comment

"Spare a thought for IMGs in the UK having spent energy, money, and time" **PARTHA KAR**
"We all need support systems, and I'm grateful for mine" **SCARLETT McNALLY**
PLUS Lade Smith on the mental health review; Ellen Fallows on obesity care

PRIMARY COLOUR Helen Salisbury

Whole system thinking

The widely predicted collapse of the NHS owing to resident doctors' industrial action just before Christmas didn't materialise. There was little change to the new normal, with too many sick people spending unacceptable hours on trolleys in emergency departments, but overcrowding was slightly less bad than last year.

One reason was that the flu peak had passed, but another well recognised factor is that when you have senior doctors making decisions at the front door of hospitals, they order fewer investigations and admit fewer patients. This isn't surprising: as a consultant you have more experience and greater confidence in your clinical judgment. You're also less likely to be blamed if you do make the wrong judgment call. Clinical decisions to not investigate or admit involve taking risk, and your capacity and licence to do so develop with experience.

The same logic applies in general practice. You need your best, most qualified people deciding who needs investigation and treatment and who can safely be sent home with reassurance, self-care advice, and safety netting. Barking and Dagenham has a GP based respiratory hub that's experimented with different skill mixes, finally settling on an entirely doctor delivered service. The measure of its success is the rates of reattendance to other parts of the local health system within a week. The data are not yet formally published but show that, with the current doctor only service, the percentage of patients re-presenting is lower than when the hub used clinical staff with more diverse training.

Looking at your practice or organisation in isolation, it can be tempting to adopt the cheapest staffing option that's compatible with ticking all contractual boxes. You want to keep within your budget—or maximise your profit—so why would you employ doctors when other, cheaper staff can do the work (at least on paper)? But if this results in patients seeking a second opinion from another service, you introduce an unwelcome inefficiency.

It's not just about money but also the patient experience. The observation that fewer patients reattend after seeing a doctor suggests either that they recovered more quickly or that they had greater faith in the advice given to them. It's probably a mixture of the two: those who needed it received the right treatment, while those who had self-limiting viral conditions felt sufficiently reassured to wait a bit longer to get better.

The advantage of the NHS, where ultimately all the funding comes from the same pot, should be that we can look at the whole system and see that, although staffing costs may initially be higher, in the long run it's cheaper and better for patients to have experts at the front door. This isn't a novel or recent insight, but it doesn't seem to have penetrated the thinking of those in charge of service design in the NHS.

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It's not just about money but also the patient experience

THE BOTTOM LINE Partha Kar

Prioritising UK medical graduates for NHS training posts could be a risky reset

The government has now made explicit its intention to prioritise UK graduates for NHS training posts. The bill, introduced by the health secretary, Wes Streeting, represents a decisive shift in workforce policy. While its stated aim—aligning medical training with national workforce needs—is understandable, the practical consequences may prove problematic.

There's a strong argument that the system needed reform. The rapid expansion of UK medical school places without a commensurate increase in postgraduate training numbers has left many domestic graduates facing career bottlenecks. Prioritising UK trained doctors for publicly funded training is not inherently unreasonable. What's harder to defend is the lack of advance planning and communication for the international medical graduates (IMGs) already in the system.

From this year IMGs will be deprioritised for foundation training, effectively turning this stage into a choke point. For specialty training in 2026, only IMGs with indefinite leave to remain will be eligible. Since indefinite leave to remain requires staying in the UK for five years, any IMG who has been in the UK for less time will be excluded from specialty training.

By 2027, IMGs' eligibility for specialty training becomes even more conditional. Access will depend on "relevant experience"—a term that remains undefined and subject to interpretation. This introduces substantial uncertainty into career planning for international doctors and risks creating a fragmented recruitment landscape.

The sudden narrowing of opportunities raises ethical questions

The new policy seems designed to gradually narrow the pipeline while leaving the door ajar for recruitment to posts that are unattractive to UK graduates. Specialty vacancies that remain unfilled may still be offered to IMGs. The sudden narrowing of opportunities raises ethical questions about fairness, transparency, and the responsibilities of regulators in managing expectations.

The policy also risks destabilising the careers of locally employed doctors. These roles—disproportionately filled by IMGs—are essential to hospital functioning. Many doctors in these posts have tolerated limited progression and insecure conditions in the hope of securing training posts. If locally employed doctors without indefinite leave to remain decide to move away from the UK because of

TALKING POINT John Launer

A bellyful of the NHS—why can't we treat our doctors like our patients?

A couple of years ago I had a bilateral nosebleed that wouldn't stop. My wife drove me to A&E at the Whittington Hospital in north London. I remember two main things about my visit. The first is that I had to wait for several hours, as the hospital seemed desperately understaffed and frantically busy. The other is that all the staff members I saw were extraordinarily kind and courteous, despite the pressure they were under. When I got home I wrote a social media post praising the service. I got a nice response from one of the consultants saying that she'd shared my comments with the team.

I didn't know the consultant personally, but she wrote to tell me she'd recently published a book and that I had a walk-on part in it, albeit anonymously. *Belly Full* is written by Heidi Edmundson, who has been an A&E consultant for more than 15 years. She describes her work in the almost unimaginably harsh conditions of a 21st century urban emergency department. She refers to the weekend I turned up as "nightmarish." When she got home, she saw my post, emailed it to staff, and cried for about an hour.

Parts of the NHS have declined almost to the point of collapse

An unflinching story

Belly Full offers a passionate and heartbreaking account of what society and politicians have allowed to happen to frontline services across the NHS—and to the people who devote themselves to it. Edmundson writes, "Every day you feel you are doing something wrong, something that goes against everything you believe. Intellectually, although you know it isn't your fault, but the fault of the system, it isn't the system that has to look patients in the eye as they lie on trolleys for hours."

The book is an unflinching account of how parts of the NHS have declined almost to the removal of training options, the NHS will struggle to fill workforce gaps.

NHS workforce planning has repeatedly failed to align training capacity, service demand, and retention. There's little evidence that these structural weaknesses have now been resolved. Some specialties will continue to rely on IMGs, but their career pathway will become narrower and more precarious.

Prioritising UK graduates may be a necessary correction, but it's not a complete solution. Without clearer definitions, transitional protections, and honest engagement with the NHS's ongoing dependence on international doctors, the policy risks replacing one workforce imbalance with another. The bill could make the simple amendment of allowing those on a work visa to be eligible for specialty training in 2026. This would avoid many IMGs already working in the system being left in the lurch.

