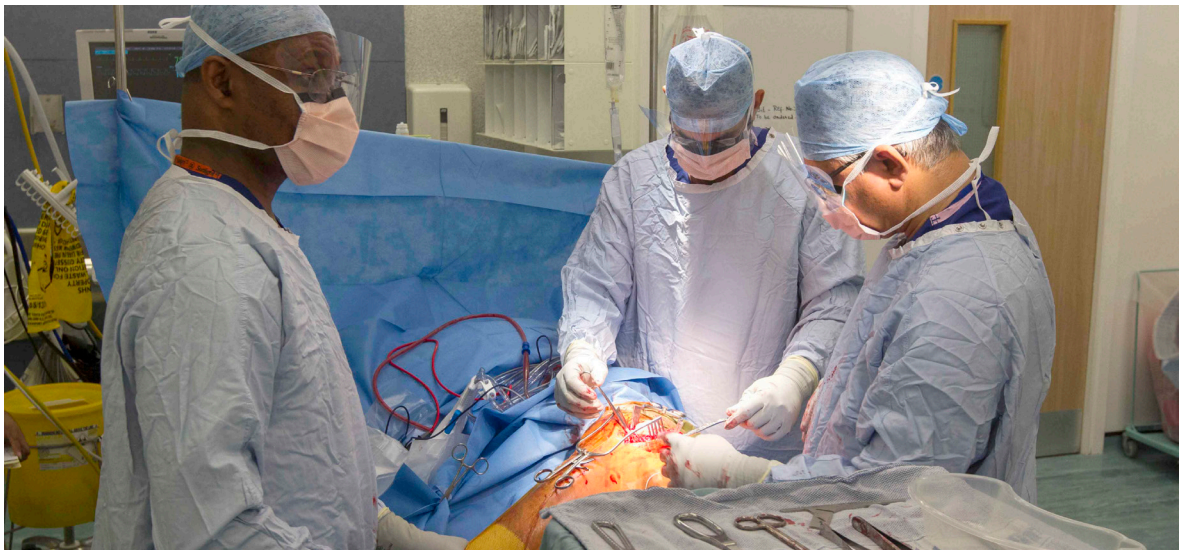


MARK THOMAS

Doubt cast on plan to cut waiting lists

The government has announced measures to cut waiting times for NHS elective treatment in England, including expanding community diagnostic centres, creating 14 new surgical hubs, and increasing the use of remote monitoring technology.

The aim is for 92% of people waiting for non-urgent elective treatment to be seen within 18 weeks of referral by the end of this parliament (March 2029). In the shorter term, it should mean 65% of patients are treated within 18 weeks by the end of 2026—equivalent to around 450 000 people, based on the current waiting list.

However, healthcare leaders have expressed doubt about whether these goals can be met. They warned the government against focusing on just one target and neglecting the need to support and grow the NHS workforce. Currently in England 7.5 million people are waiting for elective care, of whom nearly 235 000 have been waiting more than a year.

Community diagnostic centres were launched in England in 2021, with 165 sites up and running by August 2024, in places such as shopping centres, university campuses, and football stadiums, offering services including screening, blood tests, imaging, endoscopies, and health checks.

The government has now said these centres will be open for longer (12 hours a day, seven days a week) and will offer a wider range of tests.

Health and social care secretary Wes Streeting said, "The NHS should work around patients' lives, not the other way around. By opening community diagnostic centres on high streets 12 hours a day, seven days a week, patients will now be able to arrange their tests and scans for when they go to do their weekend shopping, rather than being forced to take time out of work."

Alongside these centres, 14 new surgical hubs will be opened by June, and three will be expanded. Surgical hubs are set up in hospitals and focus on performing a high volume of low complexity operations, such as cataract surgery and hip replacements. The government estimated that the new centres and hubs will together provide up to 500 000 extra appointments a year.

The government also announced it was enabling patients to choose where they book appointments through the NHS

(Continued on page 4)

The government is aiming for 92% of people waiting for non-urgent elective treatment to be seen within 18 weeks of referral by March 2029

LATEST ONLINE

- Bird flu: US reports first human death in person infected with H5N1
- Union for physician associates backs legal action for job losses after roles were restricted
- Alcoholic drinks should carry cancer warnings, says US surgeon general

MEDICAL NEWS

New GP contract for England will include extra £889m, government says

The government has released preliminary details of what it wants to include in the new contract for GPs in England, including an extra £889m to the existing budget.

Discussions on the new GP 2025-26 contract will also focus on reducing the number of targets in the Quality and Outcomes Framework (QoF) from 76 to 44 to cut bureaucracy, the Department of Health and Social Care said. The BMA's General Practitioners Committee for England would be consulted on the details of the proposals before the new contract is unveiled in spring 2025, it said.

Health and social care secretary Wes Streeting said, "General practice is buckling under the burden of bureaucracy, with GPs filling out forms instead of treating patients. It is clear the system is broken, which is why we are slashing red tape, binning outdated performance targets, and freeing doctors up to do their jobs."

Because negotiations are ongoing the government has not yet provided full details of the new contract. But it promised it would include financial incentives to reward GPs who go "above and beyond" to prevent common conditions such as heart disease. Doctors will benefit if they ensure that as many patients as possible with high blood pressure are identified and treated as soon as possible before they end up in hospital, it said.

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2024;387:q2865**

Wales

Big majority of GPs vote against proposed contract

GPs in Wales rejected the general medical services (GMS) contract for 2024-25 proposed by the Welsh government, with 98.7% of doctors (1079) voting against. The offer included a 6% pay uplift to GPs' pay, £1.8m for other practice expenses, and an additional £4m investment next year. The BMA's General Practitioners Committee (GPC) Wales had asked for £10.8m to be put into contractor GP pay, £8.9m to allow practices to cover "unavoidable" practice costs, and an overall investment of £27.2m for staff pay. GPC Wales said if the offer was not improved it would prepare for collective action.

Research

UK units face closure under new funding model

More than 500 scientists and academics wrote to the science minister, Patrick Vallance (right), urging him to reconsider a new funding model that will award large, "challenge led" grants to tackle specific research questions at newly created "centres of research excellence" (CoREs) over a time limited 14 year period. The UK Medical Research Council's new funding plans could threaten the viability of the existing 19 MRC units located at UK universities that have "long and distinguished histories" in medical research, they warned.

NIH funded research must be published without delay

Research funded by the US National Institutes of Health will have to be made publicly available without a period of delay, under the agency's new public access policy, which is set to take effect from 31 December 2025. The policy, which is open to consultation until 21 February 2025, has been designed to accelerate access to publicly funded research results as part of the institute's commitment to transparency and accessibility. Currently, the agency allows researchers to wait 12 months before making any manuscripts resulting from NIH funding publicly available.

Patient safety

Martha's rule prompts treatment changes

Almost one in eight phone calls made to NHS hospitals under the Martha's rule programme, which allows patients and families to seek an urgent care review, have led to changes in a patient's treatment, said NHS England. Data from 136 hospitals show that in September and

October a total of 573 calls were made to escalate concerns about a patient's condition, around half (286) of which required a clinical review. Some 57 reviews led to a change in care such as patients receiving antibiotics, oxygen, or other treatment, and a further 14 patients were transferred to intensive care.

Public health

Healthy life expectancy still lower than in 2017

Figures from the Office for National Statistics show that in 2021-23 men born in England could expect to spend 61.5 years of their lives in good health while among men in Wales it was 60.3 years, down by 1.7 years (England) and 1.1 years (Wales) from 2017-18. In women the figures were 61.9 years in England (down by 1.9 years) and 59.6 years in Wales (down by 2.2 years). Veena Raleigh of the health think tank the King's Fund said that improving the outlook would require cross government action and investment to "tackle the socioeconomic factors driving health inequalities."

Affordable healthy homes are priority, says Marmot

"If we build poor quality homes now, we are storing up problems for health in the future," warned the health inequalities expert Michael Marmot in a report that calls for health and wellbeing to be placed centre stage in the government's housing strategy. The Labour government has pledged to build 1.5 million new homes in England by 2029. But the report from University College London's Institute of Health Equity said that poor quality housing cost the NHS £1.4bn a year, with a broader societal cost of £18.5bn a year, and that cold and damp homes contributed to poor mental health, spread of infections, chronic respiratory conditions, and an increased risk of death.

IN BRIEF

Cancer

Early cancer diagnoses hit record high in England

Nearly three in five patients with the 13 most common cancers, including breast, prostate, and lung, had the condition diagnosed at stage I or II from September 2023 to August 2024, showed cancer registration data in England. Over that period 120 958 of the 206 038 common cancers (58.7%) were diagnosed at an early stage—up 2.7 percentage points from pre-pandemic levels. This was the highest proportion yet recorded, said NHS England, equating to around 7000 patients.

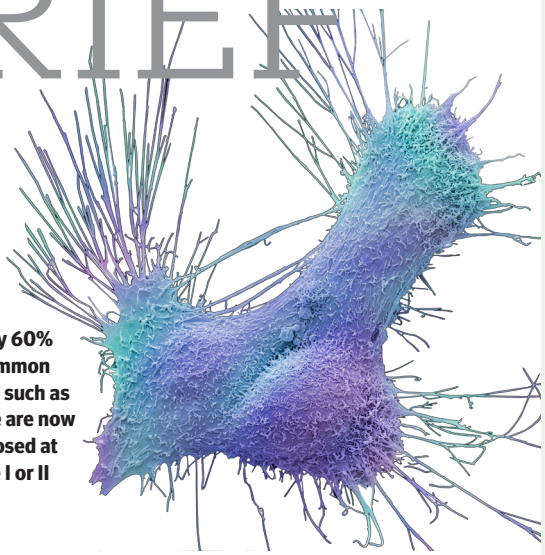
Government will publish national cancer plan

Wes Streeting, the health secretary, has said the government "will be publishing a national cancer plan" and is "working on how it is aligned with the conclusions of the 10 year health plan." Streeting was responding to the Health and Social Care Committee, which wrote to his predecessor last May calling for a long term strategy, saying the current system was preoccupied with "firefighting" rather than looking to the future.

