this week

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YUI MOK/PA/ALAMY

Junior doctors accept 22% pay deal

The longest industrial dispute in the NHS's history ended after junior doctors in England accepted a deal from the government worth 22.3% more on average over two years.

A total of 45 830 junior doctors took part in an online referendum on the deal between 19 August and 15 September, a turnout of 69%, of whom two thirds (30 227) voted in favour of the offer. The deal includes an additional backdated rise for 2023-24 of between 3.71% and 5.05% (4.05% on average), on top of the average of 8.8% previously awarded. For 2024-25 junior doctors will get a 6% increase, together with a £1000 one-off payment across grades.

The Department of Health and Social Care said the cumulative effect of the uplifts meant a doctor starting NHS foundation training will see their basic pay increase to £36 600, up from around £32 400 before the deal.

The government has also committed itself to working with the BMA to review wider issues affecting the workforce, including ensuring junior doctors are paid for any additional hours they work; reviewing the number and frequency of rotations; and working with NHS England to tackle training bottlenecks and to review the planned expansion of medical school places.

The BMA Junior Doctors Committee co-chairs, Robert Laurenson and Vivek Trivedi, said, "We have shown what can be accomplished with our determination and with a government willing to talk realistically about a path to pay restoration.

"There is still a long way to go, with doctors remaining 20.8% in real terms behind where we were in 2008. Wes Streeting [the health secretary] has talked about a journey to pay restoration. He believes the independent pay review body is the right vehicle for this. However, in the event the pay review body disappoints, he needs to be prepared for the consequences."

The health department estimates that all the healthcare strikes have cost the taxpayer almost £1.7bn since April 2023, with more than 1.5 million appointments cancelled.

Streeting said, "Things should never have been allowed to get this bad. This marks the necessary first step in our mission to cut waiting lists, reform the broken health service, and make it fit for the future."

Outside the pay negotiations, the government has agreed to the BMA's request that from 18 September "junior doctors" across the UK will be known as "resident doctors" to better reflect their expertise.

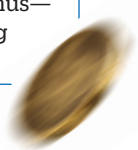
Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;386:q2038

Robert Laurenson (centre right) and Vivek Trivedi, co-chairs of the Junior Doctors Committee, warned "there is still a long way to go" to reach pay restoration

LATEST ONLINE

- Gaza: More than 22 000 people with life changing injuries urgently need rehabilitation, WHO warns
- Peer review practices are "delaying science," claims academic in lawsuit against six publishers
- How to live to 110, win a coin toss, and breathe through the anus—it's the 2024 Ig Nobel awards



SEVEN DAYS IN

BMA calls for talks with London hospitals over "suppressed" rates for extra shifts

Doctors' leaders in London have called for an end to "suppressed pay rates" for work done outside contracted hours. Leaders of all 36 BMA local negotiating committees in the capital have written to NHS trust chief executives to say that pay rates for extra shifts are lower in London than in other parts of the country. As a result they do not attract doctors to work, leaving gaps in rotas unfilled and putting patients at risk of harm.

The letter, seen by *The BMJ*, criticises NHS trusts in London for collaborating "behind closed doors" and without input from BMA local negotiating committees. This has resulted in a "London medical rate cap" that trusts have agreed among themselves.

The letter calls on London's NHS management to work with BMA local negotiating committees to negotiate a new city-wide set of pay rates for all medical extra non-contractual and locum work.

Kevin O'Kane (left), a consultant and chair of the BMA's London regional council, said, "There isn't robust data on what doctors are paid for these shifts, but anecdotally we know that in trusts in other areas of the country the hourly rate in normal hours for consultants can often be between £100 and £150, and for juniors from £35 up to £90." The rate in London is £69 to £87 for consultants and £22 to £44 for junior doctors.

Jacqui Wise, Kent **Cite this as: *BMJ* 2024;386:q2017**

Obesity

Injection is effective in children, study shows

The weight loss injection Saxenda (liraglutide) effectively reduced body mass index in children in a small phase 3 trial involving 82 children. The study, published in the *New England Journal of Medicine* and funded by the manufacturer Novo Nordisk, randomly allocated children aged 6-11 years to liraglutide or to placebo together with lifestyle intervention. A BMI reduction of at least 5% occurred in 46% of the children in the liraglutide group but in only 9% of participants in the placebo group (adjusted odds ratio 6.3 (95% confidence interval 1.4 to 28.8); P=0.02).

Long term illness

"Whole government approach is needed"

A "whole of government" approach to tackling long term sickness and economic inactivity could return as many as 600 000 people to the UK workforce within five years, say analysts. They estimate that this could deliver a £109bn to £177bn boost to the UK's GDP—equal to 2-3% in 2029—and could "unlock" £35bn to £57bn in fiscal revenue by then. The report from the NHS Confederation and the Boston Consulting Group Centre for Growth said that a common purpose and improved coordination between government departments was required, with better use of funds and resources to maximise economic and social benefits from health investment.

Endometriosis

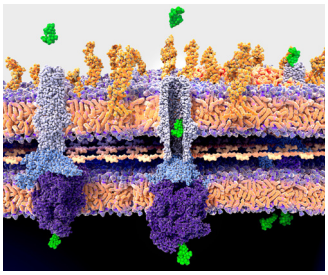
No care progress in 25 years, says charity

A survey of 1800 patients with endometriosis showed that they rated their feelings of control and powerlessness at an average of 72.3 out of 100, where 100 is the worst. Across 11 areas, including pain and emotional wellbeing, scores remained similar to or marginally worse than a previous survey carried out in 1999-2000 for Endometriosis UK. The charity's chief executive, Emma Cox (left), said, "This report is further evidence of the challenges faced by those living with endometriosis, diagnosed or undiagnosed—and that these challenges have not improved in 25 years."

AMR

Steady rise in deaths is predicted by global study

More than 39 million people around the world could die from antimicrobial resistant infections in the next 25 years, showed a global analysis of trends over time, published in the *Lancet*. From 1990 to 2021 more than a million people died each year as a result of antimicrobial resistance (AMR),



and an estimated 1.91 million could potentially die from it in 2050, an increase of almost 70% a year from 2022. From 1990 to 2021 AMR deaths among children under 5 years old declined by 50%, while those among people over 70 increased by more than 80%.

Mental health

Inquiry will uncover more deaths, says chair

The UK's first statutory inquiry into mental health deaths is expected to unearth many more deaths among Essex inpatients from 2000 to 2023 than the roughly 2000 deaths now under consideration, said the inquiry's chair, Kate Lampard. The inquiry is focusing on Essex Partnership University NHS Foundation Trust and North East London NHS Foundation Trust, along with their predecessor bodies. Lampard said that it would examine deaths that had occurred in NHS inpatient facilities and up to three months after discharge. It would look at serious failings in NHS care, including leadership, culture, and governance in NHS trusts.

Mental Health Act "reinforces inequalities"

The Centre for Mental Health called for whole system reform as the latest figures from NHS Digital showed disparities in use of the Mental Health Act. Black people and people living in areas of highest deprivation are nearly four times as likely to be sectioned, and black Caribbean people are also more than eight times as likely as white people to receive a community treatment order. The charity's chief executive, Andy Bell, said, "These latest figures expose the unacceptable inequalities which are inherent within the outdated Mental Health Act."

