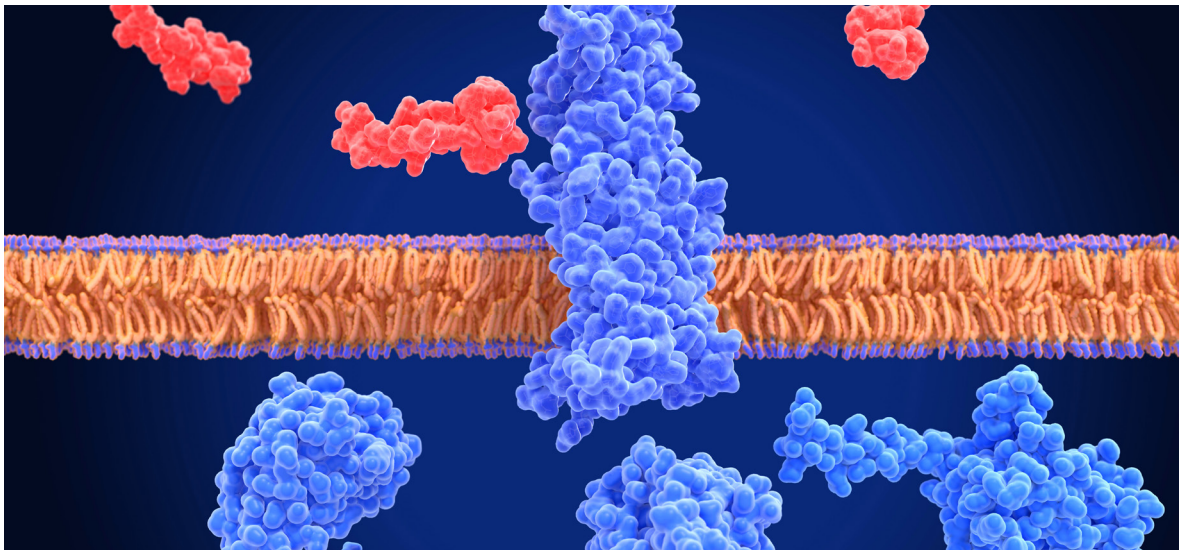
OBESITY DIAGNOSIS page 58 • **CALORIE LABELS** page 60 • **CORRIDOR CARE** page 64



JUAN GAERTNER / SPL

"GLP-1RAs could help with addictions"

US research suggests the drugs, used for diabetes and weight loss, are linked to reduced risk of substance use

Glucagon-like peptide-1 receptor agonists, used for diabetes and weight loss, may be linked with a reduced risk of substance use and neurocognitive disorders, a US study in people with type 2 diabetes found, but could also carry an increased risk of gastrointestinal disorders and drug induced pancreatitis.

Researchers at the Veterans Affairs St Louis Healthcare System in Missouri used US government databases to follow 1.96 million forces veterans with type 2 diabetes for a median period of 3.7 years and to map associations between GLP-1RA use and 175 health outcomes.

The study, published in *Nature Medicine*, included 215 970 people who used a GLP-1RA, comparing these with 159 465 people who used sulfonylureas, 117 989 who used DPP4 inhibitors, 258 614 who used SGLT2 inhibitors, and 1.2 million who used ("usual care") any non-GLP-1RA antihyperglycaemic drug. Participants were enrolled between October 2017 and December 2023.

The researchers reported that, in comparison with the usual care group, GLP-1RA use was associated with a reduced risk of substance related disorders, including alcohol, cannabis, stimulants, and opioids. GLP-1RA use was also linked to reduced risk of suicidal ideation or attempt or intentional self-harm, schizophrenia and other psychotic disorders, and Alzheimer's disease.

Other measures where GLP-1RAs were associated with reduction in risk were coagulopathy and clotting disorders, pulmonary hypertension, cardiac arrest, bacterial infections, and inflammatory bowel disease.

However, the researchers also found several outcomes where GLP1-RAs were linked to increased risk, including for drug induced acute pancreatitis, nausea and vomiting, gastro-oesophageal reflux disease, non-infectious gastroenteritis, sleep disturbances, and arthritis.

The researchers did not measure the absolute risk for the 175 health outcomes but have said that their follow-on work from this study will do so. They also noted other limitations to their study, including that the population they were studying—US veterans—mainly comprised older white men, which limited applicability of their findings to the general population, because the health effects of these drugs "may vary

(Continued on page 60)

LATEST ONLINE

- US task force recommends osteoporosis screening to prevent fractures in older women
- Trump signals US withdrawal from WHO
- FDA proposes limiting the amount of nicotine in cigarettes

MEDICAL NEWS

Define obesity as clinical or pre-clinical for better diagnosis, says global commission

A group of experts has called for a radical shift in how obesity is diagnosed, with less reliance on BMI. The commission's report, published in *Lancet Diabetes and Endocrinology* and endorsed by more than 75 medical organisations across the world, said diagnosis of obesity should be based on other measures of excess body fat as well as BMI, taking into account "objective signs and symptoms" of ill health.

The commission said considering obesity only as a risk factor could unfairly deny access to treatment for people who needed it and a blanket definition as a disease can result in overdiagnosis. Creating distinct classifications, "clinical obesity" and "pre-clinical obesity," would provide more accurate diagnosis and more personalised treatment, it argued.

The commission's chair, Francesco Rubino, chair of metabolic and bariatric surgery at King's College London, said, "We are calling for a radical change because, in the context of a billion people being classified as having obesity in the world today, no country is rich enough to be able to afford inaccuracy in the diagnosis of obesity." Rubino said two classifications would allow people with clinical obesity to access evidence based treatments "as appropriate for people with a chronic disease," while those with pre-clinical obesity could be targeted with risk reduction management strategies.

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2025;388:r78

PA regulation

Case against GMC is given High Court green light

A judge has granted permission for a case against the GMC's regulation of physician associates (PAs) and anaesthesia associates (AAs) to be heard in the High Court. The campaign group Anaesthetists United and the parents of Emily Chesterton—who died in 2022 after two appointments with a PA she believed to be a GP—said the GMC's failure to enforce a national scope of practice for PAs and AAs represents an "unlawful failure in its duty to properly regulate the clinical practice of these associate professions in the UK." The case is expected to be heard before Easter.

Overseas doctors

Trust orders independent review of pay parity

University Hospitals Birmingham NHS Foundation Trust ordered an independent review of its international medical training programmes because of concerns, first highlighted in *The BMJ*, that doctors from overseas were paid substantially less than domestic peers working at a comparable level.

The trust has already carried out an internal review "following concerns raised by staff members" about the programmes. The trust's chief medical officer, Kiran Patel (below), said that the internal review had "highlighted a number of issues, including pay parity," adding, "We will therefore undertake an independent review of each of the international training programmes we are involved in."

Drug safety

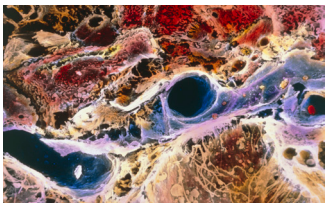
Scotland opens UK's first drug consumption room

The UK's first drug consumption room, the Thistles, opened its doors in Glasgow on 13 January for people to inject drugs in the presence of trained health and social care professionals in clean, hygienic environments. The service aims to reduce the negative effects that injecting outdoors can have on local residents, communities, and businesses and to reduce harm to users. Saket Priyadarshi, associate medical director of Glasgow's alcohol and drug recovery service, told the *Guardian* it was "very important" for the facility not to be regarded as a "silver bullet" for the drug death crisis.

Cancer

UK deaths from liver cancer double in 20 years

Liver cancer kills 5800 people in the UK every year, up from 2200 a year in the late 1990s, making it the fastest growing cause of cancer death, said an analysis by Cancer Research UK. Without action, deaths from liver cancer



are projected to rise 10% by 2040. Almost a quarter of liver cancer cases are caused by overweight or obesity, over a fifth are from smoking, and alcohol is linked to 7% of cases. The charity is calling on the government to do more to encourage healthier living.

Home bowel cancer testing is expanded to over 50s

People aged 50 and 52 will begin to receive a faecal immunochemical test kits every two years by post, as England's screening programme expands to ages 50-74. Figures show that less than 60% of 54-57 year olds take up the offer, though over 70% aged 60-74 return completed tests.

Audiology

Digital home hearing tests to be sold in UK

People will be able to buy earphones that allow them to take a hearing test at home by using a phone app that can then be switched to a hearing aid function. This follows a change in government policy to allow businesses to sell the products in the UK. The health secretary, Wes Streeting, said that the move was part of plans to embrace technology to bring healthcare into the digital age.

Infant feeding

"Unethical" service is axed in Tesco climbdown

A controversial scheme in which midwives were hired by the leading formula milk brand Danone to provide infant feeding advice to new parents has been axed after an outcry. The initiative, hosted by the supermarket giant Tesco and revealed this month by *The BMJ*, drew criticism for its parallels to discredited activities decades ago by formula milk companies. Tesco announced that the Hertfordshire pilot scheme would finish in a few weeks and that it no longer planned to roll out the service to other stores.