Illness in DR Congo

Malaria may be complicating infections

The mystery illness reported in the Democratic Republic of the Congo may be a combination of common and seasonal viral respiratory infections and malaria, said the World Health Organization. From 24 October to 16 December 891 cases and 48 deaths from the Panzi zone in Kwango province were reported, with children under 5 making up 47% of all cases and 54% of deaths. WHO highlighted laboratory results from 430 samples, which indicated positive results for malaria, influenza A, rhinoviruses, covid, human coronaviruses, parainfluenza viruses, and human adenovirus.



Nearly 60% of common cancers such as prostate are now diagnosed at stage I or II

RSV

FDA pauses all vaccine trials for under 2s

The US Food and Drug Administration put on hold all respiratory syncytial virus (RSV) vaccine trials involving infants aged under 2 years or RSV naive children aged 2-5 years, after it identified more cases of severe lower respiratory tract illness in the vaccine groups than in the control group. A trial by the drug company Moderna had been assessing two RSV vaccines. Moderna decided last September not to continue its RSV vaccine programmes for infants under 2 years old.

End-of-life care

Hospices will get £126m over next two years

Adult and children's hospices in England are set to receive an extra £100m in 2025-26 to improve their buildings, equipment, and accommodation and to improve IT systems to enable GPs and hospitals to share patient data, the government announced at the end of December. Hospices for young people will also receive an extra £26m in funding for 2025-26.

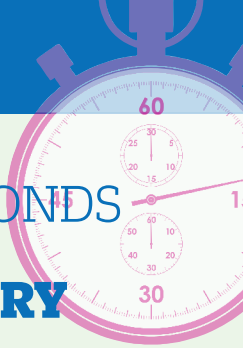
Cite this as: *BMJ* 2025;388:r8

CRUISES

There were **16** outbreaks of gastrointestinal disease on cruise ships that used a US port in 2024, the highest in over a decade. In 2023 **14** outbreaks were reported

[CDC]

SIXTY SECONDS ON . . . VEGANUARY



MAKING A MEAL OF RESOLUTIONS?
Absolutely. As the name suggests, Veganuary encourages people to go vegan at the start of every year.

TURNING OVER A NEW LEAF?
Exactly! And eating more leaves too. The benefits of a plant based diet are well documented. It's good for the planet: plant based foods produce fewer greenhouse gas emissions than animal based foods. And it's good for human health, reducing the risk of chronic disease, including cardiovascular conditions. Abstinence, you might say, makes the heart grow stronger.

I DON'T LIKE FADS
A vegan diet isn't a fad. Nor is Veganuary a flash in the pan, as this is its 10th year. New research shows more of us are choosing to eat shoots and leaves: in a survey of 10 000 people, 3% of people in the UK identified as vegan or had a plant based diet, while 10% said that they were reducing or eliminating animal products from their meals. Veganism is now baked into our culture.

OK, VEGGIE BURGERS HERE I COME
Steady on. Another study, published in the *Proceedings of the National Academy of Sciences*, ranked 24 meat and milk alternatives in terms of nutrition, health, environmental, and cost perspectives. It found that beans and peas outperformed processed products such as fake sausages and plant milks. Laboratory grown meat fared the worst.

THE ODD VEGAN SAUSAGE SARNIE?
Not so fast. Marco Springmann of the Environmental Change Institute at Oxford University, who led that study, said, "Processed plant based foods such as veggie burgers and plant milks resulted in substantial benefits when replacing meat and dairy, but the emissions reductions and health improvements were a fifth to a third less than when choosing unprocessed legumes."

SO, WHAT HAPPENS IN FEBRUARY?
With a successful Veganuary behind you, you could pat yourself on the back and return to your bacon butties. Although you might not have a choice: researchers at Exeter University have found that if you've taken part in Veganuary you're more likely to find meat disgusting. Tofu? Bring it on.

Dominic Murphy, Bath

Cite this as: *BMJ* 2024;387:q2889

(Continued from page 1)

app and it would fund GPs to get specialist advice from hospital doctors before they make referrals.

NHS trusts that make the fastest improvements in waiting times will also receive rewards, such as extra funding for capital projects.

Tim Gardner, the Health Foundation's assistant director of policy, described the targets as "stretching," given that the goal of 92% of patients receiving hospital treatment within 18 weeks had not been met for nearly a decade. "It would effectively mean the waiting list would need to fall by over three million over the next four years," said Gardner.

"Meeting the pledge would require improvements of a comparable scale to those achieved by the last Labour government in the 2000s but in more difficult circumstances and with far lower levels of funding increases."

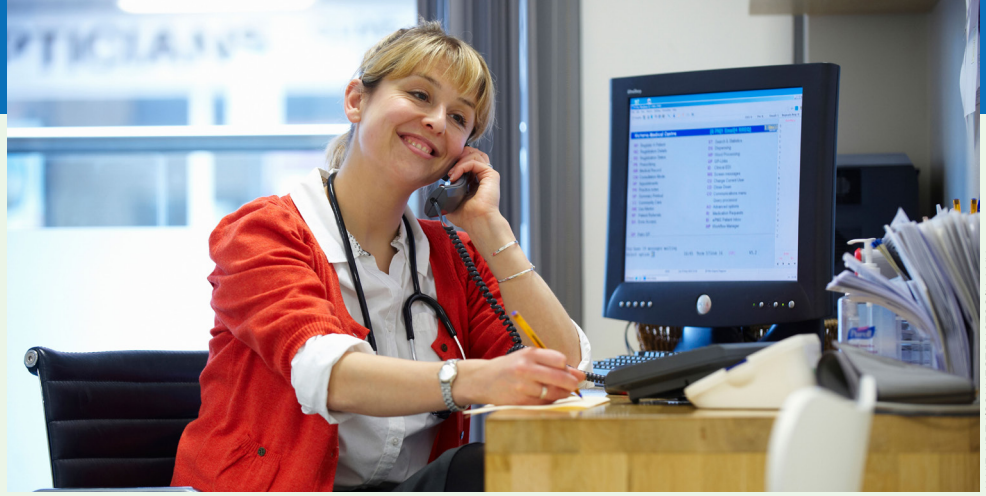
Sarah Woolnough, chief executive of the King's Fund, said the 18 week target "should not be taken as the sole measure of how the NHS is faring," because waits for GP appointments, ambulances, mental healthcare, and other services were "equally important."

BMA chair of council Philip Banfield also raised concern over the focus on the 18 week target. "The government's plan for improvements in elective care to be driven by arbitrary targets and upgrades to an app misses the crucial point: we need to treat the patients most in need first, rather than return to the wasteful obsession with artificial, non-clinically relevant targets," he said.

The 18 week target should not be taken as the sole measure of how the NHS is faring Sarah Woolnough

Banfield warned that "only when the government has laid out its concrete steps to fully support the NHS workforce can we be confident that they have a plan which can achieve this target."

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2025;388:r19



JANIE AIREY/CONNECT PHOTOS/ALAMY

GPs to get £20 for asking hospital doctors for advice on referral

GPs are to be paid a £20 fee for each call they make to a hospital specialist when they are considering referring patients for further treatment, as part of a new drive to cut England's elective care waiting lists.

Under an "expansion" of the existing advice and guidance (A&G) scheme, GPs will be encouraged to discuss with a hospital specialist the most appropriate place for a patient to be treated—in a hospital or a primary or community care setting—which might avoid the need for a patient to join an elective care waiting list.

The A&G scheme, established as a formal pathway in 2015, allows communication

Future of medical apprenticeships in doubt as pilot schemes are put on hold

Pilot medical apprenticeship programmes in England, which were being trialled as a new route into the profession, have been paused by the government.

Peninsula Medical School in Plymouth has been told not to recruit for the course—due to start in September 2025—pending a review of the scheme, that was intended to widen access to medical careers. The arm's length agency Skills England told Peninsula course leaders it would review and "discuss areas where funding for level 7 apprenticeships will be restricted, and a decision will follow in due course."

Laura Bowater, head of the school, described the move as "disappointing." She told *The BMJ* the change was part of ministers' cooling attitude towards level 7 apprenticeships.

Anglia Ruskin University has 25 medical apprentices on its course, which started last September. The University of Central Lancashire was also developing a pilot programme, while Queen Mary University of London said in October it had postponed its apprenticeship plans.

Sanjiv Ahluwalia, head of the school of medicine at Anglia Ruskin, said course leaders were discussing "future cohorts" with the government.

Workforce plan

Plans for the apprenticeships were formalised in July 2022, and in January 2023 Health Education England, the body then responsible for NHS training, confirmed pilot schemes would begin this academic year with funding for the first 200 apprentices, who receive a wage from the employing trust and do not pay university fees.

The NHS Long Term Workforce Plan set an ambition to have 2000 people a year training to become a doctor through an apprenticeship route by 2031-32. The Department of Health and Social Care said more details on the future of medical apprenticeships were expected early in 2025 and that the shift was part of a plan to focus apprenticeships more on young people and those at the beginning of their career.

Latifa Patel, chair of the BMA's representative body, said, "Medical apprenticeships are something the BMA has expressed significant concerns about on behalf of our members, and we welcome plans to halt these. We will continue to fight for improved medical student funding and widening participation initiatives."

Erin Dean, Dorset
Cite this as: *BMJ* 2024;387:q2887

The move is disappointing. It's part of a cooling towards level 7 apprenticeships Laura Bowater

between GPs and hospital consultants before or instead of a referral. But doctors' leaders have previously raised concerns because of unclear clinical responsibility for the patient, a possible shifting of workload to GPs, and risk averse decision making.