MEDICINE

Artificial intelligence

Warning over genomic health prediction

AI powered genomic health prediction (AIGHP) should not be widely rolled out in the NHS, said a report from the Ada Lovelace Institute and the Nuffield Council on Bioethics. The technology has potential benefits, including providing insight into a patient's risk of developing disease, predicting individual responses to treatment, and informing screening decisions. However, there are significant risks regarding privacy and discrimination, as well as structural and societal problems that could emerge from the use of AIGHP at the population level. The report recommends a targeted approach for cases where there is a well defined need.

AI should not be used for population level prediction decisions, warn researchers

Sodium valproate

Sanofi to pay family birth defects compensation

The drug company Sanofi was ordered to pay more than a quarter

of a million euros to Marine Martin, a mother in France whose children were damaged in the womb by the epilepsy drug Depakine (sodium valproate). The Paris judicial court ordered the French company to pay Martin and her two children nearly €285 000 (£240 000) in compensation for birth defects caused by the drug, which she took during her pregnancies.

Pay

Welsh doctors welcome pay announcement

BMA Cymru Wales has welcomed the Welsh government's announcement that the recommendations of the doctors pay review body will be accepted in full for the 2024-25 financial year. Doctors in Wales will get a 6% pay award plus a consolidated rise of £1000 for each pay point. Oba Babs-Osibodu and Peter Fahey, co-chairs of the BMA's Welsh Junior Doctors Committee, said, "While we will continue to recover the years of real terms pay cuts, today's award does provide some further reversal of that erosion."

Emergency care

Busiest ever summer for England's A&Es

NHS England performance data show record demand at emergency departments in June, July, and August, with 6 776 150 attendances, up 240 776 on the same period last year. Despite the rising pressure, 76.3% of A&E patients were admitted, transferred, or discharged within four hours in August—the highest since 2021. The backlog for elective care remained at 7.62 million in July, but waiting times of over a year dropped to 290 326, the lowest since December 2020.

NHS

Lib Dems promise "constructive opposition"

Speaking at the Liberal Democrat Party's conference in Brighton, the party's chief whip vowed that it would be "the party of the NHS and care in every part of Britain." Wendy Chamberlain said that as the third largest party in Westminster the Lib Dems would be a "constructive opposition" to the Labour government.

Cite this as: *BMJ* 2024;386:q2028

MPOX

The government has purchased

150 000

doses of mpox vaccine to enable the NHS to vaccinate people who may be at high risk of infection, after WHO warned about the spread of clade I mpox

(UK Health Security Agency)

SIXTY SECONDS ON . . . CLOWN THERAPY

IS THIS SOME SORT OF SICK JOKE?

Not at all. Researchers at the Carmel Medical Centre in Israel have found that children who are seriously ill in hospital with pneumonia made a faster recovery after a visit from specially trained "medical clowns."

I WORK WITH A FEW OF THOSE

These are actual clowns with red noses, oversized shoes, and rotating bowties. Research presented at the 2024 European Respiratory Society Congress, reported in the *Times*, followed 51 children aged 2 to 18 years who had been treated in hospital for pneumonia. One group received standard care, while the other received the same care and a 15 minute visit from a medical clown twice a day during the first 48 hours of their hospital stay.

WE NEED TO SEND IN THE CLOWNS?

Apparently so. Patients who had a clown visit stayed in hospital for an average of 43.5 hours, compared with 70 hours for the other group. They also needed only two days of intravenous antibiotic treatment, whereas the control group needed three.

WHAT DID THE CLOWNS DO?

They used music, singing, and guided imagination, which researchers said helped alleviate stress and anxiety among the children.

SO, LAUGHTER IS THE BEST MEDICINE

It could be. A *BMJ* review of 24 studies published in 2020 supports the findings that hospital clowns can help alleviate symptoms such as anxiety, fatigue, and pain.

WHAT ABOUT PATIENTS WITH COULROPHOBIA?

A phobia of clowns is rare. Previous research by the Carmel team showed that only 1.2% of 1160 children surveyed by doctors in one hospital had a fear of clowns. But an Australian survey of 987 adults found that a rather higher 53% reported a fear of clowns to some degree. They put the fear down to a variety of factors: clown makeup reminds us of death, infection, or blood injury, the makeup masks emotional signals, and clowns' unpredictable behaviour makes us uncomfortable.

Anne Gulland, *The BMJ*

Cite this as: *BMJ* 2024;386:q2004

PM says NHS must "reform or die" after damning Darzi report into state of service

JULIAN SIMMONDS/WPA/GETTY

Keir Starmer has promised to deliver the "biggest reimagining of our NHS since its birth" in response to Ara Darzi's independent investigation into the state of the health service in England.

The report by Darzi, a peer, surgeon, and former Labour health minister, said the NHS was in a "critical condition," degraded by years of austerity and "disastrous" structural reforms that were "political choices."

Starmer said the service must "reform or die" to meet the challenges, promising "major surgery, not sticking plaster solutions."

Darzi was commissioned in July by the health secretary, Wes Streeting, to assess all facets of the NHS in England, including patients' access to care, quality of care, and overall performance. Publishing his rapid review on 12 September, Darzi said he was "shocked" by his findings.

He said the NHS had been weakened over more than a decade by a lack of capital investment, leaving growing waiting lists, emergency departments in an "awful state," cancer mortality "appreciably higher" than in other countries, falling productivity, public satisfaction at its lowest ever, and many staff exhausted and disengaged, having lost confidence in the service.

Highlighting that the NHS continues to struggle with the aftershocks of the pandemic, Darzi said austerity and capital starvation "helped define" the UK's response to covid, with deteriorating access to almost every form of care, a surge in multiple long term conditions, high rates of long term sickness and mental ill health, and cash starved hospitals.

Many of the social determinants of health—such as poor quality housing, low incomes, and insecure employment—"have moved in the wrong direction over the past 15 years, with the result that the NHS faces rising demand for healthcare from a society in distress," he added.

Darzi said operational processes in the NHS were being overwhelmed. "We became clinicians to help patients get better, not to go into battle with a broken system," he said. He added that, though it would take many years, he was confident the NHS could be restored, while retaining the service as free at the point of use, not least because its "vital signs" were strong and it had an "extraordinary depth of clinical talent."

Key themes for reform

He identified key themes for ministers to take forward in a new NHS plan, including re-engagement with staff, re-empowering patients, more digitisation, rebuilding capacity, and locking in the shift of care closer to home by "hardwiring financial flows."

Darzi said, "In the past 15 years, the NHS was hit by three shocks—austerity and starvation of investment, confusion caused by top-down reorganisation, and then the pandemic, which came with resilience at an all time low. Two out of three of those shocks were choices made in Westminster.

A third of patients miss out on risk assessments before surgery

Almost one in three patients having major non-cardiac surgery still do not receive a documented individualised risk assessment, research by the Royal College of Anaesthetists (RCoA) has found.

The proportion has remained unchanged since the college's perioperative quality improvement programme (PQIP) began in 2016, which it says "represents a real opportunity for improvement."

The latest PQIP cycle included 8634 patients who had major surgery in the year to March 2024, from 135 hospitals across the UK. Comparisons were also made with earlier cohorts, making a total of 53 478 patients at 173 hospitals.

Individualised risk assessments help identify existing conditions that may cause surgical complications and enable doctors to plan tailored care. They also improve shared decision making between clinicians and patients and help ensure informed consent.

Guidelines from the Centre for Perioperative Care, a cross organisational, multidisciplinary initiative led by the RCoA, recommend that all patients undergoing surgery should have an individualised risk assessment. NHS England also advises that patients awaiting surgery be screened for health issues early in the care pathway. The RCoA recommends that hospitals use a locally agreed tool, such as the surgical outcome risk tool (SORT), to give an objective estimate of a patient's perioperative risk.

