



BEN WHITLEY/PALAMY

## “No medical evidence for Letby murders”

An investigation by a panel of 14 international experts into the cause of injury and death of the babies Lucy Letby is convicted of murdering or attempting to murder has claimed there is “no medical evidence to support malfeasance.”

Speaking at a press conference in London on 4 February, Shoo Lee, a professor emeritus at the University of Toronto and founder of the Canadian Neonatal Foundation, who led the review, said, “In all cases death or injury were due to natural causes or just bad medical care. In our opinion, the medical evidence doesn’t support murder in any of these babies.”

Letby is serving 15 whole life terms for murdering seven babies and attempting to kill seven others while working as a neonatal nurse at the Countess of Chester Hospital. The Court of Appeal has twice refused her permission to appeal.

Lee became involved in the case after being made aware his 1989 paper on pulmonary vascular air embolism in newborns was used by the prosecution’s expert witness, retired consultant paediatrician Dewi Evans, to support his theory that Letby had injected air into the babies’ bloodstreams. Lee was not asked to give evidence, but Letby’s legal team asked him to review the medical evidence. To do so he convened a panel from the UK,

US, Japan, Canada, Germany, and Sweden: 10 neonatologists, a paediatric surgeon, a paediatric infectious disease specialist, a senior neonatal intensive care nurse, and another paediatric specialist. Lee said, “We hope the authorities will consider our findings seriously, because you will not find a better panel of experts anywhere in the world.”

Presenting the findings, Lee said the hospital had many problems, with staff caring for babies “probably beyond their designated level of care,” poor resuscitation and intubation skills, poor supervision of junior doctors, and a “lack of teamwork and trust.”

Lee added that many witnesses pointed to “inadequate numbers of appropriately trained personnel.” He also said high risk infants “should have been delivered and cared for at higher level institutions.”

Panel member Neena Modi, professor of neonatal medicine at Imperial College London and past president of the Royal College of Paediatrics and Child Health, said, “What we have shown is that there are clearly systemic factors at play.”

Letby’s barrister Mark McDonald has applied to the Criminal Cases Review Commission to have her case reopened.

Elisabeth Mahase, *The BMJ*  
Cite this as: *BMJ* 2025;388:r250

**Four of the 14 neonatal experts on the international panel told reporters, “In all cases deaths or injury were due to natural causes or just bad medical care”**

### LATEST ONLINE

- Resident doctors in England enter dispute over working conditions
- UKHSA reclassifies four cephalosporins to first line use
- US websites close down after Trump’s order to recognise two sexes only



# MEDICAL NEWS

## Ministers accused of “kicking obesity issue into long grass” despite growing crisis



KIRSTY WIGGLESWORTH/PALAMY

Health leaders and MPs have accused the government of taking a weak stance on tackling the obesity crisis in England by deferring actions it could take immediately until the Department for Environment, Food, and Rural Affairs (Defra) has published a food strategy.

Last October the House of Lords Food, Diet, and Obesity Committee released a report outlining the “utter failure” of successive governments to deal with the rising prevalence of obesity. It called on the new government “as a matter of urgency to adopt a new, comprehensive, and integrated food strategy,” introduce mandatory industry regulation, and exclude any food businesses that derive more than a certain proportion of sales from less healthy products from food policy discussions.

In response the Department of Health and Social Care said it would be working with Defra to develop a strategy to “set the food system up for long term success.” However, it also said it would not exclude any food industry representatives from talks as that would “prevent effective engagement.”

Joan Walmsley (left), chair of the Lords committee, described the response as “far from bold and kicks many desirable actions into the long grass.”

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2025;388:r229

### Assisted dying

#### Bill passes final stage in Isle of Man parliament

The Isle of Man is on track to be the first part of the British Isles to legalise assisted dying. Members of its upper house voted 7-1 to pass the Isle of Man Assisted Dying Bill at its third reading. The bill will now return to the lower house for approval. When all clauses and amendments are agreed by both houses it will be sent for royal assent, and an implementation period will begin. Terminally ill residents may get the option of assisted dying from 2027.

### Kidney failure

#### Genetic test for potential donors is launched

Potential kidney donors of black African and black Caribbean heritage will be offered a simple blood test to show if they are at risk of kidney failure in later life. The test will identify people with “high risk” variants of the *APOL1* gene, which is common in people of black African and black Caribbean heritage. Those who are shown to be at high risk of kidney failure later in life and are aged under 60 will be advised against donating a kidney.

### Norovirus

#### Diarrhoea and vomiting bug hits winter high

An average of 898 people in England were in hospital with norovirus in the week ending 28 January, the highest this winter. This was up 15% on the previous week (784) and 30% higher than the same week last year (688). However, flu rates fell, with an average of 3019 patients in hospital each day, down 21% from 3833 the week before but still over a third higher than the same week last year (2226). An average of 995 patients a day were in hospital with covid, as well as 28 children with respiratory syncytial virus.

### Climate crisis

#### Sarah Benn loses suspension appeal

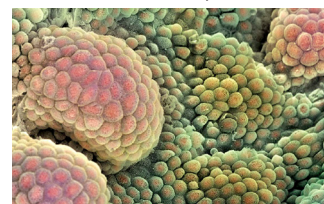
The retired GP and climate activist Sarah Benn (below) lost her High Court appeal against a misconduct finding and suspension by a medical practitioners’ tribunal over her protest actions. Benn was suspended from the medical register for five months after defying an injunction three times during protests and was sentenced to 32 days in prison. She argued that the climate situation was so desperate that lawful means were

insufficient to achieve change. But the court held that she was not entitled to rely on being a member of the medical profession while repeatedly defying a court order, which resulted in imprisonment.

### Cancer

#### Prostate cancer is now England’s most common

Prostate cancer diagnoses in England have now surpassed breast cancer for two years in a row,



found an analysis of NHS data by Prostate Cancer UK. Some 50 751 men had the cancer diagnosed in 2022, compared with 48 531 breast cancer diagnoses. In 2023 this rose to 55 033 prostate cancer diagnoses, compared with 47 526 breast cancer diagnoses. The charity said that the increase was due to more men coming forward after awareness campaigns.

### Maternity services

#### Call to bring back hospital staff rooms

NHS trusts should bring back staff rooms to promote good communication and teamwork, a

conference on improving maternity services heard. Bill Kirkup, a former regional director of public health, said that some common themes had emerged in his investigations of failings in maternity services at Morecambe Bay and East Kent Hospitals. “We’ve lost all of the common staff rooms we used to have where people could meet, decompress, and rest,” he said. “The effective maternity units I’ve visited all tend to have something where people can just get together and get to know each other.”

### Wales

#### GP leaders accept revised contract offer

The BMA’s General Practitioners Committee for Wales has voted to accept a revised contract proposal for 2024-25 after GPs overwhelmingly rejected the first offer, which matched a recommended 6% pay rise but lacked funding to meet rising expenses. The revised offer from the Welsh government included an additional one-off practice stabilisation payment of £23m, bringing the total extra investment for 2024-25 to £52.1m, alongside the 6% rise. Gareth Oelmann, chair of GPC Wales, said the settlement “did not resolve every issue” but provided a “solid foundation” for the 2025-26 contract negotiations.



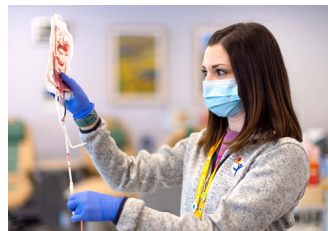
# IN BRIEF

## NICE

### Daily tablet for dust mite allergy is recommended

NICE has recommended a daily tablet for treating persistent moderate-to-severe house dust mite allergic rhinitis in people aged 12 to 65. Acarizax works by decreasing the body's sensitivity to house dust mites, and treatment lasts for three years. Clinical trials have shown Acarizax to be particularly beneficial in people whose symptoms cannot be managed by standard treatments such as steroid nasal sprays and antihistamines.

### Sickle cell disease gene editing therapy approved



In final draft guidance NICE has approved a one-off gene editing therapy to treat severe sickle cell disease in people aged 12 and over. Data suggest that a single use of exagamglogene autotemcel (exa-cel, brand name Casgevy) can stop sickle cell crises—in which blood vessels become blocked and cause extremely painful episodes. NHS England said all patients who received exa-cel in clinical trials avoided hospital admission for a year, and almost 98% avoided admission for around 3.5 years.

## Tuberculosis

### Cases in England rise 13%

Provisional data from the UK Health Security Agency showed that reported notifications of tuberculosis in England rose by 13% to 5480 people in 2024, from 4850 in 2023. Although England remains a low incidence country for TB, its notification rate rose from 8.5 per 100 000 population in 2023 to 9.5 in 2024. The data showed that 81.5% of all



Dust mites are a cause of allergic rhinitis, which can be mediated by a daily dose of Acarizax

TB notifications in 2024 were in people born outside the UK.

## Complaints

### Patients are reluctant to speak out, says watchdog

Nearly a quarter (24%) of people in England experienced poor NHS care in the past year, but only 9% lodged a formal complaint, said the patient watchdog Healthwatch England. Of a sample of 2650 people who reported poor care, 56% had taken no action. But 30% gave feedback either by speaking to staff, raising the matter with the Patient Advice and Liaison Service, filing a patient survey, or posting an online review. Of the few who had formally complained, most were dissatisfied with the process and outcome.

