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A View From the Chair: Eric Watts

In the summer edition of the newsletter I welcomed the new Secretary of State for health but there has been seismic change since then.

We welcome Yvette Cooper to her new role and it must be seen as an indication of how seriously Andy Burnham takes health that he has appointed such a senior and capable politician with much Cabinet experience to lead the health team. Her familiarity with the work of the Cabinet may well help her to secure a more favourable deal for the NHS than her predecessors.

She has shown decisiveness in the first major upset to come her way with an endorsement of the recommendations by the Thirlwall report.

The report has grabbed all the media headlines but is badly timed as the Criminal Cases Review Commission (CCRC) has yet to complete its investigation into the circumstances of the Letby trial. There has been controversy over witness statements but the Thirlwall enquiry did not deal with those matters.

The findings are similar to previous hospital disasters describing dysfunctional management and governance, a gulf between hospital leadership and conditions, and failure to understand the fundamentals of safeguarding.

These are issues which we are well aware of and lie behind the majority of health tragedies. We are not alone in calling for a better understanding by the authorities of the importance of clinicians' freedom to call attention to problems. Many expert reports have emphasised the need for clinicians to be free to speak up, not only to require investigation and mishaps but to regard near misses as important learning experiences.

However whistleblowers are too often seen as troublemakers, reminding us of the difficulties

of speaking truth to power. Similar issues occur in legal practice, a recent example being the atrocious wrongful conviction of Andrew Martinson for rape and the report by Chris Henley KC where he stated that right up to the top judges in the Court of Appeal had a deep-seated reluctance to accept criticism.

DFNHS holds its annual educational meeting on 10 October (see Page 5 for updated booking details) and we will have these issues in mind when we look at the problems working doctors have to deal with including threats to education from doctor substitution and the pressures on service including corridor care.

The Paul Noone Memorial lecture will be delivered by David Sellu who has suffered the experience of injustice and will be addressing this use of disciplinary procedures which has suddenly become topical again.

In a change to the advertised programme Radd Seiger is unable to attend because he will be overseas. He will be replaced by Mark Thompson, the Health Editor of Sky News. It will be interesting to hear his perspective and we should be able to provide him with views from people I suspect he seldom meets.

Following the educational meeting we will have the business AGM on Saturday, 14 November with a 10 am start and I urge everyone interested in the future of the organisation to join in (see Page 4 for details).

I look forward to a lively and interesting meeting in York in October.

Eric Watts
Chair

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CALLING NOTICE

AGM (Online via Zoom)

Saturday 14 November at 10 am

Members are urged to attend this AGM, which will be held online via Zoom

As well as the usual ‘business items’ of the AGM such as Officers’ reports, members will be asked to consider the future choices DFNHS has to make.

Please attend to hear about the important options being proposed. The outcome of this discussion and options to be put to members in writing will then be included in the next newsletter (due out in December).

The Zoom link is:

<https://bit.ly/4AiYYEN>

If you experience any difficulty logging in using the Zoom link or have any queries prior to the meeting, please contact Alan Taman:
healthjournos@gmail.com

Joint Conference of Doctors for the NHS and Doctors' Association UK 2026

**Saturday 10th October
10 am to 5.30 pm
at Bedern Hall, Bartle Garth,
St Andrewgate,
York YO1 7AL**

Revised Booking Information

Note: the booking links sent to you with the programme have malfunctioned and may not allow you to book. Please use the following links.

To book to attend at Bedern Hall please go to:

<https://bit.ly/4iBzVGG>

To book to attend online via Zoom please go to:

<https://bit.ly/3TDwTaz>

(The Zoom link will be sent to you the day before Conference)

If you encounter problems paying via Eventbrite, you can pay directly by BACS.

Account name: Doctors for the NHS

Sort code: 83 – 23 – 10

Account number: 00229809

Reference: AGM

Please let Peter Trewby know if you pay via BACS (trewbyp@gmail.com)

Any further problems or enquiries: please contact Alan Taman
(healthjournos@gmail.com)

DFNHS-DAUK Joint Conference 10 October York

Revised Programme

10.00 am – Registration for a 10.30 am start. Tea and coffee available

10.30 am – Opening welcome from the chairs of DAUK and DFNHS

11.00 am – Dr Louella Vaughan – Education and the threat of doctor substitution. Followed by questions.

12.00 pm – Dr Sarah Jacques (DAUK) and Dr David Zigmond (DFNHS) – The problems facing general practice. Followed by questions.

1.00 pm – Lunch

2.00 pm – Dr David Nicholls (DAUK) – The role and dangers of Palantir in the NHS. Followed by questions.

3.00 pm – Mark Thompson, Health Editor for Sky News. Followed by questions.

4.00 pm – Tea and coffee break

4.30 pm – *The Paul Noone Memorial Lecture*

Delivered by Dr David Sellu – Misuse of disciplinary procedures and injustice in the NHS. Followed by questions.

5.30 pm – Chairs' closing remarks

6.00 pm Close of Conference

Optional evening meal at 'The Giggling Squid' Thai restaurant.

'Palantir out of the NHS!' – why the contract for the Federated Data Platform should now be terminated

The uncritical and widespread planned use of Palantir for NHS data – our data – leaves grave doubts over confidentiality and much more. EC member John Puntis describes why.

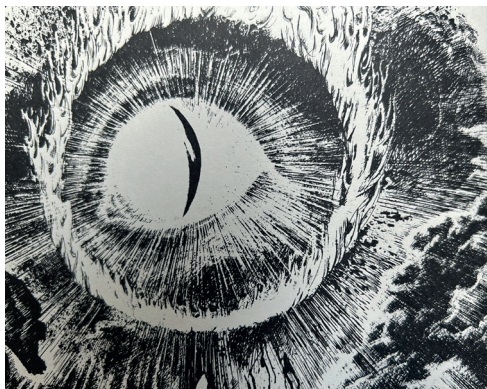
What is 'Palantir'?

Palantir Technologies (1) is a company founded in 2003 by US billionaire Peter Thiel. Palantir's software programs (2) can process vast amounts of data to identify previously undetectable patterns and connections.