It's of particular concern that 67% of patients with anaemia did not receive treatment before surgery
Report authors

The college has identified individualised risk assessments as one of five priorities that will help reduce costs by preventing operations being cancelled and reducing complications among patients. Other priorities are improving the management of anaemia, optimising diabetes care, increasing the proportion of patients who drink, eat, and mobilise (DrEaM) within 24 hours of surgery, and using data to drive quality improvement.

Without radical action, the NHS won't survive
Philip Banfield

"It took more than a decade for the NHS to fall into disrepair, so it's going to take time to fix it. But we in the NHS have turned things around before, and I'm confident we will do it again.

"We need to rebalance the system towards care in the community rather than adding more and more staff to hospitals. And we need a more honest conversation about performance—the NHS is now an open book."

Emphasis on prevention

In a speech at the King's Fund on 12 September Starmer said Labour's upcoming 10 year plan will be framed around "three big shifts" rooted in Darzi's recommendations. "First, moving from an analogue to a digital NHS. Second, we've got to shift more care from hospitals to communities. Third, we've got to be much bolder in moving from sickness to prevention," he said.

"Only fundamental reform and a plan for the long term can turn the NHS around and build a healthy society. It won't be easy, it won't be quick. But I know we can do it."

For his review, Darzi brought more than 70 organisations together in an expert reference group and sought input from staff and patients.

Health and medical leaders welcomed Darzi's analysis, calling it accurate and sobering. Philip Banfield, BMA council chair, said, "While the findings are unsurprising, this report is sobering. Without radical action, the NHS won't survive."

Matthew Limb, London
Cite this as: *BMJ* 2024;386:q2001

The PQIP report said it was of "particular concern" that 67% of patients with anaemia did not receive treatment before surgery. It also found that only 75% of patients with diabetes had their HbA_{1c} measured before surgery.

Ramani Moonesinghe, chief PQIP investigator from University College London Surgery and Interventional Science, said, "Lord Darzi's report stated that NHS providers will need to 'bring down waiting lists by radically improving their productivity.' Our report highlights multiple opportunities to achieve this ambition, by reducing cancellations, postponements, and postoperative length of stay while also improving patient care and outcomes."

Jacqui Wise, Kent
Cite this as: *BMJ* 2024;386:q2035

Four in five general practices are taking collective action, says BMA

More than 80% of general practices in England are already taking some form of collective action over their contractual terms and in response to insufficient funding for general practice, the BMA has said.

In a ballot over the summer GP partners in England voted overwhelmingly in favour of collective action, with 98.3% of members voting yes. The BMA called on GP contractors to start taking at least one action from a menu of 10 actions from 1 August.

In a video statement released on 13 September, Katie Bramall-Stainer, chair of the BMA's General Practitioners Committee for England, said that the committee had given the new government an opportunity to get around the table but that it was "still waiting to hear back."

She told GPs, "The clock is ticking. Over 80% of practices are already taking at least one or more actions from our safe, sustainable action menu. Remember: none of them breach your contract, but they will help you manage your workload.

"These actions will work and they will build growing leverage over the months ahead to support us in negotiating for you and your practice and team."

The BMA is sabre rattling. Collective action is unnecessary and will harm patients
Wes Streeting

England has around 6400 general practices. The menu of actions available to them includes seeing no more than 25 patients a day, delivering only core services, opting out of secondary use data sharing agreements, and switching off NHS software that tries to cut prescribing costs. The BMA detailed these actions in a handbook for GPs on safe working published earlier this month.

Increasing the burden on colleagues

Speaking on BBC Radio 4's *Today* programme on 13 September, the health and social care secretary, Wes Streeting, accused the BMA of "sabre rattling." He said GP collective action was unnecessary and would harm patients and increase the burden on their colleagues in other parts of the NHS.

On the same programme Bramall-Stainer said she was "disappointed" by his remarks. She said, "We have lost 2000 practices over the past 15 years—that's 20% of GP surgeries gone. Thousands of GPs have been haemorrhaged from the NHS.

"One in four GPs knows another GP who has taken their own life—my own GP took his own life in 2021—and that is not sabre rattling, that is because general practice is collapsing now."

Ara Darzi's independent investigation into the NHS (see left) said that the system needed to be "rebalanced" towards care in the community rather than adding more and more staff to hospitals. The prime minister has said Darzi's report would help shape the government's upcoming 10 year plan for the NHS but added that there would be "no extra NHS funding without reform."

Bramall-Stainer said, "We are not in a position to be able to wait for long term plans next year or consumer spending reviews. Our action isn't striking, it's not withdrawing labour or shutting our doors, it's action that is legally permissible to stop more practice closures."

Jacqui Wise, Kent
Cite this as: *BMJ* 2024;386:q2026

WE HAVE LOST 2000 practices over the past 15 years—that's 20% of GP surgeries gone. Thousands of GPs have been haemorrhaged from the NHS
Katie Bramall-Stainer

DIABETES: **Once weekly insulin could be as effective as daily injections, studies indicate**

Daily injections can be a burden to patients but are the cornerstone of type 1 diabetes management and often become necessary for type 2 diabetes. Could they soon be a thing of the past, asks **Jacqui Wise**

The effectiveness of a new class of once weekly basal insulin, called efsitora alfa, has been tested in two separate phase 3 trials: one in patients with type 1 diabetes and one in those with type 2. The results, presented at the European Association for the Study of Diabetes in Madrid on 10 September and simultaneously published in the *New England Journal of Medicine* and the *Lancet*, show that the weekly injection is as effective as a daily injection of a long acting basal insulin, although with type 1 diabetes there was a higher incidence of hypoglycaemia, including severe hypoglycaemia.

What is the evidence for weekly efsitora for type 2 diabetes?

Previous studies have been limited to small phase 1 or phase 2 trials. The new phase 3 study, published in the *New England Journal of Medicine*, included 928 patients with type 2 diabetes who had not previously received insulin and were taking oral antidiabetes medications but were still not at their glycaemic goals. They were randomly assigned to efsitora or degludec (a standard long acting basal insulin that gives patients with diabetes a steady stream of the drug over 24 hours). The mean glycated haemoglobin level (HbA_{1c}) decreased from 8.21% at baseline to 6.97% at week 52 (least squares mean difference 1.26%) with efsitora and from 8.24% to 7.05% (difference 1.17%) with degludec. This was a significant treatment difference of 0.09% that demonstrated "non-inferiority" between the two treatments. Similar results were seen in subgroups of patients using and not using GLP-1 agonists.

Efsitora has the potential to address treatment burden and improve adherence
Carol Wysham

The incidence of combined clinically significant or severe hypoglycaemia was 0.58 events per participant year of exposure with efsitora and 0.45 events per participant year of exposure with degludec, but this finding was not statistically significant. No severe hypoglycaemia was reported with efsitora, while six episodes were reported with degludec. The incidence of adverse events was similar in the two groups.

What is the advantage of weekly injections for type 2 diabetes?

When patients with type 2 diabetes find that their oral medications alone can no longer control their blood sugar, insulin therapy is added. Having daily injections can affect compliance: some patients fear needles, while others may worry about hypoglycaemia and weight gain. The alternative to insulin injections, an insulin pump, is generally offered on the NHS only to some children and adults with type 1 diabetes and not for type 2 diabetes.

