where a failed road redevelopment became famous for funnelling traffic very quickly from one bottleneck to an even bigger one. Making access to GPs easier without taking concrete steps to increase capacity feels like much the same failure of planning.

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Patients message us with questions they would never have booked an appointment to discuss

ACUTE PERSPECTIVE David Oliver

What should remain within NHS central agencies?

The latest major reorganisation of the NHS's government departments and central agencies raises the hypothetical question of which functions can best or only be served by central bodies operating at national level. Hypothetical or not, I do have to give the question some empirical constraints.

First, data from the British Social Attitudes survey and other big datasets such as the Health Foundation/Ipsos rolling polls on public perceptions of the NHS show little support for a wholesale shift away from a tax funded, universal, free-at-point-of-care health service and continuing support for the NHS's founding principles, even though satisfaction with the current service is at a record low.

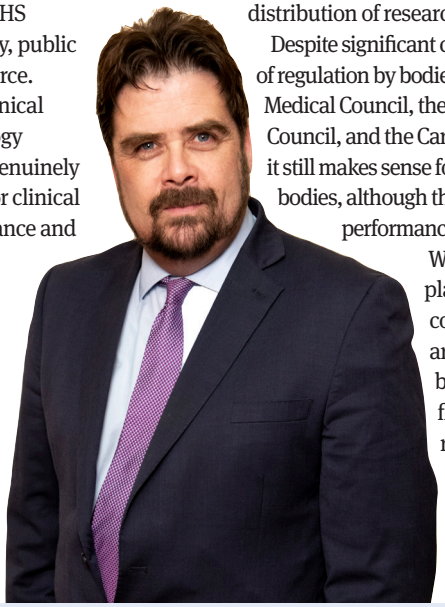
Second, even within universal healthcare systems in high income nations with publicly funded services rather than insurance or copayment models, the NHS is arguably the industrialised world's most centralised. Several others have more devolution of power and accountability to regional administration.

My question is, what are the things that can be done only at national level in our current publicly funded system? Imagine starting with a clean slate.

Well, I'd say the traditional civil service roles supporting government policy development and commitments, implementation, primary and secondary legislation, and government communications are a given. So too is the departmental funding round with the Treasury and the distribution of that funding from general taxation and national insurance to NHS organisations. Price setting for activity and contracts is another one.

National datasets

It also seems clear that a government department or other arm's length agency is best placed to collect and produce genuinely national datasets—on NHS performance and activity, public health, and NHS workforce. Likewise for national clinical guidelines and technology appraisals, along with genuinely national programmes for clinical audit or quality surveillance and improvement.



Screening, vaccination, and health protection programmes also seem to me to sit best at national level, as well as programmes to tackle health inequalities, whether or not with local oversight. I'd also argue that centralised control makes sense for commissioning of services for highly specialist or rare conditions, which will cover huge populations and need to be distributed at regional level. The same could apply to procurement of key equipment and of procedures best not duplicated by hundreds of local organisations—for example, cybersecurity and the administration and distribution of research funding.

> I can't see the government relinquishing control of things better done at local level

Despite significant concerns about the quality of regulation by bodies such as the General Medical Council, the Nursing and Midwifery Council, and the Care Quality Commission, it still makes sense for these to be national bodies, although they must improve their performance to restore confidence.

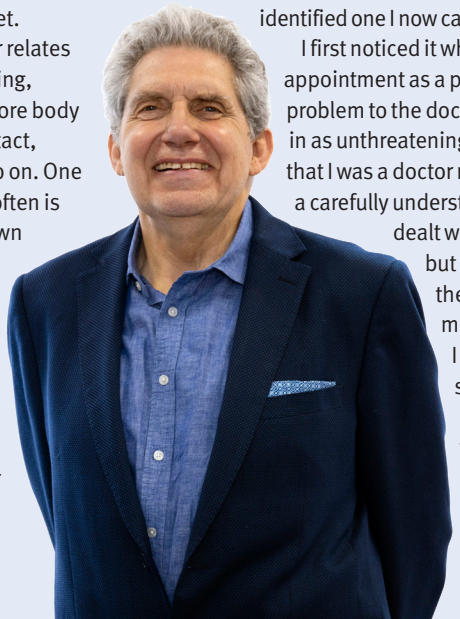
What about workforce planning and terms and conditions? I've seen arguments these should be devolved to give flexibility to "hard to recruit" disciplines or localities. And I can see an argument for at least some local flexibility and pay incentives on top

TALKING POINT John Launer

Watch out for that indulgent smile

I spend a lot of time teaching communication skills, although I prefer to call them interactional skills, which suggests more of a two way street.

Much of what I cover relates to speaking and listening, although you can't ignore body language too: eye contact, sitting position, and so on. One experience I mention often is seeing a video of my own consultations for the first time. I was horrified to see how much I fidgeted, played with my pen, and looked at the computer—and how distracting this was for the patient.



Since then, I've always been on the lookout for different forms of bodily expression, whether positive or negative. A couple of years ago I identified one I now call the indulgent smile.

I first noticed it when I had a clinic appointment as a patient. I'd explained my problem to the doctor and then mentioned, in as unthreatening a manner as I could, that I was a doctor myself. I also added, in a carefully understated way, that I'd often dealt with the condition as a GP but was interested to know their view and what they might advise. It was then I received the indulgent smile.

Afterwards, I realised what the smile implied. It was something like: "You're old and I'm young, so your knowledge is likely to be out of date and inferior to mine." It may also have meant: "You may be a doctor, but you're not the doctor in this consultation." Either way, I'm afraid its effect was to make the doctor's effort at charm seem like a thin veneer for patronising me and disqualifying my lived and professional experience.

Of course, the indulgent smile isn't dependent on the patient being older or a doctor. Once you start looking out for it, you see doctors doing it almost every time a patient hints at expertise in their own condition. It also goes without saying that the indulgent smile isn't specific to one condition or specialty.

Since identifying it, I've seen it on the faces of everyone from senior surgeons to GP residents. I'm sure that I've purveyed indulgent smiles myself down the years, and I blush to

of national pay bargaining. I also think a free-for-all and letting the market reign could lead to huge pay differentials between specialties, dominance of employers that can pay more, a further worsening of recruitment, and no ability for central agencies to tackle shortage areas or to plan and fund training posts.