## Sleeping sickness

### Guinea eliminates African trypanosomiasis

Guinea has eliminated the *gambiense* form of human African trypanosomiasis as a public health problem, the World Health Organization confirmed. This form of human African trypanosomiasis, the only type transmitted in Guinea, is the first neglected tropical disease to be eliminated in the country. The vectorborne parasitic disease, carried by tsetse flies, is also known as sleeping sickness. Symptoms include fever, headaches, joint pain, and, in advanced stages, neurological symptoms such as confusion and behavioural changes.

Cite this as: *BMJ* 2025;388:r224

# SIXTY SECONDS ON... NHS LEADERS



## LEADING BY EXAMPLE?

You'd hope so. But there was friction last week when a committee of MPs criticised the evidence it heard from senior NHS figures about the health service's performance. The appearance of NHS England chief Amanda Pritchard (below) and other officials before the Health and Social Care Committee came hot on the heels of a separate damning report from the Public Accounts Committee, which accused senior NHS leaders of lacking initiative and dynamism to drive change.

## DID THEY SHOW ANY DYNAMISM IN FRONT OF THE MPs?

Not according to Layla Moran, chair of the Health and Social Care Committee. In an uncommon move, Moran gave a statement after the session criticising the evidence. "We had hoped for a sharpness in witnesses' responses but were exasperated by the lengthy and diffuse answers that were given to us," she wrote.

## OUCH

Indeed. Moran said the committee was "left disappointed and frustrated" by the responses it received. This unfiltered feedback suggests that an end of term report from these MPs would probably say "must do better."

## THAT'S WHAT YOU CALL DUTY OF CANDOUR

NHS England did at least show some initiative in defending itself to the committee, with Pritchard arguing that there were "factual inaccuracies" in the report from the Public Accounts Committee. "NHS England is absolutely not complacent about productivity, and it is completely wrong to suggest otherwise," she said.

## PERHAPS THE NHS LEADERS SHOULD FOCUS MORE ON HOMEWORK?

Pritchard said that because she was giving evidence before the publication of the NHS's 2025-26 planning guidance, which sets out priorities the government wants it to focus on, it was hard to go into depth about the service's transformation plans. Moran said the committee will be writing to NHS leaders "to seek the clarity that we expected to hear in the evidence session."



Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2025;388:r227

## Antidepressants are effective for managing anxiety, finds review

A Cochrane review has concluded that antidepressants are more effective than placebo in reducing symptoms of generalised anxiety disorder (GAD) in the short term.

NICE recommends antidepressants, particularly selective serotonin reuptake inhibitors and serotonin and noradrenaline reuptake inhibitors, for people with GAD as an alternative to cognitive behavioural therapy. Published randomised controlled trials have shown some evidence of efficacy of the drugs, but no systematic review of all antidepressants in treating GAD has been conducted recently.

The meta-analysis and systematic review included 37 randomised controlled trials with 12 226 patients. Most trials were conducted in high income countries and recruited adults, 60% of them female. The review authors concluded there was “high certainty evidence” that antidepressants

provide a benefit over placebo in rate of treatment response, measured as a 50% or more reduction on the Hamilton anxiety rating scale. The results from 20 studies with 7267

participants showed a 41% higher response rate among those taking an antidepressant than those taking a placebo.

The analysis found that antidepressants were similar to placebo in the total number of dropouts and had fewer dropouts owing to lack of efficacy. Antidepressants were less tolerated than placebo, however, as they had more dropouts because of adverse effects.

Limitations of the analysis included that most studies lasted between four and 12 weeks, with no long term follow-up.

Gemma Lewis, senior research associate in psychiatric epidemiology at University College London, who was not involved in the study, said, “We know many people use antidepressants for much longer than four to 12 weeks, often for several years. We need trials that follow people for longer.” She added, “Another limitation of the data is that most studies only included people with a clinical diagnosis of anxiety, which is quite severe. Many people are prescribed antidepressants for milder symptoms.”

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r209

## Warning over raised risk of GLP-1 agonists in surgery

Glucagon-like peptide-1 receptor agonists such as semaglutide (Wegovy and Ozempic) and tirzepatide (Mounjaro) may increase the risk of pulmonary aspiration among patients undergoing surgery or procedures with general anaesthesia or deep sedation, the UK drugs regulator has warned.

In an alert to patients and doctors the MHRA said that the drugs, used for weight loss and diabetes, slow down the emptying of the person’s stomach. This means that, despite normal preoperative fasting advice being followed, patients taking these drugs may still have “residual gastric contents” and could experience pulmonary aspiration, potentially causing pneumonia.

In light of this, patients have been told that before any surgical procedure they must tell their healthcare professional team, including their anaesthetist, if they are taking these drugs. But they must



**Because of private prescriptions, and online access, patients don't always disclose taking them**

Kariem El-Boghdadly

not stop taking their prescribed medication without discussing this with their doctor first, the MHRA said.

Anaesthetists are also advised to “consider the potential risk of aspiration within their risk assessment of patients being treated with GLP-1 or dual glucose dependent insulinotropic peptide receptor agonists (GIP)/GLP-1 receptor agonists for all indications and manage the aspiration risk, in line with usual anaesthetic practice.”

Anaesthetists must also provide an individualised assessment of the risk of aspiration and consider that

patients taking these drugs who have “underlying diabetic gastroparesis, as well as other comorbidities such as obesity or gastro-oesophageal reflux disease, and symptoms of delayed gastric emptying may be at higher risk of aspiration.”

The MHRA emphasised that patients

## Anger over Cochrane’s cancellation of exercise therapy for CSF review

A decision to cancel a planned update of a Cochrane systematic review of exercise therapy for chronic fatigue syndrome has met with anger from a group advising the review and among patients.

The decision has reignited calls for the review—which includes studies only up to

May 2014—to be withdrawn for being outdated and misleading.

The review recommends exercise therapy to treat myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), concluding that this “probably has a positive effect on fatigue in adults compared to usual care or passive therapies.” But the treatment is controversial and has been criticised by patients’ groups, which said it can worsen symptoms. Guidelines from NICE published in 2021 specifically advise against graded exercise therapy.

The Cochrane systematic review was modified slightly by its authors in 2019 to place more emphasis on the limited applicability of the evidence to definitions of ME/CFS used in the included studies, the long term effects of exercise on symptoms of fatigue, and the limitations of evidence on harms that may occur.



**Karla Soares-Weiser, Cochrane’s editor in chief, committed to a full update of its systematic review in 2019**



should be asked whether they are taking GLP-1 or dual GIP/GLP-1 receptor agonists and that those who may have bought these drugs for “aesthetic weight loss” may not readily disclose this information “unless directly asked.” In addition, private prescriptions may not be included in medical notes.

### Online prescriptions

The MHRA said it had received a “very small number of reports of aspiration during a surgical procedure associated with GLP-1 including one case that resulted in aspiration pneumonia.” It said any suspected adverse drug reactions should be reported through the MHRA’s yellow card scheme.

Earlier this month several organisations, including the Association of Anaesthetists, British Obesity and Metabolic Surgery Society, Centre for Perioperative

Care, and Royal College of Anaesthetists, issued a joint statement advising that patients should “continue these drugs before surgery, have full risk assessment and stratification, and receive perioperative techniques that may mitigate risk of pulmonary aspiration before, during, and after sedation or general anaesthesia.”

Consultant anaesthetist Kariem El-Boghdady, a coauthor of the statement, told *The BMJ*, “One point in which the MHRA advice is particularly helpful is emphasising that patients should be asked about taking these drugs, given private prescriptions, and online access to these drugs means patients do not always disclose taking them.”

“Specific questioning about GLP-1 RA/GIPs may be warranted, given the widespread use.”

Elisabeth Mahase, *The BMJ*  
Cite this as: *BMJ* 2025;388:r205

But Cochrane’s editor in chief, Karla Soares-Weiser, said then that the amended review was outdated, and she committed Cochrane to a full update, “in consultation with an independent advisory group we intend to convene.”

That advisory group was set up in 2020, and the project was supposed to take two years. But the pandemic hit, and Cochrane lost funding and was restructured, leading to lengthy delays.

Last December an editorial note attached to the review said that the full update was not going ahead.

### Dismay and concern

The independent advisory group has now written an open letter to Susan Phillips, chair of the Cochrane governing board, expressing “dismay and concern at the rejection of our formal advice to append an editorial note to the current version of the review stating that it is out of date and should not be used for clinical decision making, as Cochrane has done

for other reviews. Instead, Cochrane reissued the review in December, dated it 2024 despite the last search for studies being over 10 years ago, ostensibly affirming its content as current.”

The letter said that Cochrane had not properly considered criticisms of the review, subsequent evidence and developments in the field, or its outdated methods.

Hilda Bastian, group lead of the independent advisory group, told *The BMJ* that people would be misled to think that this was a new systematic review, since it was now dated 2024.

A Cochrane spokesperson said the review would not be withdrawn, because it did not meet widely used journal retraction policies.

Bastian, one of the founders of the Cochrane Collaboration, said the review did not need to be retracted but should be “retired” and labelled as out of date.

Jacqui Wise, Kent  
Cite this as: *BMJ* 2025;388:r169

## NHS England cuts targets in drive to reduce waiting times

The number of targets for the NHS in England are to be cut from 32 to 18 in 2025-26, so as to focus on reducing waiting times. NHS England’s operational planning guidance has had a mixed response, with some welcoming the move but others voicing concern that important areas such as mental healthcare and dementia care will suffer as a result.

