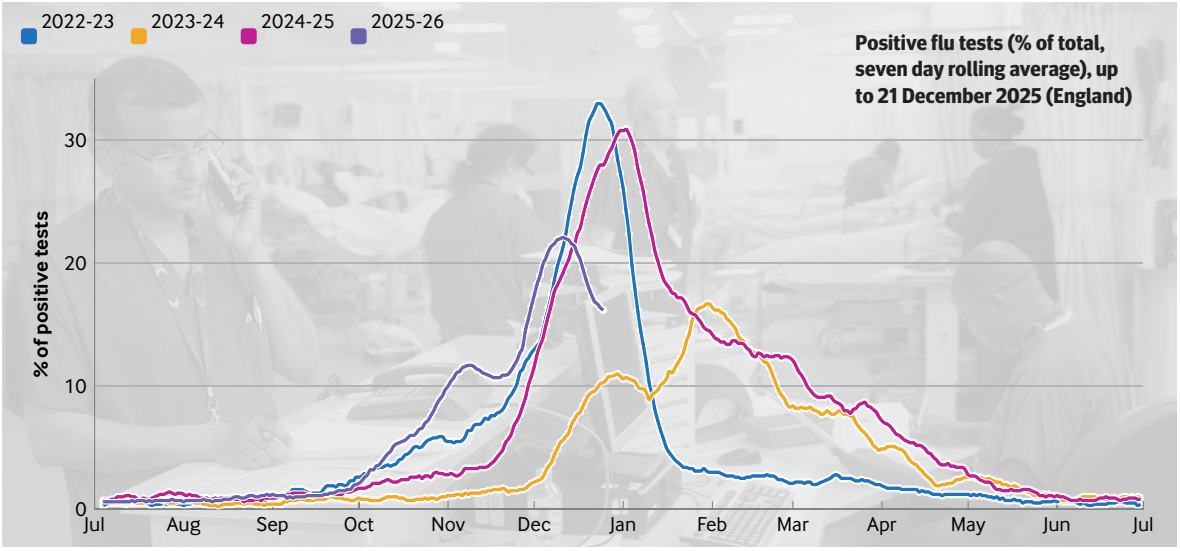
CONDOM TAX page 3 • **JUNK FOOD AD BAN** page 4 • **PUBERTY BLOCKERS TRIAL** page 6



Ministers accused of overstating flu risk

The government has been accused of overstating the threat from "superflu" this winter as latest figures show case numbers and hospital admissions have been falling steadily since mid-December.

A wave of early season flu cases and admissions prompted warnings from ministers and NHS leaders of a crisis. Health secretary Wes Streeting also linked flu with the latest resident doctors strike, arguing it had put patient safety at risk.

However, latest figures show cases and admissions are falling and did not eclipse those seen in 2022-23 and 2024-25.

UK Health Security Agency data from 24 December show the average weekly flu positivity rate for 15-21 December fell to 17.2%, from 21.1% the previous week. And NHS England data published on 2 January show hospital admissions fell by 14.7%, from 3140 in the week ending 14 December to 2676 in the week to 28 December.

The dominant flu strain this winter is a mutated version of the influenza A (H3N2) strain dubbed "subclade K," rather than the previously dominant A(H3N2). This led to fewer people having immunity to the virus, prompting some ministers and NHS leaders to label it as "superflu."

But former deputy chief medical officer Jonathan Van-Tam commented in a LinkedIn post, "I think we should deal in facts. Looking at the hospital admissions curve . . . it is essentially the same shape of predecessors in 2022-23 and 2024-25. The difference is that it is nudged to the left.

"Hospital admissions at the census point are roughly 66% of the 2024-25 peak and 50% of 2022-23 peak. I don't see evidence of anything 'worst ever' about these data."

He added, "I have not seen any science data to suggest this year's H3N2 strain is more virulent. So I'm very unclear what is meant by the rather silly term 'superflu.'"

Tim Gardner, assistant director of policy at the Health Foundation, said, "The rhetoric we've been hearing has been really hard to reconcile with the data.

