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MATTHEW SAYWELL/BMA

Resident doctors urged to avoid strikes

Six well known senior clinicians have urged resident doctors to reject a call from the BMA for strike action over pay, arguing that such action would be futile and damaging.

A letter signed by Clare Gerada, former chair of the Royal College of General Practitioners and who also served on the BMA's council, and John Oldham, a health adviser to several governments, published on 8 June in the *Guardian*, acknowledged the significant problems with conditions and training that need "firm resolution" but said "this will not be achieved through strikes."

Last month the BMA sent ballot papers to its resident doctor members on possible industrial action after an award of an average 5.4% pay rise (made up of a 4% increase and a £750 consolidated payment), which it said failed to move towards pay restoration.

The ballot closes on 7 July, and if members vote for action the BMA will have a mandate for action lasting from July to next January.

The letter continued, "A strike now would harm patients and diminish the cause of these doctors. The calls to strike misjudge the mood in the country. There is no spare money—this is a futile gesture, guiding people into a maze without a thread."

Another strike would undermine the NHS and diminish its ability to function, said the authors, who also included David Colin-Thomé , a former national clinical director for primary care; James Kingsland, of the University of Central Lancashire, a former ministerial adviser; Fiona Cornish, a GP in Cambridge and former member of the BMA's General Practitioners Committee, and John Ashton, former regional director of public health for North West England. "We urge resident doctors to keep to the spirit of the Hippocratic oath—vote for the NHS and vote no to strike action," the letter ended.

The co-chairs of the BMA's Resident Doctors Committee, Melissa Ryan and Ross Nieuwoudt, responded to the call, saying, "Resident doctors are paid 23% less than in 2008. Even after this year's pay award it would still need a rise of 26% to bring pay back to that level. We don't believe any of the doctors in this letter are worth 23% less than in 2008, and neither presumably do they."

At the rate being suggested by the health secretary, Wes Streeting, it would take more than a decade to restore pay levels, they added. "No doctor wants to strike. All Mr Streeting needs to do is follow his own advice when he was in opposition and negotiate with us in good faith."

Adrian O'Dowd, London

Cite this as: *BMJ* 2025;389:r1196

Melissa Ryan and Ross Nieuwoudt, co-chairs of the BMA's Resident Doctors Committee, said their members' worth had not dropped 23% since 2008

LATEST ONLINE

- NHS England faces investigation over granting Foresight access to GP patient data
- NHS calls for more blood donors amid risk of shortages
- Deprivation in childhood has lifelong effects on health

MEDICAL NEWS

Weight loss drugs could make oral contraception less effective, MHRA warns

Women who take weight loss drugs should use barrier contraception if they are trying to avoid pregnancy, the MHRA has advised. The agency said it had received reports of 40 pregnancy related adverse events but that this number was likely to be inaccurate because it is not compulsory for yellow card reports to include whether a patient is pregnant.

Women should also be advised not to take weight loss drugs during pregnancy, while trying to get pregnant, or when breastfeeding because there are not enough safety data to know whether taking the drugs could harm the baby.

This advice is already contained in patient leaflets that accompany glucagon-like peptide-1 (GLP-1) drugs—semaglutide (Ozempic and Wegovy), tirzepatide (Mounjaro), and liraglutide (Saxenda and Victoza)—but the MHRA said some people were not using these drugs safely.

Alison Cave (left), MHRA chief safety officer, told BBC Radio 4's *Today* programme, "There is evidence from animal studies that these medicines may harm the unborn baby, but we don't know whether we would see the same effects in humans. Much more data is needed to determine that, and therefore this is precautionary advice."

Adrian O'Dowd, London **Cite this as:** *BMJ* 2025;389:r1169

Cancer

Liquid biopsy becomes available in England

A blood test that speeds up cancer diagnosis by two weeks and can help patients with suspected lung or breast cancer receive targeted treatment is now available across the NHS in England. The circulating tumour DNA (ctDNA) test will be used before traditional tissue biopsies in a "blood test first approach," said NHS England. The NHS will be the first national service in the world to offer liquid biopsy testing routinely. As many as 15 000 patients with suspected lung cancer and 5000 with advanced breast cancer could benefit from the test each year.

Regulation

Fake doctor is told to repay NHS £400 000

A woman who faked her medical degree and worked as a psychiatrist in the NHS for more than 20 years has been told she must pay back more than £400 000 or serve more jail time. Zholia Alemi dropped out of her course at the University of Auckland in New Zealand but obtained registration with the GMC after producing a forged certificate and a letter of verification with the word "verify" misspelt. She was jailed for seven years in 2023 after being convicted of 13 counts of fraud.

Paediatrics

Parents' intuition should not be ignored

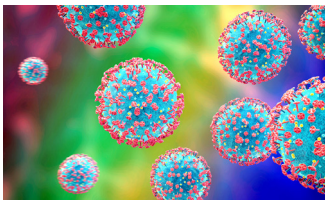
Parents' or other carers' concerns may be a better indicator that a child in hospital is deteriorating than certain traditional early warning signs such as heart rate, breathing rate, or blood pressure, a prospective study concluded. The authors of the Australian study, published in *Lancet Child and Adolescent Health*, said that parental intuition was a "signal we can't afford to ignore" and suggested that hospitals should actively seek parents' and carers' concerns and incorporate these into hospital systems used to detect deterioration in their paediatric patients.

Covid-19

US stops advising vaccination in pregnancy

Healthy pregnant women and children should no longer receive covid vaccinations, said the US health secretary, Robert F Kennedy Jr (left). A week earlier two key officials of the US Food and Drug Administration, writing in the *New England Journal of Medicine*, recommended that covid vaccinations be limited to people over 65, as well as those aged over 6 months with factors that put them at high risk for severe covid infection. Until now the FDA had recommended covid vaccination for everyone aged over 6 months.

New variant spreading across Asia is found in UK



A new strain of the SARS-CoV-2 virus that is fuelling a fresh wave of covid-19 sweeping through Asia and the Western Pacific region has shown up in the UK. The World Health Organization has warned that dwindling rates of testing and sequencing are frustrating experts' efforts to assess the situation. The new variant, NB.1.8.1, is a descendent of the JN.1 omicron subvariant that drove surges in the UK winter of 2023. Countries such as China and Thailand are seeing more hospital admissions, although it is still considered a low overall risk to public health.

GMC

Guidance on fitness to practise is published

The GMC published new guidance to provide greater clarity and consistency in handling concerns about fitness to practise. The GMC's thresholds for these concerns are unchanged overall, but for the first time a single set of core principles will be applied by all GMC fitness-to-practise decision makers. It will also bring the guidance for decisions about doctors into line with how cases involving physician associates and anaesthesia associates are considered.

Science integrity

Project to root out bad research is launched

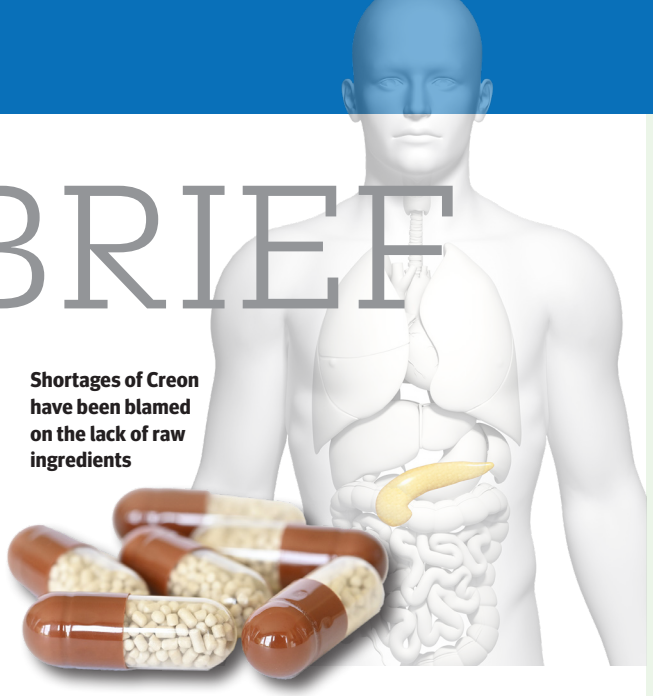
The Center for Scientific Integrity, a US non-profit organisation that runs the Retraction Watch website, launched a project aimed at rounding up flawed and fake medical research papers that directly affect human health. The Medical Evidence Project has a $900 000 (£663 000) grant from the funder Open Philanthropy in San Francisco to run for two years. It aims to publicise flawed papers that affect treatment guidelines by skewing meta-analyses.

IN BRIEF

Creon shortage

Shortage protocol is extended to November

The Department of Health and Social Care extended its serious shortage protocol for the pancreatic enzyme replacement therapy Creon until 21 November. The protocol has been in place for a year. Creon helps digestion and is prescribed to patients with cystic fibrosis, pancreatic cancer, and chronic pancreatitis. The department said Europe-wide supply problems were caused by limited availability of raw ingredients and manufacturing capacity. Medical charities said shortages had caused significant stress for the people affected.