Spare a thought for IMGs who came to the UK having spent energy, money, and time, who are left wondering about their uncertain future. Whichever way you look at it, the NHS has exploited IMGs to keep the system running.

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the point of collapse. It's also interwoven with Edmundson's personal story of how, in the space of a year, she developed an enormous belly. She describes, very persuasively, the depths of her denial about its significance.

Edmundson was distracted by her overwhelming workload and, ironically, her commitment to staff welfare. After a year she saw her GP and a gastroenterologist colleague, who diagnosed the rare malignant condition of pseudomyxoma peritonei. Mercifully, a 10 hour operation, hyperthermic intraperitoneal chemotherapy, and walking on the beach in her native Northern Ireland seem to have healed her.

The NHS didn't cause her cancer, but one can't help wondering how much suffering Edmundson might have been spared if she'd worked in a system that was as kind to her as she was to others.

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DISSECTING HEALTH Scarlett McNally

What my OBE means to me

For me, 2026 started with a huge bang. I was honoured with an OBE in the New Year's honours list for services to medicine, surgery, and the NHS. This has prompted me to reflect on my career, leadership, and experience.

I'm often asked how I manage to do so much, whether being a patient has changed my view of healthcare, and what I'm doing next. I do tend to take on too much, but I try to nurture others and have succession plans so that the organisation and team continue to thrive when I step down. I want to use my position to empower colleagues to value themselves and respect others—drawing on their own knowledge, skills, and experience, especially to benefit the NHS.

I've often grappled with ideas about what works in health and healthcare. As a surgeon I keep finding things that need fixing—diversity, exercise, human behaviours, education—alongside my day job. I've been in dozens of national committees and organisations and enjoy finding opportunities for change. This work doesn't happen alone, and I genuinely believe that diversity within groups and teams is essential for good work. When challenges or different views are shared respectfully (if sometimes vociferously) and met with understanding, this strengthens the agreed outputs.

Unfortunately, certain work and perspectives are undervalued in healthcare. Women doctors are treated differently from men, every day. Although I'd written booklets on unconscious bias, it wasn't until I was president of the Medical Women's Federation that I realised how, as a surgeon, I'd been treated with the authority of a male doctor for 30 years. We must do more to value the untapped potential of the 50% of licensed doctors who are women. Many of them, especially resident doctors, are silently struggling or leaving the workforce owing to inflexible work environments, pregnancies, childcare, and being seen as replaceable.

With the UK's ageing and increasingly comorbid population we need more than ever to retain doctors who can manage risk, working in a strong team. My own experience as a patient with myeloma, as well as having cardiac and orthopaedic procedures, made me more focused on wider issues that influence patient outcomes. Seeing care from another perspective reinforced my belief that patients need their views and expectations to be valued with honesty, options, and shared decision making. They need to know that the team treating them is experienced and cohesive. Opportunities to be healthy should be built into care interactions.

Like most people accepting an award, I want to thank my back-up crew. Many NHS staff quietly plan and assist my work. We all need support systems, and I'm grateful for mine. As to the future: my children are now adults, so I have more time to think, write, and plan my next adventures. Thank you to everybody who has believed in me. I love operating and having the platform to work with others to fix problems. There's still lots more to do.

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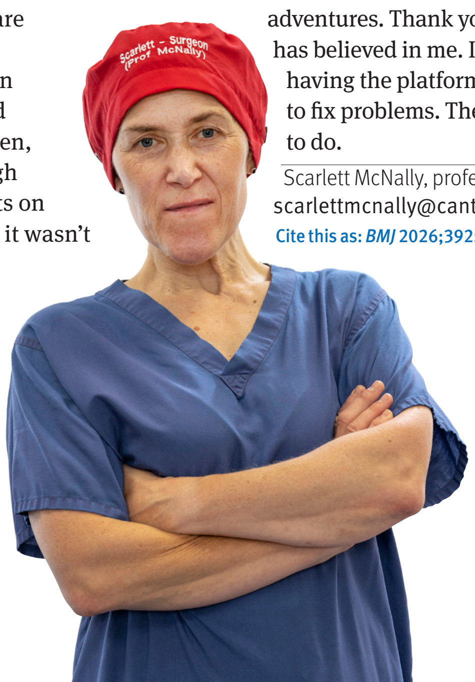
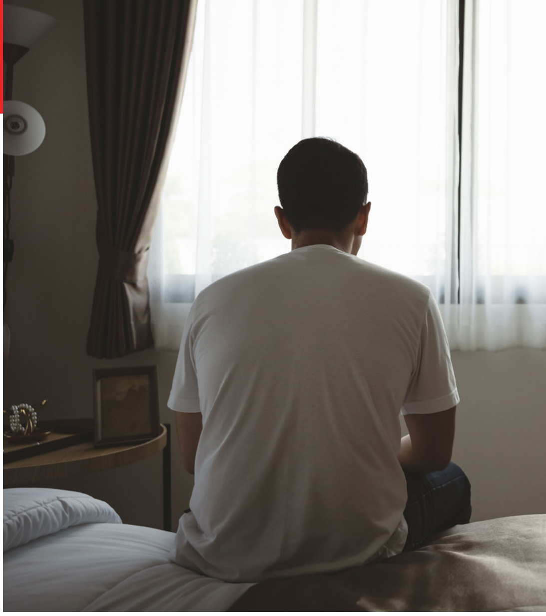


We all need support systems, and I'm grateful for mine

OPINION Lade Smith

Government review must avoid stigmatising mental illness

An focus on overdiagnosis should not overshadow access to care



News of the UK government’s review into rising demand for mental health, attention deficit/hyperactivity disorder (ADHD), and autism support in England has largely been welcomed by the sector.

It presents us with an important opportunity to examine the changing needs of our patients and services, while also addressing the ongoing debate around overdiagnosis.

The review will need to consider the complex reasons around why more people need mental healthcare, and it is positive that the health secretary, Wes Streeting, stressed this will be done through a “strictly clinical lens.”

With the leadership of psychologist Peter Fonagy, psychiatrist Simon Wessely, and consultant in children’s neurodisability Gillian Baird, we expect that it will build on existing knowledge to help everyone better understand what can be done to support people in need and meet the scale of this challenge.