The founding premise was that governments and public agencies hold a lot of information, but it is difficult to access and is poorly organised. If properly collated and arranged, the data could be employed to enormously powerful effect. *Foundry* and *Gotham* are its leading software, with further analytics and decision-making through the AI Platforms, *Apollo* and *Ontology*. The company name comes from the 'palantiri' – all-seeing magical orbs in Tolkien's *Lord of the Rings* (LOTR) trilogy. Bizarrely, employees are sometimes referred to as 'hobbits' (3) and their mission as being 'protection of the Shire'. For some, such appropriation of playful words, rather than being reassuring, helps paint an increasingly clear picture (4) of members of a repugnant neo-reactionary movement that misses the irony of Tolkien's palantiri – promising foresight but ultimately leading to ruin.

Peter Thiel – billionaire 'libertarian' Trump fan

Thiel is a co-founder of PayPal, a Facebook investor, venture capitalist and a Trump supporter who has given generously to Republican candidates in the US elections. He has recently hosted a series of lectures philosophising about who the



'The eye of Sauron: the evil being that took over the 'palantiri' in The Lord of the Rings

antichrist (a false saviour substituting for Christ before his second coming) could be and warning that Armageddon (the final battle between good and evil at the end of the world) was coming.

The Epstein files show that he remained in contact with the financier for years after Epstein's 2008 conviction for soliciting prostitution from a minor. He is on record as saying that the NHS makes people sick, and that the public's affection for it is a case of Stockholm syndrome – the term for hostages developing empathy with their captors. Thiel has argued that rather than receiving more funding, the NHS should be ripped up and subjected to market mechanisms. Palantir was a client of Global Counsel, the political lobbying and advisory firm co-founded by Peter Mandelson.

Thiel is said to have become fixated on Islamic terrorism (5) and developed hardened views on immigration, creating Palantir as a tool to reduce

terrorism by processing and spotting patterns or connections in massive tranches of data. Early funders included In-Q-Tel, the venture capital arm of the Central Intelligence Agency, the US foreign intelligence service. A self-declared 'libertarian' (he stands for "authentic human freedom and against confiscatory taxes and totalitarian collectives"), Thiel declared in 2009 that "freedom and democracy" are not "compatible" (6). The respected political commentator Chris Hedges (7) talking of the situation in the United States (8) says that:

"Thiel is sweeping up all our information gleaned from government tax, medical and law enforcement records. This information is being delivered to databases that can be exploited for state control and profit. Thiel and his coterie of technocratic billionaires are implementing the agenda he envisioned 16 years ago: to make technology an alternative to politics."

Palantir's business

Palantir serves two broad types of clients including big businesses such as British Petroleum, Airbus and Coca-Cola, together with civil government sectors, such as America's Inland Revenue Service and the UK's NHS. The second type of client is military, defence and intelligence services. While Thiel remains chairman of Palantir and a major shareholder, Alex Karp (also a co-founder) is the chief executive. Karp openly acknowledges that Palantir's technology can be part of military operations in which people are killed. He characterises Palantir as being dedicated to serving the West and the United States, and there to "scare our enemies and on occasion kill them" (9). A military mindset (3) has pervaded the internal culture at Palantir since its inception.

Palantir's business model is widely described as 'land and expand' (10) with targeting of government and large commercial organisations with low-cost pilots, low barrier entry trials or short-term engagements to demonstrate value. Palantir 'landed' in the NHS during Covid in 2020 with an initial short-term contract for the NHS Covid-19 Data Store, at a cost of £1. This contract was to help manage Covid-19 data and help shape the government response. Initially short term, it was given a number of extensions, with Palantir thereafter being granted the contract for an NHS Federated Data Platform (FDP).

The FDP is designed to allow hospital trusts, local systems, and national coordinators to look

"Thiel ... recently hosted a series of lectures philosophising about who the antichrist could be."

at real-time information in one place without logging into multiple networks with the aim of increasing NHS efficiency and productivity.

While NHS England claims that (11) "the platform was procured via a rigorous, competitive procurement process in line with government procurement legislation", the contract was only published after considerable pressure from campaigners and with 200 pages blacked out. In order to win the contract, Palantir has been accused of widespread lobbying (12) of government ministers and civil servants as well as operating a 'revolving door' for a number of key NHS executives. As far as 'expanding', the company now has contracts with multiple UK government bodies (13) with at least 34 current and past state contracts across at least 10 government departments (including the NHS), local councils, and police authorities.

The campaign to get Palantir out of the NHS

Campaigners against Palantir have many objections to its involvement in the NHS including its unethical behaviour through complicity in multiple

human rights violations, such as the genocide in Gaza, mass deportation and detentions (15) by US Immigration and Customs Enforcement Agency (ICE), military interventions in Iraq and Afghanistan (16), and discriminatory policing practices (17). Contracts with ICE have included designing a system to track undocumented migrants and select candidates for deportation.

The company signed a \$10 billion deal with the US Army and a recent contract included a \$795 million uplift to help the Pentagon develop an AI-targeting system called Maven (18). In early 2024, Palantir signed a deal with the Israeli government to provide "support for war-related missions". The company is explicitly mentioned by the UN special rapporteur on human rights in the occupied Palestinian territories (19). Her report urges member states to enact sanctions, pursue criminal investigations of corporate executives, and enforce an arms embargo.

A wide range of organisations including Keep Our NHS Public (KONP) (20), Medact, The Good Law Project (21), Amnesty International, Doctors' Association UK (22), Just Treatment, Foxglove (23), Liberty, medConfidential, Global Justice Now, the British Medical Association (24) and War on Want oppose Palantir being involved in the NHS. A coalition of activists has been organised under the banner 'No Palantir in our NHS' (25) with local groups across England. A briefing in March 2026 from Medact (26) urged NHS trusts and ICBs not to implement the FDP and for NHS England to terminate the contract. Over August 2026, KONP held twice weekly anti-Palantir demonstrations outside the Department of Health in London.

The Medact report notes that partnering with Palantir risks weakening patients' trust while "driving out locally tailored and trusted data solutions". Thursday 1 October was designated an

international day of action (27) against Palantir and demonstrations planned around the UK.

Confidentiality of patient data

For those concerned about who has access to their private data, Palantir insists that it is only a processor of patient data (28), not a controller, and has never been in the business of collecting, mining or selling data. In reality, NHS England has allowed staff (29) from the US tech firm and other contractors to access patient data before it has been pseudonymised, despite internal fears of a "risk of loss of public confidence".

"Any reassurances from the UK government should also be seen in the context of its current policy to harness the power of data to drive economic growth."

Furthermore, US legislation like the Cloud Act, the USA Patriot Act and the FISA (Foreign Intelligence Surveillance Act) allows the US government to compel US-headquartered companies to hand over data, regardless of where that data is physically stored or what local contracts say. Any reassurances from the UK government should also be seen in the context of its

current policy (30) to harness the power of data to drive economic growth including a reduction in data protections and an increase in access to our personal health data by private corporations. It is not possible for patients to opt out (31) of their data being processed by the FDP.