Shortages of Creon have been blamed on the lack of raw ingredients

Drug regulation

Free Olympics tickets breached industry code

The drug company Sanofi was reprimanded by the regulator for offering free tickets to patients to attend last year's Olympic and Paralympic Games in Paris. The Prescription Medicines Code of Practice Authority judged Sanofi had breached the Association of the British Pharmaceutical Industry's Code of Practice by giving 21 tickets, collectively worth €2190 (£1845), through a patient organisation. Sanofi, a corporate sponsor of the games, said the offer was an isolated mistake.

Homelessness

Letter calls for end to street discharges from hospital

More than 1000 clinicians and homelessness workers backed an open letter calling for an end to discharge from hospital to the street. The letter to the prime minister, Keir Starmer, was coordinated by the charity Pathway and signed by leading organisations, including the Royal College of Physicians. It highlights that more than 4000 patients are discharged to no fixed abode every year because of a lack of safe alternatives. It urges investment in specialist intermediate care in the forthcoming UK spending review.

Obesity drugs

Study warns on age related macular degeneration

Weight loss drugs may double the risk of patients with diabetes developing age related macular degeneration, said a study published in *JAMA Ophthalmology*. The Canadian study included 46 334 patients with diabetes who were prescribed glucagon-like peptide-1 receptor agonists (GLP-1 RAs) for at least six months. Each patient was matched with two patients who also had diabetes but were not taking the drugs. Those who had been exposed to the GLP-1 RAs were more than twice as likely to develop neovascular age related macular degeneration as the matched cohort.

Northern Ireland

Options for GP collective action are considered

The BMA in Northern Ireland has announced it is developing voting options for collective action after the Northern Ireland health minister imposed the General Medical Services contract for 2025-26 despite it being overwhelmingly rejected by GPs.

Cite this as: *BMJ* 2025;389:r1186

MEASLES

Outbreaks continue in England, with **109** cases confirmed in April and **86** in May. Since 1 January, **420** laboratory confirmed measles cases have been reported

[UK Health Security Agency]

SIXTY SECONDS ON . . . FREE SCHOOL MEALS

YOU WANT MORE?

Apparently, yes. The government has announced that half a million more children in England will get free school meals from September as it expands eligibility.

WHO WILL BENEFIT?

Every pupil whose household is on universal credit, regardless of their parents' income. The government says this will lift 100 000 children across England out of poverty. Sabine Goodwin, director of the charity Independent Food Aid Network, said the move will ease pressure on families "but ultimately free school meals should be available to all children regardless of family income status, removing stigma and shame from the equation."

DO SCHOOL MEALS MATTER?

Many would say so, arguing that having at least one nutritious meal a day improves school results, behaviour, and health. William Roberts, chief executive of the Royal Society for Public Health, said wider provision of free school meals also lowers the risk of childhood obesity and absenteeism. TV celebrity chef Jamie Oliver posted on X that the government had effectively given half a million children the "nutrition they need to learn, grow, and thrive."

BREAKFAST OF CHAMPIONS?

School meals have not always had the best reputation and may conjure up images of mash, gravy, chips, and custard (not necessarily on the same plate). A 2022 study in the journal *Nutrients* analysed 3303 children's school lunches and found that 64% of the energy came from ultraprocessed foods. Oliver famously campaigned against cheap processed foods in the early 2000s and fought for strict nutritional standards to be introduced. Initiatives such as the Bite Back in Schools programme are trying to improve things through grants to educate children and transform school canteens.

MY STOMACH'S RUMBLING . . .

While more children will get free meals, the money available is no banquet. In April the government increased the meal rate for universal infant free school meals and further education free meals by 3p more per meal—from £2.58 to £2.61—for next academic year. Feeling full yet?

Adrian O'Dowd, London

Cite this as: *BMJ* 2025;389:r1177

Streeting's emergency care plan for England lacks ambition, doctors' leaders warn

A £450m government plan to improve urgent and emergency care in England and avert a winter crisis could have shown more ambition in tackling long waiting times, doctors' leaders have said.

The Royal College of Emergency Medicine welcomed elements of the urgent and emergency care plan for 2025-26, including commitments to publish NHS trusts' emergency department performance data and increase vaccinations among staff to help protect patients. "However," it added, "the college has concerns about the lack of a cast iron commitment to ending dangerous and demeaning 12 hour waits in emergency departments."

The plan aims to reduce the problem of corridor care that has become endemic in many hospitals. It includes pledges to improve patient assessments and tackle delayed discharges, with better coordination across the health system and better use of virtual wards that use technology to care for patients at home.

It also pledges 40 new "same day" centres to fast track treatment and up to 15 mental health crisis assessment units, together with nearly 500 new ambulances by March 2026.

The health and social care secretary, Wes Streeting, said the plan would radically improve patients' experiences and cut waiting times. "Far too many patients are ending up in A&E who don't need or want to be there, because there isn't anywhere else available," he said. "The package of investment and reforms will help the NHS treat more patients in the community, so they don't end up stuck on trolleys in A&E."

The plan aims to reduce all ambulance handovers to less than 45 minutes and to cut ambulance waiting times for category 2 patients—such as those with a stroke, heart attack, sepsis, or major trauma—by over 14%, from 35 to 30 minutes. It would also reduce the number of patients exposed to emergency department waits of 12 hours to less than 10%.

A minimum of 78% of patients who attend emergency departments (up from 75% currently) would be admitted, transferred, or discharged within four

FORTY new "same day" centres to fast track treatment are promised, as well as nearly **500** new ambulances by next March

FACT CHECK

Will disposable vapes ban mean 200 000 more smokers?

Richard Sloggett was the author of the report for Kenvue, which owns Nicorette

On 1 June it became illegal in the UK to sell or supply single use vapes. The ban was marked by press headlines warning that denying people access to such vapes would lead to 200 000 taking up smoking. But does the figure stand up to scrutiny?

Where did the 200 000 figure come from?

It was given in a report published by Future Health, a research centre founded and managed by former government adviser Richard Sloggett. The report was commissioned by the global consumer healthcare company Kenvue, which owns the nicotine replacement brand Nicorette.

The report warned that banning disposable vapes could undermine government plans to tackle vaping among children and to create a smoke free Britain. It called for a campaign to cut smoking and for more funding for smoking cessation services.

How was the figure calculated?

The report used data from a poll of 4393 UK adults, who were asked various questions about smoking and vaping habits.

Of the total, 9% said that they had vaped. The report did not provide absolute numbers of respondents, but *The BMJ* calculated this could amount to 395 people. Of these, 58% said they had used disposable vapes "always," "often," "sometimes," or "rarely."

Of the 229 respondents (*The BMJ*'s calculation) who had used disposable vapes, 12% said that, if a ban on disposable vapes was implemented, they would "stop vaping and smoke/smoke more instead." That amounts to 27 of the 393 people surveyed.

Future Health then used population data to run modelling scenarios and concluded that these "indicate that the smoking rate could increase by between 90 000 and 200 000 as a result of the disposable vapes ban."

The report acknowledged that "any modelling based on polling such as this can only ever be an estimate for what may happen in practice." But it did not include a response rate for its poll.

What is Future Health?

The centre describes itself as a "new and future focused research centre, with a mission to advance public policy thinking that improves the health and wealth of people, communities, and nations." It lists two employees on its website: director Rebecca Lynch and founder, programme director, and report author Sloggett.

A spokesperson for Kenvue said it welcomed the report. A statement said, "We support the government's smokefree ambitions and the recent ban on disposable vapes to reduce the appeal of these products to young people and non-smokers. For the disposable vape ban to be truly effective it's crucial that robust strategies are in place to support disposable vape users to remain smoke free."

What do public health researchers say?

May Van Schalkwyk, an Edinburgh University research fellow who specialises in the commercial determinants of health, said because the number of people who said they

hours, which the document said would mean 800 000 people a year receiving more timely care.

Staffing and integration

Adrian Boyle, president of the Royal College of Emergency Medicine, noted "some good and some bad" in the plan. "Some parts lack ambition—for example, accepting that 10% of people will face A&E waits of more than 12 hours, when no patient should," he said. "Also maintaining the four hour standard at 78% when the stated aim is that 95% of patients should move through the [emergency department] within this time—something which hasn't happened for a decade."

Boyle said the college was concerned about how the maximum 45 minute ambulance handover would be achieved without exposing patients to risk and increasing overcrowding in emergency departments.

NHS Providers said it expected the plan to result in "meaningful progress compared to last winter" and that publishing it in early summer would help trusts with implementation.

BRICKSTOCK/ALAMY

Mumtaz Patel, president of the Royal College of Physicians, called on NHS England to publish data on the prevalence of corridor care "as a priority," to show whether measures such as improving the timeliness of discharge and the use of urgent treatment centres were working.

The package of investment and reforms will help the NHS treat more patients in the community Wes Streeting

Matthew Limb, London

Cite this as: *BMJ* 2025;389:r1184

vaped was low "it would therefore be reasonable to conclude that the survey was not large enough to be able to reliably use analysis on this subgroup of respondents to extrapolate to the UK adult population."

She also emphasised the importance of being "very transparent when reporting on the report that it explicitly recognises the limits of the analysis and that it predicts a range of possibilities which are based on people stating what they may or may not do. The report is not based on what people are actually doing or on data from other places where similar bans are in place."

What can we conclude?

The media should quote the 200 000 figure with extreme caution and include the caveat that it is an industry funded study that extrapolated a headline grabbing figure that was based on small numbers.