"This feels quite disappointing, especially given that it's coming just weeks after the latest report from the covid inquiry, which highlighted the need for better public communications around this type of health situation and the risk of undermining public trust if this is done without best evidence and without the best comparisons."

The Department of Health and Social Care was approached for comment.

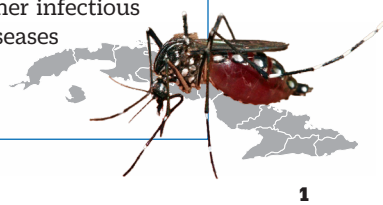
Adrian O'Dowd, London

Cite this as: *BMJ* 2026;392:s13

The latest data show that this year's "superflu" was less virulent than predicted

LATEST ONLINE

- NHS "online hospital" will prioritise menopause and prostate and eye conditions
- Pill version of obesity jab is approved in US, with UK decision pending
- Cuba hit by surge of dengue and other infectious diseases



MEDICAL NEWS

STRIKES: **BMA promises "constructive spirit" to avert further walkouts**

MARK THOMAS

The BMA says it will adopt a "constructive spirit" to try to avoid further strikes by resident doctors in 2026, as the latest five day walkout came to an end on 22 December.

Jack Fletcher (left), chair of the BMA's Resident Doctors Committee, made a fresh appeal to health and social care secretary Wes Streeting for "less name calling and more deal making" in 2026.

The latest strike action prompted the government to make a last minute offer. This included the creation of 4000 more specialty training places, funding resident doctors' royal college exam and membership fees, and prioritising UK medical graduates for training places. However, members rejected the deal, with 83% voting against it.

Despite the rejection, Fletcher said the government's offer left him optimistic. In a letter to Streeting on 22 December he said that "constructive conversations" before the latest strikes showed "progress is possible when there is meaningful engagement on the substance of our members' concerns. It is in that same constructive spirit that we wish to continue."

After the strike, Streeting said, "I do not want to see a single day of industrial action in the NHS in 2026 and will be doing everything I can to make this a reality."

Adrian O'Dowd, Kent **Cite this as:** *BMJ* 2026;391:r2675

Resident doctors

Scotland's doctors vote to strike for first time

Resident doctors in Scotland voted to strike for four days this month, after accusing the Scottish government of breaking its promise on pay restoration. In a poll by the BMA's Scottish Resident Doctors Committee 92% of members voted in favour of striking. Just over 3000 of Scotland's 5185 resident doctors (58%) took part in the ballot. Strike action is scheduled from 7 am on Tuesday 13 January to 7 am on Saturday 17 January.

Doctors in Wales vote to accept new contract

Resident doctors in Wales voted to accept a contract that includes a rise in basic pay, more flexible study leave, and a review of training bottlenecks. The contract, which will replace the 2002 contract, was put to BMA Cymru Wales's resident doctor members and final year medical students, of whom 83% (971 of 1176) voted to accept. BMA Cymru Wales said that resident doctors had seen a real terms pay cut of 19.1% since 2008-09 but that the new contract would reduce this to 16.1%.

Gender dysphoria

"Unacceptable" waits at adult clinics in England

Patients referred for treatment at adult gender dysphoria clinics in England face "unacceptable" waiting times and poor safety monitoring, an inquiry found. Clinics struggled to meet rising demand and failed to assess patients consistently or collect data on their outcomes, said the NHS England commissioned review of its gender services for adults. Patients waited an average of five years and seven months for a first assessment, while referrals to a clinic more than doubled from 4933 in 2022-23 to 9985 in 2024-25.

Criminality

French anaesthetist who killed 12 is jailed for life

Frédéric Péchier (below), a French anaesthetist, was sentenced to life imprisonment for poisoning 30 patients, of whom 12 died, at two private clinics from 2008 to 2017. The Doubs criminal court in eastern France ruled that Péchier, who worked first at the Franche-Comté Polyclinic and then the Saint-Vincent Clinic, both in Besançon, would be eligible for parole after 22 years in jail. He claimed innocence throughout his three month trial and concluded his testimony by saying that he had always respected the Hippocratic oath.