Stigma and discrimination

Yet, as discussions around overdiagnosis continue, we must be mindful not to perpetuate stigma and discrimination, or discourage people from coming forward for support. People with mental illness are not “fake sick.” There are logical explanations for rising levels of need.

Exacerbated by the covid-19 pandemic, the past decade has seen a huge increase in financial, housing, and food insecurity, as well as loneliness and isolation—all risk factors associated with mental ill health. We’ve seen an almost 20% increase in the proportion of people classified as disabled because of anxiety and depression—both eminently treatable conditions and both driven, to a large extent, by social determinants.

In addition, current NHS figures show an increase of almost 30% (28.4%) in the proportion of adults aged 16-64 years reporting mental health problems between 2007 and 2023-24.

We have seen the prevalence of eating disorders rise, which is unsurprising given that people who experience anxiety, depression, and other common mental health conditions are nine times more likely to develop an eating disorder.

And far too many people with severe mental illnesses, such as schizophrenia and bipolar illness, in particular, are unable to access the care they need: half who have screened positive for bipolar disorder and a fifth of those identified with psychotic disorders are not receiving any mental health treatment at all.

OPINION Ellen Fallows

Effective obesity care: We need to ask less about weight and more about patients’ lives

The latest guidelines on obesity from NICE suggest that clinicians should always ask permission before discussing obesity with patients.

In my experience, asking permission hasn’t been an effective way to mitigate the stigma usually experienced by people with obesity. This approach implicitly tells patients that their doctor thinks obesity is the problem, and it can create barriers to effective consultations.

Unless a patient is requesting advice about weight loss, I’ve found that it hasn’t been helpful to bring up weight in a short primary care consultation. Just as it is correct but unhelpful to tell a patient, “COPD is bad for your health, you should improve your lung function—it has contributed to your shortness of breath,” it isn’t always helpful to tell someone that “obesity is bad for your health, you should lose weight—it has contributed to your hip pain.”

In practice, I have found it more useful to use the limited time in a consultation to explore the potentially modifiable drivers of symptoms that matter to the person. This means spending less time assessing the degree of obesity and more time assessing its causes.

People with obesity have usually experienced stigma

For example, in a short consultation about knee pain or type 2 diabetes, rather than trying to shoehorn in a discussion about weight, I have found it more helpful to sensitively inquire about drivers of poor health and obesity through questions such as, “Do you ever have difficulty making ends meet at the end of the month?”, “When did you last eat a green leafy vegetable?”, “Are you a shift worker?”, “What does your job involve?”, to assess what may be driving multiple health conditions.

Reframing our short consultations to focus on causes rather than conditions and to understand the person’s life could help doctors avoid value-laden discussions about numbers on scales. This might be one way to mitigate weight stigma in time-poor healthcare settings. These conversations can help us focus on the factors that shape patients’ health more widely and to link these to other common symptoms that often matter more to people than body mass index, such as fatigue, pain, and low mood.

Changing perceptions

Such discussions also have the potential to shift a wider

People with mental illness are not "fake sick"

The number of people waiting for mental healthcare now stands at 1.8 million, with repercussions affecting every section of society, from education and health to the economy and criminal justice system. Indeed, the ADHD Taskforce Report concluded that ADHD is underdiagnosed, undertreated, and its economic impact alone is £18bn.

We must therefore ensure that the debate around overdiagnosis does not overshadow the more pressing issue of access to adequate care. The biggest concern is the unacceptably long waits for treatment that people with acute needs are facing, while services become increasingly overstretched. The number of people waiting for mental health treatment, or assessments or support for ADHD or autism, is not going to fall by casting doubt on whether they need our help or not.

Our focus should be on prioritising their assessment, to understand who has an illness that needs specialist care rather than questioning whether they will one day receive a formal diagnosis. Specialists can say when someone is ill, but also if they are not and suggest more appropriate non-specialist support.

Package of care

It is essential that people with mental illness and neurodevelopmental conditions have access to evidence based, comprehensive assessments from trained psychiatrists or qualified mental health professionals, which formulate their problems, clarify their diagnosis, and provide a package of care and treatment to enable them to have the best quality of life, should they need it.

We are concerned that too many people are not able to access this type of high quality assessment and treatment by qualified mental health staff and are forced to navigate their condition alone. We know from clinical experience that when misdiagnosis—a term that is preferable to and more accurate than "overdiagnosis"—does occur, it is largely driven by people being left to diagnose themselves or being assessed by those with no or inadequate specialist skills and training, too often a consequence of a lack of available services.

Many of our members have directly experienced or witnessed moral injury caused by insufficient resources available to them. Now is the time to identify and explore these gaps in the mental health system and develop practical solutions, working closely with people with lived experience and clinicians. The good news is that there are many methods of treatment and support that already work, but these need to be scaled up.

The entire mental health sector will need to be brought together to support this review and ensure future reforms deliver more holistic care to people in need.

This review could help ensure millions of people receive the care they need, both now and for generations to come. Caring for people with mental illness and preventing others from becoming mentally unwell in the first place is good for individuals, the NHS, and the economy.

Lade Smith, president of the Royal College of Psychiatrists

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perception that new weight loss medicines could be simple, quick fixes and should be central to treating obesity. Instead, we could view these treatments as wraparound support options to be used alongside core interventions, such as help to improve diet, relationships, and sleep; increase physical activity; and reduce stress and harmful technology use.

Increasingly, in real world settings we are seeing that the use of glucagon-like peptide-1 medicines without meaningful support to improve these wider factors can lead to reduced efficacy and sustainability of treatment, as well as complications.

Doctors can offer people tangible support to improve the quality of their diet. Clinicians can also provide "may be fit for" certification to request adjustments in shift work, or help people to increase their activity levels by providing discounts to council gyms or referrals to a social prescriber, health coach, or dietitian.

By taking this approach, we may find that multiple downstream health conditions improve. Notably, none of these interventions, at least in an initial short consultation, requires a discussion about the person's weight.

Even better still would be to ask patients, "what matters most to you right now about your health?" and use the answer to drive our consultation approach. This might refocus our consultations back to people's real lives rather than downstream biometrics that are surrogate markers for poverty, food insecurity, sedentary and stressful jobs, shift work, social isolation, technology harm, and smoking and alcohol use.