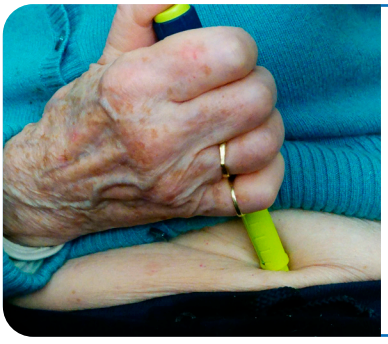
The type 2 diabetes study's lead author, Carol Wysham, clinical professor of medicine at the University of Washington School of Medicine, said, "Traditionally, basal insulins are dosed once a day, a treatment schedule that can make compliance difficult for a significant portion of people living with type 2 diabetes. Efsitora has the potential to address treatment burden and improve adherence — all while lowering HbA_{1c}."

Katie Bareford, senior clinical adviser at the charity Diabetes UK, told *The BMJ*, "Keeping blood sugars in target range with insulin therapy can be relentless and exhausting. A reduction in the number of insulin injections could lessen the burden of living with diabetes and better support people in their efforts to manage their diabetes."

What does the study of patients with type 1 diabetes show?

The phase 3 study, published in the *Lancet*, randomised 692 patients with type 1 diabetes to once weekly efsitora or once daily degludec. Mean HbA_{1c} decreased from 7.88% at baseline to 7.41% at week 26 with efsitora and from 7.94% at baseline to 7.36% at week 26 with degludec. There was a non-inferiority margin of 0.4%, which meant that efsitora wasn't worse than degludec in reducing HbA_{1c}.

However, the incidence of hypoglycaemia was higher with efsitora than with degludec: 14.03 versus 11.59 per patient year of exposure, which was an increased risk of 21%. And 10% of patients taking efsitora but only 3% in the degludec group experienced severe hypoglycaemia. The lead



In patients with type 2 diabetes, the mean glycated haemoglobin level (HbA_{1c}) decreased from 8.21% at baseline to 6.97% at week 52 (absolute change 1.26%) with efsitora and from 8.24% to 7.05% (absolute change 1.17%) with degludec, a statistically significant treatment difference of 0.09% that demonstrated "non-inferiority" between the two treatments.

HYPOGLYCAEMIA incidence among patients with type 1 diabetes was **21%** higher with efsitora than with degludec

author, Richard Bergenstal, from the International Diabetes Center in Minneapolis, said, "More work is needed to evaluate efsitora dose initiation and optimisation of basal-bolus insulin dosing to maintain efficacy while mitigating the risk of hypoglycaemia with weekly efsitora treatment in people with type 1 diabetes."

Is efsitora the only once weekly insulin in the pipeline?

No, Novo Nordisk has icodec, a once weekly basal insulin injection. Last year research published in the *Lancet* found that icodec was as effective as daily injections of degludec in reducing HbA_{1c} after 26 weeks in patients with type 1 diabetes. However, the study, involving 582 patients, found significantly higher rates of combined clinically significant or severe hypoglycaemia with icodec.

In July this year the US Food and Drug Administration rejected icodec for patients with type 1 diabetes, after seven of the 11 panellists on the FDA's endocrinologic and metabolic drugs advisory committee ruled that the data available showed that the benefits of icodec did not outweigh the risks of hypoglycaemia. The committee did not vote on icodec's suitability for patients with type 2 diabetes.

What could this mean for patients in the UK?

Eli Lilly has not yet requested approval in the UK or US for efsitora. Icodec does not currently have a marketing authorisation in the UK, although the National Institute for Health and Care Excellence is currently appraising it for treating type 2 diabetes, with publication expected in May 2025.

Partha Kar, a consultant in diabetes and endocrinology and the NHS's national specialty adviser for diabetes, told *The BMJ* that weekly insulin injections were an "exciting development in type 2 diabetes and part of the evolution of insulin itself, similar to how GLP-1 agonists have evolved."

The advent of continuous glucose monitoring and the newer automated insulin delivery systems have already changed the management of type 1 diabetes. But Kar said there was less appetite and enthusiasm for weekly insulin injections at this stage for type 1 diabetes until further research showed that the hypoglycaemia issues settling. "It's not something I am keen on at the moment, especially in an environment where the majority of people with type 1 diabetes are now eligible for hybrid closed loops in the NHS."

A hybrid closed loop system or "artificial pancreas" links continuous glucose monitoring with insulin pump technology to monitor blood glucose concentrations and automatically adjust the amount of insulin given through a pump to people with type 1 diabetes. After a successful pilot scheme by NHS England, the first rollout of the systems started in April this year.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;386:q2005

Junk food TV adverts to be banned before 9 pm in bid to tackle childhood obesity

Public health leaders and campaigners have welcomed the government's announcement that it will legislate to ban advertisements for junk food on television before 9 pm as part of efforts to tackle childhood obesity. A government consultation published on 12 September also sets out plans to ban unhealthy products from being promoted on websites aimed at children.

The new restrictions, which follow a commitment in the king's speech and in Labour's election manifesto, are expected to start next year. The previous Conservative government first promised to implement a 9 pm watershed for junk food advertisements in 2021, but the measures were continually delayed.

A Department of Health and Social Care spokesperson said, "One in three children leave school overweight or obese, holding them back at the start of their young lives. This government will ban junk food adverts targeted at children, as part of our plans to give every child a healthy, happy start to life.

"Prevention is better than cure. Shifting our focus from treatment to prevention could stop an additional 20 000 children from growing up obese and ease pressure on the NHS."

EVIDENCE "COMPELLING" THAT MARKETING UNHEALTHY FOOD TO CHILDREN INFLUENCES THEIR PURCHASING

Commenting on the announcement, Greg Fell (below), president of the Association of Directors of Public Health, said there was "compelling evidence" that marketing unhealthy food and drink to children influences their purchasing and consumption and that food and drink habits are formed at an early age. He said, "This type of advertising ban on television and online is long overdue and would be a big step in the right direction to creating a healthier environment—one where junk food is not seen as the norm—for our children."

James Toop, chief executive of the youth led charity Bite Back, which has been campaigning for stricter rules on food advertising, said, "We welcome the government's efforts in acting quickly to implement this legislation. These restrictions will help shield children from exposure to unhealthy food and drink advertising, which research shows significantly shapes their relationship with food.

"While the previous government dragged its feet and effectively kicked the can down the road, this government has taken decisive steps to clarify matters for businesses and the public. It's a critical move toward a healthier future for the next generation."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;386:q2006

THE BIG PICTURE

WHO acts to boost access to mpox vaccine

The World Health Organization has added the MVA-BN mpox vaccine to its prequalification list, making it accessible to UN agencies and therefore low income countries.

Yukiko Nakatani, WHO's assistant director general for access to medicines, said, "This will help accelerate ongoing procurement of the mpox vaccines by governments and agencies such as Gavi and Unicef to help communities on the front lines of the emergency in Africa and beyond."

The vaccine is currently not licensed for anyone aged under 18 years, but WHO said it may be used off label in these age groups in an outbreak. Last month WHO declared the escalating mpox outbreak in the Democratic Republic of the Congo (DRC) and neighbouring countries a public health emergency of international concern.

Jacqui Wise, Kent Cite this as: *BMJ* 2024;386:q2024

Jean Kakuru Biyambo, a father of six from the Muja internally displaced persons camp in DRC, is receiving treatment for mpox at Goma general hospital

Robert Musole, medical director of Kavumu Hospital, visits patients recovering from mpox in Kavumu village, in DRC's South Kivu province, which has recorded more than 5000 cases since the start of the year. The area around the hospital has had more than 800 cases, including eight deaths, all children aged under 5. Across the country at least 16 000 cases have been reported, including more than 500 deaths.