The government said it wanted to optimise referrals through the A&G scheme so GPs would receive £20 per A&G request, to recognise their role in ensuring that patient care took place in the best setting. It said it expected increasing uptake, with more patients benefiting when their GP accessed rapid specialist advice that could lead to care being provided in primary and community care settings rather than the patient joining a waiting list.

This expansion would deliver up to four million advice requests from GPs in 2025-26, it predicted, a rise from 2.4 million in 2023-24. This could lead to a rise in diversions from elective care from 1.2 million in 2023-24 to two million in 2025-26, meaning 800 000 more patients being treated in the community each year rather than in hospitals.

To allow for this, the government is allocating £80m to primary care, taken from existing secondary care budgets.

The Royal College of General Practitioners welcomed the government's plan to fund better referrals for patients but warned that GPs had not always had positive experiences of using the A&G scheme so far. RCGP chair Kamila Hawthorne said, "In the past GPs have reported issues with using A&G services, including that they shift care into general practice without appropriate resource. We are pleased to see that general practice will be funded to help improve the referral experience for patients, by increasing use of A&G services."

We are pleased to see general practice will be funded to help improve the referral experience for patients Kamila Hawthorne

BMA chair of council Philip Banfield was similarly sceptical. "Setting out a plan with bold steps to overhaul the way in which patients receive their treatment is a welcome sign that ministers are serious about giving this country the healthcare service it needs," he said. "But the reality is that, without the workforce to meet constantly rising demand, we will not see the progress we all hope for."

TO DIVERT patients to the community, the government is allocating **£80m** to primary care, taken from existing secondary care budgets

Adrian O'Dowd, London

Cite this as: *BMJ* 2025;388:r22

Commission on social care reform to report in 2028

The government has announced the launch of an independent commission into adult social care in England, which will inform the creation of its proposed National Care Service.

The commission, led by the cross bench peer Louise Casey, will be split into two phases and will make "clear recommendations for how to rebuild the adult social care system to meet the current and future needs of the population."

The first phase, expected to report in mid-2026, will identify the main problems with the current care system and set out recommendations for "effective reform and improvement in the medium term." These recommendations will be aligned with the government's spring spending review. The second phase, set to report in 2028, will then make longer term recommendations for the transformation of adult social care.

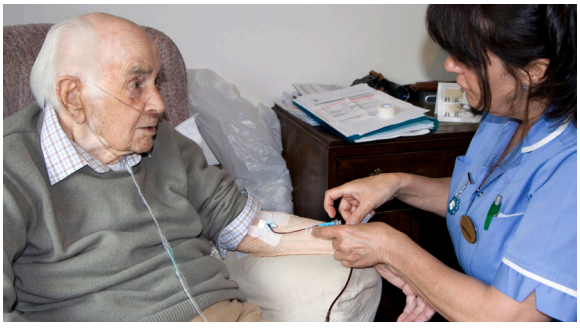
Health and social care secretary Wes Streeting said, "I have written to opposition parties to invite them to take part in the commission's work and asked Louise Casey to build a cross party consensus, to ensure the national care service survives governments of different shades, just as our NHS has for the past 76 years."

Commenting on the announcement, Sarah Woolnough, chief executive of the King's Fund, said that the plans "offer a real opportunity to break the cycle of failure to reform social care." However, she also urged the government to "accelerate the timing of the second phase" because the timetable to report by 2028 was "far too long to wait for people who need social care and their families."

Political will

Hugh Alderwick, director of policy at the Health Foundation, said the options for reforming social care were well known. "What's needed now is political will and long term investment to finally implement reform and improve the lives of millions of people and their carers. The new commission must be an opportunity to deliver reform, not delay it."

The government also announced more immediate measures to "ease pressure on the sector and improve support for care workers." These include an £86m boost to the disabled facilities grant for this financial year, bringing the total budget to £711m, and plans to develop a shared digital platform so that medical information can be shared between the NHS and care staff.



LIFE IN VIEW/SPL

The new commission must be an opportunity to deliver reform, not delay it Hugh Alderwick

Natasha Curry, the Nuffield Trust's deputy director of policy, said she was "concerned that this is still insufficient given the immense financial pressure that the sector is under."

Separately, the government said it would publish a policy framework for the Better Care Fund in 2025-26, which will focus £9bn of NHS and local government funding on moving care from hospital to the community and from sickness to prevention. Improvements will be expected on emergency admissions, delayed discharges, and admissions to long term residential care.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2025;388:r4

RCP guidance limits PA role to "basic tasks"

Physician associates must "never function as a senior decision maker," and resident doctors should never supervise them, says interim guidance from the Royal College of Physicians of London. The guidance adds that PAs should not prescribe medications, must "clearly explain" their role to patients, families, and carers, and should carry out only "basic clinical and administrative tasks" under the supervision of a senior doctor. The PA role "must not compromise the training experience of doctors" and should "not replace doctors in any role, including the on-call rota," said the interim guidance, published as a placeholder until Gillian Leng's independent review of associate roles, which is due to report in spring 2025.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2024;387:q2842

Gaza: WHO urges Israel to stop blocking medical evacuations

It will take five to 10 years to evacuate all the critically ill people from Gaza waiting for urgent treatment if the "excruciatingly slow" pace of approvals continues, WHO has warned. More than 12 000 people, including thousands of children, need urgent treatment, with many at risk of dying while waiting to be evacuated. WHO has urged Israel to "increase the approval rate for medical evacuations, including no denials of child patients; expedite the process of approvals; and allow all possible corridors and border crossings to be used." Since October 2023 just 5383 patients have been evacuated with WHO's support, and just 436 have been evacuated since the Rafah crossing was closed in May.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2024;387:r13

NEWS ANALYSIS

FLU AND COVID: **Could NHS do more to ensure doctors get vaccinated this winter?**

With respiratory illness vaccination rates continuing to fall among staff, **Emma Wilkinson** asks why and reports on efforts to tackle it

A flu outbreak can be absolutely devastating for bed capacity
Adrian Boyle

Flu hit early this year, and NHS hospitals are being inundated with respiratory illnesses. Beds are full, and surveillance across primary and secondary care suggests that the rate is increasing steeply.

Yet when winter respiratory viruses are circulating it is not just the patients who are affected. Data for the week to 15 December showed that 54 165 staff were off sick, around 4476 more than in the same week in 2023. The numbers exemplify why the NHS made an operational decision to offer influenza and covid vaccines to frontline workers (those involved in direct care).

But there has been a noticeable decline in vaccine uptake among staff in recent years. In England in 2023-24 less than half (42.8%) of staff in NHS trusts involved in direct care of patients had had a flu vaccine—a seven percentage point drop from the previous year. This was the third year in a row that the proportion had fallen and was the lowest uptake since 2010.

The latest figures for up to the end of November show that only 24.3% of frontline healthcare workers have been vaccinated against flu. Uptake is down across acute care, ambulance, mental healthcare, and community trusts and in general practice.

Although vaccine uptake in nurses is usually a little lower than in doctors (43% versus 48% in 2023), uptake was poor in both groups in 2024 (31% of nurses and just under 35% of doctors)

Pressure in emergency departments

The figures have not gone unnoticed, and last month NHS England issued pleas to healthcare staff to get vaccinated.

Adrian Boyle, president of the Royal College of Emergency Medicine, said it was something that NHS trusts needed to tackle. He said that NHS staff absences in England rose 10% in the week up to 8 December. "Given that we have very tight bed numbers and continue to have lots of open bays, a flu outbreak can be absolutely devastating for bed capacity," he said.

Emergency departments were already seeing very long waits and care occurring in corridors. "I'm fairly certain we're giving people flu in our emergency departments and on our wards," said Boyle. "People are losing confidence in going to emergency departments, and that's a real worry."

He said there was a strong moral imperative for healthcare workers to be vaccinated, not least to protect patients. But in his view the main barrier was incredibly busy and pressured staff pushing getting vaccinated down their to-do list.

Boyle said a registrar in the emergency department where he works did a quality improvement project whereby staff were vaccinated as they were leaving a night shift at 7.30 am. "It worked a treat," he said. "There are lots of staff who work nights or weekends. It is about ease of access, and

hospitals need to be bringing the vaccine to people."

Wide variation in vaccine uptake among trusts, which last year ranged from 7% to 82%, indicates room for improvement. While also seeing a downward trend in uptake, general practice tends to do better—last year achieving 61% uptake—which may be because it is easier to organise smaller groups of staff to be vaccinated. Also, added Boyle, "culturally they are focused on preventive care."

Proactive efforts

Back in 2017, before the covid-19 pandemic, Nick Hopkinson, professor of respiratory medicine at the National Heart and Lung Institute, was one of the authors of a study that reported that a 10% increase in vaccination uptake was associated with a 10% fall in staff sickness absence.

Other research has shown that trusts that do well in vaccinating staff use a range of strategies, including setting higher targets than the year before, involving a broad range of staff groups in the campaign, and making access easy—such as by enabling vaccination in individual departments rather than just putting on one clinic per hospital and at different times. Better performing trusts also use a greater range of communication strategies, providing real time feedback on uptake. Having vaccination considered important by managers was also key.

Hopkinson said, "You need a mixture of planned clinics, open access, as well as doing it opportunistically [to increase uptake]." If staff see long queues at clinics it will put them off. He added that where staff had chosen not to be vaccinated—which is their right—trusts should ask them why and allow staff to ask questions, if needed. "This is something trusts need to invest money in," he said.