Ultimately, I hope this approach may potentially avoid adding to polypharmacy and overprescribing harms when, in the words of former government food tsar Henry Dimbleby, most evidence suggests that for many people, "the problem is food."

Countries such as Japan, France, and South Korea have turned the tide of their obesity epidemics without people having to "inject [their] way out" of it. Perhaps one place to start might be talking more in the consulting room about real lives rather than numbers on a scale?

Ellen Fallows, GP and fellow, British Society of Lifestyle Medicine

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LETTERS Selected from rapid responses on bmj.com

BULLYING OF DISABLED DOCTORS

Ableism in medicine is a systemic workforce risk

The BMA's *Disability and Neurodivergence in the Medical Profession* report highlights persistent systemic barriers for disabled resident doctors (Medical news in brief, 13-20 September). The survey findings support growing evidence of higher bullying rates, poorer career progression, and disproportionate capability procedures for disabled staff.

The fragmented accountability for reasonable adjustments between local education providers and postgraduate training programmes manifests as delays, inconsistencies, and attrition risk. GMC evidence of poorer day-to-day experiences, reduced support, and greater workload strain among disabled doctors strengthens concerns in the 2019 *Welcomed and Valued* report about the absence of coordinated, standardised support.

Cultural assumptions compound structural barriers. Competence is too often viewed through a deficit lens, despite guidance from the Academy of Medical Royal Colleges promoting capability based progression and workplace flexibility. Without explicit safeguards, assumptions about physical or sensory "capabilities" risk entrenching ableism. The academy's statement for action on health and work emphasises "good work" as a determinant of health, but workplace pressures may worsen the health conditions for which support is sought, with disabled residents being at higher risk of burnout than their peers.

Across employers and training bodies, confusion about reasonable adjustments and Equality Act obligations continues to undermine equity. Disabled staff are significantly less likely to report equal access to development opportunities, and when doctors must fund adjustments, re-explain their needs, or use annual leave for medical appointments, inclusion is treated as optional, not integral, to workforce planning. These practices create additional administrative burden, contribute to burnout, and weaken efforts to retain a diverse, sustainable workforce.

If the NHS Long Term Workforce Plan is to succeed, disability inclusion must be treated as a core workforce priority. Clarifying accountability, ensuring consistent implementation of adjustments, challenging ableist assumptions, and strengthening oversight are essential to retaining the skilled clinicians the NHS urgently needs.

Susan Stokes, specialty trainee in paediatric dentistry, Leeds; James Broadbent, academic clinical fellowship specialty trainee in public health, Warwick; Hannah Barham-Brown, general practitioner, Dundee; Amy Martin future leaders fellow, Leeds

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MEDICAL MISOGYNY

Improving experiences of gynaecological procedures

Waters raises awareness of the urgent need for action to improve patient experiences of gynaecological procedures (Feature, 13-20 September). These issues are long standing, and many people have shared their harrowing accounts, for many years, through many forums.

We know that many women find these procedures exceptionally painful or distressing, or both. We know that guidelines are not followed consistently and that variations in care are enormous. We know that more research is needed to make sure that care is evidence based and that effective pain management is embedded in practice.

Only concrete and urgent action and investment will shift things at the pace this deserves. Patients must be part of the conversation at all stages, helping to shape services and ensure they are truly inclusive and person centred and that every patient receives the best possible care. All patients deserve to be heard, believed, and treated with compassion.

Stephanie O'Donohue, founder, TIGER UK

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DEFENSIVE MEDICINE

Trusting judgment, not just scans

Beardsell laments the rise of defensive medicine (Opinion, 25 October–1 November). From the start of our careers, we are told to be "safe," but safe has come to mean "leave nothing unchecked." The result is a generation of doctors who reach for investigations before reasoning, having absorbed the lesson that a missed scan is more dangerous for our careers than a missed opportunity to trust our judgment.

What excites me about emergency medicine is its reliance on sharp thinking under pressure and the ability to weigh risk in real time. What unsettles me is how quickly that curiosity is replaced by fear. If we want to shift this trajectory, we need visible leadership that models courage as well as competence. Juniors must see seniors making evidence based decisions, sharing uncertainty openly with patients, and being supported by their institutions.

Julia Ali, junior clinical fellow in emergency medicine, London

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Medicine is cooked

Doctors used to be paid for their opinion—for balancing experience, probability, and uncertainty. The best clinicians were those able to weigh risk and communicate that uncertainty clearly to patients. But with the rise of technology, implementation frameworks, and guidelines, experience and judgment have been usurped.

Artificial intelligence (AI) may sweep all this aside. It will use vast datasets to build opinion based on probability and will express that opinion clearly, without fear of offending or challenging convention. Why wouldn't patients go directly to an AI clinician that can assess, investigate, and interpret efficiently? Initially, human oversight will be needed, but as data accumulate, AI will improve—it will be better than us and a lot less fearful.

Medicine as we know it is cooked. The question is how we as doctors choose to respond. It's not a catastrophe but an opportunity.

Des Spence GP, Glasgow

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MEDICAL EDUCATION

Why listening to learners matters

Launer calls for NHS leaders to listen to the "hundreds of clinical educators" and "thousands of learners" before reorganising medical education (John Launer, 27 September - 4 October). Two biostatistics studies provide empirical evidence that effective, practice oriented training arises from the ground up, not from managerial design imposed from above.

The first study found that medical students overwhelmingly preferred a practical biostatistics model using real research articles over traditional, memory based instruction, reporting less stress, greater understanding of material, and more satisfaction. They showed higher confidence in applying statistical methods.

The second study found that inadequate statistical training in PhD programmes leads directly to widespread statistical errors in published science. It showed that, when learners' and educators' voices are ignored, teaching becomes abstract, stressful, and ineffective. When their insights shape curriculums, education becomes practical, relevant, and resilient. The message is simple: protect education by grounding it in evidence and learners' experience.

Michal Ordak, assistant professor, Warsaw

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Departments should receive direct funding

Launer notes that medical education nearly always loses out to service provision in NHS reorganisations. This reality has been magnified by trusts having to urgently deal with financial deficits, resulting in ongoing inadequate investment in medical education infrastructure, including the workforce required to train increasing numbers of doctors and other healthcare professionals. The potential diversion of funds allocated for medical education to other trust priorities may ultimately compromise the quality and safety of patient care.