IN BRIEF

Patient safety

US follows UK and bans Red No 3 food dye

The US Food and Drug Administration banned the use of a synthetic dye called Red No 3 (erythrosine) in foods and medicines. The dye gives food and drink a bright cherry red colour. The move follows two studies that showed cancer occurring in male rats exposed to high levels of the additive. The dye is already banned for food use in the UK, the EU, Australia, and New Zealand except in certain kinds of cherries. The additive was banned in California's schools last year after another study linked it to increased hyperactivity in children.

Red dye used in foodstuffs has been linked to hyperactivity

Marburg virus

Tanzania confirms case in northwestern region

At a WHO press conference on 20 January Tanzania's president, Samia Suluhu Hassan, said one case of Marburg virus disease had been confirmed in the Kagera region, which borders Rwanda and Burundi. A total of 25 people had been reported with suspected cases as at 20 January, all of whom have tested negative and are currently under close follow-up, the president said. Tanzania previously reported an outbreak of Marburg in March 2023, in which nine cases and six deaths were reported.

Climate protest

GP activist is jailed for damaging petrol pumps

A Bristol GP has been jailed for a year for damaging petrol pumps in Thurrock, Essex, during a Just Stop Oil protest. Patrick Hart received a 12 month sentence after a jury last October had found him guilty of criminal damage. Hart will now face a medical practitioner tribunal, which could suspend him or strike him off the medical register. Hart acknowledged that his actions "have already cost me greatly" but added, "I regret nothing—because to not do it would have been to give up on caring, and that would be worse."

Isle of Man

Vast majority of doctors vote for industrial action

Doctors on the Isle of Man have voted to take industrial action for the first time because of real terms pay cuts over the past 15 years. A total of 121 of 127 doctors (95%) on the island voted yes in a ballot over their pay, the BMA announced. The doctors, who are employed by Manx Care, the Isle of Man government's healthcare system, are asking for a 12.6% backdated pay rise for 2023-24.

Mpox

Sixth clade Ib case identified in England

The UK Health Security Agency has reported a new case of clade Ib mpox in England, the sixth case since October. The patient, under specialist care at Guy's and St Thomas' in London, had recently returned from Uganda. The agency said the patient had "no links to previous cases in England" and is contacting people close to them to offer tests and vaccinations.

Cite this as: *BMJ* 2025;388:r115

FLU

Hospital admissions for flu in England fell to **9.47** per 100 000 population in the week to 12 January, down from **13.4** per 100 000 the previous week

[UK Health Security Agency]

SIXTY SECONDS ON . . . FOOD NOISE

SHHHH. DON'T EAT SO LOUDLY

We're not talking about crisp crunching in the cinema. "Food noise" refers to the constant and obsessive thoughts some people report having about food.

NEED NOISE CANCELLING?

In effect, yes. The term is being discussed in relation to glucagon-like peptide-1 receptor agonist (GLP-1RA) weight loss drugs such as semaglutide (Ozempic, Wegovy), liraglutide (Saxenda), and tirzepatide (Mounjaro), with people reporting these drugs have silenced their internal food chatter. Videos on the subject have gained millions of views on platforms such as TikTok, and major news outlets such as the *New York Times* have covered it.

WHERE DID IT COME FROM?

The term's origins aren't clear, but an internet search shows that "food noise" has been around for at least a decade, being used in nutrition blogs and by celebrities promoting their brands. The meaning of the term seems to have evolved in recent years, however, from the idea of being surrounded by too much food related content or unhealthy food options to constantly thinking about food and when you can next eat.

FOOD FOR THOUGHT

In a 2023 paper in the journal *Nutrients* entitled "What is food noise?" US researchers looked at the anecdotal evidence that GLP-1RAs quieten food noise in people with obesity. They found that people reported "feeling as if their lives revolved around food" and said differences in how our brains react to cues such as seeing or smelling food "might help to partially explain why some people are more susceptible than others to overeating."

NO LONGER EAR-RESISTIBLE?

Other studies have indicated that GLP-1 can affect brain levels of dopamine, serotonin, and glutamate, affecting a person's mood and potentially reducing the "reward" associated with food. Some people have said that GLP-1RAs made it easier for them to control other addictions—to drugs, smoking, alcohol, and shopping. Researchers have warned, however, that temptations may return once a person stops taking the medication.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2025;388:r98

(Continued from page 57)

across age, race, ethnicity, and sex."

Ziyad Al-Aly, assistant professor of medicine at Washington University School of Medicine and chief of the research and education service at the VA St Louis Healthcare System, suggested two possible mechanisms to explain the possible wide ranging effects of GLP-1RAs.

One is that obesity itself increases the risk of heart and kidney problems and increases risk of infections and clotting, so that "when treating obesity effectively by using GLP-1 receptor agonists you see beneficial effects that are beyond a reduction in BMI or weight loss."

He continued, "The second potential pathway is that there are GLP-1 receptors throughout the body, including in the brain, and they act to suppress centres of the brain that are involved in impulse control and reward signalling. By doing so, you can actually explain why these drugs may also reduce the risk of addiction disorders, like alcohol use disorders, cannabis use disorders, opioid use disorders, etc."

YOU SEE BENEFICIAL EFFECTS BEYOND A REDUCTION IN BMI OR WEIGHT LOSS
Ziyad Al-Aly

GLP-1 receptors also have a "stabilising effect" on the endothelial cells that line the blood vessels, meaning these drugs could have "potential effects on the heart," while research indicated that they could "reduce the propensity for clot formation and inflammation, including neuroinflammation," Al-Aly said.

But these drugs "are not without risks," he emphasised. "For example, acute pancreatitis could actually land people in the hospital or result in death."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2025;388:r123

Calorie labelling has "modest" effect on choice, says review

This may have some impact on health at the population level
Gareth Hollands

Putting calorie information labels on menus and food products has a small but important effect at a population level on the choices that people make, a large Cochrane review has concluded.

UK researchers analysed findings from 25 studies and found that calorie labels on supermarket products and on menus in restaurants led people to select food with a smaller number of calories. They identified a 1.8% reduction in calories selected when labelling was in place, which they calculated meant 11 fewer kilocalories for a 600 kilocalorie (2.5 MJ) meal.

Their results indicated that there may be a bigger effect of labelling on the food that people actually consumed (rather than just selected), with a 5.9% reduction, but the evidence to support this finding was weaker.

A previous Cochrane review published by the same team suggested a bigger effect of calorie labelling, but more high quality research has been done since then. If sustained in the long term, the results indicated that such calorie labelling policies could have a "meaningful" impact at a population level, the study concluded.

Study leader Gareth Hollands, principal research fellow in evidence synthesis and behavioural science at the UCL Social Research Institute, said that the government had estimates showing that 90% of 20-40 year olds will gain 9 kg over 10 years. Yet reducing daily consumption by roughly 1% of the recommended adult intake, or just 24 kcal, would prevent this increase happening.

Calorie labelling on menus of larger "out of home food businesses" was introduced in England in 2022. This applies to restaurants, cafes, and takeaway outlets that employ 250 or more people across the business. As part of its obesity strategy, the previous government also announced plans to consult on calorie labelling for alcoholic drinks, which are currently exempt. Only two of the studies included in the updated analysis included alcoholic drinks, and their results were too uncertain to draw

Risk of death more than doubles with long emergency waits, analysis shows

Patients who spent more than 12 hours in A&E departments were more than twice as likely to die within 30 days as those seen within two hours, even after a wide range of sociodemographic and clinical factors were accounted for, an analysis by the Office for National Statistics has found.

The ONS analysed the linked health records of 6.7 million people in England who attended an A&E department at least once between 21 March 2021 and 30 April 2022 and did not die during their attendance. Of these, 1.3% (88 657) died within 30 days of leaving A&E to return home or be admitted to inpatient care.

This was after adjustment for a range of sociodemographic and clinical factors.

The risk of dying within 30 days of discharge increased the longer the patient spent in A&E. Compared with patients requiring non-immediate care who spent two hours in A&E, the odds of post-discharge death were 1.1 times as high among patients who spent three hours in A&E, 1.6 times for six hours, 1.9 times for nine hours, and 2.1 times for 12 hours.

The data show that, among patients spending up to two hours in A&E from arrival to discharge for non-immediate care, 0.02% of patients aged 20 years died after discharge. This figure rose to 0.1% in patients aged 40 years, 0.3% in patients aged 60, and 0.8% in patients aged 80

RAMIN TALAIE/GETTY

any meaningful conclusions, the researchers said.

Although the review did not identify any difference in effects in relation to people's socioeconomic status, this was an area where more evidence was needed, the researchers said.

Not a "silver bullet"

Hollands said the updated review meant they could "now say with confidence that there is very likely a real, albeit modest, effect" of calorie labelling. He said, "This may have some impact on health at the population level, but calorie labelling is certainly no silver bullet." He emphasised that calorie labelling would ideally be used alongside a broader set of changes to place more onus on the industry rather than individuals, such as taxes, marketing restrictions, and product reformulation.

Greg Fell, president of the Association of Directors of Public Health, said the report confirmed that providing information about calorie content can help tackle obesity but added, "We [also] need continued commitment from government to limit the marketing of high fat, sugar, and salt foods, encourage reformulation, and give more power and resources to local public health authorities to introduce measures that are tailored to the needs of local communities."