Social media

Australia ban comes into force despite concerns

Australia's ban on social media use by young people came into effect, requiring platforms including Facebook, Instagram, Reddit, TikTok, and YouTube to verify the age of users and restrict access by anyone under 16. The federal government's legislation to set a minimum age for social media use took effect on 10 December despite more than 140 Australian and international experts, academics, and organisations signing an open letter criticising the ban. Clinicians and researchers have raised concerns about the ban being a blunt instrument for a complex problem.

Maternity care racism

Ministers reject mandatory training for midwives

The government rejected MPs' calls to require midwives to undertake cultural competency training to tackle racism in maternity care in England—a key recommendation of the Health and Social Care Committee's report on black maternal health, published last September. The committee heard that black women were 2.3 times as likely as white women to die in pregnancy, childbirth, or the

postnatal period and concluded that racism in NHS maternity care was an ongoing problem responsible for these poorer outcomes.

Global health

UN declaration passes despite RFK objections

The UN General Assembly adopted its first political declaration on non-communicable diseases and mental health after objections caused a delay of almost three months. In September the US health secretary, Robert F Kennedy Jr, said the US opposed the declaration. Argentina followed suit. After further consideration the World Health Organization confirmed the adoption on 16 December after 175 nations voted in favour and two opposed—the US and Argentina.

IN BRIEF

Only people at high risk of myocardial infarction and stroke benefit from cutting the amount of saturated fats they eat, researchers say

Saturated fat

Reduced intake "benefits only those at high risk"

Patients at high risk of myocardial infarction and stroke would benefit from cutting down on saturated fats and replacing them with polyunsaturated fats, but those at low cardiovascular risk would gain little or no benefit, said researchers. The authors of a systematic review in the *Annals of Internal Medicine* concluded that recommendations on saturated fat intake should be tailored. The review identified a trend showing reduced risk with lower intake of saturated fatty acid, but this did not achieve statistical significance.

Discharge delays

Patients face "dangerous" waits in hospitals

NHS hospitals in England face "critical" pressures this winter if they are unable to discharge patients who are medically fit to leave, a report warned. The Health Foundation found that the bed days used by patients whose discharge was delayed rose from 10.1% to 11% in September. This was driven by an 8% year-on-year rise in delayed discharges.

Viral infection

Dengue cases in five countries fall by 70%

Five countries have achieved an average 70% fall in new dengue cases from the previous five year average, thanks to a project led by the Pan American Health Organization and funded by the EU. Working with authorities in Bolivia, Guatemala, Honduras, Panama, and Paraguay, the project designed a strategy to strengthen clinical care. This included training more than 200 health professionals to improve capacity for timely detection and the accurate classification and treatment of patients with dengue.

Waiting lists

Government pledge is "near impossible" to meet

The NHS in England will find it almost impossible to meet the government's pledge on cutting waiting times without more investment in operating theatres and surgical staff, said the Royal College of Surgeons of England. Commenting on the results of its latest UK surgical workforce census, the college highlighted insufficient theatres available or fit for use, staff shortages, and too few beds. It called for transparent workforce numbers, more training posts, guaranteed theatre time for training, and improvements to the working environment.

Lung cancer

NICE recommends new drugs for advanced disease

A new first line treatment for more than 1000 people with advanced lung cancer in England has been recommended by NICE. Final draft guidance released on 18 December recommended amivantamab (Rybrevant) plus lazertinib (Lazcluze) for adults with advanced non-small cell lung cancer with specific EGFR gene mutations. NICE said an estimated 1115 people in England would be eligible.

Cite this as: *BMJ* 2026;392:s5

NICOTINE POUCHES

More than half a million people

(522000)

now use oral nicotine pouches in England, Scotland, and Wales, a study by researchers at University College London suggests *[Lancet Public Health]*

SIXTY SECONDS ON . . . CHINA'S CONDOM TAX

WHY ARE CONDOMS BEING TAXED?

It's all part of a "carrot and stick" approach by the Chinese government to try to boost birth rates. Since 1 January condoms and other contraceptives are no longer exempt from China's 13% value added tax (VAT). This will be the first time since 1993.

IS SAFE SEX NO LONGER IMPORTANT?