GLODY MURHABAZI/AFP / GETTY IMAGES)

EDITORIAL

Commercial influence in early career medicine

Industry influence still threatens the integrity of healthcare and harms patients

"To influence physicians from the bottom up" reads an internal company document published in the late 1990s from the drug manufacturer Parke-Davis.[1] This memo, outlining the company's business strategies for a section of its market, became public through litigation around off-label drug promotion. Among the company's key promotional strategies was "to solidify Parke-Davis's role in the resident's mind as he/she evolves into a practising physician."[1]

Over two decades later, drug and medical device industries globally continue to target clinicians early in their careers, including during periods of training, to cultivate long term, reciprocal relationships through payments, free meals, and sponsored education. Researchers recently examined payments to cardiology fellows in the United States before and after graduation, finding that 73% of cardiology fellows received payments in the year before graduation, jumping to 88% in the first few years after graduation.[2] For fellows in specialties that use a lot of technology (referred to as "procedural intensive"), the proportion was even higher: 80% received payments before graduating, and 96% afterwards.[2]

Cardiology is a leading specialty when it comes to industry payments.[3] In one study, just 11 of 195 directors of cardiac catheterisation and electrophysiology laboratories received no industry payments in a single calendar year.[4] The more recent study of cardiology fellows provides evidence of the early targeting of physicians by industry,[2] which serves the strategic purpose of forming long term relationships that will foster familiarity, uptake, and allegiance to their products.

Drug companies seek to cultivate brand allegiance early

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Health professionals often think that industry payments have no effect on their clinical decision making. But a growing body of evidence finds that receipt of payments, gifts, meals, and other forms of sponsorship from drug companies is associated with increased prescribing costs and volumes.[5,6] Even the receipt of low value industry sponsored meals is associated with increased prescribing of the promoted brand name medication.[7] In specialties such as cardiology, doctors might also be involved in the selection and review of devices and equipment that are purchased by hospitals. Industry payments are associated with increased uptake of devices such as stents.[8]

Vulnerabilities

Doctors in training might be particularly vulnerable to the effects of drug promotion as they are still developing a professional identity and forming their practice patterns.[9] Thus, drug and device companies seek to cultivate familiarity and brand allegiance early and frequently through forms of sponsorship that do not always "feel" like promotion such as sponsored education, presence of device representatives in clinical spaces, and payments for training or education.[10]

Ultimately, these relationships threaten the sustainability of healthcare and expose patients to unnecessary risk or harm. Drug promotion can affect health by contributing to overtreatment, undertreatment, and mistreatment.[11]

At the individual level, training on conflicts of interest arising from industry payments should become a mandatory part of the curriculums of medical schools and residency programmes. Educational interventions should challenge the common belief among health professionals that they are immune to commercial influence, teach them how to assess information received from industry critically,[9] and point them to independent sources of prescribing information.

Most important, however, is action at the institutional, professional, and policy levels. The characteristics of learning environments can shape trainees' behaviour, including their attitudes towards the drug industry. A specific term—"hidden curriculum"—has been used to describe the "implicit lessons communicated through institutional policies and role models."[13] If students are trained in environments that lack policies to regulate relationships with industry and witness their supervisors and teachers interacting with industry on a daily basis, they absorb and normalise this behaviour. Medical schools, teaching hospitals, and healthcare institutions need explicit institutional policies that promote and sustain independent clinical decision making (such as eliminating gifts and industry sponsored meals), and robust, enforceable processes to prevent or manage conflicts of interest arising from financial and gift relationships with industry.

Healthcare institutions must acknowledge the extent of commercial influence in healthcare and the risk of patient harm, and prioritise the integrity and independence of all clinical decision making.

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EDITORIAL

Darzi review shows depth of problems for Labour

Findings may buy time but highlight government policy tensions

Ara Darzi's independent review into the performance of the NHS in England, commissioned soon after Labour's election victory in July, was published on 12 September.[1]

The idea was to provide a rapid assessment of the state of the health system—focusing on problems, not solutions. Darzi's findings are intended to inform the government's 10 year plan for reforming the English NHS—expected in spring next year.[2] The report comes around 16 years after Darzi's last review into the English NHS.[3]

Darzi paints a bleak picture of a health system in crisis.[1] People are waiting too long for care in hospitals, primary care, mental health services—everywhere. Long waits in major hospital emergency departments are pulling at the social contract underpinning the NHS and likely to be contributing to thousands of additional deaths. Quality of care is mixed. And care in some areas, such as for people with cardiovascular disease, seems to be going in the wrong direction. The share of NHS resources going to hospitals is increasing, despite repeated political promises to do the opposite, and NHS productivity has stalled. The NHS's problems pre-date the covid-19 pandemic.

The review points to a combination of factors behind the decline. Austerity in the 2010s left the NHS constrained by sustained low funding growth. Weak capital investment—in buildings, equipment, and information technology—has held back staff and their ability to work productively. The 2012 reforms introduced by then health secretary, Andrew Lansley, to the structure of the NHS caused ongoing harm and disruption—described by Darzi as "a calamity without international precedent."[1] Covid-19 came amid the mess and made it much worse.

None of this is new. Analysis of these and other problems in the NHS is well known.[4 5] The decline in NHS performance over 14 years of Conservative governments is plain to see.[6] So what do we learn from the review? Darzi's report illustrates four broader tensions in Labour's policy approach.

Detail on how government will make changes is lacking

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Rhetoric meets reality

First is when to shift from problems to solutions. As with the economy,[7] Labour's political narrative on the NHS so far has emphasised the depth of the crisis inherited from the Conservatives. In his response to the review, the prime minister, Keir Starmer, said that "until this morning, we didn't know the full scale of the damage."[9] This line may buy time. But the responsibility for fixing these problems now belongs to Labour. The government has pointed to broad changes it wants to make to help address these challenges, such as shifting care from hospitals to the community.[10] But details on how are lacking.

Second is which problems Labour should prioritise. Darzi was asked to focus on the NHS, and his diagnosis runs to more than 150 pages and several hundred more of technical annexes. Yet the task of improving the nation's health is about more than the health service—as Darzi acknowledges.

Health and health inequalities are shaped by social, economic, and environmental factors, such as income, jobs, and housing.[11] Since 2010, life expectancy in England has stalled, and health inequalities between richer and poorer areas have widened.[12] Public health budgets have been cut,[13] and investment in wider services that shape health has been weak.[14] Labour knows this and has set ambitious goals to reduce health inequalities through a "health in all policies" approach.[10] But the risk is Labour's health mission gets skewed towards the NHS—and skewed even further towards meeting high profile targets to reduce hospital waiting lists.