Greg Hartwell, clinical assistant professor in public health at the London School of Hygiene and Tropical Medicine, said, "Extrapolating a tiny subgroup to make nationwide generalisations raises major concerns. Broadly, industry funded research is fraught with conflicts of interest so should never be used to guide policy making."

Sloggett did not respond to *The BMJ*'s requests for comment.

Elgan Manton-Roseblade, *The BMJ*

Cite this as: *BMJ* 2025;389:r1194

Call for GP partnership model to be protected as numbers dwindle

The Royal College of General Practitioners has called for more support for GP partnerships to "remain a realistic option" for general practice among other approaches to working in primary care.

It said the partnership model should be protected and developed to encourage doctors to take it up as a way to improve care of patients and ensure strong finances.

The RCGP's report cites last year's report by Ara Darzi, which said strong financial management and the cost effectiveness offered by the model, as well as its ability to deliver "local innovations that improve access and quality of care, while also relieving pressures on acute hospitals," should be recognised and protected.

Echoing that message, the new report's authors said they were concerned by the growing numbers of newly qualified GPs avoiding traditional partnerships because of worries over financial risk and the burden of bureaucracy.

> The number of GP partners in England has dropped by almost 25%, from 24 491 in 2015 to 18 425 in December 2024, while the number of salaried GPs in England has risen by 81% over the same period, from 10 270 to 18 557, now representing 48% of the workforce

Various ways of approaching the model had been developed, they said, including associate partnerships, super-partnerships, GP federations, community interest companies, limited liability partnerships, and employee ownership trusts. Different approaches should be scrutinised by the college, government, and BMA and be piloted and evaluated before rollout, it said.

Kamila Hawthorne, RCGP chair, said there were elements of partnerships that could be improved and modernised, while retaining core strengths. "Members tell us they are concerned about the unlimited personal liability exposure, the financial risks associated with owning or leasing premises, and the burden of management responsibilities related to running a business and employing staff," she said.

"The RCGP wants to safeguard the future of general practice, and that means looking at ways to remove these barriers while being open to exploring alternatives."

Adrian O'Dowd, London

Cite this as: *BMJ* 2025;389:r1178

MARMOT: **A million excess deaths are linked to poverty**

From 2009 to 2020 around one million excess deaths were associated with deprivation, Michael Marmot (below) has told the Royal College of Physicians' annual conference.

Marmot, professor of epidemiology at University College London and director of the Institute of Health Equity, said differences in life expectancy between the most and least deprived areas in England widened after 2010.

Of the million excess deaths, Marmot calculated that 148 000 could be directly linked to austerity measures brought in by the coalition government in 2010. "Arguably, austerity killed 148 000 people. That was a pretty momentous political choice," he said.

Life expectancy had been improving year on year since the end of the first world war but stalled in 2010. In 2009-10 public spending expenditure was 42% of GDP; this then fell each year so that by 2019 it was 35%, he told the physicians. "Some 7% of GDP was knocked off, which means £180bn a year was taken away from public sector expenditure. Do you imagine you can do something like that without causing any damage?"

Marmot said public expenditure in the UK was low by European standards, and it was the country's poorest areas that suffered the most. He would like the government to be spending more money, "but the 'Marmot places' show what can be done with what we have." The 50 Marmot places are areas where the Institute of Health Equity has been working with local communities and agencies to reduce health inequalities.

Sally Warren, director general of the NHS 10 year plan, told the meeting, "We are not spending the money we have well. The public are seeing waste, staff are seeing waste. We can deliver better outcomes with the money we have."

Warren would not give details of the plan but said it would focus on health inequality—in particular, on NHS commissioning. "Integrated care boards must have a detailed understanding of the needs of their population, including inequity. They need to understand how to commission services that meet those needs and ensure they are commissioning for improving outcomes," she said.

Jacqui Wise, Kent Cite this as: *BMJ* 2025;389:r1147

Most resident doctors unhappy with their training, RCP warns

More than half (58%) of resident doctors surveyed by the Royal College of Physicians do not believe the process for medical training recruitment is fair, while just 44% are satisfied or very satisfied with the clinical training they have received.

Findings from the survey were presented at the RCP's annual conference (pictured right) in London on 3 June. It was promoted to resident doctors on the college's website and through its social media and WhatsApp channels. It received 1684 responses, of which 1010 were from resident doctors working in the UK.

Results showed that just 2.5% (22) of respondents strongly agreed and 15% (132) agreed that recruitment in medical training was fair. In contrast, 31% (274) disagreed and 27% (241) strongly disagreed with the statement, while 24% (215) remained neutral.

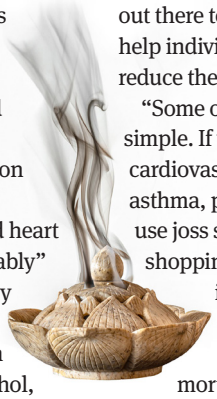
When asked how satisfied they were with the clinical training they received, just 8.6% (67) of the respondents said they were very satisfied, 35% (274 of 782) were satisfied, and 26% (200) were dissatisfied or very dissatisfied.

"Internal medicine training is a joke—just service provision from disinterested seniors," said one respondent. Another said, "I honestly have felt like giving up on medicine on a near weekly basis for the past seven years."

GIM training has too little focus on chronic disease management
Catherine Rowan

Patients with asthma or heart disease should "avoid incense sticks"

Air pollution is the least recognised of the big five preventable causes of disease in the UK, and doctors should take it more seriously, England's chief medical officer has said.



Chris Whitty said that the effect of reducing air pollution on cardiovascular disease, stroke, and heart disease, and "probably" dementia, was "very profound" but that, in comparison with smoking, alcohol, obesity, and inactivity, air pollution was underrated as a major cause of disease.

He told the RCP annual meeting, "As individual clinicians we do need to take this seriously. I think large numbers of physicians do not realise, for example, how much of an increased risk air pollution is for people living with early cardiovascular disease. It's really important that we put scientific evidence out there to society but help individual patients to reduce their individual risk.

"Some of which is really simple. If you've got cardiovascular disease or asthma, probably don't use joss sticks, and go shopping at a time which isn't the peak traffic time."

Annual mortality related to human made air pollution in the UK is roughly equivalent to between 28 000 and 36 000 deaths every year. It is estimated that between 2017 and 2025 the total cost to the NHS and social care system of air pollutants will be £1.6bn.

Whitty said the UK had done "extraordinarily well" in reducing air pollution in some areas, chiefly in the "stunning" success of reducing sulphur dioxide, a big driver of asthma, among other diseases.

But he pointed out that particulate matter in urban areas remained too high and that progress had slowed. "Why does this matter? Because these have very big impacts on many, many diseases. If we reduced particulate matter by 1 µg [/m^3] overall, we would probably reduce, in terms of numbers, lung cancers by about 4000 over time, and asthma by about 9000. But that's actually dwarfed by the much bigger impacts on cardiovascular disease and probably on dementia."

Rebecca Coombes, *The BMJ*
Cite this as: *BMJ* 2025;389:r1146

JOHN BARLOW/RCP

RCP resident doctor committee co-chairs Anthony Martinelli and Catherine Rowan gave the example of general internal medicine (GIM). They said, "Since the Shape of Training review in 2015, there's been a push to develop more physicians accredited in GIM, equipped to manage patients with multiple long term conditions.

"But in practice GIM training is often equated solely with the acute medical take—the 'front door' of the hospital—with too little focus on chronic disease management, balancing uncertainty, and cross sector working. That must change if we're serious about shifting care into the community."

"Reform no longer optional"

When asked whether doctors in training thought their current role was preparing them to submit a competitive application for the next stage of their career pathway, just one in four (183 of 702) said yes, half (333) felt partly prepared, and a quarter (185) did not feel prepared.

RCP resident doctors committee member Hatty Douthwaite, presenting the findings, said, "Without change, we risk worsening recruitment, retention, and morale at a time when the NHS can least afford it. Reform of medical training is no longer optional, it is essential."

NHS England is conducting a review of postgraduate medical training, looking at placement options, flexibility of training, rotas, and the balance between developing specialist knowledge and gaining a broad range of skills.

Half of respondents to the survey said that that geographical rotational training should continue but with reform. Of the 603 doctors currently in a training post, 31% (185) said geographical rotation training has had a mostly negative effect on them, while 26% (156) said it had a very positive impact or mostly positive impact.

Martinelli and Rowan concluded, "Resident doctors are not just service providers. They are the future specialists and clinical leaders of the NHS. If we want them to stay we must build a training system that respects their time, supports their growth, and gives them reason to believe in the future of the profession."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2025;389:r1166

If we want resident doctors to stay we must build a training system that respects their time
Anthony Martinelli

"Supported exercise can help more people survive colon cancer"

A three year programme of structured exercise reduced the relative risk of disease recurrence, new primary cancer, or death by 28% in patients with stage III and high risk stage II colon cancer, a phase 3 randomised trial has found.