Adam Briggs, senior policy fellow at the Health Foundation, also noted that the review reported very few data on the potential downsides of calorie labels, including disordered eating.

A Department of Health and Social Care spokesperson said the government was committed to tackling the obesity crisis head on with a range of measures, adding, "We will continue to evaluate the impact of out-of-home calorie labelling, including on people with eating disorders."

Emma Wilkinson, Sheffield

Cite this as: *BMJ* 2025;388:r106

Adrian Boyle, president of the Royal College of Emergency Medicine, said the "seminal" analysis "validates and reinforces what we know: long waits in A&E are extremely dangerous and a significant threat to patient safety."

"This is a serious problem that needs urgent political action," Boyle said.

The relation between total time spent in A&E and post-discharge death among patients requiring non-immediate care varied by age, region, chief complaint, and admission status, the ONS's analysis found. For example, among patients aged 20 the odds were 4.6 times as high at 12 hours in A&E as at two hours.

The ONS said that not all factors relating to time spent in A&E and to 30 day post-discharge mortality could be adjusted for. For example, data on overcrowding were not available, and some patients may have waited longer because they needed access to specialist treatments, advice, or services.

This is a serious problem that needs urgent political action Adrian Boyle

The study period was during the pandemic, when A&E departments brought in additional infection prevention control measures, meaning the results did not necessarily reflect current post-discharge mortality, the ONS pointed out. However, attendance numbers at emergency departments had largely returned to their pre-pandemic level by June 2021, after falling in the early months of the pandemic.

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r119

Bereaved families query vaccination strategy at UK pandemic inquiry

The Hallet inquiry's fourth module is examining vaccines and therapeutics. **Jacqui Wise** reports on the evidence

Prioritising keyworkers for vaccination

Giving evidence to the inquiry, Jean Rossiter, founder of Covid-19 Bereaved Families for Justice UK, questioned whether key workers such as teachers and transport workers should have been prioritised for early vaccines.

Rossiter's son Peter was a music teacher who received his first vaccine dose only in May 2021, five months after the first vaccine was given in the UK. He contracted covid soon after a delay in receiving his second dose in July. He was admitted to intensive care in hospital and died on 11 August. Covid inquiry chair Heather Hallet said, "You had a fit and healthy young son, under 40, and so it helps to remind people that we're not just about protecting people who some may think have had a good innings, we're about protecting the whole population."

COVID-19 BEREAVED FAMILIES FOR JUSTICE

Mistrust among ethnic minority groups

The inquiry heard that ethnic minority groups, people with disabilities, clinically vulnerable people, and migrants often faced major barriers in getting vaccines, antivirals, and other drugs during the pandemic. These included a lack of information in different languages, discrimination, and a lack of trust in vaccine safety.

Salman Waqar, a GP representing the Federation of Ethnic Minority Healthcare Organisations, said there was a historical mistrust of the healthcare system and of vaccines among ethnic minority groups, partly linked to under-representation in clinical trials. Another matter he raised was that the yellow card scheme for reporting side effects of drugs and vaccines was available only in English and did not collect ethnicity data.

Vaccine manufacturing capability

Matt Hancock, who was health and social care secretary from July 2018 to June 2021, told the inquiry that the UK must build its own vaccine manufacturing capability as a critical part of preparing for a future pandemic. He said that at the start of the pandemic the UK was in an excellent position with respect to research and development of vaccines but not in terms of their manufacture. He said there was an assumption that it didn't matter where vaccines were manufactured, and "in normal times it doesn't," but during a pandemic there is enormous demand and competition from other countries for vaccines.

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r114

Coroner questions suicide risk advice on SSRIs after death of financier

KINGSTON KIRSTY O'CONNOR/PA/ALAMY

Thomas Kingston and his wife Gabriella Kingston at Prince Philip's memorial service in March 2023

A coroner has questioned whether enough information is provided about the risk of suicide associated with selective serotonin reuptake inhibitors after the son in law of Prince and Princess Michael of Kent shot himself after taking the antidepressant drugs.

Thomas Kingston, 45, died of a self-inflicted shotgun wound to the head last February while visiting his parents in Kemble, Gloucestershire.

Katy Skerrett, senior coroner for Gloucestershire, has sent a regulation 28 report, intended to prevent future deaths, to NICE, MHRA, and the Royal College of General Practitioners. The organisations must respond by 3 March with proposals for action.

Her report questions if there is adequate communication of the risks of suicide associated with SSRIs and if "the current guidance to persist with SSRI medication or switch to an alternative SSRI is appropriate when no benefit has been achieved and/or especially when any adverse side effects are being experienced."

Kingston had been experiencing anxiety but had not expressed any suicidal thoughts, said Skerrett. On 25 February 2024 he took a shotgun that he had recently borrowed from his father for a shoot and shot himself in a bathroom in an annexe to his parents' property. Skerrett said he took his own life while "suffering adverse effects of medication he had recently been prescribed."

The inquest heard that Kingston, a financier, had been prescribed the SSRI sertraline and the sleeping pill zopiclone by a GP at the Royal Mews Surgery, a practice at Buckingham Palace, after complaining of poor sleep and stress at work. After he found the drugs were not working, he was switched to citalopram, another SSRI. In the days leading up to his death he stopped taking the drug.

The inquest heard the drugs had been prescribed in accordance with NICE guidelines.

If you're struggling, you're not alone. In the UK and Ireland, Samaritans can be contacted on 116 123 or jo@samaritans.org or jo@samaritans.ie

Meet the new chair of The BMJ's ethics committee

Siobhán O'Sullivan tells Zosia Kmietowicz that AI and trust are the ethical challenges of today

How did you get involved in medical ethics?

I was working in translational medicine at the Royal Free Hospital in London in 2000, and there was some discussion around the retention of children's organs without consent—sparked by what had been happening in children's heart surgery at Bristol Royal Infirmary and then uncovered at Alder Hey Children's Hospital in Liverpool in the 1980s and 1990s. Every department had to audit what materials they might have, and I was involved in doing that for our department.

These events sparked my interest in ethics and the importance of trustworthiness in the clinical research process. Trust is foundational in medicine and research: without it the quality of care can be affected, and progress can be impeded. I subsequently trained in healthcare ethics and human rights law.

In 2002 I returned to Ireland to take up a post as inaugural director of the Irish Council for Bioethics—an independent body established by the government to provide advice on ethical questions arising out of developments in science and medicine. The council was also tasked with promoting public understanding of contemporary bioethical issues with societal implications, requiring reflection on what values should underpin our efforts in these areas.

How do leaders embed ethical thinking into organisations?

Ethics requires more than guidelines: it needs safe spaces for doctors to tackle real world dilemmas. For example, during covid-19 I helped develop a framework for ethical decision making in Ireland, on issues such as resource allocation. However, doctors needed practical support for tough choices, such as deciding who gets the limited treatments.

Ethics education in medical training has dwindled, making it crucial for institutions to foster mentorship and discussion. Leaders must create environments where challenges are openly addressed, much like *The BMJ*'s ethics committee supports its community.

What have you noticed in your time in the field of medical ethics?

In my 20-plus years working in this field I've seen an evolution in awareness of the importance of ethical issues in medicine and clinical research, both at a principle and practical level. Ethics has been integrated into the medical curriculum, and grant awarding bodies and journals have been key in leveraging support for—and compliance with—meeting ethical obligations.

I do worry that in the past couple of years we've seen a retraction in the role of medical ethics. Medical ethics is now "competing for space" in medical curriculums, and there's been a decrease in funding for research in this area, with fewer and fewer established posts in the field. This decline stems partly from a misconception that ethics hinders progress—

Giving evidence to the inquest, psychiatric expert David Healy said sertraline and citalopram were essentially the same. He said Kingston's statement that he was continuing to experience anxiety while on sertraline was a sign that SSRIs did not suit him and he should not have been prescribed the same thing again.

Healy told the inquest the guidelines and labels for SSRIs were not clear enough, adding, "We need a much more explicit statement saying that these drugs can cause people to die by suicide who wouldn't have otherwise."

A NICE spokesperson said in a statement, "We will consider the matters raised by the report and respond to the coroner directly. We follow an established process when making sure our published guidelines are current and accurate and take a proactive approach to responding to events (with an assessment of priority) that may impact on our recommendations."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;388:r67

We need a more explicit statement saying these drugs can cause people to die by suicide
David Healy

Leaders must create environments where challenges are openly addressed
Siobhán O'Sullivan

an idea I reject. Ethics is about enabling innovation responsibly, equipping professionals with the tools to navigate dilemmas, and framing ethics as a supportive resource rather than a barrier.

What are the challenges ahead?

Ethics should be seen as a catalyst for progress, guiding society in defining its values and priorities. Advances in technology such as AI, robotics, and neurotechnology all have enormous potential to transform our healthcare systems, both in terms of helping us tackle increasing demographic pressures and improving patient care.

We need to ensure that these technologies are deployed transparently and equitably, mitigating risks such as inequality or misuse.

Trust in science remains critical. The pandemic showcased both the power of innovation and the public's scepticism of expertise. To sustain trust, healthcare professionals must consistently demonstrate their trustworthiness rather than relying on authority. Ethics plays a vital role in this, ensuring that progress aligns with societal values and needs.