Beyond these central functions, priority setting, service configuration, and community collaborative focus would sit far better at local or regional level, with power devolved to local service leaders. This is in line with health secretary Wes Streeting's rhetoric, if not recent government actions—although with a caveat that big local acute hospital trusts could still dominate other less powerful and visible interests. In reality, the government is staking its reputation on cutting elective waiting lists, improving productivity, reducing pressure on acute services, improving access and continuity in primary care, and (perhaps) increasing provision to community health services.

I can't see the government relinquishing control even of things that would be better done at local level by people who understand, work in, and live in those communities. Besides, there are still no credible central plans for resourcing local government run services such as adult social care, public health, or housing.

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You spot it almost every time a patient hints at expertise in their condition

think how often. I now feel guilty about having surrendered to yet another of our profession's institutional vices.

A lot is said and written these days about doctor-patient partnerships, shedding power, shared decision making, and similar concepts. But I wonder if the first step in adopting such approaches would be to notice when that indulgent smile starts to creep across your lips. You may decide to wipe it off your face, as our schoolteachers used to say. You might think you know better than the person who is across the desk or lying in a hospital bed, but possibly you don't.

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DISSECTING HEALTH Scarlett McNally

Schoolchildren give me hope for future generations of NHS staff

I recently had an amazing time when invited to speak at a primary school careers day. We played with plastic bones and passed around joint replacements and intramedullary nails.

I explained that NHS staffing isn't what you see on TV: only 12% of NHS workers are doctors and 26% nurses. I explained that there are 14 allied health professions and that half of our 1.7 million staff have jobs involving computers, maintaining buildings and equipment, and organising other staff and procedures. We worked out that the number of workers needed to keep the NHS running would fill thousands of classrooms.

The children were dressed up for their dream job. Aspiring astronauts, firefighters, and doctors asked insightful questions. After 30 years as a surgeon I found this one of the most powerful reflections I've done, seeing my career through their eyes. They asked what my most difficult operations had been. I explained that, before seatbelts and airbags, two cars would crash into each other and we'd have to operate on the occupants of both, one after another.

Did I ever have to do operations I didn't like? I replied that surgeons used to have to do whatever operation was needed and to keep operating through the night. I described how this had changed with new rules in 1998, stating that it was better for most patients to wait for a fresh operating team the next day or a little longer for a specialised team. I remember that the new "life or limb threatening only" rule was better for us surgeons too and allowed us to sleep.

I explained to the children that many important people still wrongly think you have to be a heroic surgeon who can do every operation without needing sleep—and this expectation means that some doctors are discouraged from becoming surgeons.

After 30 years as a surgeon, this was one of the most powerful reflections I've done

Surgery now needs teamwork, and we refer tricky operations to the surgeons who are best at them.

I told them I love my job. Work, whether paid or voluntary, is a key social determinant of health and gives people a sense of fulfilment and purpose. Colleagues can be like a supportive second family. I'm grateful to a former manager who helped me back to work part time while I was undergoing chemotherapy, while others were advising me to take ill health retirement.

I didn't tell the children that 29% of NHS workers are thinking of leaving. The Royal College of Nursing describes nurses quitting as a "perfect storm" that threatens patient care. The 74% of NHS workers who are women will be disproportionately affected when budgetary changes in April increase the care costs for children and older people, which may make it unaffordable to work.

I also didn't tell them about government plans to "sweat the assets" with three session day operating. The "assets" are our staff, and we need them energised, including the 7% who report a disability. More flexibility in staffing, such as two surgeons sharing a list with early and late sessions, may be helpful. Since 10% of planned operations are cancelled at short notice, clarifying roles to ensure good pathways, patient preparation, and team communication would be a better way to increase efficiency than reinforcing archaic views about surgeons' productivity.

The children's enthusiasm gives me hope for the future. I trust them to work hard in teams and to look after the rest of us. We should nurture this generation of NHS workers. I encourage other NHS staff to connect with their communities—it brings joy.

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OPINION Kate Womersley, Stephanie Kelly, and Nora Murray-Cavanagh

The MRCP exam disaster has created a hidden, unremediated cost for women

Solutions and compensation offered to affected doctors is insufficient

On 20 February nearly 300 doctors were told they had been given the wrong results for part 2 of the Membership of the Royal College of Physicians (MRCP) UK exam which they had taken nearly a year and a half earlier.

Of the 1451 candidates who sat the paper, 61 found out that they hadn't failed as they had been led to believe, and months of further revision and resittings of the exam had been unnecessary. Meanwhile, 222 candidates who thought they had passed the exam were told that they hadn't. This group is now facing the prospect of returning to intense revision to resit the exam with uncertainty about their future career progression. But the consequences for these doctors are much greater than a further exam attempt.

The Federation of UK Royal Colleges of Physicians, responsible for designing and delivering these exams to assess competence and professionalism of medics in training, administers three sittings (or "diets") of MRCP part 2 per year. With this routine, you'd expect the process to be slick and reliable. How could it have gone so wrong?

Prompted by discrepancies identified during a question setting meeting in early 2025, the federation conducted an internal audit of the September 2023 sitting which uncovered a catastrophic failure of oversight, undermining the integrity of the process and calling into question wider processes for all royal college exams.

Exams are a visceral reality for doctors, affecting our lives and putting strain on those in our support and caring networks. Exam progression fundamentally shapes our choices: where we can live and work, our future professional opportunities, and our career progression to higher training.

Planning and budgeting

Even under ideal circumstances, the timeline for completing membership exams (with several attempts for each sometimes required) in time to qualify for higher specialty training requires planning and budgeting across three years of full time training, and months of evenings and weekends set aside for revision.

To compensate for their error, the federation has opened up a full diet of part 2 so that the "false positives" can retake the exam, just six weeks after being notified of the error. A quick retake may benefit some, but it clearly does not fix the problem for most, particularly those who have non-negotiable caring commitments outside work.

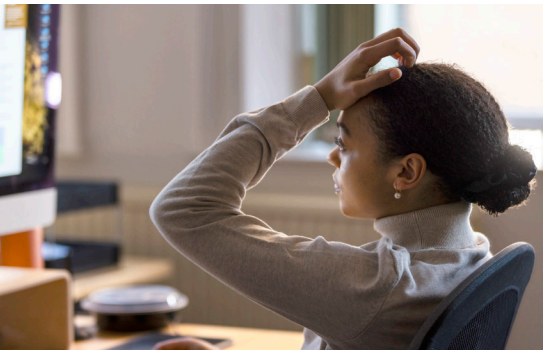
Meanwhile, the Statutory Education Bodies (SEBs) of the devolved nations and the GMC have made it clear that affected doctors will not be allowed to continue their applications for specialty training this year, even if they have passed the final part of MRCP and met all other training competencies.