Third is how quickly Labour can address these problems. Labour has promised to meet key NHS performance standards, such as at least 92% of patients starting consultant led treatment within 18 weeks of a general practitioner referral, within five years.[15-17] Yet these targets have been routinely missed for nearly a decade.[18] Darzi's review states that "it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term."[1]

And fourth is the mismatch between Labour's ambitions on funding and reform. Darzi points to underinvestment as a root cause of the NHS crisis. This includes weak capital investment compared with other European countries.[20] Recent analysis suggests that NHS spending would need to grow by around 3.8% a year in real terms over the next decade—much higher than current projected spending—to achieve the kind of improvements set out by Labour.[21]

But the health secretary has emphasised reform over investment.[22] Policy change is no doubt needed to redefine NHS priorities, align public policy levers—such as targets, regulation, and payment systems—behind them, steer new technology towards the NHS's objectives, and more. But Labour should remember that its last round of reforms responsible for turning around NHS performance in the 2000s did so backed by annual spending growth of close to 7%.[23 24]

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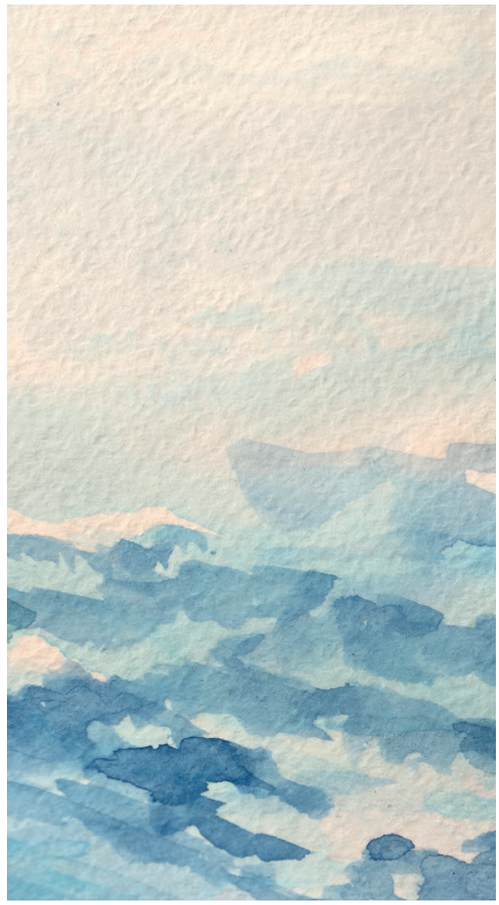
“All I could see were tasks mounting, appointments being booked, and people constantly knocking on my door”

A recent report has set out recommendations to help prevent doctors from taking their own lives. **Adele Waters** speaks to affected families



Sarah Jacques remembers the day she came close to killing herself.

The 46 year old former GP from Battle, East Sussex, says she “just snapped” one day at work, drove to the seafront, parked her car, and got out to watch the sea. She stayed there for six hours, thinking about drowning.

“I just kept wanting to walk into the sea. I wouldn’t have tried to swim,” Jacques says. “Looking back, I don’t think I was conscious in that moment of how bad I was, how strong those feelings were. I just felt completely overwhelmed.”

That morning—1 August 2022—began like any other, with a 7 30 am drive to her workplace, a surgery in Heathfield where she worked as a full time partner. “I suddenly found myself crying. I’d never done that before—cried as I drove to work,” she recalls. “I got to work and had to drag myself out of the car—I didn’t want to go in.

“And then it got to 11 am and even though I hadn’t stopped since 8 my screen was still full. It seemed like I hadn’t made any inroads into the workload. All I could see were tasks, instant messages, more appointments being booked, and people constantly knocking on my door for other things to be done.

“I managed to type ‘help’ by instant message to one of the managers. She came to the room and found me in a distressed state. One of the partners came in and suggested I work from home, so I left. But I drove past my house and to Bexhill beach instead.

“It’s hard to remember what stopped me from walking into the sea, my memory is hazy. But eventually I got some awareness of where I was and I suppose the ‘normal me’ won so I got up and went home.”

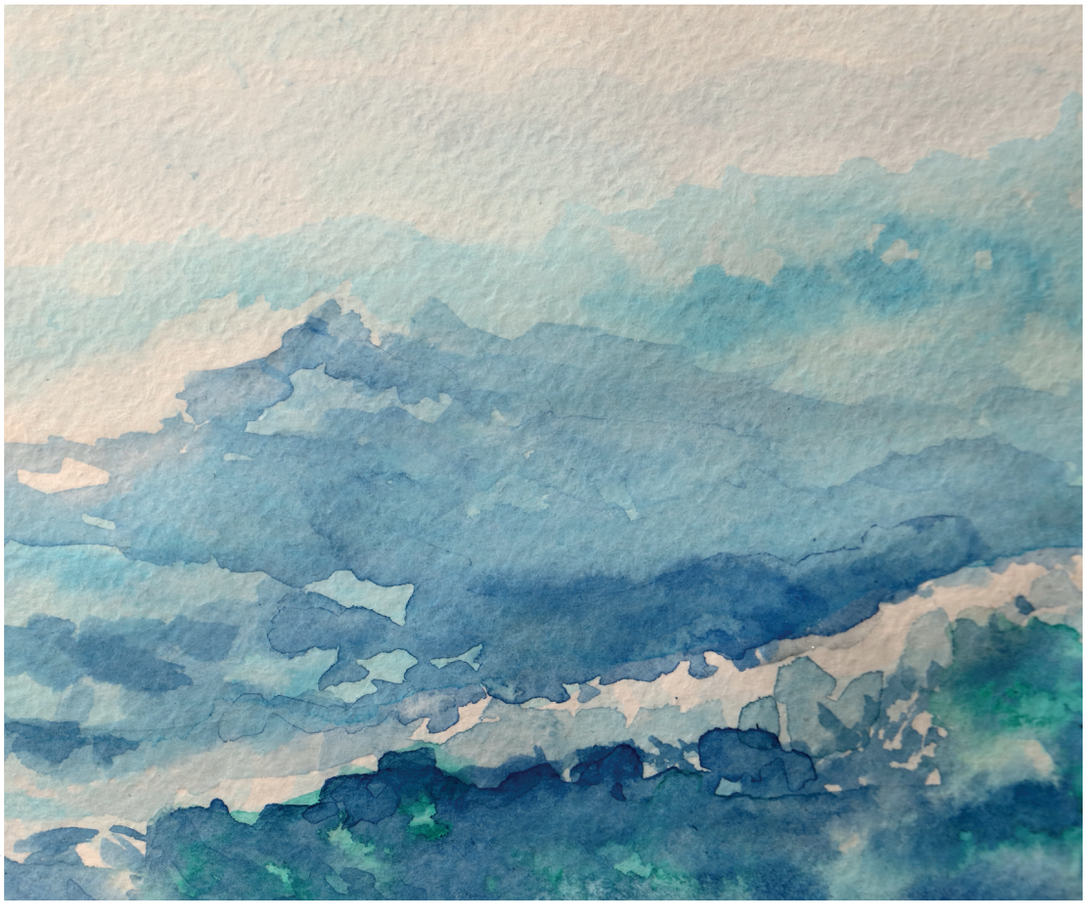
Jacques describes her workload in the run up to her breakdown as overwhelming. She was doing eight clinical sessions a week and was the lead for human resources, safeguarding, and clinical governance. With 3000 patients registered under her, she would see 30 patients a day and deal with 100 tasks on top.

There must be a cultural shift in how doctors are treated at work
Amandip Sidhu (below)

“I couldn’t see that it was going to get better. This followed years and years and years of hard slog where it had only got worse, and I didn’t feel that there was any light at the end of the tunnel.”

Jacques is not alone in reaching such a dark place. According to some estimates, one doctor dies by suicide every 10 days in the UK. Around 6500 clinicians across England and Scotland access NHS Practitioner Health, a mental health treatment service mainly for doctors, every year. Around a third have already had suicidal thoughts when they register.

Research recently published in *The BMJ* found that rates of suicide among doctors from 20 countries (mainly Australasia, Europe, and North America) have declined over time, but are still higher for female doctors compared with the general population.