Yes, it is. Sexually transmitted infections are on the rise globally, and the World Health Organization recently reiterated that condoms are "one of the most effective methods of protection against a range of infections, including HIV."

A STRANGE POLICY CONCEPTION?

It's a sign of the times. Between 1979 and 2015 China imposed a "one child policy" to slow population growth, which had soared to a peak of around seven births per woman in the 1960s. But by 2023 the birth rate had fallen to a historical low of around 1.0.

ARE THERE OTHER CREATIVE IDEAS?

The Chinese government raised the limit to three children per couple in 2021 and is now piloting other incentives. Some provinces and local governments have tried offering discounts on IVF treatment or extra days of paid leave to newlyweds.

THERE'S THE CARROT—WHAT ABOUT THE STICK?

It was recently reported that some women in Yunnan province in southwestern China were being required by local authorities to report the date of their last period. The local health bureau said such data collection was necessary to identify pregnant and expectant mothers.

DOESN'T THE UK TAX CONDOMS TOO?

It does, but at a heavily reduced VAT rate of 5% as an essential health product, rather than the standard UK rate of 20%. In some cases condoms can be exempt if prescribed or given free through sexual health clinics.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2026;392:s7

Chickenpox vaccine available to young children across UK

All young children in the UK will now be offered vaccination against chickenpox on the NHS for the first time. There will also be a single dose catch-up programme for children born from 1 January 2020 to 31 August 2022.

Like other child vaccinations in the UK, MMRV is not mandatory, but parents are strongly advised to to take up the offer to get their child protected. Until now the standalone varicella (chickenpox) vaccine was available only privately, costing around £150 for a full course of two doses.

"Reassurance to parents"

Health and social care secretary Wes Streeting said, "This new protection will give parents reassurance that their children are protected from a disease that sends thousands to hospital every year." He also emphasised the jab's social and economic benefits: "Families will save both time and money—no longer facing lost income from taking time off work or having to fork out for private vaccinations."

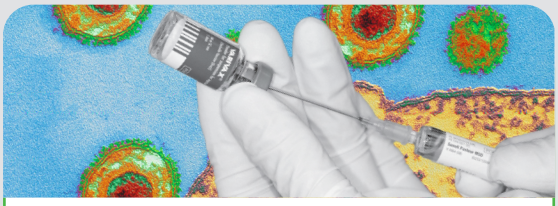
NHS England claimed the rollout will save £15m a year by not having to treat severe infections. Although most people recover from chickenpox within one to two weeks, serious complications can occur, with 20 or so deaths recorded each year.

Jonathan Stoye, a virologist and emeritus scientist at the Francis Crick Institute in London, told *The BMJ*, "The best way to prevent infection and reduce virus spread is to get the vaccine." He added that the US Centers for Disease Control and Prevention estimates that 238 000 hospital admissions and 2000 deaths have been prevented since the US launched a chickenpox vaccination programme 25 years ago.

The vaccine contains an attenuated live strain of the varicella zoster virus. A single dose confers immunity to around 85% of people vaccinated, rising to 98% after two doses.

The UK Joint Committee on Vaccination and Immunisation recommended in 2023 the varicella vaccine be part of routine childhood jabs. This was not implemented then, owing to cost and fears it might lead to an increase in shingles in older people. However, the JCVI has since determined that nations with routine vaccination over the past 20 years have not had a rise in shingles.

Katharine Lang, Bristol Cite this as: *BMJ* 2026;392:s16



From 2 January general practices will offer a combined measles, mumps, rubella, and varicella (MMRV) vaccine for all children born after 2020. Children born on or after 1 January 2025 will be offered two doses of the jab routinely: one at 12 months of age and the second at 18 months. Those born from 1 July to 31 December 2024 will be offered two doses of MMRV: one at 18 months old and another at 3 years and 4 months. Children born from 1 September 2022 to 30 June 2024 will be offered one dose at age 3 years and 4 months.

"Loopholes" in junk food ad ban need to be closed, campaigners say

Campaigners have welcomed restrictions on junk food advertising to combat childhood obesity finally coming into effect in the UK.

They warned, however, that allowing companies to continue to advertise their brands weakens the potential impact of the ban and restrictions must go further.