A potential solution might be to ensure that medical education departments receive direct funding in an agreed and transparent way, and are then able to fund courses, develop their resource priorities, and remunerate educators directly. These arrangements should be separate from other contractual trust arrangements, and medical education departments should be held accountable for the use of resources. These arrangements might encourage more doctors to become trainers, enhancing their own career experience while also benefiting patient care.

Babulal Sethia, retired consultant cardiac surgeon, Cold Ashby

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Integrating students into clinical teams

Launer pits medical education against service provision. But many "service provision" activities can be educational—particularly in the earlier years.

Referring patients to another specialty, for example, often involves performing a structured clinical assessment and producing a structured handover, providing students with the opportunity to practise history taking, examination, and clinical reasoning.

If students were more integrated into the team and had an expectation of meaningful contribution, clinicians would be more incentivised to teach them to ensure clinical tasks were performed to expected standards. It would also free up resident doctors' time and allow more teaching for the students.

A balance would have to be sought so students would not lose time for self-study and other educational activities. But greater incorporation into the team seems likely to benefit future and current clinicians.

Nancy Penny and Bennett Wollas, junior clinical fellows, Derby

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LECANEMAB FOR ALZHEIMER'S DISEASE

Anti-amyloid antibodies are not truly disease modifying

Australia has approved Alzheimer's drug lecanemab after two rejections (News, online 30 September). The amyloid hypothesis posits that amyloid is the cause of Alzheimer's disease and underpins claims that anti-amyloid antibodies such as lecanemab and donanemab are "disease modifying." But numerous trials targeting amyloid have failed to show meaningful clinical improvement. Although lecanemab and donanemab reliably clear plaques and yield small statistical signals on cognitive scales, these changes have not translated into a truly substantial functional benefit. An alternative explanation is that amyloid is not the ultimate driver of disease and that these antibodies are not truly disease modifying.

Until we identify and target root disease causes and achieve profound clinical benefit, no therapy can be called "disease modifying." The future of Alzheimer's therapy requires an individualised medicine paradigm, tailoring interventions to the genetic, molecular, and clinical risks of each patient, with a sharp focus on therapy improving cognition and daily function.

Bryce Vissel, programme head, Sydney

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ARMS INDUSTRY AND HEALTH

Health professionals must speak out

Bellis and colleagues' analysis of the arms industry came at a crucial time as the UN commission of inquiry confirmed the genocide in Gaza (Cover, 13-20 September). Our duty is to patients but also to our colleagues who are victims of war and conflict.

Harm from the arms industry affects not only those at the receiving end of weapons, but also the ones pulling the trigger. Anxiety, depression, post-traumatic stress disorder, and psychosis can arise. The families of victims are also left with mental scars that they hold for the rest of their lives.

We need to speak out against injustices and explore the short and long term damage that war has on our patients and peers. I call on all NHS leaders to scrutinise their business dealings and on healthcare professionals to speak out against the harms of the arms industry like we do with tobacco, drugs, and alcohol.

Assad Malik, clinical teaching fellow, London

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MARTIN LEE/ALAMY

ANALYSIS

How should public health respond to rise of alcohol-free and low alcohol drinks?

John Holmes and colleagues argue for a precautionary approach that is guided by public health interests and considers both risks and benefits

Nolo drinks have obvious potential to improve public health

Sales of alcohol-free and low alcohol (nolo) drinks have increased substantially over recent years, driven by improved manufacturing techniques and consumer demand for better and healthier alternatives to alcoholic drinks (box 1).[1] Nolo drinks have obvious potential to improve public health, depending on who drinks them, to what extent, and in which contexts. The more people replace alcoholic drinks with nolo alternatives, the more they reduce their risk of alcohol related disease and injury. This is particularly true for heavier drinkers, those in lower socioeconomic groups, and people drinking in high risk circumstances, such as when pregnant, driving, or in adolescence.

However, the World Health Organization (WHO) and alcohol charities have argued that no and low alcohol drinks also pose risks

KEY MESSAGES

- Alcohol-free and low alcohol (nolo) drinks are increasingly popular with consumers in high income countries
- Nolo drinks have the potential to affect public health, but there is little evidence on whether benefits or harms are being realised now, or will be in the future
- Public health actors should help develop and implement a strategic and precautionary approach to nolo drinks to minimise risks
- This includes agreeing on the basic aims of nolo drinks, the actions that might deliver these aims, and where further evidence is required

to public health.[2-4] The risks include companies using marketing of nolo drinks to deter or circumvent restrictions on alcohol marketing, particularly when they share branding with alcoholic products (so called surrogate marketing).[5] Similarly, nolo drinks or related marketing may encroach on otherwise alcohol-free spaces, such as gyms and sports events or in supermarket lunchtime meal deals.[6,7]

Concerns also exist about whether the nutritional profile of nolo drinks is more or less favourable than the alcoholic or soft drinks they may replace, and the potential for the alcohol industry to draw attention or resources away from more effective public health activity by presenting nolo drinks as a solution to alcohol related harm.[1] They also have the potential to widen health inequalities because of lower take-up among lower socioeconomic groups (which experience higher rates of harm from alcohol).[8-10]

Despite these concerns, market analysts expect consumption to continue to grow in many countries, including Brazil, Japan, South Africa, the UK, and US.[11] In Britain, the country with the most published data, one in five adults reports consuming nolo drinks at least once a month, and nolo drinks now account for 1.4% of total alcohol sales.[12] The majority of these sales (84%) come from products that share branding with an established alcoholic drink, typically produced by a multinational coroporation.[12] To protect public health a precautionary approach is required that aims to facilitate and enhance potential benefits while also preventing or minimising any harms.

Box 1 | What are "nolo" drinks?

The term "nolo" generally refers to variants on standard alcoholic drinks (eg, beers, wines, spirits) that contain little or no alcohol. The exact alcohol content differs between countries, but in the UK is no more than 1.2% alcohol-by-volume (ABV).[1]

Nolo drinks are distinct from reduced strength drinks, where the ABV is lower than normal but still sufficient to cause intoxication and longer term health problems, such as wines at 5-10% ABV or beers at 2-3.5% ABV.

Nolo drinks are also distinct from a wider set of alcohol alternatives that are essentially soft drinks marketed as substitutes for alcohol, including kombuchas and botanicals.