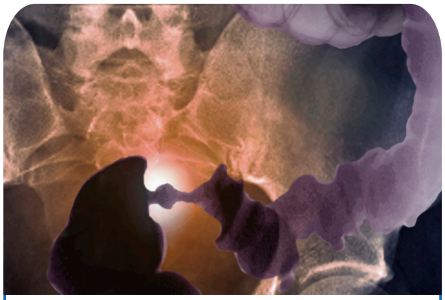
The magnitude of benefit from exercise delivered after surgery and adjuvant chemotherapy was similar to that of many standard drug treatments, the authors said. Previous observational studies had shown that patients with colorectal cancer who increased their physical activity after treatment had a lower risk of cancer recurrence and death, but this—the Challenge study—is the first randomised trial to show this.

Challenge, published in the *New England Journal of Medicine*, randomly assigned 889 patients with resected colon cancer who had completed adjuvant chemotherapy to an exercise group or to a health education group. The health education materials contained information promoting physical activity and healthy nutrition. Those in the structured exercise programme had behavioural support and face-to-face coaching sessions weekly for the first six months and once a month.

The exercise intervention met its goal of increasing moderate to vigorous physical activity from baseline by about 10 metabolic equivalent task hours a week—equivalent to 45-60 minutes of brisk walking three or four times a week or 25-30 minutes of jogging three to four times a week.

At a median follow-up of 7.9 years, disease recurrence, new primary cancer, or death had occurred in 93 of 445 participants in the exercise group, compared with 131 of 444 in the health education group (hazard ratio 0.72 (95% confidence interval 0.55 to 0.94), P=0.02).

The results showed that at eight years 90% of people who had done the structured exercise programme were still alive (374 of 445), compared with 83% in the health education group (356 of 444)—a 37% lower risk of death.



At a median follow-up of 7.9 years, disease recurrence, new primary cancer, or death had occurred in 93 of 445 participants in the exercise group, compared with 131 of 444 in the health education group

Vicky Coyle, consultant medical oncologist at Queen's University Belfast, who led the research in the UK, said, "Our study gives clear evidence that physical activity can reduce the risk of cancer returning for some people with colon cancer. We now need to work with policymakers and healthcare providers to embed exercise into treatment plans where appropriate."

Regulating hormone levels

The researchers believe exercise could be linked to the way physical activity helps to regulate hormone levels, reduce inflammation, and strengthen the immune system.

Commenting on the results, Marco Gerlinger, a consultant medical oncologist at Barts Cancer Institute, Queen Mary University of London, said, "One of the commonest questions from patients is what they can do to reduce the risk that their cancer comes back. Oncologists can now make a clear, evidence based recommendation for patients who just completed their chemotherapy for bowel cancer and are fit enough for such an exercise programme."

Jacqui Wise, Kent

Cite this as: *BMJ* 2025;389:r1139

Can a focus on reducing the UK's inmate population benefit public health?

The capacity of the prison estate hasn't kept pace with population growth

"Chemical castration" forms part of ministers' plans to ease prison overcrowding. **Ella Hubbard** explores this and other proposals

An independent sentencing review commissioned by the government has proposed radical reforms to reduce the prison population. The review was ordered last October by the justice secretary, Shabana Mahmood, in response to a prison system so overcrowded that prisoners were released early in emergency measures to avoid complete collapse.

Plans to expand the use of so called "chemical castration" have dominated the headlines, but the review also includes proposals to reduce prisoner numbers, with recommendations to dramatically cut the use of sentences of less than a year, as well as suggestions for more alternatives to custody—particularly for women, older people, and those experiencing poor mental health.

The government has accepted most of the recommendations, and Mahmood said the reforms would "ensure we never again run out of prison places for dangerous offenders."

Overcrowding crisis

England and Wales has the highest per capita prison population in western Europe, having doubled from just over 44 000 in 1993 to nearly 88 000 by the end of 2023.

The reasons are complex. The total number of people sentenced to prison actually fell from 98 044 in 2012 to 67 812 in 2022, suggesting the growth in the prison population is not due to more convictions. But the average length of sentences increased markedly over the same period, from 12.5 months in 2012 to 21.4 months in 2023. Other factors include court backlogs, which leave record numbers of people in prison on remand, awaiting trial.

The capacity of the prison estate hasn't kept pace with this growth: just 500 places have been added in over a decade, resulting in increasingly overcrowded prisons, prompting the government to look for alternatives.

Chemical castration

One proposal—to expand pilot schemes that use drugs to manage problematic sexual arousal in people convicted of sexual offences, sometimes called chemical castration—has attracted the most attention. But Belinda Winder (below), professor of forensic psychology and research director at the centre of crime prevention and engagement at Nottingham Trent University, says that the term is a misnomer.

"The phrase 'chemical castration' sounds quite aggressive, which the public might like or appreciate," Winder tells *The BMJ*. "But you're talking about a medication that's part of a therapeutic relationship." She says that anti-androgens and GnRH agonists, which block or suppress testosterone, and more recently selective serotonin reuptake inhibitors (SSRIs), which can have unwanted side effects of sexual dysfunction, are both used to reduce problematic sexual arousal.

PRISON population has doubled over the past 30 years, from just over 44000 in 1993 to nearly 88000 by the end of 2023

Winder is the chief investigator of a planned randomised controlled trial looking at whether the SSRI fluoxetine reduces problematic sexual arousal in men convicted of a sexual offence. The research might ultimately lead to the possibility of SSRIs being prescribed in primary care as a preventive measure for men experiencing problematic sexual arousal. "Often people have had various attempts at talking to people before they've ended up in prison," says Winder. But currently there's a lack of early intervention services to stop people committing sexual offences in the first place.

Crucially, the medical management of problematic sexual arousal "isn't just pills," says Winder. Rather, it's a "therapeutic relationship," where a patient works with a prescriber to titrate medicine according to the symptoms they are experiencing, supported by psychological interventions.

While the latest review has recommended that small scale pilots of the medical management of problematic sexual arousal should continue, Mahmood said that the government would go further, with a national rollout of the scheme. And although the review noted that "gaining valid, informed consent to a course of treatment is a key tenet of medical law and ethics," Mahmood said that the government would explore whether such interventions could be made compulsory. Medical management of sexual arousal is mandatory in some jurisdictions, including Poland, Moldova, and South Korea.

However, Winder points out a lack of evidence for mandatory medical management. "Making something mandatory and coercive goes against the therapeutic relationship," she says. "If you're being forced to do something, then that could feed into the hostile, grievance laden mindset that is actually another risk factor for sexual offending."

Fewer short sentences

A key recommendation of the review is that sentences of less than a year be used only as a last resort, and the review's chair, David Gauke, said that data showed reoffending rates to be lower among people sentenced to community alternatives than among those given short term prison sentences.

Seena Fazel, professor of forensic psychiatry at Oxford University, says reducing the number of people on short sentences is "entirely commendable" and "evidence based" because short prison terms can increase risk factors for reoffending, as prisoners are "dislocated from their family relationships [or lose] their work."

Emma Plugge, professor of public health at the University of Southampton, who researches the health of people in the criminal justice system, agrees "reducing the number of imprisoned people is a laudable goal." For most people, she says, imprisonment damages

IN PICTURES LTD/CORBIS/GETTY

their health, especially if they are incarcerated in overcrowded prisons. "The increase in rates of self-harm, illicit drug use, and violence seen in overcrowded prisons has been well documented," she tells *The BMJ*.

The move to reduce short sentences would particularly affect female offenders: 77% of women sentenced to prison last year received a sentence of 12 months or less.

Laura Abbott, a specialist midwife and associate professor at the University of Hertfordshire, who researches the incarceration of pregnant women and mothers, welcomes the proposals, given "the profound harm that imprisonment inflicts on women and their families."

But for the reforms to achieve meaningful change they need to be backed up by investment in other services, such as women's centres and trauma informed probation services, Abbott tells *The BMJ*. Alongside such investment, implementation would require a "cultural change," she says, recognising that "many women in prison are themselves victims of childhood trauma, violence, and poverty, and community based alternatives are more effective and humane."

Reducing the number of short sentences is commendable and evidence based
Seena Fazel

Increasing self-harm, illicit drug use, and violence in overcrowded prisons is well documented
Emma Plugge

Community based alternatives are more effective and humane
Laura Abbott

Community alternatives to custody

The review includes proposals for more alternatives to prison, such as suspended sentences, financial penalties, and community sentence treatment requirements (CSTRs), in which offenders engage with alcohol, drug, or mental health treatment programmes.

But Fazel says that this doesn't go far enough to tackle the fact that, for at least some offenders, mental health problems drive offending in the first place. "It's not a question of having one or two solutions at the point they've already offended," he says. "It's about creating a system that prevents violence and offending in the first place. And to do that you need good quality mental health services wholescale."

Plugge says that, despite evidence to support the use of CSTRs, "none of this can work effectively in isolation." She points out that someone who is vulnerable because of their housing, for example, needs a safe place to live to be able to effectively engage with support for their mental health.

She adds, "Austerity, a political choice made in 2010, significantly pared down public services. Braver political choices with increases in spending on public services will be needed to ensure that fewer people go to prison and that the public remains safe."

Ella Hubbard, *The BMJ*
Cite this as: *BMJ* 2025;389:r1160

Plastic surgeon who faked PhD is suspended for a year

A plastic surgeon who falsely gave the impression that he had a Harvard PhD in NHS job applications and provided falsified studies to support his claims of published research has been suspended from the UK medical register for 12 months.