From 1 January 2026 adverts for less healthy food and drinks will be barred from appearing on television between 5 30 am and 9 pm, and paid adverts will be banned online.

The ban only covers adverts in which unhealthy products can be identified by viewers, however. This means companies will still be able to advertise using brand names or logos. Other types of advertising, such as billboards, are unaffected.

The new rules cover items high in fat, salt, and sugar across 13 categories considered most significant for childhood obesity and include breakfast cereals, porridges, cakes, pizza, and soft drinks.

Emma Boyland, professor of food marketing and child health at the University of Liverpool, told *The BMJ*, "The new rules are much stronger than what we've had until now and should make a meaningful difference to children's exposure to unhealthy food product advertising."

But she added, "There are gaps that are problematic. For example, brand only advertising is exempt from the restrictions, and there is growing evidence that exposure to this sort of advertising affects what we buy and eat.

"In the future this should be tackled, along with similar restrictions for adverts in other media and settings where young people are exposed, such as sports events, radio, and podcasts."

GP suspended for faking online patient appointments to pick up her children on time

I am thoroughly ashamed and am determined to never compromise the profession or myself again Helen Eisenhauer

A GP has been suspended from the UK medical register for five months for booking fake medical appointments so she could leave work in time to pick her children up from an after-school club.

Helen Eisenhauer (right), 43, had had telephone consultations with two patients on the morning of 17 July 2024 but booked false face-to-face appointments for them later in the afternoon. This was so she could leave the surgery by 4 45 pm to collect her children by 6 pm. "I was worried about what might be booked in and the impact this might have on my finishing time," she told a medical practitioners tribunal hearing.

False entry in notes

She booked a face-to-face appointment with one of the patients at 4 30 pm, which she later changed to a face-to-face appointment for the second patient. But two days later a partner at the Stenhouse Medical Centre in Arnold, near Nottingham—the practice where she was a part time salaried GP—messaged

The food industry has been lobbying against any wider advertising ban.

Last year *The BMJ* exposed how plans to ban junk food advertising in outdoor spaces were derailed by industry lobbying. Freedom of information requests showed advertising firms and lobby groups deployed a "tobacco playbook" to target local council policies to restrict junk food advertising.

Fran Bernhardt, commercial determinants coordinator at the food and farming alliance Sustain, said, "This government pledged to raise the healthiest generation of children and yet they've ignored the evidence, instead pursuing a policy that essentially enables business as usual."

D'Arcy Williams, chief executive of Bite Back, a youth led campaign group, said, "The long delayed and now diluted restrictions on junk food advertising are finally coming into force. But young people and the public are urging the government to go further. We need to see the loopholes closed and the regulations extended to outdoor spaces."

Kath McCullough, special adviser on obesity at the Royal College of Physicians, said, "While these regulations go some way in shifting the balance away from commercial interests and back towards children's health, we were disappointed to see industry successfully lobby for their watering down on brand advertising. It is not just junk food, but the well known brands children associate them with that should have fallen under this legislation."

Latest data show that one in 10 children starting school in England have obesity, with the proportion rising to one in five by the time children leave primary school.

LATEST data show that **1 in 10** children starting school in England have obesity, with the proportion rising to 1 in 5 by the time children leave primary school

Excluding the peak in 2020-21 during the pandemic, when prevalence was 14.4%, this is the highest rate of obesity in reception age children since the programme began in 2006.

Jacqui Wise, Kent

Cite this as: *BMJ* 2026;392:s17

HELEN EISENHAUER/CAVENDISH PRESS

her to point out that there was no entry in the second patient's notes. In response, she made a false entry in the notes, stating untruthfully that she had seen the patient face to face and examined her.

The tribunal noted that Eisenhauer, who joined the practice in 2018, did not initially disclose her dishonesty, which had emerged only after an investigation by her colleagues, and when confronted she sought to deny it.

She referred herself to the GMC without accepting that she had been dishonest, but by the time of the hearing she had admitted everything. She told the practice "some time between February and September 2025" that she would be admitting the allegations.