The NHS has a new national ambition for 65% of patients to have elective treatment within 18 weeks by March 2026 and for every trust to deliver at least a 5% performance improvement this year, says the guidance.

Reducing the number of targets to 18 would give local systems greater spending flexibility and the power to use funding on what they deemed most important, said NHS England.

In its accompanying *Mandate for Reform of the NHS* the government set out five objectives: reform to cut waiting times, improve primary care access, improve urgent and emergency care, move to a more devolved system, and improve efficiency and productivity.

Targets being dropped include ensuring 75% of people with severe mental illness receive a full annual physical health check; increasing to 67% the proportion of people living with dementia who have a diagnosis; pledges on women’s health hubs; increasing the cancers diagnosed at stages 1 and 2; and increasing childhood vaccination rates.

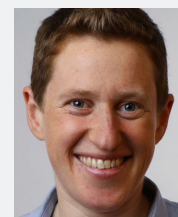
However, the guidance does call for a new ambition to speed up cancer diagnosis, saying that next year around 100 000 more people referred for urgent cancer checks will get a diagnosis or an all clear within four weeks.

All NHS systems have been asked to deliver 4% overall improvement in productivity in 2025-26 and to reduce their cost base by at least 1%.

Becks Fisher, the Nuffield Trust’s director of research and policy, said, “Many of the indicators dropped or missed out were important and will be painful to let go of—but the reality is the list of goals from last year was already too long. For now, the reforms which will be promised in the NHS 10 year plan later this year will be largely put on ice.”

However, Sarah Hughes, chief executive of the mental health charity Mind, said the government seemed to be “deprioritising mental health.”

Adrian O’Dowd, London Cite this as: *BMJ* 2025;388:r235



**The list of goals from last year was too long**  
Becks Fisher

**THE NHS** has a new national ambition for **65%** of patients to undergo elective treatment within 18 weeks by March 2026

# SPECIALTY TRAINING: BMA apologises after it called for UK graduates to be prioritised

The shortage of training jobs has angered resident doctors' leaders. **Ella Hubbard** looks at how the landscape of specialty training has changed

**T**he BMA has apologised for any “upset and distress” caused by the announcement that its Resident Doctors Committee planned to lobby for UK graduates to be prioritised when applying for specialty training posts.

In an email to members last month the committee said it had passed a resolution “to prioritise lobbying for a method of UK graduate prioritisation for specialty training applications and on the issue of training bottlenecks during this session.”

The committee bemoaned the high competition ratios for specialty training. “This is not the future we were promised when we began our medical training, and urgent action needs to be taken,” said the email.

“We want to see a policy solution that ensures UK graduates are not fighting year on year for a stagnant number of specialty training places.

It’s also our priority that international medical graduate (IMG) colleagues who work in the UK are protected from exploitation and we will continue to push for this.”

However, BMA chief officers subsequently released a clarifying statement saying the association’s longstanding policy “maintains that all doctors currently practising in the UK, regardless of nationality or place of primary medical qualification, should have access to training opportunities, prior to recruitment from abroad.”

The BMA officers also acknowledged the challenges faced by resident doctors seeking to enter specialty training who had “felt compelled” to “tackle the very real crisis experienced by resident doctors seeking access to specialty training and the avoidance of unemployment.”

They added that “the committee will engage with resident doctors affected



**We need a collaborative, nuanced approach**  
Selvaseelan Selvarajah

by specialty training bottlenecks, including both UK graduates and IMGs in the UK.”

Selvaseelan Selvarajah, a GP partner in east London and member of the BMA UK Council, said, “IMGs have historically supported underserved specialties and regions . . . They sustain the NHS in service provision roles.” He welcomed the statement from the BMA chief officers, saying that a “collaborative, nuanced approach is needed, such as prioritising experience in the NHS over where one obtained their degree.”

## Fight for training places

It’s no secret that competition for specialty training is increasing. Medical leaders have been raising concerns about the shortfall of posts for years.

A recent analysis by *The BMJ* found that applications for specialty training posts had increased from

## “Ask patients at checkups, to reduce gambling harms”



GPs and other healthcare professionals should ask patients about gambling during routine checkups and ensure access to early effective help for those at high risk of harm, NICE has said in its first clinical guidance on the issue.

NICE said its recommendations could lead to effective early identification and treatment that may reduce the number of people experiencing longer term or more serious harm from gambling. Experts said the guidance would bring a unified approach to tackling problems that wreck health, finances, and lives and are

estimated to be linked to hundreds of suicides a year.

Liz Ritchie, who cofounded the charity Gambling with Lives after the gambling related suicide of her son Jack and who was part of the NICE committee that wrote the guideline, said the guidance would “save lives.” She said, “At last, GPs and health and social services professionals will ask about gambling as part of routine checks, and they will be trained to recognise the very high suicide risk connected to gambling.”

Simple questions could be added to routine assessments,

**GPs, health professionals, and social services staff should ask about gambling**

including GP registrations and NHS health checks, NICE said, in the same way patients discuss smoking and alcohol. It was “important to proactively ask about gambling to identify concerns as soon as possible and support people to access help,” NICE said.

GPs, health professionals, and social services staff should ask about gambling when people attend in any setting with a mental health problem or concern, thoughts about self-harm or suicide, depression, anxiety, psychosis, or bipolar disorder.

Other people who may be at higher risk include those with alcohol or substance dependence, people taking drugs that may affect impulse control, people

experiencing safeguarding issues, violence, or homelessness, and those with a family history of gambling. Young people who have recently left home for the first time may also be at higher risk.

People who have concerns should be encouraged to complete a questionnaire on the NHS website that is based on the problem gambling severity index. A score of 8 or above indicates they should be guided to specialist treatment. Those with lower scores may also benefit from support.

Matthew Limb, London  
Cite this as: *BMJ* 2025;388:r187

If you’re struggling, you’re not alone. In the UK and Ireland, Samaritans can be contacted on 116 123 or [jo@samaritans.org](mailto:jo@samaritans.org) or [jo@samaritans.ie](mailto:jo@samaritans.ie)



23 040 in 2019 to 59 698 in 2024, but the number of training posts barely changed over the same period, rising by under 600, from 12 175 in 2019 to 12 743 in 2024. The overall competition ratio in 2024 was 4.7, up from 3.3 in 2023 and 1.9 in 2019.

These data refer to total applications rather than unique applicants. But medical leaders say that, with a huge shortfall in the consultant workforce, there shouldn't be such a scramble for places.

Against this backdrop is a growing number of IMGs joining the NHS. The number of candidates sitting the General Medical Council's Professional and Linguistic Assessments Board (PLAB) examination, the route through which most IMGs join the UK workforce, has doubled in four years, from 10 601 in 2020 to 21 058 in 2024.

In 2023, 68% of doctors joining the UK medical workforce were IMGs, up from 47% in 2017.

Critics have said that IMGs already face significant challenges in career progression when compared with home grown doctors, such as being less likely than UK qualified doctors to be offered training posts.

#### Failure of workforce planning

Chandra Kanneganti, a GP and former president of the British International Doctors Association, said the Resident Doctors Committee's proposal "demonstrates an attitude which overlooks the contributions of IMGs and takes them for granted. We should be united as a profession and advocate for more training posts instead of creating division among ourselves."

Others agree that the row has exposed the need for urgent reform of workforce planning to meet the needs of UK graduates and IMGs in the NHS.

Mala Rao, director of Imperial College London's Ethnicity and Health Unit and clinical adviser to the GMC on IMGs, said, "What a tragedy it would

**IN 2023**, 68% of doctors joining the UK medical workforce were IMGs, up from 47% in 2017

be for UK graduates to be driven out of the UK in search of specialty training and employment elsewhere. That said, IMGs too deserve to be treated with justice and fairness.

"A coherent workforce plan which ensures that UK graduates are able to fulfil their career aspirations and that IMGs are recruited in numbers that address the NHS workforce needs but also enable them to fulfil their career goals must be developed as a priority."

The BMA reiterated calls for "better workforce planning, including more specialty training posts," saying that "specialty training bottlenecks are an aspect of the workforce crisis that has debilitated the NHS and cannot continue."

Asked about the bottlenecks in training, an NHS England spokesperson said, "The NHS is constantly looking for ways to improve the experience of applicants for specialty training, and we continue to listen to the profession about how to do that."

Ella Hubbard, *The BMJ*  
Cite this as: *BMJ* 2025;388:r157



**We should be united as a profession and advocate for more training posts**

Chandra Kanneganti

## Novo Nordisk's third rebuke sparks call for UK Sunshine Act

The Danish drug giant Novo Nordisk, known for its antidiabetes and weight loss drugs such as semaglutide (Ozempic or Wegovy), has been censured by the UK's Prescription Medicines Code of Practice Authority (PMCPA) for failing to properly disclose payments to healthcare organisations and patients' groups between 2015 and 2022.

It is the third time in less than a year that the PMCPA, the self-regulatory body that administers the code of practice of the Association of the British Pharmaceutical Industry (ABPI), has reprimanded the company. Experts in research transparency have said that the repeat offences make a mockery of self-regulation

and that only a law to disclose payments backed by financial penalties will deter companies.

Last July Novo Nordisk admitted it had failed to disclose around 500 payments totalling £7.8m to 150 recipients, including doctors, patients, journalists, and healthcare organisations, between 2020 and 2022. And in March 2023 its membership of ABPI was suspended for two years after it failed to clearly disclose sponsorship of a weight management training course for healthcare professionals.