Is the FDP really delivering benefits to the NHS?

Many of those working in NHS IT have expressed scepticism about the benefits of the FDP, with some local NHS trusts and bodies refusing to comply (32) with the roll-out. Specific examples are Leeds Teaching Hospitals NHS Trust which told NHS England that it would lose functionality rather than gain it if it adopted the FDP and NHS Greater

Manchester saying its local capability exceeds anything the FDP currently offers. Government claims that the FDP is delivering benefits have been undermined through an investigation by Foxglove (33) which found that almost a third of English hospital trusts using the FDP tool were carrying out fewer operations than before they started using it.

An early adopter of the FDP, Chelsea and Westminster Foundation Trust, was regarded as “a national exemplar for AI”. An apparently successful pilot of a precursor of the FDP developed by Palantir was promoted to persuade other hospitals to sign up. Problems were then highlighted in the *British Medical Journal* (34), casting doubt on positive outcomes. While it was claimed that the inpatient elective surgery waiting list had been brought down by 28%, in fact, improvements were most likely due to post-pandemic recovery with data showing no meaningful difference between FDP adopters and non-adopters.

There was no evidence of a unique impact of the FDP at Chelsea and Westminster. It also happened that Matthew Swindells, the trust’s chair from April 2022 to March 2026, not only previously worked with Palantir through Peter Mandelson’s firm Global Counsel but also chaired the company’s health advisory committee – a clear conflict of interest (35). Swindells was forced to resign after the *Financial Times* revealed he had privately urged colleagues to add GP patient data to the FDP in a bid to demonstrate its effectiveness.

Up until May 2026, NHS England’s website was trumpeting how the FDP was delivering more procedures, shorter stays in hospital, improvements in cancer diagnosis, and reductions in referral time. Since then it has added a note explaining that before/after comparisons showing improvements following the introduction of the FDP cannot generate firm conclusions about cause and effect

since other variables were not controlled for.

The UK Statistics Authority (36) is currently investigating the Department of Health and NHS England over misuse of statistics to promote the FDP. In the meantime, the NHS is running an analysis of the commercial deal with Palantir, which is due to report this autumn. It has also commissioned a three-year independent evaluation by Imperial College, with findings expected in 2029.

Terminating the contract

The FDP contract is due to run for an initial three-year term, followed by three possible extension periods. The first term ends in March 2027, and to continue beyond that point, the Department of Health and Social Care must actively choose to trigger the first extension (37). If it does not, the contract will naturally come to an end. MPs debated the FDP on 16 April 2026, with several Labour and Liberal Democrat MPs urging the government to remove Palantir as the contract supplier. In response, the health minister Zubir Ahmed said that while the government was “no fan” of Palantir’s politics, the FDP had been exceeding its performance targets since it went live in March 2024 (38). Asked whether the government would exercise the break clause in Palantir’s contract in 2027, Ahmed said:

“If at that point in the break clause we evaluate and we find that there are other providers that can do the job better, of course then that needs to be looked at. We will decide later this year whether to extend it.”

In a June 2026 report (39), the House of Commons Science, Innovation and Technology Committee concluded that Palantir’s growing role in the NHS and wider public sector was creating an

“Almost a third of English hospital trusts using the FDP tool were carrying out fewer operations than before they started using it.”

“unacceptable point of weakness” for the UK. The Committee recommended breaking the contract for the FDP and either developing an in-house replacement or transitioning to an alternative UK-based supplier. In addition, it also commented that reliance on major US-based tech firms like Palantir leaves public service digital transformation at risk and “at the mercy” of foreign actors.

The report called for a clear strategy to diversify suppliers, enhance digital resilience, and achieve technological sovereignty. The Health and Social Care Committee also recommended (40) that government drop the contract with Palantir, citing serious mistrust among the public, unproven efficacy and the existence of alternatives already in place across NHS bodies.

Of course, cutting links with Palantir will not signal the end of our unhealthy dependency on big US corporations (41), but rather, should be the first sweep of the broom aimed at establishing our digital sovereignty.

On the international stage, opposition to Palantir is becoming more visible. New York City’s public hospital system, the Dutch Ministry of Defence, the French intelligence service and the Danish government have all either not renewed Palantir contracts or are actively looking for new suppliers. Switzerland’s army raised concerns that confidential military data could be passed on to US intelligence agencies if defence contracts were awarded to Palantir.

Summary

In the UK, arguments for triggering the fast-approaching break clause for Palantir’s contract for the FDP include:

- Concerns around patient-data privacy and trust with a US technology company being embedded in NHS data infrastructure.
- Palantir’s work with US government agencies, particularly immigration enforcement and military/intelligence bodies.
- Human-rights concerns, given Palantir’s involvement in the genocide in Gaza.
- Worry that the NHS could become dependent on a US supplier.
- Procurement and transparency and how the £330m contract was awarded in the first place.
- Access by Palantir personnel to NHS systems.
 - Effectiveness and value for money.

“Palantir is a secretive US data company that wants a long-term role deeply embedded in NHS infrastructure. However, it has spent most of its history helping the powerful abuse the powerless.”

As the ‘No Palantir’ coalition has summarised: Palantir is a secretive US data company that wants a long-term role deeply embedded in NHS infrastructure. However, it has spent most of its history helping the powerful abuse the powerless. For years, Palantir’s tools have been used not to care – but to

harm. For all the above reasons, a company like Palantir has no place in our NHS.