I couldn't see that it was going to get better

Sarah Jacques

The UK charity Doctors in Distress was set up by Amandip Sidhu following the suicide of his brother, consultant cardiologist Jagdip Sidhu, in November 2018 (see box 1). Sidhu says the charity is not so much a legacy for his late brother but more "a way to say to doctors, 'look what happened to him and make sure it doesn't happen to you.'

"Soon after Jagdip died I realised that what happened to him had happened to others in the medical profession—in secondary care and in general practice," Sidhu says.

Doctors in Distress provides doctors and other healthcare workers with free access to support groups and mental wellbeing programmes. Since its launch in 2020 it has supported more than 3000 healthcare professionals. As well as aiming to cut suicide rates, it also wants to reduce the stigma around poor mental health in the healthcare sector. "Whether they care to admit it or not, doctors are human. There must be a cultural shift in how they're treated at work and an acceptance that they can be affected by stress and poor mental health," says Sidhu.

An increasing problem

Earlier this year, Ananta Dave, psychiatrist and chief medical officer for NHS Black Country Integrated Care Board, published a review of suicide in the medical profession.

While there have been several reports on the subject, Dave's review is the first to tackle the problem across the span of a medical career, she says, from students to trainees and qualified staff. Among the recommendations (see box 2, overleaf) are the roll out of teaching and training on mental illness and suicide prevention for all staff, as well as the provision of reflective spaces.

Box 1 | Case study

"My brother spent most of his time at work. In the months before he died, he was probably working 70-80 hours a week," says Amandip Sidhu. "Outside of his contracted hours, he was going in on days off and on the weekend as well."

Sidhu's brother Jagdip (pictured), a consultant cardiologist, died by suicide in 2018, aged 47.

"He was an interventional cardiologist so he did all the procedures by himself, but he also ran a department, he was a teacher, a mentor, and he had to do lots of admin too. For a number of months, he was doing the job of two consultants because one had been off sick.

"My brother was the type of doctor who often said, 'Don't judge me by the letters after my name or where I work or my job title or publications or all that stuff, just judge me on the outcomes of my patients, that's all I care about.'"

In the run up to his death, Jagdip became worried about making a mistake. "Nursing colleagues noticed a change in his behaviour—repeating instructions, being overly fastidious, and showing physical signs of anxiety. He told me that he didn't feel safe to be a doctor—'What if I made a mistake about this patient?' he would ask. That was catastrophic for him, since his whole life and vocation was about fulfilling the identity of being a doctor."

Amandip remembers his brother withdrawing from family life and activities he usually enjoyed as he became more consumed with work. "He didn't engage as he used to. It was like a light had gone out. He shrunk in his personality.

"The last time I saw him, he was in a high state of anxiety. Even though he'd been signed off work with stress, he was on his phone making sure that patients were handed over to his colleagues. I could hear him saying to one of his colleagues to make sure that Mrs X's blood results were followed up. He just couldn't let go. He couldn't switch off from being a doctor. At one point, he broke down in tears, one of only two times I ever saw him cry. The other time was when our father died."

Dave says that the prevalence of mental health problems among doctors has increased in recent years because of a combination of factors, including work pressures.

"People are working in a stressed system where there's a mismatch between demand and capacity. Typically, there's not enough time for staff to take breaks or to look after themselves, which inevitably will affect their health."

This can lead to moral injury, she says. "Doctors feel they're not able to give the care they'd like to, and that doesn't square well with their conscience and can be extremely stress inducing."

Bullying, harassment, and discrimination across UK healthcare—both in the NHS and independent sector—also take their toll on people's health, she says.

"Additionally, the kind of decisions doctors have to take and the kinds of things they face—death, injury, trauma, bereavement—are difficult. They need an outlet for these emotions, where they're able to talk openly, where they're able to process the emotional impact of their work."

There's not enough time for staff to take breaks or to look after themselves
Ananta Dave

Box 2 | Ten recommendations from Ananta Dave's report

- A good induction at the start and points of transition for all doctors
- Teaching and training on mental illness and suicide prevention for all staff
- Accountable officers for mental health and wellbeing in all organisations
- Provision of reflective spaces
- A compassionate and fair referral and investigation process by the General Medical Council
- Mental health services for healthcare workers
- Provision of suicide bereavement support
- Investment in research into healthcare workers' mental health and wellbeing
- Training doctors to treat doctors
- A new centre of excellence aimed at collaborative working

Stigma

Five years ago Juliette Stern's GP husband, Miles Christie, died by suicide at the age of 43, after he became overwhelmed by stress. They have two children together, who were aged 2 and 4 at the time.

"After Miles died I learnt how little support there is for GPs. They work independently and day to day often have little connection with their fellow professionals. Miles's workload was huge but it wasn't just that, it was the sorts of things he was dealing with—people's health, their lives—he was sometimes dealing with very difficult things.

"There should be spaces for doctors to check in and discuss their work, their difficult cases. Where it's safe to say, 'I'm really struggling with this.' It should be a regular diary appointment.

"Miles was an amazing man but he couldn't admit he needed help. He had a real fear of being seen as someone with a mental health problem and that if that went on his medical records it could affect his ability to earn a living."

Not wanting to admit to any mental distress was also something that worried Gail Milligan, according to her husband. After working tirelessly during the covid-19 pandemic and with no apparent signs of mental struggles, the Surrey GP died by suicide two years ago, aged 47, leaving behind two teenage sons.

Doctors need to be more aware of colleagues' mental health
Chris Milligan

Her husband, Chris, recalls, "Gail had a fear of letting down the team and the practice. That was a big thing with her, because they were all under a huge amount of pressure. And she felt the pressure not to be the weak link.

"She couldn't admit that she was not well. I don't even know if she knew how unwell she was. It was only in the last few days of her life that I was really concerned; she completely fell apart."

He says that Dave's recommendation for more research into healthcare workers' mental health and wellbeing—so that NHS bodies better understand risk factors and effective interventions—is a good idea.

"I don't think Gail's colleagues had any idea there was anything wrong," Milligan says. "She was masking it so well and just carried on. But I think doctors do need to be more aware of their colleagues' mental health."

Like Stern, he recognises the need for greater opportunities for doctors to debrief from stressful caseloads. "I was touched by some of her patients who wrote to me after she died but it made me realise the burden she was carrying, the things she'd seen and done, that she didn't speak about."

The families of Gail Milligan and Miles Christie cite the pressure of their jobs as GPs as one of the factors in taking their own lives

Sources of support

Former GP Nigel Gray, 80, from Truro, lost his fiancé Cindy Madonald, also a GP, to suicide more than 20 years ago. He supports Dave's recommendation for training more medical specialists to assess, treat, and enable the rehabilitation of doctors.

"Suicide leaves you with a nasty taste. You feel massively let down by the person, you feel betrayed. They are difficult feelings to have for someone you loved," Gray says. "The person who helped me the most to cope was the occupational health doctor."

But just how seriously are the government and other bodies taking the threat of suicide in doctors? Earlier this year, the signals from the Conservative government were not good.

Just a few months after Dave published her report, NHS England moved to end NHS Practitioner Health by stopping any more patients signing up. Following an outcry and petition, it reversed its decision, agreed funding for another 12 months, and committed to review mental health support services for NHS staff.

The BMJ asked NHS England and the GMC about their plans to support doctors. An NHS England spokesperson said there was already a range of mental health support available for staff, including access to confidential support services. It is also strengthening occupational health services and reviewing the mental health and treatment offer for staff.

"We know there is much more to do to ensure everyone working in the NHS feels comfortable asking for help and gets the right support when they do."