However, the PMCPA has looked again at the company's financial disclosures, after an investigation by Bath University and Lund University in Sweden

alleged it had failed to correctly disclose £1.2m paid to healthcare and patient organisations. It was found to have breached the ABPI code 48 times across 15 clauses and "had brought discredit upon and reduced confidence in the pharmaceutical industry."

A Novo Nordisk spokesperson said it had "already implemented mitigating actions to future proof how we track and disclose transfers of value and continue to



collaborate with external partners to ensure robust systems and processes are in place."

However, Emily Rickard and Piotr Ozieranski, from the Department of Social and Policy Sciences at Bath University, said it was clear the self-regulatory approach was "not fit for purpose and should be urgently overhauled to protect patient health from the impact of conflicts of interest." They have called for legislation akin to the US Physician Payments Sunshine Act.

"Financial penalties must be proportional to each company's revenue to ensure the consequences are not superficial 'slaps on the wrist,'" they said.

Elisabeth Mahase, *The BMJ*  
Cite this as: *BMJ* 2025;388:r178

NEWS ANALYSIS

# ASSISTED DYING: What next for the law proposed for England and Wales?

Do doctors need to be involved? Should neurological conditions be included? As MPs' scrutiny of the bill begins, **Jacqui Wise** reports on the issues being discussed



**Family coercion in my experience is rare**  
Andrew Green



**The bill will not help people like me who have Parkinson's disease**  
Nicholas Mostyn



**Doctors are not trained in having advanced care planning conversations** Rachel Clarke

**What is the current situation?**  
The Terminally Ill Adults (End of Life) Bill was backed by MPs, by 330 to 275, in November. The bill would make it legal in England and Wales for people aged over 18 who are terminally ill to be given assistance to end their life under certain circumstances.

To be eligible, someone must be expected to die within six months, have the mental capacity to make the choice, and be deemed to have expressed a “clear, settled, and informed” wish, free from coercion.

Although the bill passed by a comfortable majority, some MPs who backed the bill want to introduce more safeguards and will table amendments over the coming months.

**Who is scrutinising the bill?**  
The bill will be scrutinised line by line by a committee of 23 MPs, 14 of whom voted for the bill and nine who voted against it. The committee includes two ministers—health minister Stephen Kinnock and justice minister Sarah Sackman—both of whom voted for the bill.

It also includes vocal opponents, including the Tory Danny Kruger. There are also MPs who voted for the bill but want it amended, such as Marie Tidball, a Labour MP who has been disabled since birth. She said the law must be amended to ensure doctors present all options to patients.

The committee stage of the bill started on 28 January, with MPs due to hear evidence from experts over several weeks.

**How will mental capacity be assessed?**  
The Mental Capacity Act will be the basis for assessing people who

want to request an assisted death. England's chief medical officer, Chris Whitty, told the committee that doctors and nurses use this act every day and that it is well tested.

But Rachel Clarke, a hospital palliative care doctor, told the committee that the “elephant in the room is the capacity assessments.” She said, “They are often poorly conducted—the doctor doesn't understand the criteria for assessing capacity. And that is if they are even done at all.” She said that more safeguards were needed, including a mechanism for any member of staff or family to raise concerns.

**Would vulnerable people be protected from coercion?**  
Opponents of the bill are concerned that terminally ill people, particularly those who are elderly, disabled, or vulnerable, could be pressed or coerced into ending their life. The bill says that anyone who coerces someone to have an assisted death will be liable to 14 years in prison, but the challenge is that coercion can be difficult to detect or prove.

Others worry people may choose assisted dying because they believe themselves to be a burden. The former home secretary James Cleverly intends to amend the bill so the person is eligible only if they are seeking it for their own sake and not because they don't want to be a burden on society.

Andrew Green, a retired GP and chair of the BMA's medical ethics committee, told the MPs that all doctors are trained in safeguarding. He said that patients often make important decisions with the help of family members but that coercion “in my experience is rare.”

But Clarke disputed this, adding, “Not only are the majority of doctors not trained in spotting coercion explicitly, they are not trained in having advanced care planning conversations.”

**Should the eligibility criteria be expanded?**  
The bill stipulates that patients should have less than six months to live, meaning that most people would need to have terminal cancer before being allowed an assisted death. Nicholas Mostyn, a former High Court judge who has Parkinson's disease, told the committee that the bill would not help someone like him and that his choice would be a “poor death here [in the UK] or to go somewhere like Dignitas.”

Greg Mewett, a palliative care physician from Victoria, Australia, told the committee that most Australian states stipulate that a person must have six months or less to live to be eligible for assisted dying, except when they have a neurodegenerative disorder, in which case it is 12 months.

“This does not seem logical,” he said. He told the committee the Victoria review board was currently considering changing it to 12 months for everyone, as already occurs in Queensland.

Kruger questioned why the bill had no mention of pain or suffering, only that the person must have a terminal illness. Clare Fellingham, deputy director of medical services for Royal Perth Hospital, replied that in Western Australia one of the criteria for assisted dying was that a person is “suffering intolerably” and that all steps have been taken to alleviate this.

**Should assisted dying services be outside the NHS?**  
The BMA is calling for assisted dying to be arranged through a separate service, although this could be within the

NHS. Green told the committee, “We do believe it should not be part of any doctor’s normal job to provide assisted dying. It should be set up as a separate service. It would reassure patients that it is not part of [doctors’] normal care.”

Lucy Thomas, a palliative care doctor, told BBC Radio 4’s *Today* news programme on 28 January that she was not opposed to assisted dying in principle but added, “We should completely demedicalise assisted dying and separate it from the healthcare process.” She said there was no reason for doctors to be involved in administering an assisted death and that it could be run by non-medical volunteers, as it is in Switzerland.

### ? Will medical staff need specific training?

Whitty told the MPs that doctors were used to dealing with issues to do with mental capacity and managing the end of life and that this training would need only slight adaptation. He said a large number of doctors will need to have a general understanding of the issues, in case, for example, a patient raises the issue with their GP. A much smaller number, who choose to be involved in the later stages, would need specific training.

Clarke said that, to make the bill as robust as possible, education and training in death and dying needed to take place “from day 1 of medical school.” She added that it was “impossible for her to overstate how much avoidable suffering occurs right now in the NHS,” not because of a lack of resources in palliative care but because of a “lack of confidence, skill, and expertise among the medical profession [in having] these very difficult conversations.”

### ? Will doctors be able to opt out?

Under clause 23 of the bill no medical practitioner would be required to participate in providing an assisted death. Green said that doctors must be able to opt out of offering it at any stage. He said that assisted dying must not be a “tick box in discussions that patients have with their doctors.” But he said that in some circumstances doctors should be able to raise the issue with their patients, and he urged MPs not to pass legislation that would

make it harder for doctors to have these difficult discussions.

Whitty told the committee it was important to ensure that the wishes of health professionals were respected as well as those of patients. He said most doctors who didn’t want to discuss assisted dying would have no problem referring a patient to someone else. For the few for whom it was a point of very strong principle there should be alternative routes for patients to access help, he said.

### ? Is palliative care currently fit for purpose?

Whitty told MPs that the introduction of legal assisted dying should not make any difference to palliative care provision. But Sarah Cox, president of the Association of Palliative Medicine, said recent evidence showed that, although palliative care has improved in countries where assisted dying has been implemented, it has improved “three times better” in countries without legal assisted dying.

Cox also expressed concern about the effects on funding for palliative care if it came from the same pot as assisted dying. She accepted that some people would choose assisted dying even with a very good palliative care system. But she said current palliative care was “inadequate” and needed to be improved so patients will have a real choice.

### ? Is a High Court sign off necessary?

The bill states that two independent doctors must be satisfied

that the person is eligible for assisted dying and that a High Court judge must hear from at least one of the doctors and can also question the dying person.

But Jonathan Sumption, a member of the House of Lords and former Supreme Court judge, told the MPs that the requirement for signing off by a High Court judge was “unnecessary and in some respects undesirable.” He said it wasn’t clear what the judge was supposed to do: was it to ensure that the two doctors had done their job or to form his or her own view? He said, “If the latter, one is talking about quite a time consuming process, involving a lot of additional evidence.” He added that he was aware of no other country that had this extra protection.

### What are the next steps?

The bill’s committee stage is expected to be completed by the end of April. It will then, with any amendments, be again put to a Commons vote. If it passes, the bill will go to the House of Lords, where it could be amended further and returned to the Commons. If passed by both houses and given royal assent, the government will have two years to implement the legislation.

Fellingham told the committee the UK now had a “golden opportunity” to look at every jurisdiction that already has laws in place and “cherry pick” the very best bits to create the “very best, most robust, and most patient centred legislation possible.”