References

1. Palantir UK (2026) Homepage [Available at www.palantir.com/uk]
2. Palantir UK (2026) ‘Platforms’ [Available at: www.palantir.com/platforms]
3. Goode, L., et al. (2025) ‘Decoding Palantir; the most mysterious company in Silicon Valley’ *Wired*, 15 August [Available at: <https://tinyurl.com/mrythe2d>]
4. ‘Informed Alarmist’ (2025) ‘Palantir: how tech

- bro's misread Tolkien' *The Informed Alarmist*, 21 April [Available at: <https://tinyurl.com/yvv6wz6a>]
5. Milmo, D. (2023) 'Palantir's Peter Thiel: NHS is a natural target for outspoken tech billionaire' *Guardian*, 21 November [Available at: <https://tinyurl.com/3n5cecd5>]
6. Thiel, P. (2009) 'The education of a Libertarian' *From Scratch*, 13 April [Available at: <https://tinyurl.com/y7ck658a>]
7. Wikipedia (2026) 'Chris Hedges' [Available at: <https://tinyurl.com/ms7se99r>]
8. Hedges, C. (2026) 'The next election may be our last' *The Chris Hedges Report*, 31 August [Available at: <https://tinyurl.com/yruehzhv9>]
9. Ahmed, S. (2025) 'Transcript: Palantir's relentless rise' *Financial Times*, 20 August [Available at: <https://tinyurl.com/4a398m23>]
10. Kishor, N. (2024) 'Palantir's Acquire, Expand and Scale Strategy Breakdown' *Linked-In*, 7 January [Available at: <https://tinyurl.com/4tzx6en3>]
11. NHS England (2026) 'Contract explainer' [Available at: <https://tinyurl.com/nhkcxe4>]
12. Geoghegan, P. and Amin, L. (2026) 'This looks absolutely rubbish' *London Review of Books*, 23 July [Available at: <https://tinyurl.com/mu6rse2w>]
13. NHS Support Federation (2026) 'Palantir, the controversy, the contracts and the campaign against the FDP' *The Lowdown*, 31 March [Available at: <https://tinyurl.com/4wbz74rv>]
14. Amnesty International (2025) 'Pull the plug on the political economy enabling Israel's crimes: What states and companies must do to stop fueling Israel's genocide, apartheid and unlawful occupation' *Amnesty International*, 18 September [Available at: <https://tinyurl.com/32xx89nn>]
15. Good Law Project (2026) 'Palantir uses medical records to target people for ICE in the US – will the UK be next?' *Good Law Project*, 23 January [Available at: <https://tinyurl.com/37zaannp>]
16. Peretti, J. (2017) 'Palantir: the 'special ops' tech giant that wields as much real-world power as Google' *Guardian*, 30 July [Available at: <https://tinyurl.com/4vktxtaw>]
17. Winston, A. (2018) 'Palantir has secretly been using New Orleans to test its predictive policing technology' *The Verge*, 27 February [Available at: <https://tinyurl.com/2uekervd>]
18. Wikipedia (2026) 'Project Maven' [Available at: <https://tinyurl.com/yvcedtu9>]
19. United Nations (2025) 'A/HRC/59/23: From economy of occupation to economy of genocide - Report of the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967' [Available at: <https://tinyurl.com/2vn8ka2f>]
20. KONP (2026) 'Palantir out of our NHS' [Available at: <https://tinyurl.com/yprd7c8n>]
21. Good Law Project (2026) 'Stop Palantir in the NHS' [Available at: <https://tinyurl.com/2nafmtrs>]
22. DAUK (2023) 'Foxglove, DAUK and other campaign groups are preparing to sue the government over Palantir deal' 16 March [Available at: <https://tinyurl.com/5xdnxfzn>]
23. Foxglove (2026) 'New Health Secretary Yvette Cooper: Trigger the break clause and get Palantir out of the NHS' [Available at: <https://tinyurl.com/yu66u62j>]
24. BMA (2025) 'ARM 2025: BMA passes resolution on Health Information Management and Information Technology' *BMA Statement*, 25 June [Available at: <https://tinyurl.com/5fpza9z4>]
25. Medact (2024) 'No Palantir in the NHS! Campaign toolkit' 6 November [Available at: <https://tinyurl.com/28cburzj>]
26. Medact (2026) 'Briefing: Concerns Regarding Palantir Technologies and NHS Data Systems' 12 March [Available at: <https://tinyurl.com/2mtjnv3>]
27. Amnesty International (2026) 'People vs Palantir - International Day of Action' [Available at: <https://tinyurl.com/4mek3t2r>]
28. Medium (2023) 'Palantir and the NHS' 21 November [Available at: <https://tinyurl.com/3bnrhyn5>]
29. Booth, R. (2026) 'Palantir's access to identifiable NHS England patient data is 'dangerous', MPs say' *Guardian*, 11 May [Available at: <https://tinyurl.com/4a2ftx42>]
30. KONP (2026) 'Health Data Working Group' [Available at: <https://tinyurl.com/7vny8ekf>]
31. The A Register (2026) 'NHS patients can't opt

out of Palantir's data platform – but their hospital can' 13 June

[Available at: <https://tinyurl.com/y4yxdark>]

32. Corporate Watch (2025) 'No Palantir in the NHS and corporate watch reveal the real story behind the federated data platform rollout' 13 August

[Available at: <https://tinyurl.com/msh2snpu>]

33. Foxglove (2026) 'Our investigation shows a third of NHS trusts using Palantir's FDP tools are seeing fewer operations than before they started using it' 16 June

[Available at: <https://tinyurl.com/3rhykntp>]

34. BMJ (2026) 'Palantir: NHS pilot's "success" is questioned as second figure at major trust is linked to the tech giant' *BMJ* 2026;393:s680

[Available at: <https://doi.org/10.1136/bmj.s680>]

35. Cumbers, S. (2026) Linked-In post, 6 March

[Available at: <https://tinyurl.com/y4p2jja9>]

36. Armstrong, S. (2026) 'Palantir: NHS England is warned by statistics watchdog over FDP claims' *BMJ* 2026;394:e100402

[Available at: <https://doi.org/10.1136/bmj-2026-100402>]

37. (2026) 'Palantir NHS contract: what the Federated Data Platform break clause means for public sector suppliers' 1 May

[Available at: <https://tinyurl.com/3sza35tn>]

38. BMJ (2026) 'Palantir: MPs call for "shameful" NHS data deal to be scrapped' *BMJ* 2026;393:s738

[Available at: <https://doi.org/10.1136/bmj.s738>]



39. UK Parliament (2026) 'MPs warn that Palantir's increasing presence in the UK public sector is an "unacceptable point of weakness"'

[Available at: <https://tinyurl.com/2u3kwpmh>]

40. Moran, L. (2026) 'Letter to Parliamentary Under-Secretary of State for Health Innovation and Safety' 8 July

[Available at: <https://tinyurl.com/595ac6t9>]

41. KONP (2026) 'After Palantir – what comes next?' 1 July

[Available at: <https://tinyurl.com/4udue4j7>]

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Human or Cyborg?

Healthcare's trajectory in our digital age

Science and technology are essential bedrocks to our current healthcare: used with probity and competence they must be 'good', surely? Yet more of something good is not necessarily better: it may generate new and serious problems, says EC member David Zigmond.