Although covid vaccination figures have not yet been published for 2024-25, rates fell from 42% in 2022-23 to 30% in 2023-24. Boyle said that, although just a theory, making vaccination mandatory for care home staff, often a first job for nurses from overseas before they move to the NHS, may have had an effect if staff resented it.

One advanced clinical practitioner working in primary care in Yorkshire told *The BMJ* that she couldn't have the covid vaccine at first because she'd recently had covid, and then there was no stock left. She eventually went to her own GP for the flu jab because she had been too busy to have it while at work.

Vaccine fatigue?

David Strain, professor in cardiometabolic health at the University of Exeter Medical School, said that his NHS trust had also seen a decline in vaccine uptake. "We think this is in part due to vaccine fatigue and in part due to people not seeing the impact of being unvaccinated," he said. His trust had just extended the staff vaccine schedule by a month, he said, "because hospitalisation for both covid and influenza have shot up in the last couple of weeks, and a new group of staff are suddenly coming forward."

Susan Michie, professor of health psychology at University College London, said that the reasons for non-vaccination were various. "It is about ensuring healthcare staff have the knowledge about vaccine effectiveness and side effects, which are the things people worry about. It is also about motivation, explaining that they're not just doing it for themselves. But vaccination should also be in work time and really encouraged."

Michie said that her trust published ward-by-ward trackers of vaccine uptake, which can be very motivating for staff. "Senior leaders should also make it very clear that they have been vaccinated and why," she said. Alongside this, "staff need to be reassured that, if they have symptoms after vaccination, they can take time off, because these are the concerns that stop people."

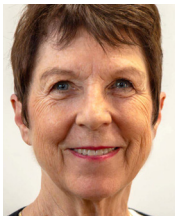
She added, "If all these things were in place I think we'd see the rates going up a huge amount."

An NHS England spokesperson said, "While hundreds of thousands of frontline staff have already protected themselves by getting vaccinated, uptake among staff is still too low, and with an earlier than usual flu season it is vital anyone yet to get vaccinated does so without delay.

"[In December] we wrote to NHS leaders outlining measures they can take to keep encouraging colleagues to come forward, including raising awareness in staff networks and team meetings, offering drop-in sessions to discuss questions with clinicians, and making it as easy as possible with out-of-hours vaccinations and pop-up clinics."

Emma Wilkinson, Sheffield

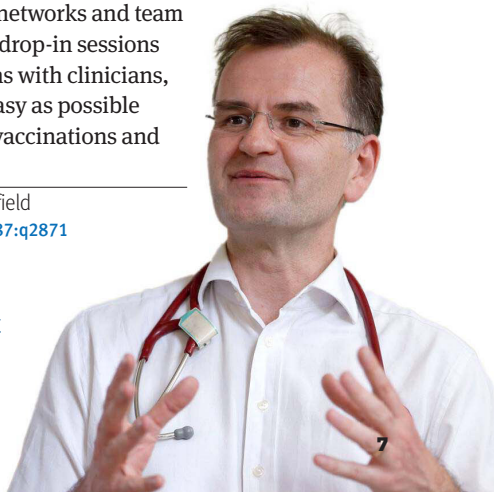
Cite this as: *BMJ* 2024;387:q2871



Senior leaders should also make it very clear that they have been vaccinated and why
Susan Michie

A new group of staff are suddenly coming forward for vaccination
David Strain

You need a mixture of planned clinics, open access, and opportunistic vaccination
Nick Hopkinson



COVID vaccination figures have not yet been published for 2024-25, but rates fell from 42% in 2022-23 to 30% in 2023-24

Anger at Danone's use of midwives in Tesco store to give branded infant feeding advice

EXCLUSIVE Campaigners for impartial nutritional advice are dismayed at a service that seems to be adopting marketing tactics dubbed scandalous 50 years ago. **Rebecca Coombes** reports

The supermarket giant Tesco is being urged to drop an "unethical" pilot of an in-store infant feeding advice service in which midwives funded by the formula milk firm Danone are expected to wear branded uniforms and undergo training by the company.

Critics said the initiative, running in a Tesco flagship store and set to be rolled out shortly, was a backward step and reminiscent of the "milk nurses" scandal of the 1970s, in which formula industry salespeople dressed as nurses to promote formula milk to parents.

One midwife hired by Danone last month quit the pilot at the Tesco Extra store in Cheshunt, Hertfordshire, telling *The BMJ* that she couldn't be associated with an "unethical" service.

A spokesperson for Danone UK and Ireland said that it intended only to provide "impartial, nutritional expertise," that the branded uniforms were optional, and that it was happy to "take on board feedback."

Tesco said it intended to continue the pilot in two further stores in the first months of this year, "providing the same support from healthcare professionals."

Tesco's venture came as the UK Competition and Markets Authority prepared to deliver findings of its investigation into the formula milk industry. Its interim report highlighted a "lack of timely, clear and impartial information for parents and carers about formula" and said that parents seemed to be paying "over the odds."

Prices of baby formula milk in the UK rose by between 18% and 36%, depending on the brand, in the two years after December 2021.

It's unethical. It was the line I couldn't cross—women trust me because I am a midwife
Midwife hired by Danone

The branded uniform that Danone expected midwives to wear in the Tesco store

Alarm bells

The midwife who left the Tesco role after several shifts, and who asked to remain anonymous, said that the role was well paid at £40 an hour, twice what she earned in her community role. Alarm bells started to ring when she discovered Danone's involvement through its Aptaclub baby club. Aptaclub has the same colour palette, font, and imagery as Danone's Aptamil products.

The midwife told *The BMJ*, "Because of the history, I just don't want to be associated with formula companies breaking the International Code of Marketing of Breast-Milk Substitutes. It's unethical. That was the line I couldn't cross—women trust me because I am a midwife."

The code, adopted by the World Health Organization and Unicef in 1981 and as law in more than 100 countries, states that "marketing personnel" should avoid direct or indirect contact with "pregnant women or with mothers of infants and young children." UK law covers some but not all the code's provisions.

The midwife who was involved in the pilot told *The BMJ* that the midwives were expected to wear branded uniforms. "The uniforms had a massive Aptaclub logo. We said, 'We can't wear this.' The response was, 'Why can't you?'"

The midwives decided to wear their own clothes and bought blue, unbranded "midwife" lanyards.

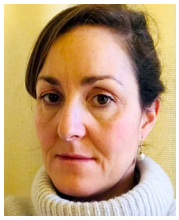
Danone said it adhered in the UK to those aspects of the code that were included in domestic law: "We adhere fully to the WHO code as implemented in UK regulations, and this trial is not in breach of that. We provided uniforms and badges as part of the service; however, midwives had the choice to wear their own professional clothing if they preferred.

"We take all feedback on board as part of the pilot and will explore any areas that need adapting."

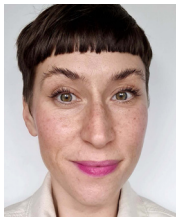
Danone defended the pilot because it gave parents "easy and convenient access to high quality information about nutrition."

A Tesco spokesperson added

PRICES of baby formula milk in the UK rose by between 18% and 36% in the two years since December 2021



Danone is using its baby club name to promote its service and so indirectly promoting its products
Vicky Sibson



How can this be happening in plain sight?
Olivia Hinge

Tesco should remove Danone from the picture and allow midwives to use NHS information
Robert Boyle

that the pilot was intended to offer customers "additional support." They said, "This complements the professional advice available from our pharmacists in store and adheres fully to the WHO code on breastfeeding as implemented in UK regulations. We comply with the UK regulations governing infant and follow-on formula that cover some parts of the WHO code."

Advice sessions

The Tesco Extra store's new health consultation rooms host the free infant feeding advice sessions alongside paid-for services, such as a £45 consultation with a clinician on managing menopause symptoms. By booking a session with "Aptaclub from Danone" parents can talk to a healthcare professional in private for 30 minutes. The online booking form links to an Aptaclub branded page, and Aptaclub leaflets are available in the waiting room.

A job advertisement posted in October sought a registered nurse or midwife to deliver consultations to families on key topics such as "infant feeding and pregnancy" and the "benefits of Danone and Aptaclub."

Vicky Sibson, director of the charity First Steps Nutrition Trust, which promotes healthy eating in children up to 5 years, said that Danone was using a tried and tested marketing tactic. "They're not breaking UK laws, but they do break the International Code of Marketing of Breast-Milk Substitutes, which clearly advises against marketing personnel seeking direct or indirect contact with pregnant women or mothers. The issue is that UK laws fall short of what they should be. Danone is using its baby club name and logo to promote its service and so indirectly promoting its products," she told *The BMJ*.

Research shows that such indirect marketing works, said Sibson. "The awareness of that brand in the background and the association with a trained healthcare professional are creating a suggestion that this is a brand to be trusted."

This brand loyalty contributed to families' willingness to pay higher prices at the checkout, she added. "Danone's Aptamil brand is the most expensive product on the market. It's not fair to parents, particularly in the midst of a cost-of-living crisis, that you've got all these indirect tactics which are suggesting to parents that if they want to do best for their babies they should buy Aptamil."

Sibson called on Tesco to end its partnership with Danone. "It's really inappropriate. It's not fair to mothers, it's not ethical," she said. "What we know is that most women in the UK want to breastfeed in some ways, and this is an example where they undermine women's self-efficacy to breastfeed. It is at odds with Tesco's objectives around improving the healthfulness of their retail offer. It is time they took a better look at the baby food aisle."

Olivia Hinge, a lactation consultant and midwife who was not involved in the Tesco pilot, said that the service made her "feel like we are going backwards." She asked, "How can this be happening in plain sight? Danone must be thinking 'this is brilliant,' and Tesco makes a lot of money out of selling formula milk—it is a booming business."