Jacqui Wise, Kent

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**Palliative care has improved three times better in countries without legal assisted dying**

Sarah Cox



**Signing off by a High Court judge is unnecessary and in some respects undesirable**

Jonathan Sumption



Supporters outside parliament as the bill was introduced to the Commons on 29 November





MOIZ SALIH/ANADOLU/GETTY IMAGES

# Ending pollution and health harms from plastics

Corporate interests threaten the scope of the global plastics treaty

**P**lastics are exacerbating pressures on all Earth's planetary boundaries, compromising the foundations of healthy human life.<sup>1</sup> Greenhouse gases, toxic chemicals, microplastics, and nanoplastics are released across the entire plastics life cycle—from the extraction of fossil feedstocks that form over 90% of plastics, to polymer and product manufacturing, (re) use, recycling, and end-of-life fates.<sup>2</sup> Ending plastics pollution is a global health imperative,<sup>3</sup> essential to protecting the human right to health<sup>4</sup> and to a safe, clean, healthy, and sustainable environment.<sup>5</sup>

In 2025, almost 500 million tonnes of primary plastics will be produced globally and over 400 million tonnes of plastics waste generated, most of which will be sent to landfill, incinerated, dumped, or burnt.<sup>6</sup> Two gigatons of greenhouse gases will be emitted across plastics life cycles and more than 24 million tonnes of plastics, including microplastics and nanoplastics, will leak into land, rivers, and oceans.<sup>6</sup> Further delays in decisive action will likely see these figures rise.<sup>6</sup>

Human health is at risk from the beginning of plastics life cycles. Fossil fuel extraction and petrochemical industries emit dangerous quantities of hazardous chemicals.<sup>2</sup> In 2024, ethylene oxide air pollution in parts of Louisiana's "cancer alley"—an area lined with petrochemical plants and refineries—reached 1000 times "safe" levels, with excess cancer risks as high as 1 in 1000.<sup>7</sup> Local people face higher rates of childhood leukaemia, cardiovascular and respiratory diseases, premature births, and low birthweight.<sup>2</sup>

More than 16 000 chemicals have been identified in plastics.<sup>10</sup> Less than 6% are regulated globally, although a quarter are known to be hazardous, and most have never been tested.<sup>10</sup> Carcinogens, mutagens,



**A minority of predominantly petrochemical producing nations are blocking legally binding commitments**

and endocrine disruptors in plastics are linked to reproductive and developmental disorders.<sup>12</sup> Mandatory chemical transparency and traceability is critical to ascertaining health hazards, identifying safe and sustainable alternatives, and underpinning effective regulation.

Just 11% of plastics are recycled globally.<sup>6</sup> Even with major technical advances, investment, market incentives, and plastics redesign, recycling will not solve plastics pollution.<sup>13</sup> Mountains of discarded plastics waste create dangerous conditions for around 20 million workers in the informal recycling sector.<sup>2</sup> In many countries, open burning remains a primary recourse for waste, contributing to respiratory disease.<sup>2</sup> Plastics accumulation can disrupt food production,<sup>14</sup> compromise sanitation systems,<sup>15</sup> and spread infectious disease.<sup>16</sup> Microplastics have been identified in human blood, placenta, liver, and kidneys, with early evidence of tissue damage and immunological responses.<sup>17</sup> Coordinated global action to end pollution across the entire plastics life cycle is vital.

## Industry influence

In 2022, the United Nations Environment Assembly adopted resolution 5/14 to develop an international, legally binding treaty by 2024 to end plastics pollution.<sup>18</sup> The treaty remains under negotiation, with parties reconvening in 2025. Over 100 countries have formally

backed global targets to cut plastic production, and more than 85 support legally binding commitments to phase out harmful plastic products and chemicals of concern.<sup>19</sup> However, a minority of predominantly petrochemical producing nations are blocking legally binding commitments, favouring voluntary measures and a sole focus on plastics waste management.<sup>19</sup>

Global experts have affirmed priorities in the treaty to protect human health. These include a clear objective to end plastic pollution; global, legally binding targets to reduce plastics production; chemical simplification and elimination of hazardous chemicals; mandatory transparency across plastics life cycles; integrating health throughout treaty articles; no sectoral exemptions, including for healthcare; and mechanisms for strengthening the treaty over time.<sup>20-22</sup>

Powerful economic interests and industry influence must be overcome for a meaningful treaty. Fossil fuel and chemical industry representatives outnumbered all countries and several regional delegations at the November 2024 negotiations, some registered within government delegations.<sup>23</sup> Looking ahead, negotiations must remain transparent and open to independent scientists and civil society. Greater presence of health ministries within delegations could protect human health concerns in the treaty and create synergies with global public health policies.

Finally, interdisciplinary scientific collaborations must continue to provide robust and actionable evidence to inform decisions. Strong science-society-policy partnerships and mitigation of conflicts of interest in negotiations could achieve an ambitious global plastics treaty in 2025.

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# To get Britain working we need better health

An approach linking health and skills could boost employability

In the UK, 2.8 million people are economically inactive and in receipt of health related welfare benefits.<sup>1</sup> Almost a million young people aged 18-24 years are not in education, employment, or training, and one in five of those receives health related benefits, largely for mental health conditions.<sup>2</sup>

Following a decade of austerity, and exacerbated by the covid-19 pandemic, ill health and health inequalities have worsened in the UK such that it is the “sick (wo)man of Europe.”<sup>3</sup>

The UK has far higher rates of health related worklessness than most other comparable economies (including Germany, Sweden, and France).<sup>4</sup> It faces a serious economic challenge because of stagnating growth and widening inequalities in productivity, which contribute to rising rates of poverty and further inequalities in health.<sup>5</sup>

Health related worklessness became a problem for the UK in the 1980s when rapid deindustrialisation led to mass unemployment, particularly in the north of England, Scotland, and Wales.<sup>1</sup> Between the late 1970s and the mid-1990s, the proportion of the working age population receiving benefits related to disability more than doubled, to almost 7%. To address rising numbers of claimants, substantial changes to eligibility, generosity, and assessments were introduced and expanded over the past 30 years.<sup>6</sup> However, prevalence remained generally static at about 7% of the workforce.<sup>1</sup>

Successive UK governments have tried—but failed—to tackle health related worklessness. Much of it is still concentrated in the most deprived and deindustrialised areas of the UK, such as the wards of East Marsh and Port in Grimsby, Central Easterhouse in Glasgow, and Birkenhead Central, where around 30% of the working age population are receiving health related



MARK WAUGH/ALAMY

**Poor quality, insecure jobs can be less healthy than unemployment**

benefits, and life expectancy is 12 years less than the national average.<sup>7</sup>

In the Get Britain Working white paper, launched by the prime minister, Keir Starmer, in November 2024, the government promised to “join up” health with skills and employment support on the basis of local communities’ unique needs.<sup>8,9</sup> Moreover, it has promised to fix the NHS, cut waiting lists to help people back to health and work, and place a greater focus on preventive measures to stop people becoming ill in the first place.

## Health first approach

Success will depend on strong implementation, monitoring, and evaluation to avoid exacerbating inequalities. One reason that previous policies failed is that they largely ignored the employability boost from improving recipients’ health.<sup>10</sup> International research suggests that a correctly implemented “health first” approach could be beneficial.<sup>11</sup>

The government’s proposal to expand mental health support and launch an independent review into how employers can better support people with disabilities is therefore welcome.<sup>8</sup> Some European countries have long integrated a health care component (eg, rehabilitation, physical exercise, cognitive behavioural therapy, and health advice and counselling) into active labour market policies, showing some improvements in re-employment rates.<sup>11</sup> Employers

can also be supported more—in the US, for example, work opportunity tax credits incentivise the hiring of people with disabilities.<sup>12</sup>

However, the prime minister also announced that in 2025 there will be further reforms to the health and disability benefits system, to tackle a “spiralling” welfare bill.<sup>9</sup> If (as seems likely) this means continuing to reduce the value of benefit payments alongside increased use of conditionality and sanctioning, it could adversely affect health, not just for individuals but also for their children.<sup>13</sup> Such measures also risk driving people further from the workforce<sup>14,15</sup> or trapping them in exploitative or harmful jobs.<sup>16</sup>

A supportive benefits system that allows people to leave health harming work can also boost economic growth, acting as a catalyst for nudging the entire labour market towards higher wages and better jobs.<sup>17,18</sup> Reducing the higher rates of health related worklessness in the north of England to match those in the rest of the country could yield substantial economic benefits, generating an additional estimated £13.2bn a year.<sup>19</sup> Improving workforce health should therefore be integrated into the government’s economic, industrial, and regional strategies.

A health first approach recognises that not all work is good for health—poor quality, insecure jobs can be less healthy than unemployment,<sup>20</sup> especially for workers with disabilities. The need for higher quality jobs is noted within the government’s Employment Rights Bill, announced in October 2024, which aims to make work more secure with employment rights “from day one.”<sup>21</sup> The future requires more of such “carrots” and fewer “sticks.”

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# McDonald's triumphs in legal row over health concerns

The fast food giant used a GP to support appeals against planning decisions in deprived areas with some of the worst rates of food related ill health in England. Then it threatened councils with bills for the legal costs.

**Sophie Borland** reports



**M**cDonald's is overturning councils' attempts to prevent new fast food outlets by claiming they will encourage healthier lifestyles, *The BMJ* can reveal.

The firm has used a playbook of arguments to win planning appeals against local authorities in some of England's most deprived areas with the poorest public health outcomes. Its tactics include arguing that customers can order salad from drive-through branches, they could cycle or walk there, and its sponsorship of local football teams promotes health and wellbeing.

McDonald's has also deployed a specialist GP who claims obesity is caused by "over 100" factors other than fast food and its menu contains nutritious and low calorie options. In some cases McDonald's threatened to force councils to repay its costs, saying they had behaved "unreasonably."

Experts tell *The BMJ* that the threat of a McDonald's appeal has a chilling effect on councils and means they would be more inclined to wave through a planning application for a new branch regardless of the public health concerns, describing it as a "David and Goliath" battle.