Sotirios Foutsizoglou, who was in private practice but doing occasional NHS locum work, applied in May and July 2021 for permanent posts at the Bedfordshire Hospitals and Sheffield Teaching Hospitals trusts.

In these applications Foutsizoglou claimed to have coauthored three published articles and gave the impression that he had obtained a PhD in biostatistics and epidemiology from the Harvard School of Public Health.

His first application, to Bedfordshire, was not shortlisted. At the Sheffield trust he was told during a job interview that staff had been unable to find his name on a research article of which he had claimed authorship. He told the interviewer that there had been many researchers and only the top authors had been named.

Later he emailed Sheffield falsified copies of three articles with his name among the authors. The trust reported him to the GMC.

At his hearing Foutsizoglou acknowledged the documents were falsified and admitted most of the charges against him. He had made a positive decision to mislead, he told the tribunal, adding that he put it down to an ego driven desire to achieve and to be seen to achieve to a high level.

The charges that Foutsizoglou contested related to Harvard. He had in fact begun a PhD course run by the University of Athens in conjunction with Harvard and had completed more than a year of work on it. He contended that his references to this were not actually a claim to have obtained a PhD.

But tribunal chair Christopher Harper noted that he had written unambiguously on the Sheffield application: "I also hold a master's degree and a PhD in biostatistics and epidemiology."

Harper added, "The tribunal found Dr Foutsizoglou's explanation and rationale for how he had completed the application lacked credibility.

"The more egregious aspect of the dishonesty was that Dr Foutsizoglou had sought to persist in his deception by the falsification of research papers in support of his applications. The alterations were sophisticated in nature and included the matching of fonts and formatting."

Foutsizoglou sought to persist in his deception with the falsification of research papers

The tribunal also "concluded that Dr Foutsizoglou had failed to explain or evidence how he had satisfactorily reflected on these matters, developed the necessary insight, or remediated to remove the risk of repetition."

But although the case was "on the borderline of suspension or erasure," and the GMC had requested erasure, the tribunal had opted for suspension, Harper said. Andrew Hockton, the surgeon's lawyer, had pointed to his previously unblemished career, his substantial admissions, and the fact that it was not related to his ability to treat patients.

"Dr Foutsizoglou is now in a position to move forward on his journey of insight and remediation," said Harper. "He has demonstrated the capacity to take advantage of such an opportunity if given it."

After 12 months he will be expected to attend a review hearing, said Harper, where "the onus will be on Dr Foutsizoglou to demonstrate how he has developed sufficient insight and has remediated."

Rules provide for a 28 day period in which to lodge an appeal after a tribunal's decision.

Clare Dyer, *The BMJ* **Cite this as: *BMJ* 2025;389:r1129**


SCHOOL BUS
EMERGENCY DOOR
PORTE DE SECOURS
DO NOT PASS
WHEN RED
LAMPS FLASHING
607 NNS
SCHOOL BUS

THE BIG PICTURE

Canadian wildfires health warnings

Health leaders are warning people in Canada and neighbouring countries to protect their health by staying indoors as wildfires continue to rage.

Since the first outbreak last month more than 200 separate wildfires have been active across the country, spreading from southern parts of the provinces of Manitoba, Ontario, and Saskatchewan (pictured). At least two people have died, and tens of thousands have been forced to evacuate. Smoke from the fires has affected skies across the northern hemisphere, creating an orange haze across Europe.

Wildfire smoke contains high concentrations of PM2.5—fine particulate matter that can enter the lungs and bloodstream. Exposure is linked to worsening symptoms in people with asthma or chronic obstructive pulmonary disease (COPD), but acute cardiovascular risks, including heart attacks and strokes, may be even more pronounced.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2025;389:r1198

HO-SASKATCHEWAN PUBLIC SAFETY AGENCY

EDITORIAL

New suicide prevention guidance in England

Broader considerations required to improve care

The guidance moves away from risk assessments to a safety first approach

Faraz Mughal, general practitioner, Keele University
f.mughal@keele.ac.uk
Tamsin Newlove-Delgado, associate professor in child public mental health, University of Exeter
Andrea Cipriani, professor of psychiatry
Seena Fazel, professor of forensic psychiatry, Warneford Hospital, Oxford

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.

Around 19 people die from suicide in the UK each day,[1] and every death is tragic and potentially avoidable. In 2023, England's suicide rate was 11.2 per 100 000, similar to that in France and Sweden (11.8 and 11.7 per 100 000, respectively, in 2021).[2] NHS England has released new guidance to support the national suicide prevention strategy of reducing suicides and improving mental health services,[3 4] superseding the 2009 report on assessing and managing risk in mental health services.[5]

The main difference from the 2009 guidance is a move to focus on safety rather than risk in assessment, formulation, and management, including a recommendation not to use risk prevention tools.[5] The safety first approach prioritises exploration of the presenting problem, precipitating factors (eg, mental illness), protective factors (eg, family or employment), longstanding factors that exacerbate current difficulties, and perpetuating factors that sustain current problems. Where the guidance falls short, however, is in not considering the weighting of these different factors. Replicated research has shown that clinical factors such as psychiatric and chronic physical health conditions have much stronger effects on suicide risk than sociodemographic ones (eg, history of poor educational attainment).[6]

The guidance recommendation against using risk prediction tools is in line with the 2022 self-harm guidance from the National Institute for Health and Care Excellence.[7] The tools are criticised as unreliable, having low accuracy, and giving a false sense of reassurance for practitioners. These conclusions, however, were based on limited evidence about tools mostly developed for other purposes (eg, symptom checklists), using thresholds with low sensitivity, and research that does not evaluate these tools as adjuncts to clinical judgment, which is how they are widely used in medicine with a potential to benefit mental healthcare.[8]

While the use of tick box risk assessments is outdated and can be unreliable, new research using big data with good quality information on predictors and suicide outcomes has provided stronger evidence. The changes to research methods include use of data from national mortality registers, higher quality methods (eg, modelling age precisely and correcting for overfitting), pre-registering research protocols, and transparent reporting of a range of performance measures, including discrimination statistics and calibration. These new risk models could support a personalised approach to care, acting to support clinical decision making, rather than following checklists with binary categories of low and high risk. In other areas of medicine, risk models now use probabilistic estimates of risk—for example, of developing cardiovascular events (eg, QRISK-3 or SCORE2), cancer, or psychosis.[9 10] The new guidance does not consider this alternative approach.[11]

Another new area in the guidance is the recommendation to create personalised safety plans. This is a collaborative process between patient and doctor, focusing on emotional, physical, and social wellbeing, to agree immediate actions (eg, refer to crisis teams if appropriate) and long term safety planning. Practitioners are advised to co-produce a written plan with patients consisting of actionable steps and support services that are reviewed, shared, and incorporated into ongoing care. However, it is unclear how to best develop these safety plans with patients, and whether they are effective at reducing suicidal behaviours in the NHS.[7] Safety planning may also not be helpful to people at highest risk or when in acute distress.[12] Training practitioners in a safety-first approach, especially in marginalised and high risk patient groups, and ensuring sufficient supervision and containment for staff will require sustained financial investment and effective training.

Cultural shift required in mental health

Implementing this new guidance presents additional challenges. A big culture change is required in mental health services to adopt a safety oriented approach. This will take time and practitioner receptiveness and engagement. In addition, although the guidance was developed collaboratively with stakeholders, there was no systematic appraisal of the evidence. To account for this, the guidance should be updated at least two yearly to consider the evolving underlying evidence—for example, on the potential role of artificial intelligence and on new clinical tools based on multivariable risk models to support treatment decisions.[11]

Perhaps most importantly, research into real world mental health and suicidal behaviour outcomes is needed, including at service level. This should be informed by high quality clinical trials of new tools in the NHS and routinely collected data on risk signals and suicidal outcomes to advance our understanding on best practice and to accelerate progress in preventing suicides.

Cite this as: *BMJ* 2025;389:r1140

Find the full version with references at http://dx.doi.org/10.1136/bmj.r1140

EDITORIAL

Challenges of dementia care in the UK

Renewed focus on improving social care is required

Dementia is the leading cause of death in England and Wales,[1] and 982 000 people are estimated to have a form of dementia in the UK.[2] Although there has been some progress in developing drug treatments for Alzheimer's disease, pharmacological options remain limited, and high costs continue to pose challenges. Moreover, there are no public health interventions for dementia prevention.

Given longer life expectancies, the number of people living with dementia is expected to rise, but the necessary care provision and support are failing to keep up. People with dementia are often supported by an unpaid carer, filling the gap of care needs.[3]

The first barrier to getting appropriate care is accurate diagnosis. Diagnostic rates vary across the UK,[4] ranging from an estimated 58% diagnosed cases in Buckinghamshire to 75% in Manchester, according to the latest figures from NHS England.[5] The national target is for at least 66% of people with dementia to have a diagnosis, but we need to reach as close to 100% as possible.