The doctors who were falsely told they failed are merely being refunded the costs of their subsequent exam sittings, which does not account for the other direct costs

OPINION Alastair Paterson

The number of prospective doctors given placeholder jobs demands urgent action

The growing number of medical students put on a "placeholder" list after applying for foundation year training raises concerns about the capacity and foresight of the UK Foundation Programme Office (UKFPO).



In 2024, more than a thousand medical school graduates were left without allocated foundation year training posts and faced a prolonged period of uncertainty while emergency posts were created. This has left graduates unable to plan the next steps of their careers and personal lives. Early reports suggest that this year hundreds of students have again been given a placeholder allocation.

The shortage of foundation training posts is indicative of a growing problem, as the number of students graduating from UK medical schools is expected to continue rising. This is the harbinger of an emerging workforce crisis. Unless there is an adequately planned, sustained expansion in the number of foundation training posts available in the UK, the placeholder list is likely to get longer each consecutive year. Talented graduates left waiting with uncertainty are more likely to look for careers outside the UK or the NHS, taking with them substantial public investment in their education.

Several drivers are contributing to the problem. In 2020 and 2021, the government temporarily lifted the cap on the number of medical school places because the higher grades awarded by teacher assessed A levels during the covid-19 pandemic led to a surge in university admissions. Before this, the number of medical school places in England had already expanded by 25% between 2018 and 2020, from around 6000 to 7500. This is only set to rise further as the NHS Long Term Workforce Plan is aiming to increase the number of places to

Exams are a visceral reality, affecting doctors' lives and caring networks

of repeated attempts including travel, preparation materials, courses, and extra childcare. No compensation has been offered for the salary consequences of delayed progression or for the very real possibility that some doctors may have left training or a medical career altogether.

Such suggested solutions fall especially short for women. What about the harm that is not so easily quantified in pounds and hours? What about the consequences for family life? Postgraduate exams tend to fall in women's fertility focused late 20s and 30s, adding a layer of complexity to the considerations of exam timing and preparation, above and beyond the obvious pressures.

Women—men too, but much less so—make decisions about conception and parental leave around these exams. For many, the combination of exhaustion, pregnancy, perinatal complications, stress, and existing childcare demands makes the proposition of pregnancy, birth, and the postpartum period while studying highly challenging, or even impossible. Friends confide that "once I've got this exam done, we're going to try for a baby." This kind of discussion is commonplace between doctors but is rarely acknowledged in public settings from those with decision making power.

For candidates who already have children, many of whom are working "less than full time" (incidentally, often equivalent to full time hours in many other workplaces) to juggle childcare, the costs—financial and otherwise—of extra courses, revision, and delayed career progression can be profound.

Precious study time

Additional expensive nursery days paid for (if available at all), childcare provided by partners and grandparents, and informal favours called in to create precious study space put a demand on candidates, families, friendships, and these doctors' children. To find that this sacrifice has either happened unnecessarily, or that it needs to happen again unexpectedly, is devastating. No remedy that ignores the exigencies of these exams for those planning and caring for families can be adequate or fair.

Quite rightly, the BMA has responded by demanding further practical and compensatory proposals, such as forgoing further expense for these exams, supported study time, and discretion about when to resit the paper. In response, the federation's offers have improved, now including a "robust compensation package" to reimburse subsequent exam fees, courses, question banks, and "other financial losses incurred as a direct result of the error." But history shows that "robust" support often falls short of recognising the person beyond the professional, even though we all know that medical training bleeds into and leeches off our private lives.

Women's interests seem particularly poorly represented by what MRCP candidates are now being asked to do to fix an institutional mistake. A demand for due consideration of the personal ramifications of exams is not to reduce women to their reproductive capacity; it is an appeal to recognise the choices and responsibilities around pregnancy and childcare that loom large for many women doctors.

Mistakes like this, and a failure to acknowledge the broad implications of exams on responsibilities outside training, contribute to the "leaky pipeline" from medical student to consultant, reducing representation of women in positions of seniority and power. We cannot endorse the repeated exclusion of these considerations from discourse and policy, if we seek fairness and humanity in medical training.

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Stephanie Kelly, ST5 intensive care medicine, NHS Lothian
Nora Murray-Cavanagh, Deep End GP, Edinburgh

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Uncertain graduates are more likely to look for careers outside the NHS

10 000 by 2028 and to 15 000 by 2031. The decision by the UKFPO to remove points for intercalation, which took effect from 2023, will also likely contribute to a decline in the number of students extending their study, bringing forward their point of entry to foundation programmes. The culmination of these factors presents a perfect storm for students applying to the foundation programme going forward.

This stark expansion in medical schools' student intake was aimed at alleviating anticipated healthcare workforce shortages, but this has only worsened the emerging bottleneck faced by students entering the foundation programme—and specialty training beyond that. The NHS Long Term Workforce Plan says that it will ensure "adequate growth in foundation placement capacity"; however, the placeholder list continues to grow year on year. Data show 258 students were on the list in 2020, 494 in 2021, and 791 in 2022, with reports of around 1000 students being listed in 2024. With further increases in the number of students set to graduate in 2025, 2026, and 2027, this list can only be expected to grow if the UKFPO fails to plan properly a parallel expansion in the creation of foundation year training posts.

Entry to foundation training is a critical juncture in the path from student to NHS clinician. Currently, around one in three UK medical school graduates are planning to leave the NHS after foundation training. How many committed, talented graduates will act on plans to leave if their first experience of NHS recruitment is so stressful and demoralising?

The UKFPO has not confirmed how it will avoid a repeat of last year's placeholder problem. A coordinated effort is required from the Department of Health and Social Care (DHSC), higher educational institutions, and the UKFPO to ensure that the foundation programme has appropriate capacity for the number of graduates entering the workforce. This requires foresight, applicant centred recruitment policies, targeted investment, and a phased expansion in the number of foundation training posts available.