"Let myself down"

Eisenhauer told the tribunal she did not appreciate fully at the time the "strain she had been under from sleep deprivation resulting from her parenting responsibilities." She testified, "I feel that I have let the profession and myself down. The incident occurred at a time of particular stress for me when I was having to balance the demands of my young family with busy professional commitments.

"I am thoroughly ashamed and am determined to never compromise the medical profession or myself again."

She accepted there was nothing unusual about that particular working day and it had been a "predictable challenge that many professionals face." Eisenhauer had chosen that day to undertake additional locum session work but had not made an appropriate fallback provision for childcare.

The tribunal took into account the remediation Eisenhauer had undertaken, including a course on probity and ethics, and the support mechanisms she had put in place, including much better childcare arrangements. It agreed with the GMC that her dishonesty posed a medium risk to public protection, meriting a suspension between three and nine months, with the tribunal opting for five months.

Tribunal chairman Neil Dalton said testimonials from patients and colleagues "spoke as one regarding Dr Eisenhauer's otherwise exemplary character, her high level of proficiency as a doctor, and the affection in which she is held both by patients and by those who know or work with her."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2025;391:r2690

GENDER SERVICES

Experts behind puberty blockers study respond to mounting opposition

As the NHS launches its most contested clinical trial in decades, **Deborah Cohen** speaks to Emily Simonoff, the lead investigator, and Hilary Cass, the author of the review that led to the study

The Pathways trial—a major study into the use of puberty suppressing gonadotropin releasing hormone (GnRH) agonists in young people with gender incongruence—has ignited a political and legal firestorm.

Here, *The BMJ* talks to those who inspired it and the experts whose job it is to deliver it.

The trial, led by King's College London, aims to improve the evidence base for care of under-16s in NHS gender clinics. It will measure the effects of puberty blockers on the quality of life, emotional wellbeing, and physical development of an anticipated 226 young people with gender incongruence.

It follows a major review by Hilary Cass, former president of the Royal College of Paediatrics and Child Health, which found the evidence on these treatments to be inadequate. But the trial, which has approval from a research ethics committee and regulatory approval, faces criticism.

The hashtag #StopTheTrial has been shared thousands of times on social media platforms, flagging fears about the effect of puberty blockers on fertility, bone density, and brain development, among other areas.

Legal letters have been delivered to the Health Research Authority (HRA), MHRA, and the health secretary, threatening action over the trial's safety and ethics. Political opposition is also gathering momentum, with Conservative Party leader Kemi Badenoch writing to Wes Streeting, describing the trial as "activist ideology masquerading as research."

Former patients who regret taking puberty blockers as children have spoken out. Keira Bell said it was "disgusting" for children to be placed on the drugs. Others oppose the trial for different reasons. Chay Brown, healthcare director at advocacy group TransActual, said the randomised controlled trial design is unethical because it will leave some gender questioning children enrolled on the trial waiting an extra year for puberty suppression.

Against the backdrop of protest and unease, the trial's chief investigator, Emily Simonoff, professor of child and adolescent psychiatry at King's, is now in the unenviable position of figurehead of one of the most controversial clinical trials in recent history.

Simonoff and Cass spoke to *The BMJ* to respond to criticism, before threats to launch legal action to halt the trial were made.

Why is a trial the safest option?

The trial is a response to the UK's indefinite ban on puberty blockers for under-18s by NHS England, which said they could be used only in a research context.

All young people seeking puberty blockers must now go through new NHS gender services, which will recruit trial participants. Entry will be limited to patients deemed eligible by their NHS clinical care team and a national multidisciplinary team.

"Based on existing literature, I cannot say with certainty that there aren't children who could benefit from puberty blockers, though I believe the numbers are likely very small. This matter is unresolved, and my report reflects that," Cass says.

"While we don't fully understand the cause—it's not simply about being 'born in the wrong body'—these children have always existed, and we need to figure out the best way to support them," she adds.

But the clinical context is challenging.

The BMJ understands that referrals to gender clinics have fallen from 200 patients a month to just 30. This is not because demand has fallen but because some young people—as MPs heard during a briefing about the trial—may be getting the drugs from other sources.