'Nothing vast enters the lives of mortals without a curse.'

– Sophocles 496-406 BCE

The massive and rapid development of medical science and its applied technologies should command our profound wonder and gratitude – these have spectacularly improved the treatment and prognosis of so many conditions that a few decades ago were commonly lethal or gravely crippling. Some are now extinct and serve as gruesome historical reminders of the harshness of pre-modern times – now almost incredible.

This dramatic and indisputable progress, though, has developed its own expanding rhetoric, and from there a kind of imperial hegemony which we often equate with 'modernisation'. Such regimes grant pre-eminence to measurement, taxonomical-type classifications, executively defined and supervised standardised procedures ... modelling practice-protocols and practice-flows on mass-production manufacturing industries... First automation, then digitalisation; both are bound to either precede or follow.

The positive yield from such a tightly-managed scientific-industrial approach is certainly substantial: it accounts for so many now-established health blessings that all come from such generic and formulaic systems. A large bulk of cancers, obstetric catastrophes, cardiovascular and infectious illnesses, for example, now have unmistakably different and positive outcomes.

But the subsequent cultural and institutional

rhetoric that has been informed and mandated by such success has also incurred great losses. This rhetoric is inadequately acknowledged – it has increasingly disregarded, even destroyed, the recognition of, and stewardship for, the vast areas of healthcare that are not scientifically fixable or readily preventable. What are these?

To be specific, consider: conditions and confusions of maturation and development; stress-related and psychosomatic complaints; most disturbances of behaviour, appetite, mood and impulse (BAMI, mental illness); ageing physical degenerations that are non-prostheticable; chronic conditions (by definition); palliative and terminal care.

To contextualise these and clarify perspective, they account for most presentations to general practice and most to mental health. So most presentations to the NHS will not be adequately understood ('diagnosis') or responded to ('treatment') by the compliance-driven scientific-generic-management approach that is often so successful elsewhere.

This larger – increasingly neglected – remnant here is 'people-work' quite as much as any medical science. This medically located people-work can be monikered 'pastoral healthcare', which reflects guidance-through-relationship, rather than procedure-through-formula – the latter being the anchor of scientific medicine. Better erstwhile GPs and psychiatrists – before the modernising reforms ratcheted such standardised and micromanaged procedure and protocol – assumed a sine quo

non: that knowing each particular patient and their relationships is quite as important as knowledge of bodies and illnesses.

Yet recent decades of healthcare reforms have marginalised such an ethos, though rarely explicitly. If challenged, authorities vaunt their preferential tasks that are easier to measure, if not command: decreasing waiting lists and times for investigation and treatments for established and fixable conditions, for example. Pastoral healthcare becomes seen, rather, as an unnecessary distraction and expense, a 'soft' ineffectual option for the sentimental.

But is it? Consider these two time-separated scenarios (I):

1. 2010: London. Small traditional Family Doctor Practice

Suki, age 16, enters my room shaking and silently sobbing, trying vainly to stem her expressions of turmoil behind a handkerchief pressed to her face. I had known her since toddlerhood: I know this is uncharacteristic and therefore serious.

She now sits tensely on the edge of her seat, facing me. She gulps into a tear-sodden, tremulous cascade of words:

'Doctor, I'm so pleased you're here ... you've got to help me ... give me something to calm me down, help me sleep... I've got my GCSEs coming up and I really want to do well, but I can't face them like this...'

This will take time. I sit back.

'What is it Suki? What's happened?'

'It's about Mum and Danny [*stepfather*], see?'

'What about them?'

Another tearful convulsion.

"Most presentations to the NHS will not be adequately understood or responded to by the compliance-driven scientific-generic-management approach successful elsewhere."

'I think they may be separating, getting divorced ... they've been rowing. I wasn't trying to listen, but I could hear... Doctor, I couldn't bear it if Danny left me just with my Mum. My real dad left us when I was 2, to go to America: you know all about that. And Danny has been so good to us both, particularly with Mum being like she is: lovely but difficult. But Danny has always been like a real dad should be ... for as long as I can remember. You've seen that, haven't you doctor?'

Indeed I have, over many years, but just from my vantage point: Fiona – the mother – affective, attractive but volatile and short-fused with her

attachment insecurities; Danny seemingly rock-like in his affectionate and patiently good-humoured attentiveness.

I offer Suki words, I trust, of comfort, hope and guidance and then a small nocturnal dose of Diazepam. A personal bridge and an emotional poultice.

'Come and see me next week, sooner if you want to. I'll want to know how you are', I conclude.

She sniffs back the last of her tears and smiles at me with wistful warmth as she rises to leave.

Three days later it is Fiona, the mother, who enters as an emergency appointment. She seems, to me, anxious and wary – pausing as she enters: do I really want to talk about this?

'I don't know, doctor ... I'm not myself; something's wrong. I don't want to eat, and feel sick all the time. I think I've lost weight and have strange dizzy spells, thinking I may fall. Last night I felt really peculiar and did collapse – became unconscious ... No, I don't know for how long ... I can't remember.'

I ask the usual 'red-flag' questions and perform the kind of examination that most vigilantly competent doctors would.

We return to our seats. 'Well, that's all reassuringly OK. I don't think there's anything serious here, but we'll certainly keep an eye on things', I say, I hope with the right infusion of cheeriness. I follow it up with an ambiguously unthreatening probe:

'Can you think of anything significant that might have brought this on?'

She shakes her head and looks away, down at the floor. I persist gently; this is difficult territory, 'How's life? Work? At home, family...?'

'No ... that's all OK. Nothing there ...'. Her answer is clipped.

I notice she now briefly holds her breath, draws in her lips between her teeth, folds her arms, and looks at the door. I retreat diplomatically behind reassurance and offer another appointment to quell and contain, I hope.

It is important that, if she tells me what I already know, she does so on her own terms.

A month later this polysymptomatic kaleidoscope, projected by underlying domestic instability, is largely dimmed. Suki takes well to guided support, engages efficiently well with the GCSEs, and seeks further counselling to enhance her own internal stability. With deft encouragement Fiona warily and sparingly discloses the origin and nature of this shared melee of symptoms: she remains more cautious than her daughter of embarking on any further disclosure.

There is here no decisive fix-through-treatment, no happy-ever-after; instead we have, through improvised and bespoke dialogue, better-than-before new adaptations. This is growth and healing: achieved through relationships that can imaginatively engage with personal experience and meaning. It is resource-light: no expensive onward

referrals to hospital specialists and investigations.