The 2024 data are a warning signal of a system under stress. A workforce retention problem is insidiously growing. The UKFPO and DHSC must act to retain highly skilled graduates and avoid a catastrophic waste of public investment in undergraduate training.

Alastair Paterson, medical student, University of Manchester

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LETTERS Selected from rapid responses on bmj.com

CLOSURES IN US FEDERAL RESEARCH

Children will suffer

As paediatricians working in the US, we view the changes being made to our healthcare and education systems, research enterprise, and regulatory agencies (Opinion, online 12 February) as truly dystopian.

The damage is clear. The breakdown of information from the CDC; unjustified firing of workers from the National Science Foundation, US Department of Agriculture, FDA, and Environmental Protection Agency; decreasing the funding of university research through NIH; dismantling the US Agency for International Development; and withdrawal from WHO and the Paris Climate Agreement have disproportionately adverse effects on children. Children will suffer from diseases and disabilities that otherwise could be prevented and treated, a dire consequence of policies adopted by the very federal government entrusted with promoting and protecting their health, development, and functioning.

Dictators have historically used health as a target to destroy the core strength of their citizens. Pol Pot prioritised physicians for execution in Cambodia; Mao Zedong closed medical schools in China; Bolsonaro destroyed the mental healthcare system to favour evangelical centres in Brazil. The recently confirmed health secretary Robert F Kennedy Jr has pledged to "investigate the childhood vaccine schedule" and "scrutinise [selective serotonin reuptake inhibitors] and other psychiatric drugs." Leaders who care about their nation's citizens do not act to destroy their health; only those who seek absolute power do this.

Children do not vote, so we have to be their voice. Americans must engage our elected leaders and all those who care about children to demand action. For our medical colleagues across the globe, we need your witness of children suffering as these programmes are ending. We need pressure from your elected leaders on our current president to restore funding. The assault on child health and human rights must end before it consumes every one of us.

Colleen A Kraft, professor of pediatrics, Los Angeles; Michael Weitzman, professor of pediatrics, New York; Donna Koller, professor of early childhood studies, Toronto; Jeffrey Goldhagen, professor of pediatrics, Jacksonville; Francis Rushton, pediatrician, Birmingham

Cite this as: *BMJ* 2025;388:r572

TRUMP PRESIDENCY AND WOMEN'S RIGHTS

Calling out misogyny is more important than ever

Buse and McKee discuss the impact of a second Trump administration on global health (Opinion, online 21 November), noting the risk to organisations supporting sexual and reproductive health rights. Women's health is at risk in other ways including increased gender based violence and shifts in societal norms.

The far right slogan, "Your body, my choice," tweeted by white nationalist Nick Fuentes after Trump's 2024 victory, is only the start. A Unesco survey found that 73% of female journalists have experienced online violence in the course of their work. Online abuse has real world health consequences such as psychological harm. Misogynistic speech represents men's view of women as people who can be dominated, disrespected, and coerced.

By setting a tone that says violence against women is unimportant, the misogynistic right will set women's sexual and reproductive rights back decades. Calling out misogynist men who denigrate women is needed now more than ever.

John Oldroyd, senior lecturer in public health; Nancy Shresta, master of public health student; Alison Hughes, senior lecturer in public health, Melbourne

Cite this as: *BMJ* 2025;388:r550

INVESTMENT TO PREVENT ILL HEALTH

Dismantling the structures that have failed

Salisbury is right that preventing ill health requires investment (Helen Salisbury, 8-15 February), but we have been here before.

In 2015 Jeremy Hunt pledged an extra 5000 GPs by 2020—the number of full time equivalent (FTE) GPs actually went down. Instead, the NHS has continued to pour vast amounts of taxpayers' money and human resource into secondary care. In October 2014 the number of FTE doctors recorded in the hospital and community health services statistics (primarily hospital doctors) was 104 920. By October 2024 it was 147 120, nearly 8000 more than in October 2023.

Even with clear direction from the top, the NHS structure will fail to invest in prevention or primary care in favour of the hospital sector. Sustainability of the NHS depends on a radical upgrade in prevention and public health, and this will require dismantling of the structures that have so clearly failed.

John Ashcroft, locum GP, Derby

Cite this as: *BMJ* 2025;388:r560

LOSS OF NHS HOSPITAL BEDS

Art of "holding patient care in general practice"

Data on hospital beds are important (Letters, 22-29 March) but must not eclipse upstream priorities for tackling NHS pressures. Strengthening general practice is crucial—especially the art of "holding patient care in general practice." This means meeting patients' health needs as far as possible in primary care and avoiding unnecessary referral to secondary care.

Learners must be comfortable consulting "in the dark": navigating patient care through history, examination, incremental management, and safety netting rather than defaulting to sequential clinical tests. Final year medical students must be confident consulting without feeling compelled to investigate, prescribe, or refer.

The GMC's undergraduate medical licensing assessment favours a "hunt the diagnosis" approach, which will increase healthcare cost, drive up patient expectations, and risk staff burnout. Supporting learners in holding patients and "applying the brake" to healthcare consumption—while ensuring appropriate access to secondary care—requires nurturing but is essential for a financially and environmentally sustainable NHS.

Max Cooper, associate general practitioner; Carl Fernandes, locum general practitioner; Jason Heath, general practice partner, Falmer

Cite this as: *BMJ* 2025;388:r546

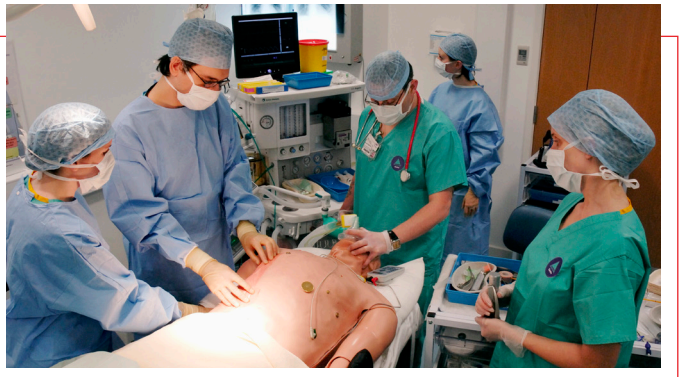
REVOLUTION IN ACADEMIC MEDICINE

Reducing bureaucratic barriers

We support the BMJ commission's effort to tackle key challenges in clinical academia, but we do not think the primary problem is lack of reward (Editorial, 14 December). Most academics are motivated by a passion for improving healthcare, not financial gain. Many dedicate their personal time to produce and share data.