Experts have told *The BMJ* that some young people seen at NHS gender services have gone overseas to have GnRH agonists prescribed. Others have self-medicated with cross sex hormones from illegal websites or dealers, and some are taking spironolactone, a diuretic that can lower testosterone concentrations and counts gynecomastia as a side effect.

Cass argues that this is why a clinical trial is needed: it would allow researchers to gather evidence safely within a structured study, rather than leaving young people to experiment on themselves.

Why is patient consent a concern?

A major concern—and the focus of current legal threats—is that the trial doesn't meet expected ethical principles because it will expose children to life altering treatments.

Studies show that very few adolescents stop treatment once on puberty blockers, with the vast majority going on to cross sex hormones. Therefore, say campaigners, parents and children cannot consent to a treatment that can lead to sterilisation, loss of sexual function, and long term cognitive harm.

Simonoff and Cass say there is a good reason to expect a different outcome from the new NHS gender services, given findings

CASS SAID she supported a cautious and selective approach, estimating that about **5** of the **75** children seen at gender services each month would be considered for trial

that the now closed Tavistock Gender Identity Development Service (GIDS) adopted an unquestioning affirmative approach that placed many patients on a medical pathway to transition. "One problems at GIDS was that clinicians felt pressured to prescribe puberty blockers when they actually wanted to provide more support and help," Cass says. "This pressure led to less frequent follow-up, and there was a big drop-off in support once patients started taking puberty blockers."

Simonoff says puberty suppression is not the initial point of care: it begins with tailored psychological and social support, lasting up to 12 months, with psychosocial interventions forming part of all treatment plans, including for young people receiving puberty blockers.

"The process will be more cautious, and it will encourage a pause between administering puberty suppressing hormones and cross sex hormones to tackle important areas, such as fertility preservation," she says. "It's crucial to evaluate the effects of this intervention separately, rather than treating all aspects of care the same way. Failing to differentiate can lead to a lack of precision in delivering care."

Critical health professionals have told *The BMJ* that fertility preservation in earlier stages of puberty is experimental and this should be made clear before young people enter the trial.

Why is there no placebo group?

One of the main criticisms of the trial is the lack of a placebo group, which critics say limits the ability to know if any observed changes can be attributed to the drug.

The open label trial has a 12 month delay arm. One group will be randomised to receive puberty blockers immediately, while the other must wait a year. This design allows researchers to compare short term effects at 12 months and to assess cumulative effects by 24 months. This delay will allow the effects of the drug to be disentangled from the psychosocial interventions given alongside.

It's crucial to evaluate the effects of this intervention separately
Emily Simonoff

Critics say this delay will not be tolerated by some, who might drop out of the trial to find treatment elsewhere. Simonoff says there are other reasons why a placebo arm is not being used. "A placebo is only effective if participants are unaware of what they are receiving. In this context, young people will quickly recognise whether they are on an active treatment or a placebo," she said.

The study was not designed to test whether puberty blockers suppress puberty, she adds.

"It's well established that puberty suppressing hormones do suppress puberty—the question we are exploring is about their secondary effects. One potential benefit of this treatment might be the assurance it provides, allowing young people to engage in other psychological interventions that focus on identity and potentially reduce anxiety, depression, and suicidality. We are trying to understand whether knowing they are receiving this treatment leads to better everyday outcomes," Simonoff says.

To avoid disappointment to participants in the delayed arm, care teams will increase assessments of anxiety, depression, and feelings of suicidal behaviour shortly after randomisation.

A linked study, Pathways Connect (see box), will use magnetic resonance imaging to investigate whether GnRH agonists affect brain development. An observational cohort study, Pathways Horizons Intensive, will run alongside to collect the same physical, physiological, and cognitive measures from participants not taking the drugs. But critics say the method carries a major flaw as the inclusion criteria are different. Trial participants want to receive puberty blockers, while some in the observational groups do not, so there's a risk of confounding by indication.

Is the timing right for the trial?

Before subjecting more children to potential risk, the Pathways trial should wait for findings from former GIDS patients, say some critics. A data linkage study of 9000 patients, now adults, has full HRA approval, and NHS England has encouraged gender clinicians to cooperate. Despite this, clinicians have refused to share their data. "I find this extraordinary," Cass told *The BMJ*.