Alice Wiseman, vice president of the

Association of Directors of Public Health and director of public health for Gateshead and Newcastle, says, "It's the fear of doing a lot of work, which is obviously resources and capacity, and then having it thrown out by the inspectors at the late stage."

Separately, *The BMJ's* investigation found evidence of McDonald's trying to derail council health policies to more widely limit future takeaway outlets. *The BMJ* discovered that the firm was deploying the same "playbook" as for the appeals process: highlighting the low calorie options on its menu and arguing that it supports healthy lifestyles by sponsoring football (box 1).

## Box 1 | McDonald's tries to block council health policies to ban fast food outlets close to schools

McDonald's is trying to derail local councils' public health policies to limit future takeaway outlets, *The BMJ* found.

It identified 15 cases since January 2020 in which the firm objected to proposals by local authorities to ban fast food outlets close to schools or in areas with a high prevalence of obesity—policies known as 'exclusion zones' (see box 2). It deployed the same "playbook" of arguments it uses to successfully overturn planning decisions.

The firm repeatedly told local authorities that it supports healthy lifestyles by sponsoring community football and claimed that its menu

contains "lower calorie options."

In at least 10 cases McDonald's submitted a 20 page objection letter arguing there was a "lack of evidence" that limiting takeaways near to schools would curb obesity. Councils receiving the letter included Brent in north London, Bristol, and Wyre Forest in Worcestershire—all of which were trying to ban takeaway outlets from opening within 400 metres of a school.

McDonald's also objected to plans by Sheffield City Council to restrict outlets opening within 800 metres of schools and by Wigan Council to limit the opening hours of takeaway

### McDonald's repeatedly told councils it supports healthy lifestyles

outlets so as not to coincide with school lunchbreaks or home times.

Most of these councils' proposed changes to their local plans are still in development, so it is not yet clear whether McDonald's objection letter has affected or will affect the policies.

But in Kirklees, West Yorkshire, meeting minutes from a panel of the local authority in August 2022 state that "minor changes" had been made to the document after objections by McDonald's and KFC.



KEMRO/LAMY

A McDonald's in Norwich, which is due to gain its 10th branch this year, for a city of 144 000 people

McDonald's says it is proud of the role it plays in local communities. A spokesperson tells *The BMJ*, "Local decision making is a critical part of the planning application process, and we always want to work in partnership with local councils to ensure our plans are right for the community."

### What *The BMJ* found

*The BMJ* submitted freedom of information requests to the national Planning Inspectorate to investigate how McDonald's is thwarting councils' health policies aimed at tackling food related ill health (box 2).

*The BMJ* uncovered five cases since January 2020 in which a local council rejected a new McDonald's branch out of concerns for health—and in which McDonald's then successfully appealed the decision, by claiming that it would in fact promote healthy living.

The firm has lodged 14 appeals with the Planning Inspectorate over the past five years and lost only one case; two are ongoing. Its other successful appeals, which involved rejections not directly related to health concerns, led to McDonald's branches being allowed to open for 24 hours a day and for large "golden arch" advertising signs to be installed beside roads.

We also identified 15 cases since January 2020 in which McDonald's objected

to proposals to ban fast food outlets in "exclusion zones" close to schools or in areas with a high prevalence of obesity.

Last December the government announced new powers for councils to ban takeaways closer to schools and in areas of poor health. Although public health experts are broadly pleased with the policy, one told *The BMJ* it would be up to local authorities to decide how—and whether—they used this guidance.

In the same month England's chief medical officer, Chris Whitty, warned that children in English cities were being "set up" to live shorter, unhealthier lives in part because of the ready availability of fast food, particularly in deprived areas.

Latest NHS figures show that a third of children in some of England's most deprived areas are obese by the time they leave primary school. Obesity was linked to 1.2 million hospital admissions in 2022-23, a rise of 8% on the previous 12 months.

### "Customers can order salad"

*The BMJ's* freedom of information requests reveal how McDonald's has persuaded planning inspectors that new branches will promote healthy lifestyles.

In one case in Norwich in 2024 the company argued to inspectors that customers could order salad, coffee, and meals of "under 400 calories" from its proposed drive-through. It said a "notable amount of custom will be on foot or cycle," even though to do so would mean travelling beside a busy ring road.

McDonald's also claimed the proposed children's climbing frame would encourage "physical activity" and "healthier lifestyles."

Norwich City Council pointed out in the appeal that the health benefits of the climbing frame could be undermined by children inhaling fumes from the nearby drive-through lane. But McDonald's insisted it was unlikely they would be exposed to "unacceptable" pollution.

The appeal was upheld by the Planning Inspectorate in May 2024, and the restaurant is due to open in the middle of 2025. It will be the 10th McDonald's in Norwich, a city of around 144 000 people.

A McDonald's spokesperson told *The BMJ* the company prides itself on "being a positive presence in the communities within which we operate."

They add, "Initiatives such as our Makin' It partnership, which funds community

### Box 2 | Two ways councils can try to restrict fast food availability

#### Impose exclusion zones

Local authorities can impose zoning to prevent new takeaway outlets being built close to schools or in wards with a high prevalence of obesity.

Thomas Burgoine from Cambridge University's MRC Epidemiology Unit cites the unit's own research from 2019 showing that 41 of 325 local authorities in England had some sort of takeaway exclusion zones around schools. One of the most common approaches is banning new outlets within a 400 metre radius of a school.

Usually councils seeking to impose new restrictions on takeaway outlets do so by amending their "local plan," a strategy document covering a period of about 15 years that sets out what can be built in the area and where building can take place.

The draft local plan goes out to consultation, with residents and stakeholders invited to comment. After this the draft and all the comments are submitted to the Planning Inspectorate, the government agency that deals with planning applications in England.

The inspectorate has the final say, and an inspector will check the local plan meets legal and procedural requirements. If an inspector is not happy they can recommend changes.

#### Reject planning applications

Councils can also object to planning applications for a new takeaway outlet regardless of whether an exclusion zone is in place.

The prospective outlet or company can then appeal this decision via the Planning Inspectorate. The company and the council will submit evidence in writing to an independent inspector, who will then make a decision.

In December 2024 the government gave councils more powers to restrict takeaway

provision by amending the National Planning Policy Framework. These include instructing local authorities to refuse applications for hot food takeaway and fast food outlets within walking distance of schools and where there is evidence that a "concentration" would have an adverse effect on health.

Although public health experts are very supportive of the guidance in the policy framework, they point out that it is up to councils whether or not to implement it. Burgoine says that the guidance on refusing planning applications comes in clause 97 of 243 clauses in the document, which "signals that it's not really that high a priority."

He says, "It will encourage local authorities to act, but it doesn't really help prioritise health and planning like it would do if it were slightly closer to the beginning of the document."

**Guidance on refusing applications is in clause 97 of 243, which signals it's not really that high a priority**

Thomas Burgoine

youth workers, and our Fun Football programme are designed to give young people more opportunities and greater access to safe spaces.

“We believe in making it easier for customers to balance health, taste, and value and in giving people choice. We will always be transparent about our ingredients and have provided nutritional information for over 30 years. Today, 57% of our menu is classified as non-HFSS [high in fat, sugar, and salt], and 90% of our food and drinks menu items are under 500 calories.”

A Big Mac served with medium fries and a medium coke amounts to 1000 kilocalories (4.2 MJ), half of the NHS recommended daily allowance for an average woman and 40% of that for a man.



## McDonald's deploys GP obesity expert

McDonald's successfully appealed planning rejections in Dewsbury in the Kirklees borough of West Yorkshire and in Mansfield in Nottinghamshire with the help of a GP who specialises in obesity.

The company submitted lengthy statements from Matthew Capehorn, the founder of a private weight management



NOTTINGHAMSHIRE LIVE

centre in nearby Rotherham, South Yorkshire, claiming its food was “healthy and nutritious.” The firm's wide range allowed customers to purchase food items and combinations that fitted their individual calorie or nutritional requirements, Capehorn said.

The GP partner, who has previously worked as a paid medical adviser to McDonald's, said that “over 100” different factors contributed to obesity.

In Dewsbury, McDonald's claimed that it encouraged healthier lifestyles through its sponsorship of local football and rugby clubs. The Planning Inspectorate upheld the appeal in March 2022, and the restaurant opened that December.

Rachel Spencer-Henshall, executive director of public health at Kirklees Council, tells *The BMJ* that since the McDonald's appeal the council adopted

a “supplementary planning document” (SPD) for hot food takeaways in September 2022. “The SPD will further support us to make evidence based and proportionate decisions regarding new hot food takeaway applications, helping us to shape areas in Kirklees that support residents' health and wellbeing,” she says.

In Mansfield, McDonald's sought to downplay the council's concerns over a branch's proximity to three primary schools and the potential effects on health. It claimed “children are likely to visit the restaurant with a supervising adult who can support the child to make responsible food choices.”

The appeal was upheld, and the restaurant was opened by the local youth football team, Ravenshead FC (above), in December 2023. The team's kit was sponsored by McDonald's, with the

## OPINION Alice Wiseman

# We need to counter industry promotion of harmful products to protect public health

Using medical professionals to help promote harmful products is one of the many tactics that big industries employ, as shown in this *BMJ* investigation.

Big industries selling unhealthy products aim to make a profit regardless of the damage caused to consumers' health. Many of these companies have millions of pounds at their disposal for marketing, advertising, and other strategies to promote their products.