Louis Appleby, professor of psychiatry at the University of Manchester, leads the National Suicide Prevention Strategy for England for the Department of Health and Social Care. He says that NHS England is taking the matter of suicide in clinical workers seriously.

It has commissioned Appleby and his team to set up a national database to monitor suicide in NHS clinical staff in England. It will provide real time recording of deaths by suicide as they occur—rather than waiting for inquest information—and aims to identify preventable risk factors. While only one year into the three year project, the ambition is that the database could be extended to primary care and non-clinical staff.

"There's no single solution—there rarely is in the case of suicide, because people's lives are complex—but it's important that NHS employers take account of the stresses that people are facing in their daily work," Appleby says.

People who've devoted their professional lives to the care of others are dying in close proximity to services that could have saved them
Louis Appleby

Any death, when it happens, is tragic
Anthony Omo

He says that, statistically, UK doctors are not at high risk of suicide. "The most recent (pre-pandemic) figures from the Office for National Statistics suggest that the overall rate of suicide in male doctors in comparison with men in the general population of the same age is low. The rate in female doctors is the same as other women in the population—so they are at higher risk than male doctors.

"Nevertheless, it's important not to diminish the problem. Low risk does not take away from the need for prevention. The tragedy is that there are people who have devoted their professional lives to the care of others who are dying in close proximity to services that could have saved them."

The regulator's role

The GMC says that reducing the impact of its processes on doctors under investigation or monitoring is a priority. Anthony Omo, general counsel and director of fitness to practise, says, "Any death, when it happens, is tragic. When a doctor dies by suicide, and they had been in our fitness to practise processes, we undertake a review. We want to ensure that we identify and act on any lessons as quickly as possible."

Omo says the GMC is working to eliminate disproportionate referrals from employers about doctors from ethnic minorities by 2026, ensuring all employer referrals are appropriate as well as reducing disproportionality in local fitness to practise processes.

Without better systems the NHS and other healthcare providers risk losing valuable doctors from their workforce. Sarah Jacques, for instance, never returned to work. "I needed some time out but months went by before I realised I wasn't able to return," she says. "The identity of being a doctor is still very much there, and something that I don't want to let go, but the thought of going back to work as a GP partner, I'm not ready for that."

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Sources of support

UK

NHS Practitioner Health
Free confidential mental health service for all NHS doctors and dentists, and addiction service

Helpline: 0300 0303 300 www.practitionerhealth.nhs.uk

Suicide Prevention UK
Supporting those at risk of suicide in the UK

Helpline: 0800 689 5652 www.spuk.org.uk

Samaritans
24 hours a day, 365 days a year

Call for free support: 116 123 or email jo@samaritans.org or www.samaritans.org

Doctors in Distress

Information at doctors-in-distress.org.uk
To donate www.justgiving.com/doctors-in-distress

INTERNATIONAL

In Ireland the Samaritans are available 24 hours a day, 365 days a year. Call for free support: 116 123 or email jo@samaritans.ie

In Australia the crisis support service Lifeline is 13 11 14

In the US the National Suicide Prevention Lifeline is 1-800-273-8255

International helplines can be found at www.befrienders.org

Wellcome's new head on the future of clinical research funding

The trust has switched from having a director to a chief executive officer, so what changes are afoot for the independent funder worth some £38bn? The BMJ asks the new man in charge, John-Arne Røttingen

John-Arne Røttingen, like his predecessor, infectious disease specialist Jeremy Farrar, is a doctor. He is also a former global health ambassador for Norway and led its research funding council.

"I'm a physician scientist. I've been really motivated by this sort of science—that's why I started studying medicine," he says. He graduated from Oslo University and holds an MSc from Oxford University.

His research has covered basic science, epidemiology, clinical trials, health services research, and global health policy. Notably, he led the steering groups for the Ebola vaccine trial in Guinea and the Covid-19 WHO Solidarity trial. "Through the Ebola outbreak of West Africa [in 2014-16], I became really engaged with the need for a long term commitment on the issue of innovation and access to medicines—and how we find models for innovating where there are no commercial markets," he says.

With Wellcome having recently embarked on a 10 year strategy, pledging £16bn in funding for discovery research over that period, Røttingen says the trust's work in building research capacity in Africa and Asia is key to its international focus, but it remains committed to supporting clinical research in the UK.

How do you see the state of clinical research in the UK?

"The UK is an international research system: it's open, it's attracting the best talent internationally, and it's delivering excellence. Coming from Scandinavia, I'd say that having a national health system is an asset to any health research system. It offers the opportunity to do clinical research and epidemiology at a large scale; to have large scale cohorts with strong follow-up. This is an asset of the UK.

"But it's also under threat. Clinical academic careers are difficult. I think universities are in dire straits. Wellcome believes it's key for the UK to continue and even increase investments in research. It should be the leading country among the G7 group in terms of research intensity. It should continue to be attractive to global talent. That means not having barriers when it comes to visas and costs for coming to the UK, and really trying to use the comparative advantage, such as on health data.

For the UK science system to thrive, it needs to continue to be open

"What I'm hearing from the leaders of the 24 Russell Group universities is that, even though they're able to fill PhD and postdoc positions, it's harder. It's harder to get the best people, and it's harder to get people from abroad.

"It's great to see that the UK rejoined the Horizon Europe funding platform—that at least it is part of collaborative projects, but also recipients of ERC [European Research Council] grants, using academic institutions in the UK as a base. But there should not be a cost barrier. The sum of the visa cost for, say, a family of four compared with going to France, I think it's a factor of 10 to 25 more to come to the UK.

"It's a cost issue, it's a time issue, and of course it's an acceptance issue. And that's a political message: for the UK science system to thrive, it needs to continue to be open."

Can Wellcome help overstretched doctors to do research?

"I do see the numbers [of medical doctors able to do research] definitely going down here. In terms of talent and human resources, the government would need to set its own ambitions. We want to collaborate with it.

"We're discussing this in a clinical research group to understand how all our ways of funding can be at least aligned to what's happening in the system, and to understand the challenges. But it's related to the general work environment for clinicians—and that's not only for medical doctors but also other allied health professionals, such as nurses."

As governments reduce research spending, how do bodies such as Wellcome respond?

"We're in a difficult period. We need global collaboration more than ever . . . across north and south, across east and west. And we need [that] scale, to find solutions where there are market figures or even government figures [on investing]. At Wellcome we've recently announced a tripartite collaboration with the Bill and Melinda Gates Foundation and the Novo Nordisk Foundation, supporting science in low and middle income countries. I hope this is a concrete way for us to come together and to deliver better together, but it's also a way to motivate others to invest in active national collaborations.

"Foundations have a role to play when markets aren't delivering the necessary incentives for private sector investments. One of the key priorities in the infectious disease space is to identify diseases where there are big gaps in solutions and where there's insufficient purchasing power—because these diseases, first and foremost, are hitting the poorer populations and countries in the world.

"Then there are government failures. Climate and health is an example of that. Politics has become short term in most countries. That makes it harder to tackle the long term challenges. I hope foundations can play a role, contributing to solutions but also [emphasising] the importance of long term investments.

"One of the learnings from the pandemic is how important it is to drive forward the life science ecosystems in Africa, in Asia, in Latin America—and for that to be seen as a way to protect not only the people in those regions but all of us. But manufacturing can't happen in isolation. We need more distributed capacity. It needs a local research and innovation system. It needs talent. But that's long term: it's not a five year plan, it's a 30 year ambition."

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