Milk nurses scandal

Robert Boyle, a consultant paediatric allergist at Imperial College London Healthcare NHS Trust, said that formula milk companies had been behaving this way for more than a century. "They have been dressing midwives up and getting people excited about their formula products in order to pay more for them and use them earlier and longer.

"It created a great scandal in the 1970s as milk nurses went into birthing units and triggered boycotts and demonstrations, which led to WHO's code. What Danone is doing here is clearly against the code."

Boyle challenged Tesco to keep the clinics "but remove Danone from the picture and allow midwives to use independent NHS information."

The midwife involved in the pilot said that she had no regrets about walking away from the job. "The bottom line is that we're making Danone look good—we're increasing their revenue and product likability, when actually that's not our role. As midwives we should protect women and advocate for them."

Consultation rooms inside a Tesco Extra store that offer free feeding advice sessions

Aptaclub leaflets in Tesco have the same colour palette, font, and imagery as Danone's Aptamil products

Rebecca Coombes, *The BMJ*

Cite this as: *BMJ* 2025;388:q2874

THE BIG PICTURE

Protesters demand Gazan doctor's release

Supporters of Palestine stage an emergency rally outside the US embassy in Nine Elms, London, to demand the release of Hussam Abu Safiya, a paediatrician and director of Kamal Adwan Hospital in northern Gaza, which was raided by US backed Israeli forces on 30 December.

Abu Safiya had spoken out just three days before the raid, warning that Israel had ordered the hospital, the last functioning health facility in the north of the enclave, to be evacuated—something he said would be "next to impossible" to do safely, as there were "nearly 400 civilians inside the hospital, including babies in the neonatal unit, whose lives depend on oxygen and incubators."

During the evacuation many staff and patients were detained by Israeli troops, including Abu Safiya.

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2024;387:q2885

2

1 **Protesters outside the US embassy in London demand that Israel release Hussam Abu Safiya**

2 **Doctors have launched a social media campaign in support of the held doctor**

3 **Abu Safiya (centre) treats a patient at Kamal Adwan Hospital, Gaza**

3

RON FASSBENDER/ALAMY

EDITORIAL

Reducing the risk of preterm birth

Evidence based guidelines work but are not universally applied

Publication of the House of Lords' report *Preterm Birth: Reducing Risks and Improving Lives*[1] coincides with the realisation that the UK will not meet its target to reduce preterm birth to 6% by 2025.[2] Currently, 7.9% of all births in England are preterm.[3]

Preterm births are an important cause of neonatal mortality. They account for three quarters of stillbirths, including late fetal losses (75%) and neonatal deaths (74%),[4] and can result in severe lifelong morbidities in those who survive.[5] The consequences have far reaching effects on families, who can experience psychological trauma and financial difficulties as they care for affected children.

Recommendations by the House of Lords select committee include that the government and NHS England provide the resources to ensure that clinical guidance is implemented consistently in all regions. Since 2019, the Saving Babies' Lives care bundle has provided guidance on how to optimise maternity services to reduce stillbirth and preterm birth and its consequences.[6]

However, as the House of Lords' report highlights, this guidance is still not being implemented universally, and large variations in care exist for women who are at risk of preterm birth.[7] Failure to follow guidelines was identified as a critical contributory factor in half of all cases in babies for whom different care might have affected the outcome (ie, stillbirth, neonatal death, or brain injury) included in the final report of the Royal College of Obstetricians and Gynaecologist's Each Baby Counts quality improvement programme in 2020.[8]

We should implement what we know are effective interventions. For example, the International Federation of Gynecology and Obstetrics (FIGO) PremPrep-5 initiative aims to disseminate key information on simple and effective interventions that can be carried out in all settings: antenatal corticosteroids, intrapartum magnesium sulphate, delayed cord clamping, early feeding with breast milk, and immediate kangaroo care. These are all cheap and robustly evidenced interventions but are not consistently used in the UK.[9]

PAUL KURODA/ALAMY

Women with the poorest outcomes find it hardest to access services

Jane Sandall, professor of social science and women's health
jane.sandall@kcl.ac.uk
Jenny Carter, senior research fellow
Naomi Carlisle, research fellow, King's College London

Improving care for all

We know the factors that can increase a woman's risk of preterm birth. Individual factors include recreational drug use, smoking, gender based violence, environmental pollution, being an unhealthy weight, and perinatal mental health disorders such as depression and anxiety.[10]

Social and structural factors include poverty and racism. Women from some ethnic minorities and living in the most socially deprived areas are more likely to experience poor pregnancy outcomes.[11-13] Currently, women with the poorest outcomes and the greatest social complexity find it hardest to access and navigate services, and we need to consider how services can be better organised to mitigate inequities rather than compound them.

The committee's report highlights the importance of listening to women and their families. This should enable clinicians to offer a "life course" approach, in which care is centred on the needs of individual women rather than based around a specific issue or condition. This approach provides personalised holistic care focused on the changing health and care needs of women throughout their lives,[14] including pre-pregnancy. Understanding women's and families' experiences of care, both during pregnancy and while their babies are in hospital, will inform how we attempt to reduce the negative effects of having a preterm baby and will help to prepare families for the future.

The report highlights the need for further research to better identify women at risk, particularly those having their first baby and who have no known risk factors, and which interventions are likely to be most effective. Potential strategies include biomarkers to better identify women at risk; digital clinical decision support tools that personalise risks, such as the QUiPP app[15] and Tommy's clinical decision support tool[16]; and redesigned care delivery models.

The NHS Race and Health Observatory has highlighted the potential of digital health interventions such as personalised clinical decision support tools to help the NHS tackle deep rooted ethnic inequalities. However, these need further testing before scale-up. This could be part of a wider commitment to improve data quality and engage with communities in co-designing equitable health services.[17]

We will not be able to prevent all preterm births, but there should be less variation in implementation of effective interventions and greater attention on how we deliver care. Inequity in healthcare and outcomes are complex issues which will require a multifaceted solution involving primary care and public health to tackle inequities and environmental factors.

Cite this as: *BMJ* 2024;387:q2772

Find the full version with references at http://dx.doi.org/10.1136/bmj.q2772

EDITORIAL

GLP-1 receptor agonists and obesity care

The need for lifelong support has implications for individuals and public health

More than a billion people worldwide are living with obesity. After many years of failed attempts to support them in losing weight and optimising their health through lifestyle intervention programmes, glucagon-like peptide-1 (GLP-1) receptor agonists are being heralded as a magic bullet for this global problem.[1]

Public discourse on these drugs has focused on their off-label use by celebrities, their exorbitant pricing, and severe supply shortages. But these issues are distractions from difficult questions about the long term implications of using these drugs in holistic obesity care systems, for both individual patients and for public health—namely, for whom, for what purpose, and how should these drugs be used when taking a lifecourse view of care for people with obesity?

In pivotal clinical trials of GLP-1 receptor agonists, cut-off points for body mass index (BMI) were ≥30, but a more nuanced health centric approach is needed. BMI is now widely recognised as an inaccurate tool for diagnosis of obesity as it can both overdetect and underdetect adiposity.[2] BMI may also be a poor predictor of health outcomes, especially cardiovascular disease.[3-5] Moreover, obesity is highly heterogeneous, and it is difficult for clinicians to predict who will respond and benefit most from GLP-1 receptor agonists.

Decisions about treatment require consideration of individual preferences and should be grounded in staging of obesity in terms of the effect on health and the presence and future risk of comorbidities, including cardiovascular disease.[2] Pragmatic staging systems amenable to widespread clinical use have been proposed, such as the Edmonton obesity staging system, and we must now make greater efforts to integrate their use into clinical practice.[6 7]

Eligible patients will require adherence support and destigmatised care to achieve sustained outcomes

Juan V A Franco, unit lead, Centre for Health and Society, Heinrich Heine University Düsseldorf, Germany
juanfranco@bmj.com

Jen Manne-Goehler, assistant professor, Harvard Medical School, Boston, Massachusetts

Weight loss is a moderate predictor of the health benefits of GLP-1 receptor agonists when used alone as a treatment goal. Several studies, including long term follow-up of the Select and STEP 5 trials,[8 9] have indicated that weight loss plateaus after 12 months; nonetheless, the cardiovascular benefits of treatment seem to occur even when weight loss is relatively minimal.[10]

If the aim is to reduce the incidence of more critical clinical outcomes, such as cardiovascular events, we should learn from the experience of statin prescribing. Here, low density lipoprotein targets were originally set but later abandoned in favour of risk stratification as a means of selecting patients and risk reduction as a treatment goal.[11] If we choose this approach for GLP-1 receptor agonists, stratification could also be based, at least partly, on cardiovascular risk. Therefore, neither weight based stratification nor weight oriented treatment goals would be optimal as the main clinical treatment goal.[4]

Better lifetime care

We also need to consider how the roll-out of these drugs will affect health systems. The chronic and relapsing nature of obesity highlights the need for some form of multimodal lifetime care. However, access to such care for people with obesity has until now been restricted to specialist clinics, often taking the form of limited capacity, individualised programmes.[12] The growing number of patients eligible for medical treatment of obesity will also require adherence support and destigmatised care to achieve sustained outcomes.

This demands honest discussions about the implications of lifelong treatment, including building the evidence on outcomes for those continuing or stopping the drugs. For instance, discontinuing these new medications leads to weight regain, which may warrant restarting treatment and subsequent weight loss. Such "weight cycling" is physically and psychologically burdensome for many people and can worsen health outcomes.[13] GLP-1 receptor agonists will therefore not solve the challenge of building a lifetime care infrastructure, and without these systems we may be setting up patients with obesity for yet another failure.

Questions about GLP-1 receptor agonists should also incorporate a better understanding of the unintended consequences of use (and non-use) of the drugs on weight stigma. The latest Canadian guidelines on obesity focus on first discussing weight with patients in a non-judgmental fashion and then exploring readiness for change.[14] The availability of what has been dubbed a wonder drug may influence how these discussions are carried out since the great pressure on people with obesity to lose weight is driven mainly by aesthetic rather than person centred health outcomes.