A critical issue overlooked by the commission is bureaucratic burden. The current systems are complex, inefficient, and repetitive. Streamlining funding application processes is urgently needed. Extensive work is currently required to secure ethics approvals, research and development approvals, and contracts, leading to major delays and frustration. There is increasing recognition of this, but incentives are necessary to encourage NHS, university, and ethical regulators to facilitate, not hinder, research.

Access to healthcare data is also a problem. Anonymised data is highly regulated, whereas commercial access to non-anonymised data are less restricted—health improvement should be prioritised over commercial interests.



Steven Thornton, consultant obstetrician, London; Siobhan Quenby, professor of obstetrics, Coventry; N A B Simpson, honorary consultant in obstetrics and gynaecology, Leeds; Andrew Shennan, professor of obstetrics; Phillip Bennett, professor of obstetrics; C Williamson, honorary consultant obstetric physician; A L David, consultant in obstetrics and maternal fetal medicine, London

Cite this as: *BMJ* 2025;388:r499

INFORMED ASSISTED DYING DEBATE

Lack of robust research

McCartney makes many cogent points about how potential legislation resulting from a private member's success is a lottery (Opinion, online 4 February). But many important issues have entered law in this way.

There will always be people with fundamental objections to assisted dying, but the current select committee seems to comprise a reasonable mix of proponents and objectors. McCartney's point about the ability of the committee to scrutinise the evidence in the same manner that might be required for a research project is important. Genuinely robust research regarding the opinions of the various stakeholders is not easy to find.

We need more research regarding the philosophical, moral, legal, and practical matters associated with assisted dying as well as proper investment in an appropriate, evidence based communication skills programme for all practitioners who might need to discuss end-of-life care plans with people. Trying to get funding to do such things is almost impossible.

Lesley J Fallowfield, professor of psycho-oncology, Brighton

Cite this as: *BMJ* 2025;388:r386

"THREE STRIKES AND YOU'RE IN"

"Rule of three" for decision making

Rosen mentions a "three strikes and you're in" rule for general practice (Opinion, online 6 February).

The rule says that the first time you see (by whatever means) a patient for a particular symptom you can do anything. The second time you have to get it sorted. If they require a third appointment, then you usually need additional help—through a colleague, referral, or admission. It's about not struggling alone with a harder problem and a patient who is potentially disappointed or whose condition is deteriorating.

The hard part is recognising when you are the third contact in the chain. The patient may have had their first two contacts in other settings, such as the emergency department, then in out-of-hours services. This kind of information discontinuity carries huge patient and professional safety risks, before any medical assessment starts.

I think the rule of threes might work in other medical settings.

Peter G Davies, semi-retired GP, Halifax

Cite this as: *BMJ* 2025;388:r471

BETTER HEALTH, BETTER WORKING

Put healthcare workers' health first

Bambra and colleagues discuss how to tackle health related worklessness (Editorial, 8-15 February). But when the health of those who look out for people's health is at risk, so are the whole population and the economy.

The healthcare system is facing a worrying number of suicides and non-intentional fatal overdoses, especially affecting women working directly with patients in highly demanding stressful situations with low salaries.

Healthcare workers are trying to hide their symptoms of burnout by pushing themselves to work despite extreme pain, fatigue, exhaustion, moral injury, and the grief of not being able to deliver the quality of care that patients need. Understaffing means that healthcare workers hardly have time to eat a nutritious meal and are sleep deprived.

Only when chief executive officers and insurance companies recognise that quality of care starts with decent and gender equal working conditions for healthcare workers can populations get healthy and working.

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SUSPENSION FOR LAW BREAKING?

Climate activism: a necessity to protect the nation's public health

We challenge Shaker's assertions about climate activism (Letters, 8-15 February).

Firstly, the climate crisis is not the "personal belief" of a few activists but an existential threat to health, driven by fossil fuel burning and based on overwhelming scientific evidence.

Secondly, his statement that "unlawful" climate activism undermines public trust in doctors is not supported by a study commissioned by the GMC. Patients' main concerns were whether doctors' actions could affect safe practice, had harmed someone, or if the doctor was aggressive or deceitful. None of these apply to non-violent climate protest.

Thirdly, government data show that public views align with those of activists, with 80% reporting concern about the climate emergency. And lastly, upholding public confidence in the profession is not the GMC's primary goal. It is to "support good, safe patient care." As we see the devastating effects of the climate crisis on public health, are we meeting our professional responsibilities if we stand by?

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ANALYSIS

Approaches to children's smartphone and social media use must go beyond bans

Supporting healthy development requires an approach to internet and mobile use that is underpinned by age appropriate design and education, argue **Victoria Goodyear and colleagues**

Children commonly use their smartphones to access social media, play games, and interact with others, accounting for the majority of overall screen use, particularly in the 8-17 age group.[1]

Most recently, banning or restricting children's (under age 18[2]) access to smartphones and social media has grasped the attention of policy makers, schools, and parents. Several countries, including France, Turkey, Norway, Sweden, as well as regions of the US and Canada, have introduced laws, policies, or guidance for schools to ban or heavily restrict the use of phones in schools.[3] In Australia, new legislation prohibits social media use for children under age 16. In the US, the surgeon general called for warning labels on social media apps.[4]

We do not have the evidence to establish the types of bans that are effective and what works best for children of different ages

Such restrictions lie within broader narratives that smartphones and social media are not safe environments for children. Moreover, bans are responses to increased public pressure to mitigate the potential harmful effects of smartphones and social media on health, wellbeing, and other associated outcomes—for example, academic performance, disruptive behaviours, and bullying.[5]

There are, however, no simple, one-size-fits-all answers. Although many policy makers, schools, and parents are primed to believe arguments that smartphones and social media are inherently harmful, the evidence about their overall effect on children is not clear cut.[6 7]

Smartphone bans have the advantage of being immediately actionable and relatively straightforward to enforce. However, despite positive anecdotal data, we do not have the evidence to establish the types of bans that are effective and what works best for children of different ages.[8 9] A recent evaluation of school smartphone policies in England reported that restricted

smartphone use in schools was not associated with benefits to adolescent mental health and wellbeing, physical activity and sleep, educational attainment, or classroom behaviour.[10] In addition, this study found no evidence of school restrictions being associated with lower levels of overall phone or media use or problematic social media use.[10]

Technology-free moments and spaces are nevertheless important for children because increased time spent on phones and social media is generally linked with worse physical, mental, and educational outcomes.[10] However, approaches that focus on simply restricting access to devices can undermine children's rights to technology design and education that will help them thrive as adults in today's world.