Such is healing and its host-territory of pastoral healthcare.

Medical science-based consultations alone cannot achieve this because objectification cannot include the crucial vagaries of personal experience and meaning; they are disregarded to a state of oblivion or irrelevance.

This story was one of many that I continue to remember many years later. Similar-minded GPs from those earlier decades recall kindred tales of such worthwhile work. My mentors in the early 1970s modelled for me such art and craft: we would often share such stories for education and interest.

"Doctors worked more autonomously in smaller, more stable units. GPs were encouraged to work in long-term partnerships with 'personal lists' of patients."

In the following decades I documented and diarised many such consultations as I realised that the reforming culture was tragically destroying the 'soil' in which such healthcare encounters could take root and flourish.

What were the earlier conditions of that soil's fertility? Well, in brief, doctors worked more autonomously in smaller, more stable units. GPs were encouraged to work

in long-term partnerships with 'personal lists' of patients. Personal continuity of care – buttressed by cooperative familiarity with staff and colleagues – was then an expected modus vivendi, not an irregular anomaly as now. There was the headspace and heartspace available – encouraged even – to establish the more nuanced approaches of pastoral healthcare.

In 2010 – the time of Suki's story – I had seen, over several years, how this was becoming increasingly resisted and dismantled.

That dismantling and radical reformation started several decades ago, in the Thatcher era, and has continued – with amplification – ever since. The underlying idea driving and buttressing these reforms is that all of healthcare can be more reliably,

safely and economically delivered by thorough and rigorous industrialisation that is further modelled on competitive manufacturing corporations.

This mission has been expedited by 4Cs: competition, commodification, commercialisation and computerisation. The last of these – computerisation – has drastically empowered the other three: such bold mass-management was simply impossible in pre-digital times.

There is a fifth cultural principle that has grown massively (sic) with digitalisation: Gigantism. This is the ability and mission to coalesce services into larger and larger teams and premises, serving larger and larger populations and areas: this was – again – impossible in a pre-digital NHS.

Sometimes these industrialisation strategies have been irrefutably and irreplaceably successful – for example, with mass screening, immunisations, data-based research and the specialist hubs to treat malignant and acute cardiovascular disease. In contrast, the place of competitive commerce and tendering in the NHS brings very few, if any, wider or enduring benefits.

In general practice and mental health – the most frequently consulted services and the major locations of pastoral healthcare – the consequences are worse still. Here is an example:

2026. Large federated primary healthcare hub. London (2)

Let us consider the likely (yet hypothetical) scenario and fate of Suki and Fiona with our current serially reformed service. We'll imagine two doctors, Dr X and Dr Y, both working in large, modern premises. The finances, premises and professional staff are all now, here, managed by a commercial healthcare provider which is tied to venture capitalists. Dr X and Dr Y reflect this culture in their portfolio careers – both work, currently as part-time GPs, two to three sessions weekly in this practice, and opportunistically elsewhere. Dr X has a three-month contract with the practice, Dr Y is paid (better) by a locum agency. Neither want to be partners in any practice – their attitude and



working arrangements are closer to gig economy workers. Dr X and Dr Y have never met and barely know other professional or reception staff; almost all 'necessary' signalling is screen-texted. Both doctors are hot-desked and sharply time-managed by people they do not know.

The patient-list for each clinic is almost entirely decided by either receptionist-triage or nurse-triage as expediences to manage patient need or demand. Both doctors usually see patients as a one-off. Sort, Fix or Send (3) is the recommended consultation formula: all else is likely to arouse discouragement or perplexity in the system.

The computer is the dominant and enduring agent both within and across consultations. This is because the digital system can manage, store and easily retrieve any amount of data about limitless people.

The working computer system can do this instantly without human fatigue, error or bias. So personal knowledge or memory is thought to be redundant: what you need to know will be found on the computer screen. It follows that any suitably qualified professional can see any patient at any time. Isn't that better for staff-management and patient-flow? Why, then, have the fussy inconvenience of any personal continuity? These, speciously, have become working maxims of NHS design and administration.

When Drs X and Y call up the records of each patient there is a swarm of data, codes, algorithmic questions and tasks that the computer system needs completed in order to proceed. The

computer 'knows' the person and their history; it is assumed (now usually correctly) that the doctor does not. But such 'knowledge' is only about code-sanctioned diagnosis and treatments, metrics, data and census-type events: it cannot be about individuals' inner or relationship-life, particularly when this is (not yet) expressed. This can only be done by the dedication and skills of people-work: pastoral healthcare.

Sadly Dr X and Dr Y have little opportunity for any professional action and initiative that may depart from the well-mapped and expected routes. Patients, too, are strongly influenced to comply: 'One complaint for one person in one session. Now, what is your problem for our attention?'

This stern and spare pragmatism has long roots. From the Thatcher-era there has been less and less reference to medical education (how to think), and almost total talk of medical training (what to think): most doctors now choose expedience and obedience.

The time-pressures are well known nationally and are sharply directed here, in this hot-desked practice. If Drs X and Y have no personal knowledge of Suki and Fiona, and certainly no knowledge of their patients' relationships, what can these doctors' professional contribution be? The odds, surely, are stacked against them.

Even if these doctors' natures are kindly and emotionally highly literate – despite the industrial and anomic nature of their working conditions – even if they manage to retain high morale and motivation – it is most improbable they can make the necessary nuanced connections. They would not know personal stories. The mother-daughter relationship would not be perceived, let alone understood: Suki and Fiona have different surnames and would each consult separate doctors – X and Y.

Would Suki even wish to consult Dr X – a complete stranger – with a matter of such delicate complexity? If she does what, in a few minutes, can Dr X understand and do? Dr X has little capacity for follow up. Referral to counselling services demands much intrusive and interrogatory bureaucracy and then a waiting list of many months – useless for such a crisis. If Suki does not seek help, what then? Increasing distress leading to a psychiatric emergency? Self-palliation with alcohol or chemicals? Self-harm?

And how will Dr Y respond to Fiona's medley

of symptoms? Dr Y has no way of knowing anything of Fiona's emotional fragility and hyperactivity, or her daughter's current predicament. This doctor in this situation is unlikely to see Fiona again, so defaults to 'defensive practice' to deflect from any culpability of missing major pathology when it first presented. Could Fiona have had a first epileptic fit? Could

she have a lethal malignancy? Of the pancreas or ovary, for example? Should she be fast-tracked for specialist investigations?