Lack of social support

Once a diagnosis is made, people with dementia may require substantial social support, such as home and day care, with most people eventually needing full time residential care. However, they are not always connected to social care because of poor coordination between health and social care services.[6 7]

England has introduced link workers, also known as dementia care navigators and dementia advisers, to help bridge the gap between memory clinics in the NHS and community social care. Most of the evidence of their effectiveness comes from the US, where studies have shown improved access to social care and reduced hospital admissions.[8 9] However, the availability of link workers across the UK is limited, and access often depends on where a person lives.[10]

LEWIS HOUGHTON/SPL

National strategies to improve dementia care have already been widely adopted across Europe

Health inequalities also arise from other factors such as gender, dementia subtype, the availability of an unpaid carer, and knowledge gaps among health and social care professionals.[11] These factors can all lead to unequal health outcomes, including different levels of health and social care use, poorer physical health and quality of life, and shorter time to care home entry and death.

While significant challenges remain, several emerging approaches offer promising opportunities to address inequalities in dementia care, supported by a small but growing body of evidence. Existing dementia specific training interventions have been shown to improve knowledge and skills,[12 13] but such training should be more consistently integrated into clinical and care guidance and prioritised across health and social care organisations. The content of these training programmes also needs broadening to include rarer dementias, such as Lewy body dementia, which are often overlooked.

Need for a national strategy

To implement meaningful solutions to enable people with dementia and their carers to live well, the UK urgently needs a national dementia strategy. There has been no strategy in place since the prime minister's 2015 challenge on dementia, which ended in 2020 but did not receive the sustained effort or funding required to lead to positive change. Nevertheless, national strategies can have a critical role in focusing government and policy attention on this often neglected area and have been widely adopted across Europe and other high income countries, such as Austria, Germany, Iceland, and the Netherlands.[14]

A strategy should also prioritise public awareness and ensure that communities, services, and infrastructures are dementia friendly. This includes support for dementia champions and dementia friendly communities, learning from the 250 that already exist in England.[15]

Finally, a national strategy must give attention to the rights and needs of unpaid carers. This includes access to psychological support through the NHS to help manage the emotional demands of care giving as well as free access to respite care or home care support to allow carers to take time away from their responsibilities when needed. The 2025 Health and Social Care Committee report rightly highlights the essential yet often overlooked role of unpaid carers, who provide a substantial share of care without adequate support.[3]

Failure to increase investment in a national strategy will only intensify pressures on the NHS,[16] resulting in higher rates of avoidable hospital admission and increased GP visits among vulnerable people with dementia.

Clarissa Giebel, senior research fellow, University of Liverpool
Clarissa.Giebel@liverpool.ac.uk
Jacqui Cannon, chief executive, Lewy Body Society, Wigan
Aravind Komuravelli, consultant, Mersey Care NHS Trust, Liverpool
Rosie Whittington, social care provider, Me2U Care, Liverpool

Cite this as: *BMJ* 2025;389:r1135

Find the full version with references at http://dx.doi.org/10.1136/bmj.r1135

NHS OVERSIGHT

How could the regulation of managers in the NHS work—and will it happen?

Samir Jeraj explores the proposals and considers the potential pitfalls

RUI VIEIRA/PA/ALAMY

What is the current status?

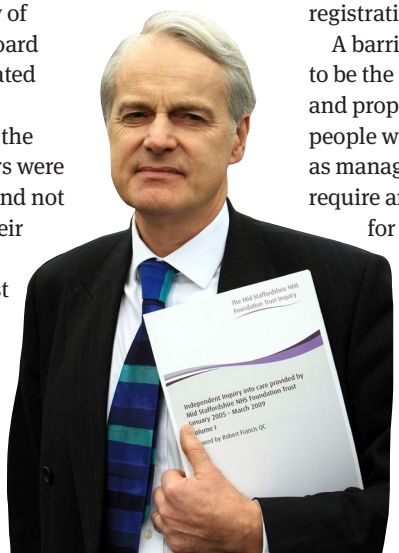
A government consultation on regulating managers in the NHS in England closed in February. This was the latest in a series of efforts over several years to grapple with the question of how to raise standards of management in the NHS while ensuring these non-clinical roles remain attractive to talented people.

There is no comprehensive unified system for regulating NHS managers. Some are covered by professional bodies that regulate their members and hold them to a set of standards, but a manager who is a clinician is part of a different professional framework than one who is an accountant or a solicitor.

The inquiry by Robert Francis (right) into serious failings at Mid Staffordshire NHS Foundation Trust recommended that a "fit and proper person test" be introduced at director level, which happened in 2013. In 2019, after Tom Kark's review of this test, it was extended to board level leaders across all integrated care systems and appropriate arm's length bodies, to tackle the perception that poor managers were shuffling around the system and not being held accountable for their performance.

Annual reporting on the test was brought in last year. The number of board members failing the fit and proper test or being referred for support has been small, according to the Department for Health and Social Care.

Moves to regulation have been criticised for lacking evidence and being unlikely to fix performance problems



The recently closed consultation was born out of plans formulated by Labour, including the now health and social care secretary, Wes Streeting, while in opposition. In the run up to the election in July 2024 Streeting pledged that NHS managers who silenced whistleblowers would "never work again" in the service.

How could regulation work?

The government consultation set out three main options: a barring system, voluntary registration, and statutory registration.

A barring system would seem to be the next step on from the "fit and proper person" test: a list of people who are barred from serving as managers in the NHS. It would require an agreed code of conduct for managers and a body that could hear and determine cases against that code.

Voluntary registration would mean that for those managers on a voluntary list there would be an agreed set of standards and a process for being struck off, but there wouldn't be a requirement to be registered to work in the NHS, other than by employers choosing to make it so.

Statutory registration would effectively put managers at the same level as doctors and nurses, requiring them to register with a regulator, meet the set standards, and be regularly reevaluated against them, on top of a process to be "struck off."

What is the evidence?

Moves to regulate managers have been criticised for lacking evidence and being unlikely to fix problems of poor performance.

"The problem with the current [February] consultation is that it risks looking like a knee jerk reaction to the Letby events and therefore risks being performative," says Roger Kline, research fellow at Middlesex University Business School. Lucy Letby is currently serving 15 whole life terms in prison for murdering seven babies and attempting to kill seven others while working as a neonatal nurse at the Countess of Chester Hospital.

Kline is concerned that policies, processes, and regulation will be put in place without the evidence that they will produce the desired outcome (better standards) and that there is a pattern of this happening in the NHS. He points to whistleblowing: "We have a whole load of policy every time there's a major scandal. The NHS puts in another layer of policy and procedure and training and expectations, and then five years later it's really surprised that it hasn't made much difference."

Are there other pitfalls?

The challenge with regulation, notes the consultation document, is that strengthening requirements to become a manager or board member in the NHS could also raise barriers to recruiting people from other sectors. On top of that, the paper notes, managers and board members may as a result become more risk averse in their decisions, which could have a knock-on effect on the performance of health services.

There is also the cost, estimated at between £2m and £10m a year (in addition to initial set-up costs), depending on the system and, for example, whether an existing regulator takes on the role.

Jon Restell, chief executive of Managers in Partnership, the trade union for managers and other senior staff working in health and care services, is adamant that a regulation process would have to be independent of the Care Quality Commission and the Department for Health and Social Care, because they have "skin in the game" when an organisation is deemed to be failing or performing poorly.

What's needed for it to work?

Alan Clamp, chief executive of the Professional Standards Authority, wants "right touch" regulation principles to be used to inform how NHS managers are regulated and says that development of regulation will need to be done "in partnership with the sector, managers, healthcare professionals, and patient groups."

LEFT Members of Cure the NHS demonstrate outside Stafford Hospital in 2010, during a standards of care inquiry

RIGHT Julie Bailey, who lost her mother Bella, aged 86 while she was a patient at Stafford Hospital, at a memorial gallery in 2009

CHRISTOPHER FURLONG/GETTYIMAGES

We have a whole load of policy every time there's a major scandal
Roger Kline

Managers want clear accountability for their responsibility
Jon Restell

It's understood there is an inevitability now to the regulation
Danny Mortimer

Danny Mortimer, chief executive of NHS Employers, says, "I think people want to understand that the process would be fair and independent." He believes there is a lot to be learnt from how professions inside and outside the NHS are currently regulated. For example, there are known challenges concerning the higher rate of referral to disciplinary processes of people from ethnic minorities.

For Mortimer, the key elements of a future system are that there is a clear set of standards and that the regulator measures complaints against those standards, investigates against those standards, and holds hearings against those standards. "It shouldn't be about a politician deciding," he says.

Restell wants to see regulation brought in firstly at the top, where the most risk is—at board level—and then to senior managers, and finally extended further down organisations. "Most managers want clear accountability for their responsibility, and the higher you go up in any NHS system the more vague that becomes."

What else might be needed?

Investment is needed, Restell says, in professional standards, competencies, and appraisal so as to raise the quality of management, but regulation by itself won't do that, and it won't happen overnight.

What Kline wants to see is relatively radical transparency and hence accountability. "All information should be available to anybody who wants to see it, unless there are very good reasons" not to, he says. That, he believes, is the way to uncover and challenge poor behaviour, pointing out that Tony Chambers, chief executive of the Countess of Chester Hospital when Letby was working there, was a nurse—and therefore already regulated.

"You can have regulation, but unless it's underpinned by behavioural change people will just try to find ways around regulation, and one of the ways around regulation is creating a climate of fear; another one is avoidance," Kline says.

Will it actually happen?

Broadly, in the past few years the consensus seems to have moved towards regulation of NHS managers, Restell believes. However, how regulation is done and by whom are still big questions that need to be answered, he says.