GLP-1 receptor agonists offer new hope for building a successful, scalable, and sustainable approach to mitigating the untoward health effects of obesity. But to do so, we must ask ourselves the hard questions now and build our answers into these new systems of care.

Cite this as: *BMJ* 2024;387:q2732

Find the full version with references at http://dx.doi.org/10.1136/bmj.q2732

Meet the IRC surgeon who is assisting clinicians in Gaza

The war has left 98% of Palestinians in Gaza in need of humanitarian aid, and health workers need support to stem the tide. **Jane Feinmann** speaks to one who joined the International Rescue Committee's efforts

Mahim Qureshi, a London based vascular surgeon, decided to join an emergency medical team trip to a Gaza hospital after reading that, every day, 10 or more children there lose one limb or more. "As a senior registrar in vascular surgery able to do an amputation quickly and safely and control bleeding, I knew I'd be able to help."

She made a 12 day trip to Al Aqsa Hospital in central Gaza in April and a two week mission to the southern Nasser Hospital in November, both times supported by the International Rescue Committee (IRC), the subject of this year's BMJ appeal.

Providing healthcare safely in Gaza is both a logistical and humanitarian challenge. Israeli airstrikes, bombing, and ground level fighting have left half of its 36 hospitals out of service and killed more than 1000 Palestinian health workers, according to the UN. More than 45 000 people have been killed in the past 14 months, and at least 100 000 injured.

"At Nasser Hospital, I knew a visiting general surgeon who had been working there in February when Israeli soldiers invaded the hospital leaving it damaged, and the accommodation flattened. There were great efforts to get it functional again. But we always knew we couldn't be safe," Qureshi recalls.

More than 45 000 people have been killed in the past 14 months, and at least 100 000 injured

Qureshi pays tribute to the IRC's "expert" logistical planning, which underpinned the emergency medical team's ability to assist Palestinian colleagues who are faced with "mass casualties, often on a daily basis." "I felt supported by the IRC's expertise and capacity for reliable risk assessment and briefing us. We had an evidence based psychological pre-briefing that I appreciated truly once I got home," she tells *The BMJ*.

Along with 12 emergency medical team missions to Gaza with Medical Aid for Palestinians (MAP) since December 2023, the IRC has procured and delivered 45 tonnes of pharmaceutical and medical supplies and organised more than 10 000 patient consultations by mobile health teams with its partner Juzoor, a Palestinian non-governmental organisation. "The medical contribution is substantial, involving a complex logistical operation of getting into and out of Gaza during this extended period of escalated violence," says Bart Witteveen, IRC country director for the occupied Palestinian territory.

The challenge of bringing medical supplies into Gaza is just as complex

owing to the severe restrictions on cargo going into the country. "Everything from scrubs and other equipment as well as food and drugs requires clearance by the Israeli military and a complex and difficult to manage operation at the Karam Abu Salam/Kerem Shalom crossing engaging with UN's rotation system," Witteveen tells *The BMJ*. "The purpose of these medical supplies is unambiguous—to save and sustain life—and as such [they] should be flowing freely into the country. But that is not the case."

Much of Qureshi's work in Gaza involved managing blast injuries that caused immediate loss of limbs, requiring clean amputation at a higher level to give the best function possible. It's a simple operation, but operating tables in the hospitals' surgical units are routinely lined with a body bag.

"After such catastrophic injuries, many patients have little chance of survival," she tells *The BMJ*. Almost as shocking, says Qureshi, was the high demand for amputation from diabetic foot disease as a result of poor nutrition and inadequate wound care.

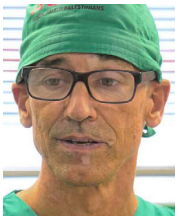
A distressing aspect was the postoperative infection rate, which is almost 100%—"inevitable," says Qureshi, "given the extreme overcrowding, extreme hunger, the lack of hygiene and a water supply, and the shortages of medical equipment, antibiotics, and other drugs. I especially remember the patients we couldn't help and the ones who died."

Qureshi was able to assist in training Palestinian medical students and newly qualified doctors. But most Palestinian colleagues, she says, were "highly experienced medical professionals who had seen terrible trauma throughout their careers, so I certainly wasn't there to tell such people what to do."

Occasionally she was able to teach new skills. In a theatre with no functioning electrical saws, she showed a Palestinian surgeon how to carry out a "through knee" amputation that didn't require a saw. "An amputation without an electrical saw is brutal, and I realised this route would be useful," Qureshi says.

Many patients had shrapnel injuries: "high speed, high heat particles destroy soft tissue and in the limbs are commonly associated with blood vessel and nerve injuries, requiring re-plumbing of blood vessels beyond the site of the injury," she adds.

An almost 100% postoperative infection rate is inevitable
Mahim Qureshi



I saw children with sniper injuries to the head
Nizam Mamode

Such cases can be hugely complex, says retired UK transplant surgeon Nizam Mamode who joined the IRC and MAP's emergency medical mission to Nasser Hospital in August and September. "I saw children with sniper injuries to the head," he told the UK Parliamentary International Development Committee in November. "They were targeted by Israeli drones while lying injured after a bombing. The drones fire small cuboid pellets that cause multiple injuries. I saw a 7 year old boy who had an injury to his liver, spleen, bowel, and arteries, quite extensive destruction from a single entry point."

Gaza hospitals, he told the committee, "faced a constant risk of being overwhelmed by wounded patients. I've worked in a number of dangerous conflict zones including the Rwandan genocide, but I have never seen anything on the scale of what I saw in Gaza."

Despite the catastrophic level of humanitarian needs, the funding to meet those needs is nowhere near sufficient, Witteveen warns. "We have a situation where 98% of the population is in a state of humanitarian need. The IRC's own staff are displaced and living in tents. The IRC is a neutral and impartial organisation and advocates on behalf of the communities we serve to ensure their access to lifesaving humanitarian aid," he says.

Qureshi agrees. "I believe the most important support we bring as clinicians from the outside is positivity," she tells *The BMJ*. "I recall our arrival in April when there was no news getting into the country and the medical staff felt forgotten, that nobody cared. As well as the actual donations to the BMJ appeal, I feel sure that Palestinian medics will also be encouraged that *BMJ* readers are interested and aware of what is happening and wish them well."

MOHAMMAD ABU SAMRA FOR THE IRC

Jane Feinmann, freelance journalist, London

Cite this as: *BMJ* 2024;387:q2848

Do smoking bans work?

Since 2007 there have been moves towards stricter regulations on smoking in public spaces across the world. But have any of these had noticeable health impacts? **Sally Howard** and **Geetanjali Krishna** report

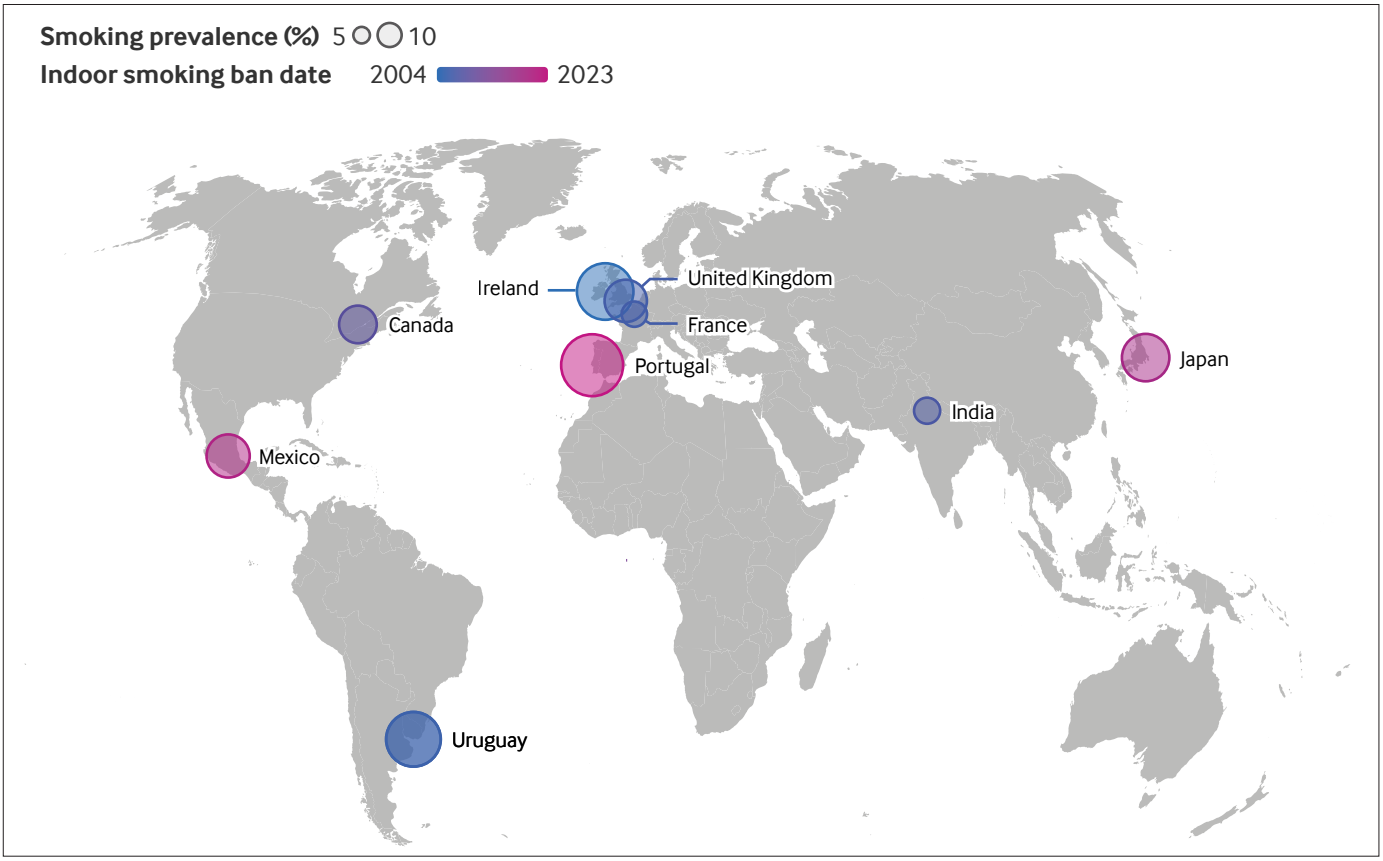
The UK's Tobacco and Vapes Bill is currently making its way through the House of Commons. It will—if passed—further restrict smoking in outdoor public spaces. Smoking in indoor public spaces has been banned since 2006. The bill also goes a step further, however, prohibiting the sale of tobacco to anyone born after January 2009.