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2025;388:r83

Ex-paediatric surgeon is jailed for home child circumcisions

A former paediatric surgeon has been jailed for five years and seven months for offences committed while operating an unsafe and unsanitary mobile child circumcision service.

Mohammad Siddiqui (below), 58, was sentenced at Inner London Crown Court after pleading guilty in October at Southwark Crown Court to 12 counts of assault occasioning actual bodily harm, five counts of child cruelty, and eight counts of administering a prescription only drug to young patients while ignoring basic hygiene rules.

NHS clinical fellow

He operated the private home service between June 2012 and November 2013 while working for the NHS as a clinical fellow in paediatric surgery at University Hospital Southampton NHS Foundation Trust. In this role he was able to source the local anaesthetic bupivacaine hydrochloride, a prescription only drug.

In 2015 he was struck off the medical register for various failures while performing circumcisions in the homes of four babies. In one case a baby was left with loss of skin on the penis shaft and had to undergo an operation. In another case he failed to recognise that the baby was having a seizure.

There is no requirement for ritual circumcisers to be medical professionals, and Siddiqui continued to circumcise boys between 2015 and 2019.

In his sentencing remarks on 15 January, Judge Noel Lucas called for regulation of people performing circumcisions "as a matter of urgency, to ensure that babies and young children are protected."

He added, "Anyone, whether they have any medical experience and training or not, is permitted to carry out non-therapeutic ritual circumcisions. These procedures are usually carried out on children who because of their age are the most vulnerable members of society.

"No training is either available or required for a person to carry out such a procedure. No guidelines have been set. No independent body oversees those who conduct such procedures. In many instances the procedures are carried out in private homes or behind closed doors."

He told Siddiqui, "In your many attempts to obstruct and hinder your trial, you have made many wholly unjustified complaints that your prosecution was motivated by Islamophobia and that persons of other religions or sects who perform circumcisions 'get away with it.' It must be clearly understood by anyone of whatever religion, creed, or sect who performs circumcisions or other procedures on children that if they fail to carry out those procedures . . . in a safe and sanitary manner, without causing the patient unnecessary pain and suffering, they will risk prosecution and a potential prison sentence."

"Complete disregard for families"

Anja Hohmeyer of the Crown Prosecution Service said, "Siddiqui showed a complete disregard for the impact of his actions on his victims, families, and communities. The delays Dr Siddiqui has caused to disrupt and elongate court proceedings while ultimately undertaking his own defence also need to be recognised.

"His actions have caused significant further disruption and distress to his victims and their families, alongside significant additional legal costs. We hope this conviction . . . brings some comfort to them."

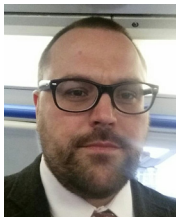
Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;388:r94

RCN report reveals scale of NHS's use of "corridor care"

Has treating hospital patients in "escalation spaces" become normalised? **Jacqui Wise** reports on the effects on healthcare staff and patients

The findings will resonate with a lot of my fellow members. But none of this is surprising
Adrian Boyle



The conditions mean patients are denied dedicated curtains, call bells, or oxygen
Nick Murch

This is a symptom of an NHS worn down by covid and a decade of too little investment
Tim Gardner

A nurse forced to change an incontinent patient with dementia beside a vending machine and a patient dying from a cardiac arrest who couldn't be given adequate CPR because of overcrowding in the corridor are just two examples from a stark new report from the Royal College of Nursing.

The report is based on a survey of 5408 UK nursing staff carried out from 18 December 2024 to 11 January 2025, in which more than two thirds (66.8%) said they had on a daily basis treated patients in inappropriate settings such as a corridor, bathroom, cloakroom, bereavement room, or converted cupboard. More than nine in 10 of those surveyed believed that patients' safety was being compromised. Nurses reported caring for up to 40 patients in a corridor but unable to access oxygen, cardiac monitors, and other vital equipment.

The report also highlights serious concerns about infection prevention and control. One nurse reported that a patient vomited on another patient because they were so close together, lined up in a corridor awaiting cubicles. The 460 page report contains many examples of patients receiving diagnoses and having discussions in public and being treated, fed, washed, and toileted with no privacy (box).

Adrian Boyle, president of the Royal College of Emergency Medicine, described the testimonies as harrowing and said the report must be a watershed moment for the government. He told *The BMJ*, "The findings will resonate with a lot of my fellow members. But none of this is surprising." He added, "For far too long the situation has become normalised."

Nick Murch, president of the Society for Acute Medicine, said that the issue of corridor care had worsened over recent years. "Our colleagues have often seen to patients in ambulances, treatment rooms, handover rooms, and extra bed spaces placed between others, often with beds touching so clinicians are unable to examine appropriately or carry out CPR effectively."

He told *The BMJ*, "It is impossible to describe the impact a cardiac arrest in a corridor has on relatives, other patients, and staff, let alone the patient suffering this as a consequence of the dire situation we find ourselves in. Colleagues say they would previously refuse to have do-not-resuscitate and end-of-life conversations in corridors, yet it is now often commonplace.

"These conditions also mean patients are denied dedicated curtains, call bells, or oxygen—all of this having a clinical and a detrimental effect on personal care and confidentiality and, therefore, reducing the safety and quality of care that can be delivered."

So many people are being treated in corridors that NHS trusts are installing power sockets and oxygen lines along corridors. The *Sunday Times* reported that Whittington Hospital in north London recently advertised for registered nurses where the role was specifically described as "corridor care" or "corridor RN."

On 13 January a joint letter signed by 15 leaders of healthcare and patients' organisations was sent to the health and social care secretary, Wes Streeting, and chief executive of NHS England, Amanda Pritchard, calling for mandatory reporting of all incidents of care delivered in inappropriate places.

An NHS spokesperson said, "All NHS trusts will begin to report a count of the number of patients who receive care within temporary escalation spaces via a new metric in NHS England's two existing situation reports from 25 January."

Call for mandatory reporting

An indication of just how much care in corridors has become normal came in September 2024 when NHS England published its *Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces*.

Julian Sheather, an ethics consultant, points out in *The BMJ* (p 86) that the title of the guidance was a contradiction, because safe and good quality care cannot be given in corridors. He wrote, "This is not good care by the standards of a G7 country; this is care reminiscent of humanitarian emergencies."

He said that corridor care harmed not only patients but the professionals

HARROWING DESCRIPTIONS FROM NURSES IN RCN REPORT

- "There have been cardiac arrests in the corridor with no crash bell, crash trolley, oxygen, defibrillator . . . straddling a patient doing CPR while everyone watches on"
- "Patients miscarrying and returning for treatment are being bedded in the busy waiting room which is used for emergency attenders and an outpatient department"
- "A patient died in the corridor but wasn't discovered for hours"
- "I could not deliver person centred care, patient was largely exposed to passers by and very distressed. There was no oxygen, suction, or calling bell—it felt very bad and unsafe"
- "I came into work to find 30 people in the corridor with four crying that they needed to use a bedpan and numerous older patients sitting in soiled blankets"
- "A 90 year old lady with dementia was scared, crying, and urinating in the bed after asking several times for help to the toilet. Seeing that lady, frightened and subjected to animal-like conditions, is what broke me. At the end of my shift I handed in my notice"

working in them. "We made exceptions for covid and for good reasons. But moral injury among health professionals has no place in ordinary care. It is a sign of a system in deep trouble."

Worst winter crisis "in history"

The Royal College of Nursing's report comes as the NHS struggles to cope with one of the worst winter crises in its history. The number of NHS trusts declaring critical incidents, citing high demand in A&E departments, reached 24 at the beginning of January, although that figure had dropped to one active critical incident last week.

The latest data from NHS England show that 96% of adult general and acute care hospital beds (97 636) were occupied in the week ending 12 January, the highest number this winter.

The winter crisis has been driven mainly by flu but also covid-19 and respiratory syncytial virus. And although flu cases in hospitals are now coming down from their early January peak, Julian Redhead, the NHS's national clinical director for urgent and emergency medicine, said that "hospitals are not out of the woods yet" and are "jampacked with patients."

It would be a mistake to think that this was all just to do with seasonal viruses, said Boyle. "Flu was the straw that broke the camel's back, but the camel's back was already broken."

Decade of underinvestment

Overcrowded A&E departments and care in corridors are nothing new. Back in 2002 Whittington Hospital was accused of leaving a 94 year old woman, Rose Addis, unwashed and untreated for three days in the casualty department. The story hit the headlines and became a political issue.

Boyle said this galvanised the government to act and establish the four hour standard for waiting times. The situation improved, and corridor care wasn't a problem 10 years ago, he said. But things have been allowed to slip and "we have allowed the NHS to get into a terrible state."

BSIP SA / ALAMY

SUCH DELAYS were a rarity before the pandemic but are now the worst we have seen since records began in **2011**

Will the elective and social care reform plans be enough to turn things around?
Liz Fisher

Tim Gardner, assistant director of policy at the Health Foundation, said, "Trolley waits in A&E—one measure of the problems in emergency care—hit record levels in 2024, with over half a million patients waiting over 12 hours for admission to a hospital bed.

"Such delays were a rarity before the pandemic but are now the worst we have seen since records began in 2011. This is a symptom of an NHS worn down by the pandemic and the decade of underinvestment that preceded it."