Phone bans are temporary solutions

Bans and restrictions have been successfully used for public health issues such as smoking.[11] But smoking is not comparable with smartphone and social media use because the harms from smoking are extensive, clear cut, and by far outweigh the benefits. Prescribing abstinence from all technologies to protect against harms is unrealistic and potentially detrimental in a society where technology use is a practical necessity and confers various benefits, including information access and social support.[12 13]

Overall, blanket restrictions are "stop gap" solutions that do little to support children's longer term healthy engagement with digital spaces across school, home, and other contexts[10] and their successful transition into adolescence and adulthood in a technology filled world.

Bans and restrictions are context dependent, and their effects will be highly variable across regions and populations. Families' experiences and perspectives related to screen engagement for their children vary by culture, religion, and socioeconomic circumstances, including internet access and quality, and access to safe and green outside spaces.[14]

Box 1 | Summary of a rights based approach to digital environments in education[2 15]

Non-discrimination

- Ensure that all children have equal access to digital environments that are meaningful for them
- Provide opportunities for learning to navigate positive as well as negative spaces on social media in a spirit of understanding, tolerance, and equality

Best interest of the child

- Ensure the fulfilment of children's rights in education in relation to digital environments
- Ensure children's rights to seek, receive, and impart information and ideas through digital technologies
- Protect children from risks and harmful effects of social media, ensuring privacy and online safety

Rights to life, survival, and development

- Create opportunities for growth through digital environments, developing knowledge, skills, talents, and mental and physical abilities to their fullest potential
- Support and develop knowledgeable and safe use of digital technologies

Respect the views of the child

- Support children's participation and inclusion in local, national, and international contexts in digital environments
- Teach and support children to express their views in digital environments
- Include children in defining the problems of digital technologies and the use of social media, giving due weight to their views and opinions in matters that affect them.

For some children, such as those who are especially vulnerable to poor mental health, access to certain digital content can result in grave harm.[5 6] However, restricting access can be harmful to other high risk populations, including children with disabilities, refugees, children in conflict settings, rural or indigenous populations, and women and girls.[12] For example, in sub-Saharan Africa, social media can provide access to essential healthcare services, including primary care and HIV surveillance.[12] In Afghanistan, social media provide a "safe haven" where girls can access topics related to women's rights, sexuality, domestic violence, and abortion.[12] In China, studies have found that social media access benefits the wellbeing of LGBTQ+ adolescents.[12]

A more constructive analogy than smoking might be driving cars. In response to increasing injuries and deaths from car crashes, rather than banning cars, society built an ecosystem of product safety regulations for companies (seatbelts, airbags) and consumers (vehicle safety tests, penalties), public infrastructure (traffic lights), and education (licences) to support safer use. Comparative efforts in product safety and education are needed to supplement debates about smartphone and social media bans and to balance the positive and indispensable role of digital technologies against their potential harms. Similar arguments have been made by others from a rights respecting approach.[9 14]

KEY MESSAGES

- Bans on smartphone and social media access have been advocated in many countries to protect children from harm despite lack of evidence on their effects
- Bans fail to equip children for healthy use of technology and the focus should shift to a rights respecting approach underpinned by age appropriate design and education
- Schools, teachers, and parents require training and guidance to help support children's healthy use of technology and shape future policies
- Legislation for the technology industry needs to be grounded in children's rights

Rights based approach to smartphone and social media use

The UN Convention on the Rights of the Child and the UN general comment in relation to digital environments provide a framework for governments and industry to respect, protect, and fulfil the rights of all children in digital environments.[2 15]

This framework is underpinned by four guiding principles: non-discrimination; acting in the best interests of the child; rights to life, survival, and development; and respect the views of the child (box 1). A rights respecting approach therefore considers the whole of children's lives and opens up ways of protecting children from harm while also approaching the healthy development of smartphone and social media use.

Age appropriate design and education are two key levers for implementing an approach based on rights.[2 15]

Box 2 | Principles in Child Rights by Design guidance[18]

Equity and diversity—All children are treated equally and fairly, and support is provided for vulnerable children

Best interests—All children's best interests is the primary consideration in the design of technologies and services

Consultation—Children have been meaningfully consulted and provided the opportunity to freely express their views

Age appropriate—The product is appropriate for children's evolving capacities and/or is adaptable for children of different ages

Responsible—The technology or service is compatible with the laws and policies relevant to children's rights

Participation—Enable children's participation, expression, and access to information

Privacy—Privacy by design has been appropriately considered in product and service development

Safety—Safety by design has been appropriately considered in product and service development

Wellbeing—The product or service should enhance not harm children's mental and physical health

Development—Products and services should enable children's learning, imagination, play, and belonging

Agency—Steps should have been taken to reduce compulsive and exploitative produce features

Age appropriate smartphone and social media design

Safety by design in accordance with children's evolving capacities is a key principle within the UN Convention on the Rights of the Child.[15]

Consensus is growing internationally that it is necessary to design for children online. For example, the EU's Digital Services Act and the UK Online Safety Act reflect a clear understanding of the need to ensure children's uses of technology are compatible with their wellbeing. Algorithms that promote "trending" content or apps that use attention and reward grabbing design features to encourage recurrent use are purposefully not supporting the development of healthy tech habits.[16 17]

Other age appropriate design features could be used to scaffold and support development. For example, app protective settings could have certain functions on by default, including limited or no notifications or warnings about length of use. In addition, app design features that give users more control could be introduced—for example, settings that help children learn new things, develop new skills, or enjoy playful activities and social interactions at their own pace or interactive features that engage peers and family members such as multi-touch input, turn taking, and family chats.[16-18]

Positive engagement with phones and social media needs to be treated as a life skill

No legislation for the technology industry is currently fully grounded in children's rights. In 2023, the UK Digital Futures for Children Centre launched guidance, Child Rights by Design, for designers of digital services and products used by children.[18] The guidance outlines 11 underpinning principles for digital innovation to ensure that children's needs and rights are a central consideration in product development (box 2).[18]

Guidance such as this is critical to help the tech industry develop a safe and healthy digital ecosystem for children. However, industry often does not take voluntary action to prioritise public health interests.[19] Consequently, legislation is needed that clearly outlines and enforces the responsibilities of technology companies regarding the safety and wellbeing of children in relation to children's rights.[17 18]

For example, governments could require technology companies to show how they are delivering on children's full range of rights to support child development and ensure appropriate safeguards in all services and products accessible to them.