They have the resources to influence the public's perceptions and downplay the harmful effects of their products. This must change, and tobacco control gives us a blueprint for reducing the harm caused by these commercial determinants of health. In addition

to clever marketing and branding campaigns, the tobacco industry led the way in recruiting doctors and trusted public figures to reassure smokers that smoking isn't harmful and dispute evidence to the contrary. Other tactics include political lobbying, industry funded research reporting favourable results, and litigation against those who spoke out against them.

Through collaborative effort, the public health community, in partnership with the community and voluntary sector, and local and national governments have shown that industry tactics can be successfully countered in a cost effective way.

If we can build a comprehensive approach to limiting harmful

products and services that doesn't rely solely on individual behaviour change, we will see a notable reduction in the number of people living with preventable illness.

A lack of time, money, and legal resources among public health teams, local authorities, and other key partners is a major problem. National policy change to help reduce the consumption of harmful products is vital, but enforcement and follow-up action are often the responsibility of local authorities.

Cross industry tactics to block legislation that would protect public health can make counter-efforts against industry an uphill battle.

Over the past year, progress has been made towards creating health promoting environments, instead of simply treating the ill health that arises from consumption of harmful products.

**Without change, existing inequalities in health outcomes will continue to widen**

For example, the government implemented a ban on junk food and drink advertising on TV before 9 pm and proposed restrictions on the sale of energy drinks. These measures will support everyone in making healthier choices, regardless of background or income.

Local authorities have powers that can be highly effective in tackling unhealthy food promotion and the proliferation of fast food outlets. However, big industries have the funds to strategically undermine policies to restrict the sale of unhealthy food by, for example, launching high profile challenges to planning decisions. With increasing rates of obesity causing serious health problems and restricting life chances, it is vital for local authorities to have the necessary tools to successfully fight planning applications for fast food outlets.

The recently announced National Planning Policy Framework includes a recommendation that

brand's golden arches adorning the shirts.

Cllr Stuart Richardson, portfolio holder for regeneration and growth at Mansfield District Council, says, "While councillors were disappointed by the result of the appeal, and while there is always a cost involved in pursuing appeals, the planning committee has a duty to consider the impact of proposals in the public interest. In this case, it was considered the concerns relating to public health warranted refusal."

Childhood obesity rates in Mansfield are among the worst in England, and 28% of pupils are obese by the time they leave primary school. The figure is 24% for Kirklees, and the England average is 22%. Mansfield and Dewsbury are home to some of the most deprived wards in the country.

Capehorn tells *The BMJ*, "At the council planning meetings you mention I was asked to provide my personal, honest, and professional opinion on whether McDonald's causes obesity." He reiterated that "there are over 100 different factors involved in why we as individuals or we as a society are getting bigger," citing the 2007 Foresight report on tackling obesity.

"Of course, the food industry is a factor, but the actual causes of obesity are complex and multifactorial and many are outside any individual's influence," he says. "Ultimately, whether someone puts weight on comes

## McDonald's food can be eaten as part of a calorie controlled nutritionally balanced diet

Matthew Capehorn, GP

down to consuming more energy (calories) than they use up, and they should have the choice of where these calories come from but need the necessary information to make educated healthy choices.

"I demonstrated in my evidence that snacks bought at a local newsagents, for less money than a typical McDonald's meal, could have far more calories (and worse fat, sugar, salt content).

"Equally, takeaways such as [those from] Indian and Chinese and other restaurants have portions of much greater calorific value and without the transparent nutritional information that McDonald's makes available on their app, tray inserts, and menu boards. McDonald's food can be eaten as part of a calorie controlled nutritionally balanced diet."

Harvard University research published in 2019 found that voluntary calorie labelling at McDonald's was not associated with changes in calories purchased, although a Cochrane review of the wider policy of calorie labelling found a 1.8% reduction in calories selected when labelling was in place.

## McDonald's threatens to bill councils for "unreasonable behaviour"

*The BMJ's* investigation identified cases in which McDonald's threatened to force councils to repay some of its costs for appeal hearings, by arguing that the local authorities had behaved "unreasonably"—although it did not in the end recover these costs.

In Coventry the city council rejected a McDonald's planning application out of concern that the outlet would have a negative effect on the health of children at nearby primary and secondary schools. There were also road safety concerns.

McDonald's successfully overturned the rejection at appeal in May 2021, claiming there was "no evidence" for an adverse health impact. The company pointed out that the schools were "around" a 10 minute walk away, beyond the council's five minute walk takeaway exclusion zone. The planning inspector then ordered the council to pay part of McDonald's appeal costs, saying that it had shown "unreasonable behaviour" in rejecting the application in the first place.

McDonald's also won a case to claim back "unreasonable behaviour" costs from Folkestone and Hythe District Council in December 2021 over a decision not directly

local planning authorities should refuse applications for fast food outlets within walking distance of schools and other places where children congregate. This is a clear message from the government that empowers local areas to act, regardless of industry pressures.

Hounslow council has already introduced a policy that restricts advertising of nutritionally poor food and drink across council owned land. This type of action is happening across the country, with Cheshire East recently becoming the 20th English council to introduce restrictions on unhealthy food and drink advertising.

Local public health teams are encouraging councils and partners to take other measures, including developing and resourcing education packages free from industry influence; supporting evidence based campaigns to raise awareness of the harmful effects of unhealthy food and drink; and investing in staffing, training, and



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resourcing for Trading Standards.

Consistent communications are vital to engage the media, and there needs to be collaboration with local champions, including political leaders and people directly affected.

While it is crucial to develop awareness and support for change among the public and to advocate on their behalf, this must be done in tandem with creating environments that promote health. For example,

healthy food is around three times as expensive as unhealthy choices. Without change, existing inequalities in health outcomes between rich and poor communities will continue to widen.

Protecting children and teenagers needs to be a particular focus so that they can grow up in healthier environments and live healthier, more productive lives—for themselves, their community, and the wider economy.

If we are to effectively tackle rates of preventable illness caused by the consumption of harmful products, we need far reaching policies that reduce the availability, affordability, and visibility of these goods. While this is already happening at a local level, thanks to a wide range of partnerships between directors of public health and other organisations, it must be adequately resourced and backed by national policy.

The Association of Directors of Public Health is working to support public health teams to share good practice and learn what works when responding to industry tactics. This can help improve outcomes for the whole population and support everyone to live healthier lives for longer.

Alice Wiseman, vice president, Association of Directors of Public Health

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related to health. In this instance the council had rejected the initial planning application over noise and light pollution disturbance, and a councillor and local residents later raised health concerns.

A McDonald's spokesperson tells *The BMJ* it did not recover these awarded costs in either of these cases. They say, "We will always carefully review the Planning Inspectorate's decision and consider the impact this might have on the local authority. In both Coventry and Folkestone, despite having been awarded costs, we determined it would have been the wrong decision to recover costs at that time."

The firm also tried to claim back "unreasonable behaviour" costs from Mansfield Council in January 2021, although the planning inspector decided against it.

In another case McDonald's threatened to claim back unreasonable behaviour costs from Chesterfield Borough Council in June 2020. There the council had turned down the initial planning application for a drive-through branch over health, obesity, road safety, and littering concerns.

But when McDonald's lodged an appeal and a "costs application" for unreasonable behaviour, the council changed its mind. It accepted a second, identical planning application from McDonald's in the same location, and McDonald's subsequently dropped its appeal.

### "Financially fuelled machine"

Experts tell *The BMJ* that a fear of a costly appeal makes councils more likely to accept a McDonald's planning application, despite health concerns.

Wiseman, public health director at Gateshead and Newcastle, says, "It's very undermining in the role of local government in being able to shape a healthy environment. We haven't got the resources that the likes of McDonald's have got to be able to get into any legal battles with this. "It's David and Goliath."

Amelia Lake, a professor in public health nutrition at Teesside University, told *The BMJ*, "Appeals involve an awful lot of human resource as well as work, and local authorities are very anxious about financial consequences. It's a perfect storm for which a well organised, financially fuelled machine can go in and present the evidence that might sway an inspector."

Research published in 2020 and coauthored by Lake found that planning inspectors lacked a clear framework for considering—and failed to engage with—the



### Since 2020 McDonald's has submitted 14 planning appeals

evidence concerning hot food takeaways, obesity, and health.

Thomas Burgoine, principal research associate at the MRC Epidemiology Unit at Cambridge University, says McDonald's and other large multinational food corporations are "more equipped than smaller businesses to object, including at appeal."

He says, "They know the sorts of arguments that work and hire planning consultants and businesses who know the ins and outs of the UK planning system to work on their behalf. Local authorities don't want to set a negative precedent by losing these battles at appeal. There's a nervousness about losing, not least because of the money it can cost to fight these cases."

A Labour MP, Matt Western, told the Commons last April that local authorities had to accept planning applications from large companies "because of a fear of not having the financial resources to contest it."

### 200 new outlets planned

*The BMJ* used the Freedom of Information Act to ask the Planning Inspectorate for details and correspondence of all appeals made by McDonalds, KFC, and Burger King since January 2020. Planning appeals are reviewed by independent inspectors from the inspectorate, who review written evidence from both sides.

It told us there were 14 appeals from McDonalds, one from KFC (which it won), and none from Burger King.