NATHANIEL NOIR/ALAMY

STEPHEN FROST/ALAMY

Maximising benefits of substitution

Any direct public health benefits of nolo drinks will come from increasing the extent to which they replace consumption of standard alcoholic drinks. Seeking to promote and facilitate such substitution, particularly among heavier consumers, more deprived groups, and others at greatest risk of harm, should therefore be the central goal of efforts to increase the availability and consumption of nolo drinks. Evidence from observational and experimental studies suggests that some replacement may already be taking place,[13-16] although the effects may be too small to deliver substantial health gains,[17] and the generalisability of some experimental findings to real world settings is unclear. Similarly, although heavier drinkers are more likely to purchase and consume nolo drinks than lighter or non-drinkers,[8-10] the low uptake of nolo drinks among lower socioeconomic groups limits their effect on health outcomes.

Nolo drinks still have the capacity to cause intoxication and health issues

There have been few direct attempts by health authorities to promote replacement of alcoholic with nolo alternatives. However, this is more likely if nolo drinks are straightforwardly available and visible in places where alcohol is purchased and consumed, such as bars and shops. Research suggests that this supports attempts to reduce alcohol consumption by facilitating people's involvement in social events without drinking alcohol.[16,18] Considering how licensing policies and social marketing might promote availability of nolo drinks in key settings is therefore a priority.

Similarly, it may be appropriate for clinical and public health practitioners to explore the potential benefits of promoting substitution between alcoholic and nolo drinks when developing or providing individual level interventions, such as psychosocial interventions in primary care, treatment, or recovery services. Relevant evidence is sparse, and it is important to remain mindful of risks, but identifying what works (or is unhelpful) for whom in which contexts would enable appropriate targeting. Meanwhile, a precautionary approach would involve ensuring that clinicians and service providers are sufficiently familiar with potential benefits and harms to discuss them effectively with patients and service users.

Minimising risk of potential harms

Although the potential harms of nolo drinks for high risk groups are serious, stronger evidence is needed on the mechanisms underlying them as these are often uncertain or have competing strands. For example, much of the public health concerns about nolo drinks has focused on the potential for their marketing to subvert restrictions on wider alcohol marketing or extend the reach of alcohol brands, and evidence of this is growing (box 2).[6,19] However, marketing of nolo drinks may also displace or dilute wider alcohol marketing or use trusted brands to encourage substitution of alcoholic drinks with nolo alternatives. How this tension plays out may depend on the extent to which restrictions on alcohol marketing are already in place.

There is also limited, and often dated, experimental evidence that nolo drinks (or related marketing)

Box 2 | Case studies of nolo drinks marketing

Surrogate marketing undermining restrictions on alcohol advertising

The Irish government introduced restrictions on alcohol advertising as part of the Public Health (Alcohol) Act 2018. However, it is unclear whether these restrictions extend to nolo drinks that share branding with a standard alcoholic product. Subsequently, beer companies have replaced adverts for standard alcoholic drinks with adverts for nolo equivalents.

For example, the Six Nations Rugby Union tournament is sponsored by Guinness (owned by the multinational drinks company Diageo) but uses branding for Guinness 0.0% (its alcohol-free variant) during matches in Ireland. The branding for these products differs mainly by the addition of a blue 0.0%, although this was not always visible or present during matches.[19] However, for six nations matches in France, which has stricter alcohol marketing rules, Guinness replaced Guinness with the word “Greatness”, but retained its standard visual design (eg, font, colours).

Away from sports sponsorship, social media users have posted before and after images of large outdoor billboard adverts for Guinness that have been replaced by similar adverts for Guinness 0.0. Extending restrictions on alcohol marketing to nolo drinks that share branding with alcoholic products would prevent this surrogate marketing.

Alcohol marketing codes should apply to nolo drinks


4KCLIPS/ALAMY

Nolo products introducing alcohol brands into previously alcohol-free spaces

The 2024 Olympics named Corona Cero as its official global beer sponsor. Corona Cero is an alcohol-free variants of Corona, owned by the multinational drinks company AB InBev. This was the first time a beer brand had been an official sponsor of the Olympics and it allowed the Corona brand to appear in a wide range of sporting and media contexts that were previously unavailable to it, as well as linking AB InBev to the wider Olympic movement and its goals.[20] Ensuring alcohol marketing codes apply the same rules to nolo drinks would prevent this encroachment of alcohol brands into previously alcohol-free forums

may prompt cravings for alcohol among people in recovery and act as cues to drink during pregnancy or among those trying to abstain or cut down,[21,22] but the real world implications of this remain underresearched. Among under 18s, nolo availability (or marketing) may facilitate earlier exposure to the taste and smell of alcohol or allow companies to build brand recognition at earlier ages.[23,24] However, there is not yet robust evidence of “gateway effects” from nolo to standard alcoholic drinks.

Similarly, alcohol-free spaces are valued by some vulnerable groups and also shape wider norms about the place of alcohol in society. Preventing nolo drinks and related marketing from encroaching on these spaces would ensure they remain inclusive for people wishing to limit their own or others’ exposure to alcohol while also maintaining social norms that keep some parts of society alcohol-free. However, some consumers may welcome nolo drinks in alcohol-free leisure spaces as alternatives to soft drinks and, more speculatively, this could facilitate the growth of night-time venues that focus less on alcohol.[25]

Finally, nolo drinks present risks to wider public health policy. They could allow drinks companies to present as contributors to reducing alcohol related harm and support their extensive efforts to develop partnerships with governments, shape policy agendas, undermine interventions that threaten their interests, and draw public health resources away from more effective activity. Where appropriate, public health actors, including governments, should therefore draw on guidelines for effective management of interactions with other unhealthy commodity industries,[26] such as restricting interactions with the alcohol industry.