NHS Employers is already engaging with Streeting and his team on regulation of managers, confirms Mortimer. "There's an understanding that there is an inevitability now to the regulation," he says. This is both because of the Letby inquiry and because leaders see regulation as desirable, he adds.

Samir Jeraj, freelance journalist, London
sa.jeraj@gmail.com
Cite this as: *BMJ* 2025;389:r1019

Weight loss jabs shine a spotlight on the problems with BMI

This flawed metric remains at the core of diagnosis of obesity. But as the prevalence of drugs such as Wegovy encourages new approaches, **Carla Delgado** reports on fresh attempts to leave it behind

The huge increase in popularity of weight loss drugs such as semaglutide (Wegovy, Ozempic) and tirzepatide (Zepbound, Mounjaro) has brought a twist to the management of obesity. Patients usually need to exceed a minimum BMI threshold and have at least one weight related health condition to get a prescription for a weight loss drug. And that has again raised questions over the way obesity is defined, measured, and diagnosed.

In January 2025 the *Lancet Diabetes and Endocrinology* global commission on clinical obesity tackled this question head on. Its report recommended a new framework that moves away from BMI as a singular indicator and instead approaches obesity as a disease spectrum. Experts say that not knowing what BMI means can lead to incorrect assumptions about a person's health and risk of disease. This can affect the quality of care patients receive and hinder efforts to prevent and treat obesity.

Simple but flawed metric

BMI has long been considered a quick and easy way to assess whether a person is at a "healthy" weight, but it does not take into account elements such as body composition, age, sex, or lifestyle factors. It is an indirect measure of body fat that does not indicate the degree to which excess adiposity affects a person's health.

BMI was never meant for evaluating health, says Fatima Stanford, an obesity medicine physician at Massachusetts General Hospital and one of the authors who contributed to the global commission report. It was initially designed to look at the "normal" height and weight of a population, she says. Although BMI may be strongly correlated with the amount of fat mass at a population level, it loses precision when applied to individuals.

As Stanford points out, people classified as having a normal weight might have a false sense of security about their health, and those with an elevated BMI might think that something is inherently wrong with them, both of which can be problematic. This has been noted before—as recently as 2022, when the American Medical Association (AMA) adopted a new policy recognising the problems in using BMI as a clinical measure. In its 2022 guidance it stated that BMI should be used alongside other tools in the diagnosis of obesity and assessment of health risks.

Yet obesity is still diagnosed worldwide on the basis of BMI alone, which tends to underestimate or overestimate both adiposity and illness. By dividing weight in kilograms by height in metres squared, BMI categorises people according to their weight status: underweight, healthy weight, overweight, and obesity. This simplicity is both the metric's appeal and its weakness.

Measures of fat

Experts tell *The BMJ* that a major failing of BMI is that it does not distinguish between muscle and fat mass, nor does it take into account the distribution of fat around the body. This means that people with a lot of muscle mass could have a high BMI despite having low body fat. Those in the same BMI category might have variable cardiovascular disease risk, depending on where fat accumulates on their body.

Furthermore, women require a higher body fat percentage and might have about 10% more body fat than men with the same BMI. Proportions of muscle, bone, and fat for the same BMI also vary with ethnicity, resulting in a lower BMI threshold for overweight and obesity classifications for certain populations.

Essentially, BMI does not provide enough information about the fat mass a person carries. Indices of central adiposity—the fat around the abdominal area—such as the waist-to-hip ratio, waist-to-height ratio, and waist circumference can be more accurate for estimating

body fat and related health risks. But multiple measures are needed to measure body fat, says Adrian Brown, NIHR advanced fellow and senior research fellow in nutrition and dietetics in the Centre of Obesity Research at University College London. "We shouldn't just be using BMI," he tells *The BMJ*. "We shouldn't just be using anthropometric measurements or measures about adiposity. We should combine them."

There are already attempts to do this. NHS England, for example, uses waist circumference and waist-to-height ratio to examine the prevalence of overweight and obesity among adults in its official health survey. But relying on BMI alone remains far too common.

Health beyond body fat

Some people might be classified as underweight or as having obesity on the basis of BMI and yet experience no health problems, says Brown. For example, people with obesity might fall under the "metabolically healthy obesity" phenotype that was first described in the 1980s. The characteristics and definition of this phenotype vary, but it generally refers to people with obesity having high insulin sensitivity, favourable lipid and inflammation profiles, and normal blood pressure. It shows that many factors must be taken into account when evaluating the health risks of people with obesity.

Brown says it's important that healthcare professionals give patients an explanation about what BMI is rather than just giving a number. This helps people understand what the number means for them. There's no point in checking a patient's BMI without asking them about other factors, such as their physical activity and stress levels, or examining their blood pressure and blood sugar concentrations, he says.

Ultimately, anthropometric measures are not a robust measure of ongoing illness or organ dysfunction caused by obesity. Body fat, by itself, cannot be an indicator of health, and health problems are not always due to excess fat. But healthcare providers have been known to overattribute symptoms to obesity and advise patients to lose weight without referring them for diagnostic testing or treatment options, such as ascribing joint pain to obesity without considering musculoskeletal conditions.

People with a higher BMI have reported finding it difficult to seek care because their health complaints were not properly investigated but rather automatically attributed to their excess weight.

The National Institute for Health and Care Excellence updated its guidance on overweight and obesity management in January 2025 and now recommends against attributing all symptoms to overweight or obesity when a patient presents with a health problem and to tackle the matter first before asking to discuss weight.

Clear definitions

The 2025 Lancet commission report covers many of the problems with how obesity is measured and diagnosed. It defines obesity as a condition characterised by excess adiposity. This should be confirmed with at least one measurement of body size in addition to BMI, two measurements of body size regardless of BMI, or direct body fat measurement. It also introduces two categories of obesity, depending on objective measures of illness at the individual level: clinical obesity and preclinical obesity.

Clinical obesity is associated with reduced organ function and daily activities because of excess body fat, whereas preclinical obesity is associated with normal organ function. The first is a chronic, systemic illness that needs appropriate treatment, while the second requires support to reduce the risk of disease.

Brown says a clear definition of clinical obesity enables health professionals to refer patients to appropriate services and treatment, such as dietary interventions, pharmacotherapy, or bariatric or metabolic surgery.

But the commission also emphasises the importance of educating healthcare providers and public health professionals about weight stigma, which it says is "shamefully prevalent."

"You can't judge a book by its cover," says Stanford. "This is where, I think, we have gotten, and this promotes weight bias and stigma."

Although BMI remains a valuable tool for screening, the commission recommends against using it as an individual measure of health. Weight bias among healthcare providers can overlook conditions such as atypical anorexia nervosa, where the weight loss of people with overweight or obesity is often viewed positively rather than a cause for concern.

"While losing weight might be part of something, they need to be treating the whole person and looking at them not just for their weight," says Stanford. "This is not the way you treat people."

BMI wasn't meant to evaluate health
Fatima Stanford

Explain BMI, and don't just give patients a number
Adrian Brown

Carla Delgado, reporter, *The BMJ*
cmdtk24@gmail.com.
Cite this as: *BMJ* 2025;388:r241

“We can’t just admire the problem”

Lucy Chappell, chief executive of the National Institute for Health and Care Research (NIHR), speaks to **Victor Adebowale** about the structural and interpersonal racism embedded in UK healthcare research

VA: You’ve said we’ve been “admiring the problem” of racism for too long. What needs to happen now?

LC: We’ve described for a while—as some people say, “admired”—the problem. So, it’s time to say, what are the interventions that work? How do we not just see them as research but say what the impact is? How do we drive them for adoption and scale them up as we go?

With a £1.6bn annual budget, the NIHR has a powerful platform. How are you using it to make change?

We’ve made research inclusion a condition of funding. Applicants are now required to show how they will ensure that their participants are representative of the population they’re studying. We’ve heard before that researchers tried but that it was hard or expensive, so now we ask them to cost it in and to report on it regularly.

Have you personally witnessed racism during your career in medicine?

I’ve seen it happen, yes—towards women in maternity care, towards black women and women from many ethnicities, and even white minority groups such as the Roma or Traveller communities. It’s about making sure that we treat women as people, not as labels. And racism towards staff can also affect how they treat patients.

And what did that look like, on your way up in your career? Did you challenge it?

Medicine is very hierarchical.

At a junior level, it can be really hard to call out behaviour. But we can be shaped by it. I call some people “anti-role models”—the ones who teach you how not to act. As you become more senior, you must call it out. In maternity we’re seeing better speak-up cultures, but there’s more to do.

Do you worry about a backlash to tackling racism, especially given political resistance to diversity work in some quarters?

We’re very clear that research inclusion is essential—not political. If your research isn’t representative, it’s not going to improve outcomes across our population. For instance, black men are at higher risk of prostate cancer, so we need them in our trials. This isn’t just moral; it’s scientific and economic.

You’ve talked about representation in research roles. How do we fix that “leaky pipeline”?

It’s about ladders and “door opening” moments. I’ve had them in my career. But not everyone does. So, we’ve started publishing our diversity data for funding committees and senior roles. And we’re learning from others—the Wellcome Trust, UK Research and Innovation—and we’re not afraid to admit when something doesn’t work. You try again.