Political will

Streeting has pledged to "consign corridor care to history where it belongs." In a statement delivered to the House of Commons on 15 January he said, "I will never accept or tolerate patients being treated in corridors. It is unsafe and undignified, and I am determined to consign it to the history books." But he said that he could not promise that next year wouldn't see patients treated in corridors.

Boyle told *The BMJ* that tackling the problem needed to be a political priority. He said politicians were aware of the seriousness of the situation, but he worries that the priority was on elective care. "That is shortsighted. We can't prioritise one bit of the NHS over another, as it is all interconnected," he said.

Liz Fisher, a senior fellow at the health think tank the Nuffield Trust, commented, "The big question facing the government is whether its elective and social care reform plans will be enough to turn things around in the NHS. With social care facing an almost existential crisis, and the government's review not set to finally report until 2028, it is hard to see the pressures on urgent and emergency care abating any time soon."

COMMENT, pp 86-7

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;388:r99

THE BIG PICTURE

Fatal attacks on healthcare in Sudan's civil war

Médecins Sans Frontières (MSF) has withdrawn from a key hospital in Sudan's capital, Khartoum, after months of violent attacks on patients and staff.

The aid organisation announced the "very difficult decision" at Bashair Teaching Hospital—which is in an area controlled by the paramilitary Rapid Support Forces—on 9 January.

Claire San Filippo, MSF emergency coordinator, said, "Intense and extreme violence continues daily. Shortages and blockages of food, supplies, and humanitarian aid leave people scrambling to survive. The medical needs are overwhelming. Injuries are often horrific. Mass casualty incidents have become almost routine."

Nearly 26 000 patients have been treated in the emergency department since MSF arrived in May 2023, with more than 9000 having injuries from blast and gunshot wounds.

Insecurity Insights, which collects data on healthcare attacks around the world, has reported more than 500 incidents in Sudan since the war began, with at least 119 health workers killed, 87 injured, and 65 arrested.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2025;388:r109

ABOVE: A Sudanese paramilitary (RSF) soldier mans a machine gun on top of a military pickup truck outside Bashair Hospital last November

MAIN IMAGE: MSF doctors treat a patient at Al Buluk Paediatric Hospital, the only remaining children's hospital in Khartoum

WASHINGTON POST /GETTYIMAGES/A AMAURY FALT-BROWN/AFP/GETTY

EDITORIAL

Ethnic mortality differences after the pandemic

Ethnic minority groups in England and Wales have regained their lower mortality

Mortality rates in England and Wales have undergone remarkable changes over the past five years, with the pandemic bringing a surge not seen since the second world war, and big differences between ethnic groups.[1 2] With the pandemic over, it's timely to review ethnic differences in mortality before, during, and since the pandemic, and likely changes in the future.

In the decade before the pandemic, all-cause mortality in England and Wales was lower (and life expectancy higher) in most ethnic minority groups compared with the white British group.[3 4] This reflected lower mortality from several leading causes of death (eg, cancer, dementia, and chronic obstructive pulmonary disease) among ethnic minorities, although these groups experienced higher mortality from some causes (eg, cardiovascular disease and diabetes).[4] Lower overall mortality in ethnic minority groups could result from several factors, including the "healthy migrant effect,"[5] whereby healthier people are more likely to migrate, and cultural differences leading to lower rates of smoking and alcohol consumption.[6]

This pattern changed during the pandemic when covid-19 mortality was significantly higher in most ethnic minority groups in the UK, reflecting their higher exposure to infection.[2-8] For example, people from these groups are more likely to live in densely populated urban areas, work in public and patient facing occupations, and have large, multigenerational households.[9 10] Lower vaccination rates also contributed to their excess covid-19 mortality.[11 12]

During 2020 and 2021, higher mortality from covid-19 reduced the all-cause mortality advantage in ethnic minority groups over the white British group and reversed it in Bangladeshi and Pakistani groups and black Caribbean men, groups with the highest covid-19 mortality.[14] The rapid change reflects the differing vulnerabilities to infectious and non-communicable diseases. Non-communicable diseases such as cancer and dementia are caused mainly by genetic, physiological, behavioural, and environmental factors over the life course, providing some protection to ethnic minority groups.[15] However these factors offered no protection against a highly infectious, fast acting agent like SARS-CoV-2.

KATHY DEWITT/ALAMY

Harnessing the power of ethnicity data is vital for understanding and addressing ethnic differences in health and mortality

As the acute impacts of the pandemic subsided, excess mortality from covid-19 fell in all ethnic groups in England and Wales.[14] By 2022 ethnic differences in all-cause mortality had reverted to pre-pandemic patterns, with most ethnic minority groups again having lower all-cause mortality than the white British group; cause specific mortality also reverted to pre-pandemic patterns.[16]

Understanding mortality differences

That overall mortality is lower among ethnic minority groups than the white British group may come as a surprise. However, the patterns of cause specific mortality are consistent with wider epidemiological literature on ethnic differences in disease prevalence and mortality in the UK.[17] Similar patterns of lower mortality among migrants are seen in some other high income countries such as Sweden, Germany, the US, and Canada.[5]

The mortality advantage in migrant and second generation groups wanes over time as selection effects wear off and they are increasingly affected by social and environmental exposure and behavioural changes resulting from cultural assimilation.[5-21] Mortality patterns in ethnic minority groups in England and Wales could therefore look different in future and possibly be higher, depending on migration levels.

Harnessing the power of ethnicity data is vital for understanding and addressing ethnic differences in health and mortality. This was never more evident than during the pandemic, when timely analyses from the UK Office for National Statistics were critical for improving public understanding of ethnic differences in covid-19 outcomes and informing strategies for saving lives and reducing the unequal harms of the virus.

The Organisation for Economic Co-operation and Development and World Health Organization have called for improved availability and monitoring of health data by socioeconomic characteristics, including ethnic group, to address inequalities in health.[13 22]

The UK is now among the international leaders on ethnicity data in health, having reported on ethnic inequalities in health for several years. The pandemic facilitated further information developments, including record linkage across health and related datasets, thereby extending the range and depth of analyses and monitoring that is possible. This resource should be exploited extensively to improve health and reduce the morbidity and mortality burden in ethnic minorities.

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Cite this as: *BMJ* 2025;388:q2856
Find the full version with references at http://dx.doi.org/10.1136/bmj.q2856

EDITORIAL

UK needs national alcohol strategy to tackle harms

Sustained funding is needed for screening and care, but industry must also shoulder costs

Alcohol is widely available and drunk by around 80% of adults in the UK. No safe level of alcohol consumption has been established,[1] and it is well recognised as a leading preventable cause of cancer.[3]

The health and social harms of alcohol are higher in socially disadvantaged groups[4] despite lower rates of use than in more advantaged groups. This "alcohol harm paradox" means that alcohol consumption is a significant contributor to health inequalities and premature death.[5-7]

The challenges faced during the covid-19 pandemic[8 9] resulted in more people drinking alcohol at higher risk levels.[10 11] Deaths from alcohol specific causes in England also rose by 42.2% between 2019 and 2023, the highest number on record, most of them from alcohol related liver disease.[12 13]

Successive government budget cuts since 2013 have led to reduced provision and quality of alcohol treatment.[14] In 2020-21, fewer than 1% of people being treated for alcohol dependence in England and Wales received treatment in a residential rehabilitation setting, compared with the European average of 11%.[15] Currently, only 15-18% of people who are alcohol dependent access alcohol services.[16] This is low compared with other illnesses (eg, 70% of people with diabetes access care),[17] and 21-43% of people affected by alcohol dependence say that shame would stop them seeking support.[9]

As the quality and quantity of specialist alcohol treatment has decreased, unscheduled admissions to acute hospitals for alcohol withdrawal have increased substantially, highlighting missed opportunities to intervene early and save NHS resources.[18 19]

Achieving system change

A national strategy to tackle the harms caused by alcohol is long overdue,

DAISY DAISY/ALAMY

Earlier intervention would improve outcomes

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and important for reducing health inequalities. Universal screening for higher risk alcohol consumption should take place in primary care, acute hospitals, and mental health services. This would enable clinicians to identify and manage patients earlier and pick up alcohol related harms (eg, liver disease). Earlier intervention would improve outcomes and better target treatment where it is most effective. Screening would also generate systematic data to facilitate quality improvements. Without an overarching strategy, attempts at universal screening to date have been patchy and short lived.[20]

Sustained funding is needed to develop and deliver integrated alcohol care pathways across health and social care, to tackle the UK's inadequate treatment services and absent secondary prevention. Currently, 71% of adults and 48% of young people entering alcohol treatment services require mental health treatment.[21 22] Between 2010 and 2020, 48% of people who died by suicide while under the care of mental health services had a history of problematic alcohol use.[23] Despite numerous policy recommendations[24] few mental health trusts have a crisis care pathway in place to respond to the needs of suicidal people who are also alcohol dependent. In 2019, the NHS long term plan committed to "optimise" alcohol care teams in 25% of acute hospitals with greatest clinical need.[25] However, this was not linked to other services and was deprioritised in March 2024. Many teams are now being dismantled, having barely become established.