If the bill is passed, it will be one of the strictest anti-smoking regulations in the world—and the first to ban smoking for younger generations. In 2022 New Zealand nearly enacted a similar "generation ban" which would have introduced a steadily rising legal smoking age to stop those born after January 2009 from being able to buy cigarettes legally. New Zealand's bill was to be implemented from July 2024, but was scrapped in November 2023 after the government which proposed it lost the 2023 national election, and the new coalition government halted proceedings.

New Zealand's backsliding is rare in a global picture which has seen a domino effect of anti-smoking legislation since 2007, a watershed year when many nations began to bring in indoor smoking bans. France, Portugal, and several Australian states and Canadian provinces have announced or implemented bans on smoking in public outdoor spaces such as beaches, public parks, and cafe and restaurant terraces. In recent years, South America has seen several comprehensive bans on smoking in public places, while governments in Japan and Thailand are two of a growing list of Asian countries instituting indoor smoking bans.

Europe is a surprising bleak spot for smoking prevalence

Despite the march of smoking bans, Europe is a surprising bleak spot for smoking prevalence—smoking rates in France in the two decades since 2006 have risen by 1.6% and by 3.6% in Portugal, alongside increasing e-cigarette use in both nations. The UK and Canada have been success stories, however, with the UK almost halving smoking rates to 12.9% of people aged 18 and over, from 25% in 2004, and Canada reducing smoking prevalence to 10.2% in 2021 from 17.7% in 2015—though many of these gains are on the back of rising e-cigarette use.



Status of cigarettes across the world

Canada

Regulations: Smoking in Canada has been banned in indoor public spaces, public transit facilities, and workplaces since 2010
Prevalence: Smoking prevalence reduced to 10.2% in 2021 from 17.7% in 2015
E-cigarette use: E-cigarette use increased to 6% in 2022 from 2% in 2013
Mortality: Smoking attributable deaths rose to 18% of all deaths in 2019 from 17.72% in 2016

France

Regulations: Smoking has been banned in all public places (both indoor and covered outdoors areas) since 2007
Prevalence: 34.6% of the adult population in France are current smokers, up from 33% in 2006
E-cigarette use: There are 3.8 million vapers (7% of the population) up from 4% in 2017
Mortality: 14% of all deaths in France were caused by tobacco use in 2019 (14% in 2010)

India

Regulations: India became a party to the WHO Framework Convention on Tobacco Control in 2005 and banned smoking in public spaces in 2008. E-cigarettes banned since 2009
Prevalence: 4.9% in 2021, down from 19% in 2000
E-cigarette use: Banned
Mortality: An estimated 1.35 million deaths occur every year from tobacco use (not only smoking) in India

Ireland

Regulations: First country to ban smoking in workplaces, restaurants, and bars in 2004. Among the last to ban the sale of vapes to under-18s in 2023. The Public Health (Tobacco) Amendment Bill 2024 proposes to increase the minimum age of sale of tobacco products from 18 to 21 by 2028
Prevalence: 23% among people aged over 15 in 2021, down from 25% in 2003
E-cigarette use: 8% of the population
Mortality: Minimal difference in deaths attributable to smoking—4382 in 2010 and 4512 in 2019

Japan

Regulations: Japan ratified the WHO Framework Convention on Tobacco Control in 2004 and banned smoking in indoor public areas in 2020
Prevalence: Japan's smoking prevalence has declined from 32% in 2000 to 16.2% in 2022
E-cigarette use: There were 2.1 million e-cigarette users in 2017, most recent data found
Mortality: In 2021 tobacco resulted in 23.7% of total deaths in Japan. 92.8% of tobacco related deaths were from smoking, and 9.1% were from second hand smoke

Mexico

Regulations: The first Latin American country to ratify the WHO Framework Convention on Tobacco Control in 2004. There is a total ban on smoking in public places, including parks, beaches, and hotels
Prevalence: From 21.5% in 2002, the percentage of smokers aged 15 and over fell to 13.4% in 2022
E-cigarette use: E-cigarette prevalence in Mexico was 1.6% in 2021
Mortality: In 2021 an estimated 395 000 deaths (8.9% of total deaths) were attributed to tobacco, of which 81.8% were because of smoking

Portugal

Regulations: Partial ban on smoking in restaurants and bars (allowed in non-table service areas) since 2021. A sweeping ban on smoking in public spaces proposed in 2023
Prevalence: 27.6% of adults smoked in 2024, up from 24% in 2006
E-cigarette use: The country has 8300 e-cigarette users, 0.09% of its population
Mortality: In 2019, 13 847 deaths could be attributed to tobacco consumption (12.3% of all deaths)

UK

Regulations: Smoking in enclosed public spaces has been banned since 2006 in Scotland, and 2007 in Wales, Northern Ireland, and England. The sale of vapes to under-18s was banned in England and Wales in 2015, Scotland in 2017, and Northern Ireland in 2022
Prevalence: In 2022 12.9% of people aged 18 and over were smokers, down from 25% in 2004
E-cigarette use: Daily or occasional vape use increased to 15.5% in 2022, from 11.1% in 2021
Mortality: In 2019 there were 74 600 deaths from smoking, a 9% decrease from 82 000 in 2009

US

Regulations: 29 states have banned smoking in enclosed workplaces including bars and restaurants, and 10 other states have the same ban but with some exceptions. Some states do not regulate smoking
Prevalence: In 2021 11.5% of US adults smoked, compared with 19% in 2011
E-cigarette use: E-cigarette use among adults rose from 3.7% in 2020 to 4.5% in 2021
Mortality: Deaths attributable to smoking marginally decreased to 342 532 in 2021 from 369 590 in 1990

Uruguay

Regulations: Uruguay was the first country in South America to ban smoking in enclosed public areas in 2006. The sale of e-cigarettes was banned in 2017
Prevalence: From 50% in 2000, the percentage of smokers in the country declined to 17% in 2015—however, in 2020 this rose to 21.5%
E-cigarette use: Banned
Mortality: 16% of all deaths in 2019, reduced from 18.39% in 2016

Nearly two decades since the first anti-smoking laws appeared, it's still unclear if they are having a notable effect on public health.

JEFF GILBERT/ALAMY

A mixed bag of evidence

Scientific evidence remains mixed. Studies suggest that comprehensive indoor smoking bans are associated with a 2.35-3.29% average reduction in the adult population who smoke tobacco products.

Partial indoor smoking bans are harder to read. Studies that have been conducted did not find any significant impact on smoking prevalence, and warned that they could even increase smoking intensity among people who smoke every day. Indoor smoking bans in public places also seem to have little impact on incidence of smoking and passive smoking in domestic dwellings, researchers report. A study in Denmark and Switzerland found positive effects on lung function in populations in the years after indoor smoking bans.

That said, several studies note other factors that impoverish indoor air quality may be affecting results. These include poor ventilation, indoor fireplaces, and the burning of black fuels such as peat and turf.

Additionally, the chronic diseases born of tobacco smoking—such as heart disease, cancer, and chronic obstructive pulmonary disease—often present after many years' tobacco use, and may not yet be captured by mortality data. In 2023, 22.3% of the world's population used tobacco (36.7% of men and 7.8% of women), with 80% of tobacco users (both smoked and smokeless tobacco products) living in low and middle income countries, according to the World Health Organization. That said, in many countries the rates of tobacco smoking are diminishing, with some of the most marked reductions in Mexico and Uruguay.

The state of the (smoking) nations

The BMJ looked at smoking regulations, smoking prevalence, and related mortality for 10 countries globally, comparing the best available national data on date and nature of smoking regulations; smoking prevalence over time; e-cigarette use; and smoking related mortality.

The findings are a mixed picture for campaigns against tobacco smoking and its ill effects. Smoking rates are increasing among young people in many African countries, where big tobacco companies are accused of staging aggressive marketing campaigns and lobbying politicians. Ten of Africa's 54 nations have not yet ratified the WHO Framework Convention on Tobacco Control, which protects countries from the aggressive advertising and marketing of the tobacco industry. As of March 2024, 183 parties have ratified the convention worldwide—including 182 countries and the European Union member states. Argentina, Cuba, Haiti, Morocco, Switzerland, and the US have signed the convention but not enacted it; and the Dominican Republic, Eritrea, Indonesia, Liechtenstein, Malawi, Monaco, Somalia, and South Sudan, among others, have neither signed nor ratified the convention.

Nearly two decades since the first anti-smoking laws appeared, it's still unclear if they are having a notable effect on public health

E-cigarettes, meanwhile, are muddying the waters. *The BMJ* found that e-cigarettes are being embraced by some nations as a tobacco cessation tool and banned in others. Studies note an increase in those who both smoke and vape—such as among youth in Ireland—with e-cigarettes emerging as a gateway to smoking. Another study reported that young people in countries with the most restrictive e-cigarette regulations, compared with countries with no regulatory policies, had 0.6 times lower odds of being current e-cigarette users.