Are you seeing progress in representation at levels of leadership?

Yes. A key change was how we approached NIHR research professorships. If institutions wanted to nominate two candidates, the second had to be a woman. If they nominated three, one had to be from an ethnic minority. It changed the shortlist—and the faces at the top. That’s not tokenism. That’s talent being seen.

What would really accelerate this work?

I think of the Born in Bradford team. They hire researchers from their local communities, and that changes everything. We can and should scale that up. It’s not one fix [on its own]. But if we can normalise inclusion, like we did with public involvement in research, that’s a cultural shift that lasts.

What about AI? There are real fears about bias in algorithms

Artificial intelligence is only as good as the data we feed it. That’s why representative data matters. We’ve moved from “data sharing” to “data access,” with secure environments and proper governance. But in communities with low trust we need to show up, listen, and work on their terms—not ours.

What would you say to a young black researcher who is hoping to lead a major study one day?

The talent is there. The challenge is making sure that the system doesn’t leak it away. To that researcher, I’d say: “We see you, we need you, and we’re working to build the structures that will support you.” Whether it’s through mentoring, fair committee representation, or simply visibility—if you can see it, you can be it.

BIOGRAPHIES

Lucy Chappell (above) is chief scientific adviser to the Department of Health and Social Care and chief executive of the National Institute for Health and Care Research. She is also professor of obstetrics at King’s College London and an honorary consultant obstetrician at Guy’s and St Thomas’ NHS Foundation Trust. Her research investigates prediction and prevention of adverse pregnancy outcomes, particularly in women with conditions such as hypertension, using a range of methodologies.

Victor Adebowale has been chair of the NHS Confederation since April 2020 and is former chief executive of Turning Point, a social enterprise. A crossbench peer since 2001, he has led commissions on mental health and housing and is co-chair of the BMJ Commission on the Future of the NHS. He holds an MA in advanced organisational consulting and serves as chancellor at the University of Lincoln and as a leadership coach.

Mun-Keat Looi, international features editor, *The BMJ* mlooi@bmj.com

Cite this as: *BMJ* 2025;389:r1113

CAREERS

WHY I... am a jazz singer

Consultant pathologist Debra Milne tells **Helen Jones** about her love of jazz—from performing in a band to helping to run a local music venue

KEN DREW

It feels like I have two different and separate lives alongside one another… I think that's very healthy and has helped to prevent burnout

"I've always loved music but particularly jazz and the great singers," says Debra Milne, a consultant pathologist at Gateshead Health NHS Foundation Trust. "One of my earliest memories of somebody singing what I recognised to be jazz is as a teenager listening to a Nat King Cole album with a friend. I just thought his voice was amazing."

When her children began playing instruments, Milne joined a singing session at the Sage music venue in Gateshead (now called the Glasshouse). "It was there that I really got into jazz singing and wanted to pursue it more, so I started joining in jamming sessions, found some singing teachers, and then began studying in my own time," she says.

The first time Milne sang in public was for a school fundraiser based on the TV show *Stars in Their Eyes* where people performed as their favourite singer. "I did Sade and Debbie Harry. It was pretty terrifying," she says.

"Jazz is a very social music community. If you go to a friendly jam session as an instrumentalist or a singer, then everyone usually knows the music and joins in. It's part of a communal process and so people just have a go. It was scary to start with, but I've become much more confident over the years."

Milne now regularly performs as part of a trio called the Milne Glendinning Band at various venues in the north east including the Prohibition Cabaret Bar in Newcastle and the Vault in Darlington, as well as taking part in the Durham Fringe Festival.

The band's repertoire includes jazz standards and jazz infused pop covers as well as original songs. She says that colleagues occasionally come and see her perform and adds, "I know several doctors who are great musicians—some of them focus on classical music but there are others who perform jazz to a really high standard."

She says that singing has an impact on her role as a pathologist as "it feels like I have two different and separate lives alongside one another." She adds, "I'm usually immersed in my work Wednesday to Friday, but then disconnect from that the rest of the time. I think that's very healthy and has helped to prevent burnout. Each week I return to work refreshed."

As well as performing, Milne helps to run the Globe, an award winning, community owned music venue and bar in Newcastle. "It's not just a jazz venue—although I run the jazz programme—it features all sorts of music including folk, blues, and punk from up-and-coming bands, comedy, and open mic sessions together with a range of workshops for people who want to play music at different levels," she says. Milne coordinates volunteers and is closely involved in running the venue.

"My day job is in a busy department, and I have a special interest in head, neck, and thyroid pathology, but I work three days a week and have done for over twenty years, which means I have time to dedicate to the Globe," Milne says. "I've sort of got dragged into it, and I'm now heavily involved. Like all live music venues, we're trying to keep our heads above water, so we recently launched a crowdfunder to ensure we're here for the next ten years and more."

HOW TO START SINGING JAZZ

- Listen to lots of different jazz singers to find out what style you like
- Try and find a local singing group, class, or jam session to give you some confidence
- Making Music is a UK organisation made up of jazz bands, choirs, music clubs, orchestras, and more. Its website (www.makingmusic.org.uk/about-us) lists a huge range of organisations and groups where you can get involved in music of all genres across the UK
- Local music venues, jazz clubs, cafes, and bars are a good place to connect with fellow jazz musicians

Helen Jones, London

Cite this as: *BMJ* 2025;389:r743

CAREERS CLINIC

How can I support my deaf or hard of hearing colleague?

There are many ways to help deaf and hard of hearing colleagues feel included and supported, **Elisabeth Mahase** reports

Don't make assumptions

George Webster, medical student and editorial scholar at *The BMJ*

"Don't make assumptions. Just because someone wears hearing aids doesn't mean they don't also rely on other forms of communication such as lipreading.

"As a medical student who wears hearing aids, I often have to ask staff to find more appropriate spaces to give teaching. We are frequently taught on busy wards with varying levels of lighting and lots of background noise. I have had to ask if things can be repeated in a quieter environment where I can clearly see the person's face. Sometimes I've been told that there are no spaces available meaning I've missed key learning opportunities. The most inclusive teaching is from those who are not afraid to ask how they can best support my learning.

"In one trust, a doctor took me aside and let me know about all the support that was available for deaf medical students and doctors. I was surprised, as it was the first time someone had made it clear that I should be receiving the same opportunities as others. Even though this may seem like a small thing, equipping yourself with knowledge of support that exists and signposting it really helps to foster inclusivity.

"Those who make time to acknowledge that I may need to approach things differently have been incredibly helpful. I use an amplified bluetooth stethoscope which, at first, took longer for me to use, leaving me feeling rushed and embarrassed. Sometimes this has led to doctors asking me to skip clinical skills practice using a stethoscope. A few extra minutes would have enabled me to feel like I'm also a part of the team."

Include your colleague in conversations

Helen Grote, consultant neurologist

"One in seven people have some degree of hearing loss, so it's likely that you work with someone who is hard of hearing or deaf. If you are a line manager or a consultant with a deaf trainee or medical student, please do ask what you can do to help them.

"Hearing loss can be incredibly isolating—and a sense of belonging is vital to wellbeing at work and to feeling valued. Please do include your colleague in conversations. Facing people when you speak to them enables lipreading, and being prepared to repeat yourself goes a long way. Providing a quieter environment for complex conversations and, where possible, social events reduces the difficulties posed by background noise.

"For online meetings, please encourage participants to put their cameras on when speaking to facilitate lipreading and ensure that captions are available.

"Reasonable adjustments are incredibly important and can make the difference between being able to function in the workplace or not. Colleagues with hearing loss can apply to Access to Work, the government scheme that provides funding for equipment. In addition to the use of hearing aids or cochlear implants, staff with hearing loss may find adapted stethoscopes and microphones helpful. I use a small desktop microphone in clinic and for ward rounds. The microphone also plugs into computers for bluetooth streaming of sound to my cochlear implant. For those who work in theatre environments where masks are worn, consider if clear masks could be obtained for the wider team to facilitate lipreading."

Understand deaf culture

Natasha Wilcock, palliative care doctor and founder of IDA, a deaf insight organisation

"Deaf colleagues have a huge amount to give to the health service. We've developed a variety of flexible communication skills and have empathy for those with communication support needs. Deaf people continue, however, to face huge amounts of stigma and prejudice.

"The deaf community is diverse—ask the individual what their preferences are and focus on these. It can be exhausting and demoralising to have to fight for your own needs, so be proactive once you understand your colleague's needs. Deaf insight training is essential to understand inclusive communication skills and put these into practice in all areas—not just in clinical settings, but in meetings and over lunch too.

"Many deaf people do not view their deafness as a disability, but as their cultural identity. For example, often deaf people are perceived as rude or unfriendly as people think we are ignoring or interrupting them or that we look angry when communicating, but these are culturally normal.

"Pervasive attitudes rooted in ableism are common, such as people trying to be complimentary and saying things like, 'I would have never even known you are deaf,' or, 'You speak so well for a deaf person.' These can be harmful statements to a deaf person, so an understanding of deaf culture is crucial.

"For deaf people, listening through hearing aids, speech reading, or sign language can be tiring, so be aware the impact of this. It's important to consider the wider psychosocial impact of deafness beyond communication and how this might impact someone in the workplace."

Cite this as: *BMJ* 2025;389:r1030