Such are the paradoxical consequences of the abandonment of personal continuity of care and relationships in pursuit of industrial efficiency and cost cutting. Without the possibility of bespoke understanding, guidance and containment with such humanly complex patterns of distress, the costs multiply and amplify – to the alienated patients and doctors, and to the already overloaded hospital specialists and investigation facilities ... and to the economy.

The old adage: Family Doctors protect patients from hospitals and hospitals from patients has become less and less true, or even possible.

We like to think that we invent and operate our machines and devices to free up our attention to, and our investment in, our more important or pleasurable human tasks: that through such

“The overuse and misapplication of computers cause the operating humans to involuntarily overadapt to the machines they operate.”

control we will have more access to our own and others' headspace and heartspace.

This, certainly, is sometimes true, but unreliably so. So often our subsequent indiscretion leads to our excessive and misapplication of our automations and cybernations. Traffic-jammed, dangerously air-polluted cities; mental and behavioural disturbances from the magical powers of digital social media; our environmental degradation from our imaginative but ineluctable use of plastics ... all of these represent the curses that emerge when we do not have the wisdom to contain, sometimes rescind, the blessings of our cleverness.

There is an additional severe loss of paradoxical nature. The overuse and misapplication of computers cause the operating humans to involuntarily overadapt to the machines they operate. In having, perforce, to continually use the machines' algorithms, codes, vocabulary and sequences, the humans find their own human imagination, resonance and improvisation increasingly redundant, eventually inaccessible. In this human-IT fusion the digital imperatives are, increasingly, proving to be more powerful than the human's wishes or influence. Dr X and Dr Y, whatever their human qualities outside the consulting room, will find they are the computer's cipher within it. Data and codes may all be in one place; the important humanity is locked out and astray.

And when AI is increasingly making evaluations and decisions, what then?

'The danger of the past was that men become slaves. The danger of the future is that men may become robots.'

– Erich Fromm (1955) *The Sane Society*

Notes

1. The first of these accounts occurred in 2010 and draws from detailed diarised notebooks I kept throughout my decades of practice. The second account, from 2026, is an imaginary composite of many real observations and accounts (both my own and many others) to construct a probable scenario – typical of many described by practitioners, their staff and patients.

2. The sources of this second imagined narrative are very wide: many years of documented interviews and conversations with patients, practice staff and managers. These often echo my own experiences. The contemporary hub-practice that employs Drs X and Y bears much resemblance to one that replaced the smaller traditional practices where I used to work.

3. Zigmond, D. (2021). 'Sort, Fix or Send?' *BJGP*, August 27

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[David will be speaking about key issues facing general practice at the DFNHS/DAUK Joint Conference in York on 10 October. See Page 5 for booking information.]

Book Review

Noctor, Noctor: A prescription for trouble

(£16.99 paperback)

Jatinder Hayre, 2026, Icon Books, 272pp.

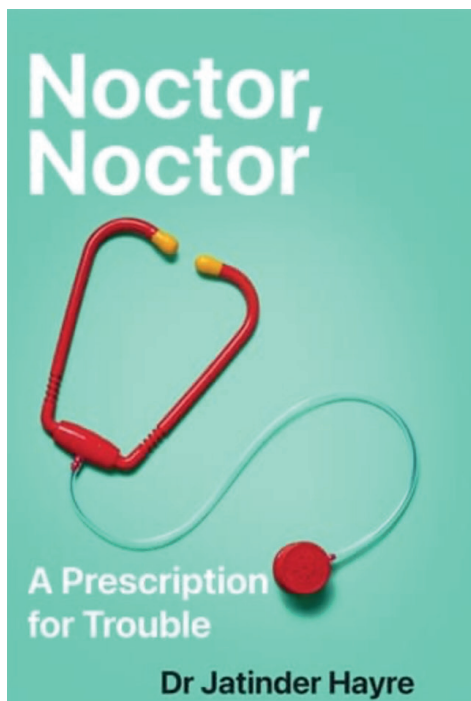
'Noctor' is slang from blending the words 'not a doctor' and this book is the story of 'Noctoring' – the systematic replacement of doctors with the 'not a doctor'.

'Noctor' refers mainly to physician associates (PA), but there are a variety of Medical Associate Professionals (MAP) (1) including Anaesthesia Associates (AA), Surgical Care Practitioners (SCP) and senior nurse Advanced Practitioners (AP).

The book is a heartfelt plea prompted by seeing at first hand the negative impact of doctor substitution on both staff and patients while having concerns brushed aside by those in senior positions. Lack of supervision of doctor substitutes results in harm that is difficult to quantify but includes over-investigation and its consequences with all the attendant costs. More deprived areas struggle to recruit doctors and rely more on noctors so that in terms of care, patients here become even more disadvantaged.

The fact that harms cannot easily be identified has led to complacency rather than a desire to rigorously evaluate the impact of MAP. This is despite a rapid review of the available scientific literature (2) concluding that the absence of evidence of safety incidents should not be misinterpreted as evidence that deployment of PA and AA is safe and that new research is urgently needed to explore staff concerns, examine safety incidents, and inform a national scope of practice for these relatively new and contested staff roles.

Some important context is missing from the book. PA were introduced to the NHS in 2003. As numbers grew, so did concern about them being used despite very limited training as doctor substitutes, threats posed to patient safety, and the potential for patients to be misled into thinking they were actually seeing a doctor. The enthusiastic support for MAP from leaders of



Royal Colleges led to a member backlash by both physicians and anaesthetists. Among others, the President of the Royal College of Physicians was forced to resign (3) after a member survey was misrepresented as showing support for PA. The British Medical Association demanded clear rules for what PA should and should not be allowed to do, and objected to the doctor's regulator, the General Medical Council, agreeing to take on the regulation of MAP and adding further to confusion over professional roles.

The 2023 NHS workforce plan anticipated a tripling of PA numbers to around 10,000 by 2036/7 together with 2,000 AA.

Outcry from the medical profession prompted

the Leng Review (4) into the role of PA and AA, commissioned by the Secretary of State for Health. Recommendations (5) aimed to make distinctions between PA and doctors more visible, while stipulating the need for senior clinical supervision. From Hayre's personal experience however, it would seem that little has changed on the ground and concerns about PA being encouraged to work beyond their competence remain. Not only that, but AP are also being used to cover gaps in doctor rotas (6).