Influencing policy

WHO has called for companies to “substitute, whenever possible, higher alcohol products with nolo products in their overall portfolios, with the goal of decreasing the overall levels of alcohol consumption in populations and consumer groups, while avoiding the circumvention of existing regulations for alcoholic beverages and the targeting of new consumer groups with alcohol marketing, advertising, and promotional activities.”[27] It has also proposed actions to reduce the risks, including preventing marketing to children, protecting alcohol-free spaces, and using taxes based on alcoholic strength to incentivise consumption of alcoholic drinks that contain less alcohol.[28]

In addition to WHO’s call to commercial organisations, the European Commission has proposed new terminology for labelling nolo products. This includes allowing companies to label wines up to 5.95% alcohol by volume (ABV) as “alcohol light,” despite them containing more alcohol than most beers,[29] although the terminology has since been modified to “reduced alcohol.”[30] The UK government has also consulted twice on its labelling guidance for nolo drinks and exempts most nolo products from taxes on high sugar drinks, while industry linked self-regulatory bodies have published advertising guidance.[31] Norway has extended its comprehensive ban on alcohol marketing to include nolo drinks that share branding with standard alcoholic products, but Ireland’s restrictions on sports sponsorship and outdoor advertising for alcohol seemingly permit promotion of nolo products with shared branding (box 2).[32]

Some of these policy decisions seem to be driven by the concerns of businesses, trade organisations, and self-regulatory bodies. Public health actors must therefore engage with the policy questions to ensure that their perspectives, and not just commercial priorities, shape regulation of the

Principles to inform a public health response to no and low alcohol (nolo) drinks and suggested policy and practice options

Principle	Example actions
Promote and facilitate increased substitution of alcoholic drinks with nolo alternatives	Independently set and monitor targets for producers and retailers to ensure commercial activity aligns with public health goals, including accessibility for disadvantaged groups Use wider alcohol policy to ensure a price differential between nolo and standard alcoholic drinks that incentivises switching to nolo drinks
Promote the normalisation of nolo drinks in alcohol purchasing and consumption settings	Create a regulatory definition of nolo drinks that is distinct from standard alcoholic, reduced alcohol, and soft drinks to facilitate effective policymaking Mandate availability of nolo products in licensed premises Develop equal prominence guidance for use within licensed premises to ensure nolo products are as visible and accessible as standard alcoholic drinks
Develop an evidence base to inform recommendations	Support studies of how nolo drinks may be integrated within treatment, including treatment and recovery services for alcohol use disorders, and treatment for other relevant conditions (eg, alcohol related liver disease) Support studies of health promotion and other social marketing campaigns that incorporate nolo drinks to establish their efficacy in reducing alcohol consumption and related harm Support studies into appropriate placement of nolo drinks in supermarkets and other retail outlets
Prevent nolo drinks from causing harm in higher risk contexts, including adolescence, pregnancy, and recovery from alcohol use disorders	Set minimum age of purchase laws for nolo drinks to match those for standard alcoholic drinks Prohibit commercial marketing that promotes consumption of nolo drinks in higher risk contexts. Social marketing (eg, drink-driving campaigns) should be exempt from these rules
Prevent encroachment of nolo drinks into alcohol-free spaces	Prohibit marketing of nolo drinks in any setting where marketing of standard alcoholic drinks is prohibited Prohibit marketing material that depicts nolo drinks in ways or settings that would not be appropriate for alcohol consumption Restrict marketing of nolo drinks that share branding with standard alcoholic brands
Monitor, reduce, and mitigate the impact of corporate political activity by the alcohol industry in relation to nolo drinks	Establish processes that promote transparency and protect decision making from interference by the alcohol industry Minimise interactions with the alcohol industry and restrict these to information exchanges that support implementation of policies or practice Avoid entering into formal partnerships with the alcohol industry

production, marketing, sale, and use of nolo drinks, and how they are framed in public debate. The table suggests some general principles and associated policies that would help achieve the overarching aim of maximising benefits and minimising risks.

Nolo drinks present a complex public health challenge


STEPHEN HYDE/ALAMY

The sparse evidence base on nolo drinks hinders efforts by public health actors to respond to policy questions. Key research priorities include understanding how much people are replacing alcoholic drinks with nolo alternatives, which groups are doing so, and whether nolo drinks are prompting, enhancing, or merely featuring in people's attempts to reduce their alcohol consumption. If nolo drinks are driving reductions in alcohol consumption, a further priority is evaluating ways to promote this, including through population-wide policies (eg, pricing, availability, social marketing campaigns) and community or individual level interventions. Regarding risks, the main priorities are evidencing the extent to which these are materialising, the mechanisms through which they may lead to harm, and the effectiveness of preventive policies or interventions.

Nolo drinks present a complex public health challenge, and the correct response may differ between highly regulated alcohol markets (eg, Scandinavia) and more liberal ones (eg, Australia). Similarly, low and middle income countries experiencing rapid expansion of their alcohol markets may place less emphasis on promoting substitution and focus more on protecting high risk groups and alcohol-free spaces. However, we believe the same principles will largely apply.

Although we argue for a public health response to nolo drinks, we are not suggesting a reduced focus on standard alcoholic drinks. Nor are we seeking to exaggerate the degree of risk that nolo drinks present; however, as with e-cigarettes and reformulated foods, we should not take market led solutions to public health problems at face value. Benefits may emerge from nolo drinks, but a hands-off approach could mean these are smaller and less equitable than desired. Public health actors should therefore develop a strategic and comprehensive response that balances different concerns and aspirations.

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THE BMJ ANNUAL APPEAL

Action is needed to break the cycle of sexual violence in the Democratic Republic of the Congo

On 7 December 2025, people in Goma woke up to horror. The body of a young girl who had been raped and killed was discovered in a residential neighbourhood. For women and girls in the eastern Democratic Republic of the Congo (DRC), the tragedy of sexual and physical violence is part of the continuous reality that we face.

Sexual violence in the DRC is a critical medical emergency that endangers the health, dignity, and lives of thousands of women, girls, men, and boys. I carry this reality in my personal life. I am a Congolese mother working with Médecins Sans Frontières (MSF). The fear that my daughters might experience the violence that I'm confronted with daily never leaves me.

I wake up every morning with the painful certainty that many women will once again enter health centres after being assaulted. I go to work thinking about how to stay safe and teach my daughters to recognise danger even before they fully understand the world. I walk with fear when night falls and I'm not yet home. For many women and girls here, survival is a daily concern.

We know what medical steps and care are necessary when someone comes to a clinic after being assaulted. But for many survivors, that care remains unavailable or impossible to access. A key example is post-exposure prophylaxis (PEP). This is a combined treatment that must be administered within three days after rape to reduce the risk of HIV transmission, prevent certain infections, and provide emergency contraception. It is basic and essential medical care, but it is often unavailable. In 2025, humanitarian budget cuts from high income countries exacerbated this crisis, leading to stockouts of PEP kits in several health zones across the eastern DRC.