Sally Howard, freelance journalist, London
Geetanjali Krishna, freelance journalist, Delhi indiastoryagency@gmail.com

Cite this as: *BMJ* 2025;388:q2759

ROLE MODEL

Michael Blaber

The palliative medicine specialist talks to **Helen Jones** about how his role can make a difficult time for patients and their families a little bit better

"I've always been fascinated by the human condition in all its complexity. From a young age I wanted to be in a profession which exposed me to people and to what it means to be human," says Michael Blaber, palliative medicine specialist at Sandwell and West Birmingham Hospitals NHS Trust.

"We all have certain physical, social, psychological, and spiritual requirements which need to be met and understood in the context of healthcare, so I find that fascinating."

Blaber says that part of his role involves identifying what is helpful for patients and their loved ones. "It's about zeroing in on their priorities, so that we know how we can make a difficult time just that bit better for people. That is very rewarding."

He adds, "I've also got a background in healthcare ethics and that certainly comes to the fore in terms of decision making towards the end of life and to ensuring we've got a robust ethical framework."

While his role is rewarding, Blaber says there is a burden in being in close proximity to a lot of distress. "There is a learning curve when it comes to managing one's emotions and making peace with what's in our control and what is not."

In 2016 he experienced a period of burnout. At the time, he says, there was a lot of stigma around mental health problems and it wasn't easy to be open about what he was going through. "It was complicated. There was a tension between wanting to pursue excellence for each patient and the reality of working in an imperfect system where sometimes it all feels a bit messy. It was about understanding what was in my control."

After a period away from work, psychotherapy, and the support of colleagues, Blaber regained his confidence. "It also helped that I'm a pastor at a local church, so the love and support of my church community as well as that of my wife helped me to get through it."

There is a learning curve when it comes to managing one's emotions and making peace with what's in our control and what is not

Blaber then started a wellbeing scheme with his friend and colleague Ross Bryson, called Professionals Together, which was aimed at people who were transitioning from student to doctor and required extra support. "It provided support and coaching on looking after yourself and others, and created a nurturing environment where we could process some of our experiences and share a curry."

That scheme has evolved and now contributes to a regional wellbeing programme called Thriving in Medicine, aimed at foundation doctors.

"I've been involved in a number of different projects which are broadly about humanising the work environment and providing pastoral support—not just for those in difficulty, but also for those who are okay but might need some help to maintain sustainable professional rhythms," Blaber says.

If he could tell his younger self anything it would be that "imposter phenomenon is common in all professions, and that most people go through these challenges but it's going to be okay. There are colleagues who want you to succeed, so enjoy the journey."

Helen Jones, *The BMJ*

Cite this as: *BMJ* 2025;388:q2807

NOMINATED BY ANNA LOCK

"Since I met Mike—when he had finished his core medical training and was seeking his path in medicine—he has been true to his fundamental beliefs of connectedness and compassion for patients, their families, and colleagues. These permeate every aspect of his practice.

"After pausing his high achieving palliative medicine career in response to an episode of burnout, he returned to clinical practice, openly sharing this experience. This informed his development of Professionals Together, a Royal College of Physicians award winning wellbeing programme for foundation trainees, which has since grown into the West Midlands regional Thriving in Medicine, a spiral training programme for foundation doctors tackling key themes around professional wellbeing.

"He's been instrumental in the development of our intensive palliative care virtual ward, bringing an academic rigour and a dedication to supporting our multidisciplinary team as we change our practice and implement this innovative approach."

Anna Lock is a palliative medicine consultant and deputy chief medical officer (integration and pathways) at Sandwell and West Birmingham Hospitals NHS Trust

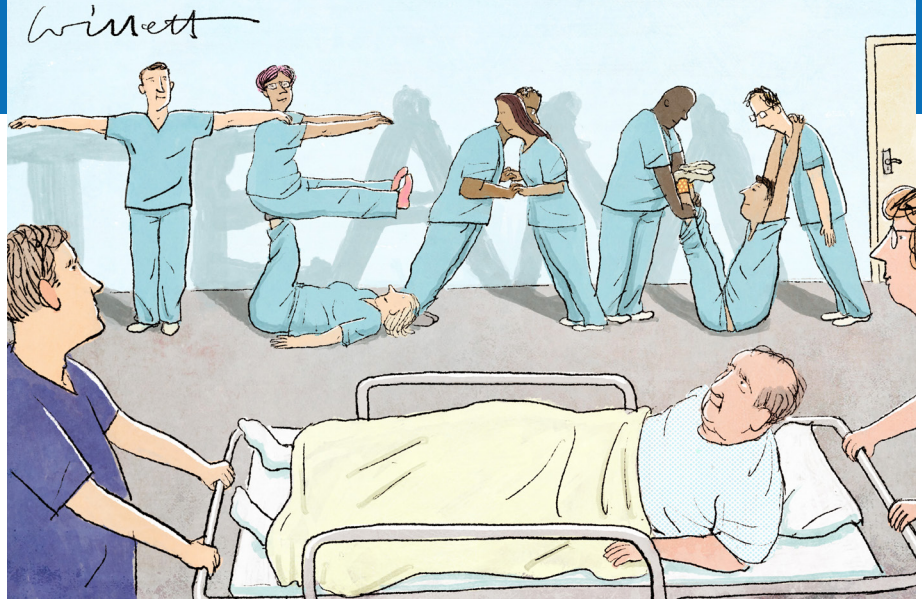
NOMINATE A ROLE MODEL

To nominate someone who has been a role model during your medical career, send their name, job title, and the reason for your nomination to arimmer@bmj.com

CAREERS CLINIC

How do we create a sense of team?

An esprit de corps at work can make a big difference and often starts with small actions, **Abi Rimmer** hears



Any team member can lead

Amrita Sen Mukherjee, positive psychology practitioner and portfolio GP

"Creating a strong sense of team at work is essential for nurturing connection, trust, and shared purpose. Strong relationships are the foundation of a successful team, so making regular opportunities for the team to connect can make a big difference.

"Shared experiences strengthen bonds and create lasting connections. These moments don't need to be extravagant—even small interactions, such as regular informal coffee chats, contribute to a deeper sense of being a unit. Simple things like asking a colleague how they are—and genuinely listening to their response—can also make a huge impact.

"Leadership is a behaviour that any team member can exhibit. Modelling trust, respect, and transparency fosters an environment where everyone feels safe to contribute and everyone has collective ownership of their goals. Encourage the team to step up, share ideas, and take initiative.

"A sense of team thrives when there's a shared understanding of purpose. Take time to articulate the team's mission, values, and collective goals. Acknowledging team and individual accomplishments can also foster a positive culture. Highlighting strengths and achievements reinforces a sense of belonging, motivates the team, and builds mutual respect.

"When teams feel connected, supported, and united under a common purpose, they're not only more effective but also more fulfilled in their work."

Watch Amrita Sen Mukherjee's TEDx talk at www.youtube.com/watch?v=Ro3SbU95qwc

Rituals can foster team working

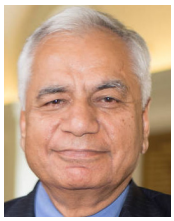
Heidi Edmundson, emergency medicine consultant

"Feeling like part of a team has been shown to improve staff engagement and patient safety. The first step is believing that it's important and not something that happens by accident.

"Next identify key moments and small acts that help to bring the team together. These will include the start and end of the shift. It's easy to dismiss little gestures but the key to making them work is by committing to doing them regularly, no matter what else is going on. By doing this you create a ritual. Kursat Ozenc, a lecturer at Stanford University, delivers a course based on the idea that you can design your culture based on rituals. What you choose to make into a ritual shows what is important to you.

"One example of this is the morning handover—I spend a few moments asking the day team to say their names and roles and to answer a question such as 'What is your favourite possession?' Questions like this may appear simple but the answers can reveal a lot. They allow the team the opportunity to have a human connection with each other at the start of the shift. I hold the time and space to do this, no matter how busy the department, as it is important to me. I enjoy this moment, and the answers can range from funny to surprising, and in some cases moving.

"As I always do it, it definitely has a ritualistic quality to it. Doing the same thing repeatedly provides a sense of security and stability in the increasingly turbulent environment in which we work. It also acts as a psychological moment to bring everyone together and announces that the shift has begun."



Teams are at the heart of healthcare

Dinesh Bhugra, professor emeritus mental health and cultural diversity, King's College London

"The patient is at the heart of everything we do and every medical discipline needs and thrives on team work. Teams are crucial because members must work together to achieve a common agreed goal. In medicine, that is about direct and indirect patient care.

"Teams can be based on the need to achieve a single function or on continuing care. Clinical teams may be led by doctors or others and their leadership style may not be entirely clear. Team leaders may be open minded in that they can cope with being challenged and may have an open door policy, whereas others may be dictatorial and controlling.

"For a team to function effectively, the leader must know the strengths and weaknesses of each member. If the leader is choosing their team, they must identify people who complement their skills and 'cover' their weaknesses.

"In any team the leader should be able to deliver a task by either dealing with it, delegating it, or ditching it (in a rational way). Delegation is not because the leader does not like the person to whom the task is delegated but because they are the most appropriate, competent, and suitably skilled person.

"It is inevitable there may be tensions in the team either because of professional rivalry or personal animosity. Mutual respect for each other's skills and recognition of each other's strengths (and weaknesses) can, however, bring the team together and bring about success. Recognition, respect, remuneration, and reward are what contribute to a successfully functioning team."

Cite this as: *BMJ* 2025;388:q2826