Legislation in this area is developing, but further work is required to ensure legislation benefits the wellbeing of all children. For example, the EU's Digital Services Act does not sufficiently address algorithmic content personalisation. In turn, the information children access from large online social media platforms can be biased for commercial or political reasons. This can limit children's freedom of choice and adversely affect their decision making processes in ways that infringe their rights and wellbeing.[20]

Education provided by schools and families

Schools and families can mitigate potential risks and maximise benefits by supporting the development of foundational skills for healthy smartphone and social media use.[13 14] A rights based approach to education entails not only knowledge and skills but the full development and growth of the child (box 1).[2 15] Positive engagement with phones and social media needs to be treated as a life skill that is crucial for the development of

personalities, talents, and mental and physical abilities.

An agency centred approach to education is one way to develop children's digital skills and strategies, and involves supporting children to have meaningful choice, intentionality, and control over how technology fits into their lives.[21] This approach co-developed with children, educators, psychologists, and experts from various domains has been adopted in education settings in the US based on work at the Center for Digital Thriving.[13 21]

A key premise is the connection between evidence based behavioural and mental health practices with children's experiences of using smartphones and social media.[21] For example, techniques from cognitive behavioural therapy can be used to reduce symptoms of anxiety from other people not responding to read messages (being "left on read").

Education can be approached across three levels: personal, collective, and proxy agency.[13 21] Personal agency involves equipping children with the skills, strategies, and dispositions to help them make informed decisions as they navigate a technology filled world[13]—for example, skills on how to spot or avoid disinformation, awareness of digital design tricks, and strategies to reduce digital distractions.

Collective agency involves peer-to-peer learning approaches and children working together to support the meaningful and intentional integration of technology into their lives.[13] For example, teenagers could form pacts to vet photos of each other before tagging or posting.[13]

Proxy agency involves the development of rules, policies, technologies, and laws that support agency.[13 21] Schools can be proxy agents by listening to children and by partnering with them to co-design relevant and meaningful device usage policies and learning experiences.[13 21] Parents are also key proxy agents, as they make day-to-day decisions that grant and limit digital access, and this process often starts with phone ownership.[13 14]

Despite its merits, an agency centred approach is not common practice.[13] In schools, the prioritisation of academic performance, teacher knowledge, and the time it takes to engage in meaningful co-design are reported as key barriers to the adoption and implementation of collaborative teaching practices related to smartphone and social media use.[22]

Contemporary digital society is very different from the childhood experiences of many adults

The contemporary digital society is also very different from the childhood experiences of many adults, and this has inevitably created challenges for the ways in which policy makers, schools, and parents attempt to provide support to children.[14 22] For example, many parents report that they tend to make decisions about their children's smartphone and social media use based on their childhood memories, and they struggle with respecting and developing the agency of their child.[14] This suggests a need for appropriate levels of professional support to ensure widespread access to the latest evidence based guidance.[22]

Sustainable action

A rights respecting approach, underpinned by age appropriate design and education, has a dual focus on protecting children from harm and supporting the development of children's digital skills and agency to participate in a digital society. In the longer term, this approach is likely to be more beneficial and sustainable as it is focused on building a safe ecosystem in a digital society.

The technology industry is capable of moving quickly on this agenda. However, as profit incentives often override other agendas,[19] new approaches to corporate regulation are urgently required to ensure the technology industry will take action based on children's rights.[18]

Public perception about risks, the prioritisation of academic performance, teacher and parental knowledge, skills and readiness, and the lengthy timescales for the development of new legislation, are other potential challenges to the adoption and implementation of the proposed recommendations.[22]

Hence, immediate priorities are to improve legislation for the tech industry grounded in children's rights and create professional training and guidance for schools, teachers, and parents to help them be actively involved in the development of children's healthy technology use and in shaping future policies and approaches.

Ultimately, there is a need to shift debates, policies, and practices from a sole focus on restricting smartphone and social media access towards an emphasis on nurturing children's skills for healthy technology use.

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OPINION Irene J Higginson and Natalie Ramjeeawon

Palliative care commission has to be radical

Last November, MPs passed the Terminally Ill Adults (End of Life) Bill by 330 to 275. One key consensus was that while palliative care in the UK can be excellent, its provision and funding are inconsistent, inadequate, and must be improved.

In response, a commission on palliative care has been established by Rachael Maskell to drive improvements in palliative and end-of-life care in the UK. More recently the expert panel of the parliamentary Health and Social Care Committee has announced it is undertaking an independent evaluation of the state of palliative care in England.

The 1946 NHS Act established a health service focused on improving physical and mental health and treating illness. This wording led many to assume that palliative care, which puts the person and their concerns before their illness, was excluded. It was not until the 2022 Health and Care Act that palliative care, along with care after illness, was introduced as a requirement.

Despite the UK's pioneering role, the provision, quality, and outcomes of palliative care remain inconsistent. Many people, along with families who provide crucial support, miss out on good quality care. A review of local health strategies found some omitted palliative care, while others were without concrete plans.

No GP contact

A 2023 national survey of bereaved relatives revealed significant gaps: nearly one in five people had no GP contact in their final three months, only 29% received home palliative care, and just 19% had hospital based support. In their final week, 35% suffered severe pain, and 40% experienced overwhelming breathlessness. Many informal (unpaid) carers provided intensive support, through direct assistance, care coordination and emergency response, at substantial personal cost to their own health and finances.

Health systems worldwide face mounting pressures—workforce shortages, rising demand, and fiscal constraints—while managing more people with complex, life limiting illnesses. These pressures are expected to grow. In this context, how can a commission or an expert panel's findings drive meaningful change?