The alcohol lobby continues to frame the problem of overconsumption (and its solutions) as one of individual responsibility rather than confronting its role in marketing of alcohol and downplaying the associated harms.[26] Whereas the gambling industry is subject to a "polluter pays" levy for associated health and social harms,[27] alcohol producers have received a decade of cuts or freezes to alcohol duty, widening rather than limiting their market. A national strategy would help frame a more consistent response to the tobacco, gambling, and alcohol industries.

Finally, we need to resist the normalisation of alcohol consumption in society. This is reflected in the ambivalence of health professionals towards asking people about their alcohol use and contributes to the stigma and shame experienced by people with alcohol related harm. The recovery community's input to the design and delivery of training and service provision may help tackle this.[28 29]

Scotland's 2009 alcohol strategy, refreshed in 2018, established national data systems on admissions to hospital for alcohol harm by levels of deprivation, introduced public health measures (including a minimum unit pricing),[30] and required an impact evaluation.[31]

The UK needs a national strategy to implement wide-ranging, evidence-based policies that together would reduce alcohol related harms. The costs of alcohol harms to individuals and society are well documented, at over £27bn in England alone.[32] But as Scotland shows,[13] much can be done when there is the government will to do it.

Cite this as: *BMJ* 2025;388:r38

Find the full version with references at http://dx.doi.org/10.1136/bmj.r38

OBESITY CARE

Can weight loss drugs like Wegovy treat obesity in children?

GLP-1 agonists for weight loss are now commonly used for adults, but might they also be for younger people? **Katharine Lang** reports

KKSTOCK/ALAMY

Obesity in children and adolescents is a growing problem. In 2022, according to NHS data, 15% of children aged between 2 and 15 were living with obesity in the UK. In the US the figure is closer to 20%, or one in five of those aged under 19.

Untreated obesity in children and adolescents can lead to lifelong health problems, including type 2 diabetes, chronic kidney disease, and cardiovascular disease, as well as mental health problems.

Glucagon-like peptide-1 (GLP-1) receptor agonist drugs such as liraglutide (Saxenda) and semaglutide (Ozempic, Wegovy) are being hailed as game changers in treating adult obesity, and possibly many other health conditions. Could they be equally useful in the treatment of younger people with obesity?

Yes, says Julian Hamilton-Shield, professor in diabetes and medical endocrinology at the University of Bristol. "It's certainly the case that adolescents and children seem to respond to these drugs in the same way that adults do, in that they lose large amounts of weight, it reduces their appetite, and they're able to leave food on a plate which they have never been able to do before. I would argue that the evidence is, overall, that they are clinically very effective."

GLP-1 agonists are not yet widely available for children and adolescents, however, as NICE has yet to publish guidance on their use in this age group. NICE told *The BMJ* that it is "unable to make a recommendation on liraglutide for managing obesity in those aged 12 to 17 because manufacturers Novo Nordisk did not provide an evidence submission." NICE is also still waiting for an evidence submission for semaglutide from Novo Nordisk. "We stand ready to review this decision if the company decides to make a submission," a NICE spokesperson said.

How is obesity currently treated in under 18s?

Structured weight management—diet, exercise, and lifestyle change—is the first course of action to promote weight loss. Failing this, there are few treatments available for young people with obesity not caused by a genetic syndrome.

"There aren't really any drugs for these children," says Hamilton-Shield. "Orlistat [a lipase inhibitor] has very poor compliance, because if you eat a burger you get oily diarrhoea and bloating, and you feel really uncomfortable. So people either stop taking the tablet when they're having a burger, or they take it when they are having a low fat meal. So that never really worked. And there are no other drugs available for children."

The situation is similar in the US. Rebecca Hicks, a paediatric endocrinologist in Long Beach, California, says, "Drugs that have been used off label in children and young people include metformin, a type 2 diabetes treatment that improves the action of insulin, and lisdexamfetamine, a stimulant used to control impulsive behaviour.

In the US bariatric surgery can be considered for those aged 14 years and over
Rebecca Hicks

"Additional interventions include behavioural therapy incorporating motivational interviewing and mindful eating approaches. In the US bariatric surgery can be considered for those aged 14 years and over or nearing growth completion with severe obesity that has not responded to lifestyle changes and medical therapy."

What is the evidence for GLP-1 agonists for children?

So far, studies show that GLP-1 agonists, in conjunction with diet and increased physical activity, seem to have effects in children similar to those seen in adults, promoting weight loss in most.

Most studies have been in adolescents, with a paucity of data for children under 12.

In a 56 week study of liraglutide, a daily 3.0 mg subcutaneous injection resulted in 51 of 113 (43.3%) adolescent participants reducing their body mass index (BMI) by more than 5% and 33 (26.1%) by more than 10%, compared with 20 of 105 (18.7%) and 9 (8.1%) of those on placebo.

In 12 to 17 year olds, semaglutide promotes greater weight loss than liraglutide. A multinational study of semaglutide (2.4 mg weekly by

subcutaneous injection) in 12 to 18 year olds recruited 201 participants, all of whom had a BMI at or above the 95th percentile or a BMI above the 85th percentile in addition to one weight related comorbidity. A total of 132 on semaglutide and 64 on placebo completed the 68 week trial. The mean percentage change in BMI from baseline to week 68 was −16.1% for semaglutide and −0.6% for placebo. By the end of the study, 95 out of 131 (73%) of those on semaglutide and 11 out of 62 (18%) on placebo had lost at least 5% of their body weight.

Only one clinical trial for children under 12 had been published at the time of writing. This study randomly assigned children in a 2:1 ratio to liraglutide (3.0 mg, or the maximum tolerated dose, daily by subcutaneous injection) or placebo for 56 weeks. The mean change in BMI was −5.8% with liraglutide and −1.6% with placebo.

A recently published observational study showed similar weight loss effects in clinical practice in children and adolescents aged between 10 and 18. All participants were attending a tertiary weight management clinic for obesity and had at least two comorbidities—such as insulin resistance, type 2 diabetes, metabolic associated fatty liver disease, obstructive sleep apnoea, or hypertension. All were treated with semaglutide, at a maximum dose of 1 mg by once weekly injection.

After six months clinicians noted statistically significant reductions in BMI standard deviation scores and body weight. In 14 patients treated for 12 months, weight loss continued. The authors note, however, "Further paediatric long term studies examining whether the weight loss effect plateaus and the potential rebound weight gain after stopping are needed."

What side effects have been seen?

In these trials, most of the children and adolescents taking the treatment experienced the same side effects seen in adults—nausea, bloating, vomiting, and diarrhoea—but few were severe enough for them to discontinue treatment.

Hamilton-Shield said such side effects are unsurprising, "It's a gastrointestinal hormone, so it's going to have gastrointestinal side effects." And for most participants, the side effects lessened with time.

Long term drug treatment of children raises concerns about the possible effect on growth and reproductive development. Stephen O'Rahilly, professor of clinical biochemistry and medicine, University of Cambridge, says he has not seen direct evidence of such effects. "There's no reason to be unduly concerned that there's some mechanism of action that's going to affect growth and reproduction. That said, until we have trials, we can't be certain," he says.

A lot of research has been put into childhood obesity prevention, with a universally negative result
Julian Hamilton-Shield

Simple dietary advice does not work in obese children
Stephen O'Rahilly

Who can access the treatments now?

"The major problem is that GLP-1 agonists are not readily available. Some clinics have access to GLP-1 agonists through the NHS, and others don't," Hamilton-Shield says.

"NHS England are looking into it, but there is a disparity in the ability to prescribe GLP-1 agonists in adolescence," he adds.

Access is equally challenging elsewhere. "As of now," Hicks says, "there are no GLP-1 agonists that are approved for weight management in children under 12 in the US or other countries. Liraglutide (Victoza), dulaglutide (Trulicity), and exenatide (Bydureon BCise) are approved for type 2 diabetes for those who are 10 and over. Semaglutide and liraglutide are approved for children 12 and over for weight management under specific criteria."

Who might benefit most?

While emphasising that GLP-1 agonists are not suitable for all young people with obesity, Hamilton-Shield has seen dramatic effects in those with comorbidities because of their excess weight.

"What people underestimate is that there is a large proportion of young people living with obesity or excess weight who have pathology at the time you are seeing them," he tells *The BMJ*. "These are young people who've already got type 2 diabetes, obstructive sleep apnoea, or abnormal liver function. They will respond to weight loss.

"The availability to paediatric units is not universal, however, and it's not equitable. I know of clinics that are using semaglutide and getting fantastic results"

As with adults, there are some patients for whom the treatments are ineffective, but Hamilton-Shield says, "In certain groups of patients it does effect a huge amount of weight loss, which can be significantly modifying to their pathogenesis and disease progression."

He adds, "Having spoken to patients I've prescribed this for, I'm certain it has an effect on their appetite. They say that for the first time in their lives, they've left food on their plate, and their parents say that for the first time in their lives they're not asking for food all the time.

"Some manage to maintain their weight loss a year, more than a year, after they come off the drug. [In] Others, I've seen [weight] go up. It's not surprising—if you have to give the drug once a week, or even once a day, to have an effect then it's not surprising that some people seem to rebound."

He stresses, however, that "even if adolescents regain all the weight they've lost, if they'd carried on gaining weight over the two years, they'd be even heavier."