In the KFC case the firm overturned a decision by Stafford Borough Council in November 2021 by arguing that its food was "prepared fresh onsite" in line with "ongoing nutrition strategy which seeks for calorie, salt, fat, and sugar reduction." KFC claimed it was a "presumption" that the food would be "inherently unhealthy" and an "irresistible and unacceptable draw" to

pupils of a nearby secondary school. The council had rejected KFC's bid over concerns that the branch would not contribute to sustainable employment.

A KFC spokesperson reiterated that the original council decision was not related to public health. Stafford Borough Council pointed us to previous comments from local councillors about the health impact.

Last August McDonald's announced plans to open 200 restaurants across the UK and Ireland over the next four years. The move, part of a £1bn growth drive, would increase the number of outlets to 1700 by 2028. The firm's own figures show a steady increase in branches in recent years from around 1300 in 2018 to 1500 in 2024, indicating that many are being approved by councils without the need for McDonald's to appeal.

The McDonald's spokesperson says it is proud of the £94.5bn it has contributed to the economy since opening its first UK restaurant in 1974. They added, "Fifty years on, our estate has grown, our menu has evolved, and with our franchisees we employ around 170 000 people. We have exciting plans to unlock more opportunities across the UK by investing over £1bn over the next four years, creating 24 000 new jobs."

Experts told *The BMJ* there is a deeper problem with McDonald's and the wider food industry's "brainwashing" of families through advertising and influencing key policy decisions.

Wiseman describes how young people in Newcastle had recently been asked to draw what they saw as "nature" and a "good place," and many of them had talked about McDonald's and KFC. "They've influenced our children and young people. It's like they've been brainwashed," she says.

Other research has shown that the food industry uses tactics—the "playbook"—in common with different unhealthy commodity industries, including alcohol and tobacco, to challenge regulations and policy that aim to reduce consumption.

Wiseman says, "We need to reduce the availability, we need to increase the price, and we need to reduce promotions. If we really want people to have free choice about what they consume, then we need to make sure they are not being unduly influenced by the industries around them."

Sophie Borland, freelance journalist, Hertfordshire  
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## CAREERS

# WHY I... paint

GP Katherine Tully talks to **Kathy Oxtoby** about how painting helps her process difficult aspects of her clinical work, remain compassionate, and avoid burnout

**K**atherine Tully's interest in the care of older people is not only part of her practice, but also the subject of many of her paintings. The GP's artworks include a series of portraits of older people.

"Sometimes older people feel like they aren't seen," Tully says. "Conversely, painting their portraits means studying their faces for hours. I've had lovely feedback from the sitters about the experience."

Tully, a GP working with a virtual ward service in Devon, spends time outside of work at her studio creating "large scale, semi-figurative, expressive work in oils."

"My paintings are about bodies falling apart and we doctors trying to hold them together using whatever means possible, even when it's clearly futile. And the absurdity of this at times.

"There is a beauty in the trying, and it comes from a good place, but it's important to be honest with ourselves and our patients about the limits of what medicine can offer," she says.

"Having a means to work through some of the difficult and sad stuff I deal with as a clinician is crucial to me. Painting



### If I weren't a doctor I'm not sure I'd be so driven to paint

benefits me in terms of my resilience and my ability to remain compassionate and avoid burnout."

Tully, who grew up in the west of Ireland, has always been creative. She studied medicine in Galway and qualified as a GP just over a decade ago. "At university I was involved in the art society, and I painted on and off, but didn't pursue it more seriously until I finished my GP training, having realised the importance of maintaining a creative outlet."

After her medical training she completed a two year, part time certificate in painting at the Art Academy in London in 2017. She went on to undertake the Turps Banana painting programme in south east London in 2019, which led her to "really develop my own painting practice."

Last September she moved to Devon and rented a studio. "I wanted to make

painting part of my new weekly routine. I see painting as essential to my wellbeing," she says.

Recently her art has involved depicting the curious ways patients describe their symptoms. "Patients have said things like, 'My head feels like it's in a cloud,' or 'My feet feel like lead.' Or they've described palpitations as 'people dancing on my chest.' I try to figure out a way to paint these descriptions, but not in a purely illustrative way."

For Tully, painting is also a way of problem solving; there's a lot of decision making involved. "This helps with my ability to problem solve in other aspects of my life," she says.

It's also lots of fun. "For me, the 'looser' and more intuitive the painting, the better. It's about painting from the heart, painting freely without self-consciousness," she says.

Having taken part in group exhibitions and a solo show in 2023 in London, in the future she would like to create a body of work for another solo exhibition. "People often ask me if I'd like to be an artist full time, and I tell them no, I love my clinical work. If I weren't a doctor I'm not sure I'd be so driven to paint."

To other doctors she says, "If you were ever in any way creatively inclined and you have not had the opportunity to pursue your creativity, it's never too late."

For Tully, "painting is a gift that I get so much out of. And for me, it's an obvious and enjoyable way to process and deal with life and its challenges."

Kathy Oxtoby, London

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### HOW TO MAKE A CHANGE

- Find an evening class—for example, "Introduction to oils." A weekend masterclass is also a good way to get started
- If you don't know what to paint, paint anything. Paint from life—a chair, a flower—or copy a painting that you like, or just paint some shapes. It's in doing that you'll discover what you're interested in—still life, portraiture, landscapes, abstraction, or intuitive mark making
- Get a set of acrylics (cheaper, quick drying, water soluble) or oils (more expensive, slow drying), and a set of student quality paintbrushes. Canvas boards are good as a surface on which to paint
- Visit art shops to look at the range of materials and see what they have on offer
- Make art with children and learn from them. They are the best artists because they are naturally free, expressive, and creative

# How should I deal with a rude colleague?

Confronting poor behaviour from someone you work with can seem difficult but there are ways to respond, **Abi Rimmer** hears



**Be compassionate with yourself**  
**Rakesh Patel, professor of medical education, Queen Mary University of London**

“While you may not have control over how a person treats you, you do have control over when and how you respond to rudeness. This may sound virtuous but the reality in NHS contexts is that a complaint is never far away—so mitigate against it where you can. That’s best done by focusing on what you can do to de-escalate situations, and change things that are in your control.

“Start with yourself. It’s normal to have an emotional reaction after experiencing rudeness. You might feel hurt, offended, angry, upset, or a mix of these. All these feelings are valid.

“Accept your response. A common response to emotional pain—especially at work—is to ignore or accept it, including being self-critical. Evidence shows that the brain interprets the impact of being devalued, ignored, shamed, yelled at, rejected, or bullied in ways similar to the experience of physical pain.

“Explore the rudeness dispassionately and with curiosity. It may have been unintentional, so reflect on whether it’s possible to interpret the person’s actions in a way that leaves you feeling less insulted. It may be that the other person misinterpreted your actions or the situation, so attempting to see the world through their eyes and asking if they could be ‘a little bit right’ may also help.

“If your values include fairness or kindness, use this opportunity to reflect on the other person’s values as well. Understanding how you feel through these values will also help you decide whether to respond, and what to say if you do.”



**How you respond is a choice**  
**Anna Baverstock, paediatrician, Somerset NHS Foundation Trust**

“If I witness rudeness between colleagues I will choose how I respond using the active bystander ‘4 Ds’ model. The first consideration is if it safe to intervene and if now is the best time.

“If direct action (the first D) is needed then can you ask the receiver if they are okay and ask the person to stop? Can you intervene with a comment like ‘Wow, did you mean to say that?’ or ‘I’m not sure if you realise but you’re shouting and it’s making us uncomfortable.’

“Distraction (the second D) may be more appropriate. Can you interrupt the behaviour with a comment such as ‘Please can we concentrate on the patient,’ or ‘I recognise we’re stressed but can we please focus on the task in hand.’ You could also interrupt the rude colleague by asking them a question, telling the receiver they need to take a call, or saying, ‘Sorry to interrupt but can I have a word?’

“You could delay (the third D) your response. Check that the receiver is okay, discuss what they would like to happen next, and reassure them that you are happy to speak to the colleague who has been rude. Ask to speak to that colleague and say you would like to share some observations about a recent conversation.

“Finally, if you or the person on the receiving end don’t feel able to speak up there are options. Can you delegate (the fourth D) to a more senior colleague? If you’re not sure who to speak to, call your local freedom to speak up guardian—all NHS trusts have one. It is possible to call out rude behaviour in a kind way.”



**Retain your composure**  
**Clare McNaught, vice president, Royal College of Surgeons of Edinburgh**

“The Civility Saves Lives campaign highlighted the negative effects that rude or unprofessional behaviour can have on our ability to perform our clinical duties, which in turn impacts the standard of care we give to patients.

“When a colleague is rude, it is important that you assess the situation and determine how best to proceed. Discourteous behaviour should never be ignored and should be addressed directly using calm, non-threatening words—for example, ‘I notice you’re stressed. Is there anything I can do to help?’

“If you’re worried that a public declaration may escalate the situation, then it may be suitable to use distraction techniques to interrupt the conversation and divert the person to a different topic or the clinical task at hand. Later you can approach the colleague who was inappropriate in a more private setting.

“If you are subjected to this type of behaviour as a trainee from a more senior doctor, you may feel unable to challenge them directly. In this situation, you should seek support from your clinical supervisor who may be able to intervene on your behalf.

“No matter what response you get from the offensive coworker, it’s important that you retain your composure and not be drawn into further confrontation. Keeping a record of the details of the interaction may help if this behaviour becomes repetitive as the matter may need to be escalated further.”

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