Palliative care is a vital, cost effective component of modern health systems. Meta-analyses and empirical studies consistently find it delivers many benefits: it enhances quality of life, emotional wellbeing, and symptom management. It costs about the same or less compared with usual services. Multidisciplinary, multicomponent, and multi-setting services have the greatest benefits. Cost savings are larger for people with more comorbidities, and when consultations are offered earlier. A recent study in Ireland found that timely hospital based palliative care shortened stays by nearly two days, saving around £1520 per admission, whereas later referrals did not reduce costs.

Trials in the UK have shown community based earlier short term integrated palliative and supportive care reduces symptom distress for older people with chronic noncancer conditions compared with usual care. Short term integrated palliative and respiratory care offered over six weeks improved quality of life and survival for people who were severely affected by breathlessness and chronic respiratory conditions. Economic modelling identified cost savings, which were highest when services were individually tailored.

Therefore, palliative care can significantly contribute to the government's three shifts for the future NHS, especially moving care from hospitals to communities and prevention.

Challenges remain, including the misconception that palliative care is only for the end of life. But it is broader. It can also offer early support to manage symptoms and improve quality of life. The misunderstanding about this delays timely care that could alleviate distress, improve outcomes, and provide greater cost effectiveness. Indeed, modern palliative care will often include physiotherapy support to help people manage symptoms.

Palliative care's holistic approach benefits patients and caregivers, particularly those with chronic conditions. Meta-ethnography finds that to provide care effectively at home, it is vital to ensure patients and their caregivers feel safe. This requires competent care to be present when needed, around the clock. By providing comprehensive, continuous care, palliative services can reduce emergency admissions, improve outcomes, and enable more people to stay in the community.

To be truly transformative, their work must drive early action not just debate

Digital technologies

Frugal innovation—with cost effective person centred approaches—could improve symptom management and patient outcomes further. Digital technologies integrated with appropriate outcome assessments could help provide early warnings when symptoms are tipping, prompting preventive action.

The question is: will this commission drive real change, or is it merely a sticking plaster, holding back a tide of unmet need? Both the commission and the expert panel have the potential to set in train bold, systemic actions to change policy, challenge entrenched barriers, and galvanise investment. Their findings could steer government commitments, strengthen accountability, lead to better monitoring of outcomes, and integrate palliative care into mainstream strategies. They might also push for better workforce planning and education, support for informal carers, and research into innovation and scalable models of care. Crucially, both must confront the pressing issues of untimely access to skilled palliative care and the persistent inequalities—ensuring that no community or group is left behind.

Yet, there is a risk their conclusions will pull in different directions. To be truly transformative, their work must align, not compete, and drive early action, not just debate. Otherwise, they risk being another set of well intentioned, dust gathering reports. The challenge is to close the gaps.

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EDITORIAL

Tuberculosis in the UK

Multipronged action is needed to reverse rising rates

Tuberculosis (TB) is the world's oldest pandemic, accounting for around a billion deaths in the past two centuries.[1] In the UK, after more than a decade of declining incidence, numbers are on the rise.

In 2024, 5480 people became unwell with TB in England—up 13% from 2023, the largest increase recorded since 1970, and reflecting a trend that started in 2021.[2] The TB Action Plan for England 2021-26[3] commits the country to meet the World Health Organization target of eliminating TB by 2035.[4] But achieving this is not certain.

TB is linked to conditions of poverty. People who become unwell face stigma, financial precarity, digital exclusion, language barriers, and housing insecurity.[5] They need scaffolding provided by support networks to enable them to complete treatment successfully.

TB exists on a spectrum between asymptomatic latent infection and active disease. Around 80% of active cases in the UK occur among people born in countries where TB is common.[6] Intersecting vulnerabilities such as HIV, deprivation, homelessness, asylum seeker status, and incarceration also increase the chance of developing the disease.[7] TB preventive strategies (including screening and treatment of latent TB infection and identification of infectious pulmonary TB in at-risk populations) are key to elimination.

Screening for active pulmonary TB is mandated as part of the UK visa application process. In 2023, 500 people were identified through this programme and treated before arrival in the UK.[6] However, this approach misses thousands of people who may have latent infection or asymptomatic disease.

The UK's current approach, identifying and treating people with latent infection from countries with high TB burden is effective, reducing the risk of active TB by 85%.[9] However, in 2023, just 11.5% of the eligible new entrant migrant population were screened,[6] and screening took place in only 27 of the 42 English integrated care boards as commissioning was informed by 2015 TB incidence data.

MARK THOMAS/ALAMY

New cases of TB increased by 13% from 2023 to 2024

TB distribution in the UK has changed.[6] Many of England's smaller TB services, especially those in low incidence rural areas, report disproportionate increases in caseload.[10] Contributory factors include policies to disperse people seeking asylum[11] and increased migration from higher TB burden countries to fill UK labour shortages.[12]

One solution would involve expanding occupation based latent TB infection screening to all private employers who recruit people from overseas to work in the UK.[13]

TB services were hit badly by covid-19[15] and remain overstretched.[10] Systems are not designed to support people who frequently move, or are moved, across administrative borders.[16] Broader policies restricting healthcare access for migrants create further barriers.[17]

Mechanisms to improve communication across administrative borders (including stronger data linkage between primary and secondary services) and related government departments, are vital for efficient, joined-up care. However, a firewall must remain between health services and immigration enforcement.

Treatment presents further challenges. There is limited access to rifapentine, a central component of shorter treatment and prevention regimens. Fixed dose combinations of anti-TB drugs, which reduce pill burden, are often out of stock, and paediatric formulations are urgently needed.[18]

Effective investment

TB is one of the top 12 best global investments.[19] Cost-benefit analysis suggests every $1 in prevention and care delivers up to $46 by saving lives and increasing economic productivity.[19] Investment in strengthening TB services will also improve pandemic preparedness as many elements can be applied to new respiratory diseases,[20] help create a strong NHS, and bolster economic growth.[21]

Elimination will not succeed without overseas investment to tackle TB in high burden countries given the UK epidemiology.[22] With the US removing funding from WHO and abolishing USAID, the UK's contribution is even more necessary.

The financial and human costs of inaction are clear. The case for investment is solid, yet insufficient resources leave UK communities at risk.

If the UK is serious about elimination, it must expand testing and treatment of latent infection in migrants from high burden countries; undertake active case finding in vulnerable populations; secure access to drugs such as rifapentine; and invest in TB services to improve early detection and treatment support. We have the expertise and commitment[23] to succeed—we need the political leadership to match.

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