What does the future hold?

Hamilton-Shield thinks the drugs are worth trying. "All the people saying that we shouldn't be treating childhood obesity, we should be preventing it—well, they'd better find something better than what's been tried to prevent it in the past 30 or 40 years, because none of it's worked. A lot of research money has been put into childhood obesity prevention strategies, with a universally negative result," he says.

O'Rahilly says, "We know that simple dietary advice does not work in obese children, so you are left either saying we do nothing, or we do something that will be efficacious and we don't know yet what the risks are. It's a difficult balance."

"Broadly," he adds, "I would anticipate that in the future we will see more, rather than less, drug prescribing for obesity in childhood and adolescence."

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Cite this as: *BMJ* 2025;388:q2656

Protecting the support for doctors feeling trapped, overburdened, and facing burnout

Increasing numbers of medics are struggling at work, while the support available to all healthcare workers is at risk. **Emma Wilkinson** investigates

When Anne Noble, a GP in Sheffield, contacted NHS Practitioner Health she was feeling hopeless and couldn't see a way out. Working as a partner in a deprived area for 10 years had taken its toll. Every consultation was complex and emotionally challenging. She was experiencing moral injury (box 1) and feeling overwhelmed at how little she could help.

That phone call with NHS Practitioner Health—a free, confidential NHS primary care mental health and addiction service for doctors—gave her the external validation she needed to take a break. She was signed off sick for a month.

"I do feel massively lucky we have that as a resource, because there was that unique recognition of what was happening for me," says Noble. She hadn't felt able to speak to her own GP about it, she wasn't interested in taking medicines, and although NHS counselling was an option, she knew that cognitive behavioural therapy wasn't the answer either.

The most recent GMC annual report into doctors' workplace experiences, which drew on data and research from 2023, found that almost a quarter of doctors (23%) had taken a leave of absence in the past year owing to stress. One in three (33%) were found to be "struggling"—regularly working beyond rostered hours and feeling unable to cope with the workload. The figures in general practice were particularly stark, as 48% said that they were struggling.

A GMC survey found 39% of doctors were at risk of burnout in 2023

In all, 39% of doctors were at risk of burnout in 2023, the GMC found, lower than 2022 but higher than 2021. The GMC's chief executive, Charlie Massey, has called on employers and healthcare bodies to respond urgently and make "targeted changes" to support doctors and prevent them experiencing burnout or leaving (box 2).

What is burnout?

The World Health Organization describes burnout as an occupational phenomenon resulting from chronic workplace stress. While it's included in the 11th edition of the International Classification of Diseases, it's not a medical condition or mental illness, although it can co-occur with substance misuse and depression.

Burnout is defined by feelings of exhaustion, increased mental distance from your job (or feelings of negativism or cynicism related to work), and reduced professional efficacy. In short, you start to become detached and depleted and feel as though you're not as good at your job as you once were.

NHS Employers notes that staff in clinical roles are more likely than most to experience burnout. Chronic workplace stress is a key factor, and the King's Fund has reported that it's "increasingly normalised" for NHS staff to have multiple competing urgent requirements that overlap with making major clinical decisions.

Research presented last year at the Society for Academic Primary Care, based on interviews with GPs who had experienced burnout, found that GPs didn't lack resilience but needed organisational support to help reduce and manage their distress.

Orla Whitehead, an academic GP at Newcastle University who conducted the research, found that GPs she spoke to were highly motivated, self-reflective, and resilient—but they had felt stigmatised at having to be away from work. The empathy, dedication, and perfectionism that had pulled them into the vicious cycle that led to burnout also made them good GPs.

Noble explains that she hadn't wanted to let her partners down and had felt incredibly trapped. That mindset "where you don't go off sick and you work long hours" starts at medical school, she adds. When she was in training, a friend of hers died suddenly. She went to work the next day without even considering it might not be a good idea. In the intervening years she'd worked intense hours, through a pandemic, and had had two children. "It was a recipe for distress and burnout," she says.

Threats to support

Last April doctors reacted with outrage to the news that NHS Practitioner Health, which is funded by the NHS in England, would be closed to new sign-ups. At the time, NHS England said it was carrying out a wider review of how all staff groups received support—most of which, it said, was through employers' health and wellbeing schemes. Such was the strength of feeling it took only a weekend for the decision to be reversed.

However, long term funding remains up in the air. When asked, NHS England said it was "committed to tackling burnout by ensuring staff get the support they need."

Box 1 | Moral distress and moral injury

The BMA defines moral distress as "where institutional and resource constraints create a sense of unease among doctors from being conflicted about the quality of care they can give."

Moral injury, the union says, can arise where sustained moral distress leads to impaired function or longer term psychological harm.

Moral injury can produce profound guilt, shame, and in some cases a sense of betrayal, anger, and profound "moral disorientation." It's also been linked to severe mental health problems.

Research has shown that the staff contacting NHS Practitioner Health services were sicker or had more serious addictions than those generally using other NHS mental health services, and some were also going through regulatory procedures. Stigma and fears about confidentiality are also major concerns among those the service supports.

Clare Gerada, former president of the Royal College of General Practitioners and the founder of NHS Practitioner Health, says that there's always been a lack of understanding about why doctors need a specialist service. She speaks from experience, having had burnout when her children were small.

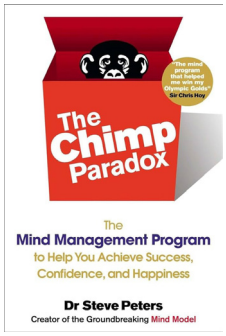
Staff contacting NHS Practitioner Health were sicker than those using other mental health services

"I realised that I was giving more to my patients than I was to my own children, and their childhood was running out, and I just felt so sad," she says. "I'd stopped caring for patients, I'd stopped being curious for them, and I felt more and more despondent."

Gerada took five months off to write a book and didn't even walk past the practice despite it being local. She reorganised her life and her roles at the practice when she returned "and never looked back." Her son is now a social worker. As a matter of routine, social workers discuss ongoing cases and can reflect on and learn from practice with their wellbeing in mind—something the medical profession could benefit from, she says.

In her book on burnout, which explores why doctors are at high risk, Gerada says that the condition often affects those who have been the most "idealistic, enthusiastic, and engaged." She's unequivocal about what the NHS should do to tackle the problem. "There needs to be a centre for wellbeing of the workforce, akin to the Care Quality Commission, that advises trusts and lobbies on behalf of the profession," she explains.

At certain points in their career, doctors need access to supervision,



Box 2 | Psychological intervention to beat burnout

A trial involving around 350 doctors run by Rotherham Doncaster and South Humber NHS Foundation Trust is assessing the effectiveness of a specific psychologically based intervention for occupational burnout.

Based on a Mind Management Skills for Life programme developed by the consultant psychiatrist Steve Peters and also referred to as the Chimp model, the trial involves sessions of guided self-help on practical strategies to help individuals understand their mindset and to set actions according to their life goals.

NHS England is funding research into the usefulness of this approach in doctors, after a clinical trial of the intervention in mental health nurses found moderate improvements in burnout and wellbeing. Doctors have been recruited from around England, and results are expected in spring 2025.

NOT ALONE

Claire Davies is a GP who began to work as a coach after experiencing burnout due to work and personal circumstances. Her main message: do not think that nothing can be done. "That is what keeps people trapped," she says. "So, by the time they have to seek help, they end up with six months off sick. It's very common, but people do feel very alone with it."

Davies is keen for doctors to be aware of the available tools that can prevent someone from reaching that point. Facilitated groups such as Schwartz rounds should be much more commonplace, she adds. The BMA also has an online questionnaire for people worried that they may be burning out. "There's a huge amount of help available, and ultimately you will help more people, and fulfil your values in the long term, if you take the time you need now to look after yourself," says Davies.

For GP Anne Noble, looking after herself meant getting back to what she loved about being a doctor. In April 2022 she moved with her family to the Isle of Skye for a year and found a different pace of life as an island GP. Now working back in Sheffield as a salaried GP, she's changed her approach to work and has taken on a new palliative care leadership role one day a week.

She says, "Skye was a huge break that taught me I didn't have to be in the same place forever—I can do different things. It was a reset. The work is no different now, but my mindset has completely changed."

By the time they have to seek help, they end up with six months off sick. It's very common, but people do feel very alone

mentoring, peer support, and reflection away from the day-to-day job, says Gerada. This could be when they're newly qualified, in the first five years, mid-career, and moving towards retirement. No more reviews are needed, she adds. "We never learn from the past—we just recreate the wheel."

Employers' role

NHS Employers has set out guidance for NHS organisations to support staff and help avoid burnout. This includes ensuring optimum staffing levels where possible, shifting towards a culture of prevention and early intervention, and recognising the pressures of "maintaining a hero identity."

The Enhancing Doctors' Working Lives programme has been running since 2016 under NHS England's workforce, training, and education directorate. The most recent annual report, from 2023, points to work being done to support flexible careers and working less than full time, as well as building a more supportive culture within NHS organisations for doctors who are in training or returning after a break.

For some doctors, burnout can lead to an incredibly dark place. Of around 6500 clinicians who contact NHS Practitioner Health in a year, a third say that they've had suicidal thoughts.