As Hayre points out, the nocter model is served by reducing medicine to a series of tasks and checklists and justified by talk of 'skill mix', 'flexibility' and 'task-shifting' as if these are all representative of progress. One chapter is devoted to 'MacDonaldisation' of medicine, reshaping care in the quest for greater efficiency and prioritising models that resemble industrial service: 'The aim is not to know the patient, but to process the presentation. Care becomes something that can be completed.' Such systems organised around throughput look to workers like MAP that can be trained quickly, deployed flexibly and governed by protocol. However, little valid research has been done on the consequences of this approach and while doctor unemployment is a significant issue, jobs for PA continue to be advertised. Rather than alleviating pressure on doctors, the nocter requires supervision, training and where necessary, correction.

Hayre identifies the rise of managerialism following the 1983 Griffiths report with the curtailing of professional freedoms as the NHS moved into the era of the financialisation of health care (7). This has been referred to by others as the proletarianisation of medicine whereby physicians are subordinated to the broader requirements of the capitalist control of profitable medical production. Over recent years, nocters have come to fill gaps left by underinvestment in training and attrition in the workforce from low morale.

Perhaps too much is made in the book of the NHS being conceived as a public embodiment of compassion, and as a civic covenant, no less

than a moral agreement between the state and its people. In fact, the government's justification for investment in the NHS rested on interlocking economic grounds rather than purely moral ones. Bevan linked healthcare to the national economic renewal of the state, arguing that treating illness early would keep people working and contributing. Investing in healthcare was seen as investing in economic output. The government proposed that a universal system would catch illness earlier; reduce expensive emergency care, and lower overall societal costs over time. Centralised funding meant lower per-person administrative costs, more predictable public spending, and elimination of profit extraction in core services.

Illness before the NHS often meant loss of income, medical bills, poverty or debt. This was economically destabilising, reducing consumer spending and increasing reliance on poor relief.

By making healthcare free at the point of use, the NHS stabilised household finances and helped maintain demand in the wider economy. The Beveridge report also argued that tackling "want, disease, ignorance, squalor, and idleness" would reduce long-term public expenditure and create a more efficient, stable society. Upfront public investment reduces future social and economic costs. Healthcare is not just a cost – it is a productive investment that reduces inefficiency, supports growth, and stabilises the economy. This is of course highly relevant to the current contradictory government position that subordinates funding needed for rebuilding the NHS to growing the economy. Meanwhile, there are 2.8 million people out of the workforce (8) because of ill health. The argument that an efficient NHS is essential for building a strong economy (9) remains valid.

Hayre concludes by summarising what might be done. If doctors are defined by capacity to navigate uncertainty, this comes from their extensive training and is not true for nocters. Job titles should be transparent as should the scope of practice including explicit boundaries. There must be a national regulatory framework



(covering training, assessment, supervision, scope of work). Supervision should be formal, structured and transparent while there must be investment in medical training to increase the numbers of doctors. Although Hayre does not suggest this, this could include career progression for some MAP who wish to re-train as doctors.

Buy or borrow this book and read it carefully. It should help to reinvigorate the debate about medical professionalism and autonomy, clinical freedom to do what is best for a patient, workforce needs, quality of care and whether the NHS is now really focussed on safety and the needs of patients. This is more important than ever given the techno-optimism of the *Ten Year Health Plan for England* (10) and its unevidenced assumptions around the transformative nature of Artificial Intelligence. Such ideas link to increasing emphasis on digital interaction with health care services, the erosion of the importance of the doctor-patient relationship and likely also to the apparent equanimity around increasing number of job losses (11). In this context further weakening of professional roles in favour of less well trained, cheaper and more compliant alternatives seems on the cards. This trend will only be stopped when neoliberal policies are abandoned and the NHS can be fully restored as a publicly funded, provided and accountable service. To quote Hayre, 'The question is not whether The NHS can function with fewer doctors...but whether it should.'

References

1. KONP (2024) 'Medical Associate Professionals and the implications for quality of patient care' 22 April [Available at: <https://tinyurl.com/yec7esy2>]
2. Greenhalgh, T. and McKee, M. (2025) 'Physician associates and anaesthetic associates in UK: rapid systematic review of recent UK based research' *BMJ* 2025;388:e084613 [Available at: <https://doi.org/10.1136/bmj-2025-084613>]
3. Ungood-Thomas, T. (2024) 'Wider use of physician associates will increase inequality, say UK doctors' *Guardian*, 30 June

- [Available at: <https://tinyurl.com/5n6bb4m2>]
4. UK Government (2025) Independent review of the physician associate and anaesthesia associate roles: final report [The Leng Review] [Available at: <https://tinyurl.com/2sak3vtz>]
5. Kar, P. (2025) 'The Leng review offers pragmatism along with lessons for the NHS' *BMJ* 2025;390:r1517 [Available at: <https://doi.org/10.1136/bmj.r1517>]
6. Campbell, D. (2026) 'Safety fears as UK hospitals use nurses to cover for doctors due to shortage of medics' *Guardian*, 25 April [Available at: <https://tinyurl.com/53y7axp9>]
7. Denticio, N. (2023) Banking on health: the surging pandemic of health financialization. *SID* [Available at: <https://tinyurl.com/5demz6v7>]
8. Elliott, L. (2024) 'Record long-term sickness bodes ill for UK economic growth' *Guardian*, 17 February [Available at: <https://tinyurl.com/yf5s37rj>]
9. 99% Organisation (2025) *The Rational Policy-Maker's Guide to Rebuilding the NHS* [Available at: <https://tinyurl.com/5btxrh7y>]
10. UK Government (2025) '10 Year Health Plan for England: fit for the future' [Available at: <https://tinyurl.com/482r8nnv>]
11. Campbell, D. (2025) 'Hospitals in England could shed 100,000 jobs in response to cost-cutting orders' *Guardian*, 8 April [Available at: <https://tinyurl.com/yz5yywvp>]

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Arun Baksi

It is with deep regret that we report the death of Arun Baksi, a longstanding member of EC and DFNHS.

Arun worked tirelessly for many years on critical issues facing the NHS, and recently worked with fellow EC members on the need to update the disciplinary process which all too often is now used by Trusts as a weapon to silence or unfairly punish doctors for speaking out or even for questioning the 'status quo'.

His work with Asian colleagues covered many aspects of the treatment of Asian doctors in the UK and he was deeply respected by the national and international organisations he worked with and for.

He will be sadly missed at EC, and we extend our sympathies to his widow Bettina, who is also a member of DFNHS. A full obituary will be published in the next issue of the newsletter (due out in December).

Arun died peacefully at his home on the Isle of Wight on 20 August.

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Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

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