PASCAL GUYOT/GETTY IMAGES

"I walk with fear when night falls and I'm not yet home"

When a survivor finds the strength to seek help—only to discover that nothing is available—it undermines their recovery and trust in healthcare. Health facilities might be hours or days away on foot along dangerous roads. When violence increases, which happens regularly, services shrink further because medical teams must withdraw for their own safety. None of this is new or surprising, but the lack of care and services prolongs the suffering of survivors.

Everyone says that access to care is a priority. But when access depends on where someone lives, on who controls a road, or on uncertain funding, we must ask: is it really a priority, or just an empty promise?

The need for action

Investments from local health authorities and international organisations must prioritise local health facilities, so they always remain open. Mobile teams must be strengthened, equipped, and protected to ensure that they can reach remote communities. Survivors must have access to safe and confidential reception centres.

Local professionals need training, ongoing support and supervision, up to date equipment, and the means to strengthen their skills over time. But above all, they need protection.

Working on sexual violence in eastern DRC can be dangerous. Health workers, counsellors, and community responders are sometimes threatened simply for helping survivors. Local authorities, in collaboration with national institutions and humanitarian partners, must actively ensure the safety of those providing care. In areas affected by conflict, sporadic clashes and attacks on health facilities make it unsafe for teams to reach patients or to respond without fear. All parties to the conflict have a responsibility to guarantee safe access for medical and humanitarian workers respecting international humanitarian law.

Humanitarian organisations like MSF provide care, accompaniment, and advocate for better access to care, but alone they cannot solve a problem that is rooted in decades of war, inequality, and impunity for violence. This is not just a humanitarian problem; it is a societal problem. Tackling sexual violence concerns local authorities, communities, security forces, international actors, families, schools, and religious leaders. Until perpetrators are held responsible, the cycle of violence will continue unchecked. Justice and accountability extend beyond legal mechanisms. Everyone, in their roles within society, communities, and households must actively challenge sexual violence and refuse to normalise it. Only through both legal enforcement and societal non-tolerance can the cycle of violence be interrupted. Sexual violence shatters lives, families, and society—but it is preventable. Real change will begin when survivors receive guaranteed care, not just compassion; effective protection from violence, not just sympathy in the aftermath; real prevention, not just awareness raising. Above all, we need accountability—because this violence must never be treated as a statistic, inevitable norm, or just another tragic story.

We know some of what could be done. The question is whether we will have the will to act consistently, urgently, and with the seriousness that our daughters and sons deserve. When we treat this crisis as a collective responsibility rather than an isolated tragedy, we can truly begin to protect the future of our society.

Anonymous

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▶ *The BMJ* has chosen MSF for its annual appeal. For more detail on donating, see pp 64–65.

EDITORIAL

Delivering change after the UK covid inquiry

Government structures and leadership development need a rethink

The covid inquiry has painted a damning picture of the machinery of British government. Established in June 2022 to examine the government's handling of the covid-19 pandemic and to identify lessons to improve future pandemic and emergency preparedness, its first report[1] concluded that the government was ill prepared to manage a catastrophic emergency, let alone the coronavirus pandemic that occurred.

The second report, published in November 2025, focused on decision making within administrative and political processes. It uncovered evidence of slow decision making, insufficient understanding of risk, failures of leadership, toxic relationships, and confused public messaging.[2] Positive policy learning processes failed, mistakes made in the first wave were repeated in subsequent waves, and there was a general lack of policy learning and coordinating capacity within and across government.

The inquiry highlighted two main requirements before the next pandemic or civil emergency: improving political and official coordination between UK central government and key partners (such as devolved governments), and creating a "whole system" approach to emergency response strategies. In both areas, the UK's centralised structures can act as either a facilitator or a barrier to effective governance. For example, during the covid pandemic the centrally led development and procurement of vaccines produced economies of scale and facilitated rollout. But the same centralisation can also be problematic if it cannot facilitate local discretion or react to feedback from delivery partners or local communities. Early in the crisis, for example, local directors of public health and NHS leaders lacked authority to react to the unfolding situation. Strengthening the statutory role of local directors of public health in emergencies could remedy this situation and reflect a positive form of policy learning.

VUK VALCIC/ALAMY

There is an urgent need to drive the scale, pace, and ambition of reform in the civil service

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At root, the covid inquiry's second report reveals a lack of "systems leadership."[3] Governing structures and cultures struggled to shift from hierarchical government—and singular conceptions of accountability centred around individual ministers and their departments—towards a more network based culture that empowers people to span sectoral and jurisdictional boundaries. Evidence suggests that the relative success of some countries in coping with covid-19 was linked to their capacity to adopt a "whole of government" approach. New Zealand, for example, had a single coordinating governmental hub with strong operational links to local services and welfare support.[4] The UK largely failed to develop an integrated strategic model, and remedying this situation would require radical rethinking of the role, capacity, structure, and relationships at the centre of government (specifically between No 10, Cabinet Office, and HM Treasury).

Learning together

The deeper challenge posed by the report is that, in focusing on coordinating capacity and whole-of-government thinking, it raises fundamental questions about leadership development, talent management, and training for both ministers and officials. The inquiry exposed a notion ingrained within Whitehall that senior civil servants and ministers, who lack specialist knowledge or training about contingency management or crisis control, can somehow be trusted to govern and cope with all eventualities. In fact, the inquiry exposes an amateurish governing culture, and how in many areas ministers and their senior civil servants could not cope.[5]

Numerous attempts to reform or "modernise" the civil service have tried to place a stronger focus on professional expertise, cross departmental working, and strategic decision making.[6] Professional development and training frameworks are being developed in the civil service, and the Civil Service College was partially re-established as the Leadership College for Government in 2022.[7,8] But there is an urgent need to drive the scale, pace, and ambition of the reform agenda.

Whether the UK's political and administrative structures can adapt and change governing styles, cultures, and processes to prevent the recurrence of similar failures is uncertain. Recommendations from independent public inquiries are rarely implemented and often quickly forgotten as there is no formal system for monitoring implementation.[13] Some form of formal and independent post-inquiry monitoring of implementation—such as a statutory independent covid implementation commissioner, drawing on the use of similar bodies in Australia and Canada—is likely to be needed if the lessons of covid are not to be quickly forgotten.[15]

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