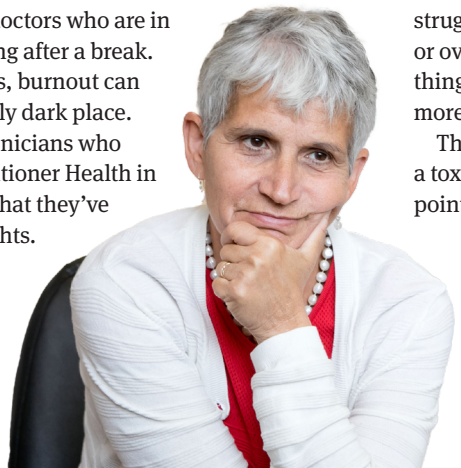
Ananta Dave, a psychiatrist and chief medical officer of the Black Country Integrated Care Board, last year published a review of suicide in the medical profession, looking at the whole of a career from student onwards. Among her 10 recommendations are provision of reflective spaces, teaching and training on mental illness and suicide prevention for staff, and accountable officers for mental health and wellbeing in all organisations. She also wants to see a centre of excellence set up to share best practice.

Burnout essentially arises out of poorly managed workplace conditions
Ananta Dave

Dave says that the statistics on burnout among doctors are damning and that the onus should be on employers to frame workplace culture. "Burnout essentially arises out of poorly managed workplace conditions," she says. "The important thing in all this is early recognition and a culture where senior leaders encourage staff to come forward. They can do that by modelling healthy behaviours and self-care, talking about sources of support, and signposting people to them."

It's also vital that anyone who does come forward to say that they're struggling is not bullied, harassed, or overlooked, she adds, because "if things are left to fester it can become more difficult to recover from."

The medical profession has had a toxic culture for a long time, she points out, which has made it hard for people to admit that they're struggling, as it was seen as a sign of weakness.



We never learn from the past—we just recreate the wheel
Clare Gerada

Work being done by a range of organisations is helping to "chip away at these myths," says Dave—including efforts from the GMC, NHS Employers, and the royal colleges. She's working with the Royal College of Psychiatrists to develop a retention charter for organisations to sign, including compassionate and inclusive leadership. "The more people talk about it and share personal stories, it gives people hope that you can recover from this and come out the other side," she says.

A spokesperson for NHS England says that NHS staff are working incredibly hard to meet rising demand for care, which can take a toll on their wellbeing: "While there is more we could and should do, the NHS is offering more flexible working options than ever before, and there is a range of mental health support available for staff, including access to coaching and wellbeing resources."

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Cite this as: *BMJ* 2025;388:q2858

If you need urgent help you can contact NHS Practitioner Health at www.practitionerhealth.nhs.uk or tel 0300 0303 300. After hours, you can text NHSPH to 85258.

If you're struggling, you're not alone. In the UK and Ireland, Samaritans can be contacted on tel 116 123 or email jo@samaritans.org or jo@samaritans.ie.

WHY I... play video games

Jamie Sherrington, a GP and child palliative care doctor, tells **Kathy Oxtoby** how video games offer him an escape from his busy medical roles

Jamie Sherrington is a GP at Okehampton Medical Centre in Devon who also works at children's hospices in Devon and Cornwall as a doctor in paediatric palliative care. He finds his work "incredibly rewarding."

At the hospices, he'll go on the Playstation with the children. "Playing video games means you can be on the same level with them, and it helps them to see me as a normal person and not a 'scary' doctor," he says.

He recalls one child with severe disabilities, "who in the real world couldn't walk, but in the video world could fly. Playing video games meant they could be a superhero."

There is joy that comes from working at the hospices, and then there are days that can be very difficult. "You come home and you're not yourself. Playing video games is how I unwind," Sherrington says. "My wife Ana, who is also a doctor, says she can tell if I've been playing video games for a time, because I'm much calmer and happier."

Growing up in the 1990s, Sherrington said most kids of his generation played video games. At medical school, playing helped him to study. "Throughout my entire medical degree I played a game called Skyrim—an action role playing game where you save a magical world. It was great escapism."

During his foundation years, and since qualifying as a GP four years ago, he has found gaming to be a good way to separate the medical world from his home life.

He plays all sorts of games. As well as action adventures, there are also "cosy games" which have relaxing tasks and include activities like nurturing animal characters.

You come home and you're not yourself. Playing video games is how I unwind

A smart phone or computer are all that is needed to join the gaming world, but there are also consoles which cost around £600, he says. Some games are free, while others can cost up to £100.

As a gamer you don't need to play alone. "Through social media, I've ended up amassing a group of medics who play video games, who come from all over the country and across the world," he says.

Sherrington's love of being a clinician is also reflected in his gaming. "If there's a game that has a doctor role or healing role, I almost always go for that. And with games that require you to 'build' a character I always build a healer."

He recommends other doctors take up gaming as it offers excellent escapism. "Some of these games are like blockbuster movies, and you aren't just watching the main character—you are the main character," he says.

"It can also be quite sociable. I don't have much time to meet up with people, but you can play for an hour or two with people online and socialise with those you might never meet."

Gaming has "something for everyone," Sherrington says, and it can open up worlds with limitless possibilities. "Sometimes these games can allow people who can't walk, to fly."

HOW TO MAKE A CHANGE

- Look for a genre that appeals to you—for example, cosy games or action adventure
- Watch snippets of games on YouTube to see what you might be interested in
- There are lots of demos to try free of charge, and your phone has lots of free games too
- Don't get disheartened by difficulty. Playing a game at the lowest difficulty rating to enjoy the scenery and the storytelling is as valid as anything else
- Many of the games you may have loved as a child are still available as reboots or remasters

Kathy Oxtoby, London

Cite this as: *BMJ* 2025;388:q2832

CAREERS CLINIC

I've been asked to do something that falls outside of my role

There are ways to deal with this, **Abi Rimmer** hears

Establish boundaries early

Ashley Simpson, medical education fellow, NHS Lothian

"Being asked to undertake a task you believe is outside your role can be challenging.

"As a resident doctor rotating though departments, it's important to clarify the typical responsibilities of team members in each setting. A task outside your role in one department may fall within it in another. Establishing role boundaries can empower you to handle situations like this more effectively.

"Occasionally you may be asked to complete tasks typically assigned to others—for example, phlebotomy—because of workload or staffing pressures. In these instances, working collaboratively may be the best approach for patient care. If this becomes a frequent occurrence, impacting your own clinical responsibilities or professional development, you should escalate this to your clinical or educational supervisor.

"The General Medical Council (GMC) requires doctors to work within their competence. If you are asked to perform a task that you are not trained to undertake, you must voice this.

"In emergencies, you may not have time to pause and seek advice. In these rare situations when there are no alternatives, adaptability may be required to provide the safest care possible, even if the task is outside your usual remit. In such instances, perform the task to the best of your ability, document your actions transparently, and seek senior guidance as soon as possible."

Stepping up can be positive

Shamim Nassrally, consultant physician, Guys and St. Thomas' NHS Foundation Trust

"If you're asked to take on a task or role outside your usual duties, how you approach it will depend on several factors, with the context being key. The GMC's guidance emphasises that doctors must 'provide a good standard of practice and care and work within [their] competence.'

"For instance, stepping up as the internal medicine trainee year 3 registrar on call as an internal medicine trainee year 2 who has membership of the Royal Colleges of Physicians could align with these standards, given your qualification and experience. Performing an unsupervised procedure that you are unfamiliar with would breach these principles, however, and potentially jeopardise patient safety.

"When deciding whether to take on such a role, there are several key factors to consider. The first is competence and confidence. You must feel personally satisfied that you possess the professional competencies required to fulfil the role effectively and safely.

"The second is supervision and support. Ensure there will be adequate supervision proportional to the demands of the role. It's essential to have a shared understanding with your supervisor that, because of the unfamiliarity of the task, you may need additional guidance and support.

"Finally, consider whether the role offers opportunities for personal and professional development, and ensure you are recognised and acknowledged for taking on the additional responsibility."

Can someone support you?

Nikki Nabavi, academic foundation doctor

"As a foundation doctor I've already noticed how often tasks are asked of me that fall outside the remit of my role, for myriad reasons.

"Firstly, ask yourself, 'Why have I been asked to do this?' Staffing and resource provision are regularly stretched, so this could be the reason.

"Before you undertake the task, ask yourself if you are competent to carry it out safely. Is there anyone else more appropriate who is available to do it?

"Assessing what you should and shouldn't do is easier said than done, as often the list of tasks feels endless, and it becomes a matter of effective clinical prioritisation. If you feel overwhelmed ask yourself, 'If I do this task now, can anyone support me with my other tasks? Can any of my other jobs be handed over?'

"If you do take on extra tasks, it's important to reflect on why they landed on you. Was the shift understaffed? Is there a systemic problem that means it keeps happening? Is it compromising your ability to continue with the other tasks expected of you? If so, it's important to escalate this to seniors.

"Finally, if you have capacity and are competent to carry out this additional task—why not do it? There are many benefits to spending extra time with patients and building connections with them or other members of the multidisciplinary team. The role of a doctor is not as rigid in its definition as we may have been taught."

Cite this as: *BMJ* 2025;388:q2869