NHS England did not reply when asked for an update.

Simonoff argues, however, that even if these data became available they would be unlikely to inform the trial. As such a study cannot determine if a specific intervention cause benefits or harms, much less the balance, and is unlikely to produce high quality evidence. She adds that GIDS records were incomplete and not standardised, leaving gaps in the evidence base.

Simonoff says. "One reason retrospective research may not answer certain questions is our lack of knowledge about the characteristics of the young people who attended GIDS. We know there were more birth registered females, but we lack comprehensive data on their underlying characteristics, including neurodiversity and experiences of childhood adversity."

As well as the timing of the trial, there are concerns about its length. Critics say young people will not be followed for a sufficient duration, given the life changing nature of puberty blockers and the potential transition to cross sex hormones. The trial will monitor children for two years, with annual follow-up for up to five and a half years, as long as funding permits. Participants, along with others in related studies, will also be asked to consent to follow-up into adulthood through national health registries and NHS datasets.

The study protocol says this will enable the systematic capture of clinically relevant endpoints, such as fracture incidence, fertility related interventions, and major health events.

But there are more uncertainties involved, including whether recruitment will reach the planned 226 participants. Cass says she supports a cautious approach, estimating that about five of the 75 children seen at gender services each month will be considered for trial. "The researchers are not going to pressure clinicians to take on more cases. They will only enter those that clinicians believe should be treated."

Michael Absoud, consultant in paediatric neurodisability and the trial's deputy chief investigator, said, "This work sits alongside other international studies. Together these efforts will consolidate the evidence base and inform future policy and practice."

Deborah Cohen, investigative journalist and senior visiting fellow, LSE Health

Cite this as: *BMJ* 2025;391:r2660

WHAT IS PATHWAYS?

The Pathways programme brings together several linked studies into the care of young people referred to NHS gender services.

Pathways Horizon is a long term observational study following participants over several years, irrespective of treatment. Embedded within this cohort is the Pathways trial itself, a randomised controlled study comparing outcomes among young people who begin puberty blockers immediately with those who start after a planned delay.

Pathways Horizon Intensive is a subgroup of the broader observational study that involves around 300 young people who are not receiving puberty blockers but are studied more closely than other Horizon participants.

Pathways Connect is a study of cognition and brain development across the same cohort, following young people who are receiving puberty blockers and those who aren't.

Finally, Pathways Voices is a qualitative study aiming to capture lived experiences.

ENDING PASSWORD FRUSTRATION: **Can the NHS solve its logging-in problem?**

IT issues are a bugbear for NHS staff, and the 10 year plan includes an ambitious goal for change. **Chris Stokel-Walker** asks whether streamlining logins—with a "single sign-on"—is achievable

Staff see technology as a barrier and a cause of frustration rather than helpful Pritesh Mistry

I wouldn't be surprised if the NHS used over 100 000 pieces of software Phil Booth

Through its *10 Year Health Plan for England* published last July, the NHS is aiming to be "fit for the future." One of the three core pillars of change outlined in the document is to help digitise the NHS.

Part of that digital transformation includes making single sign-on (SSO) a key priority to unlock efficiency and improve staff experience.

SSO will supposedly enable staff to access different healthcare systems and digital tools using a single set of credentials—improving productivity, reducing time wasted on repeated logins, and limiting security risks.

"One of the problems that people have is dozens of logins, and so the single sign-on is one solution," says Pritesh Mistry, a fellow in digital technologies at the King's Fund.

The travails of staff trying to log on, and NHS IT woes in general, are well documented. The *Independent Investigation of the National Health Service in England*, published in September 2024 and better known as the Darzi review, concluded that "the NHS is in the foothills of digital transformation."

Mistry says, "It calls out the fact that staff in the healthcare system see technology more as a barrier and a cause of frustration rather than helpful." In a staff survey by the BMA, 80% of doctors said that improving IT infrastructure would have a positive effect on tackling patient backlogs.

Vast scale

The true scale of the NHS's IT infrastructure—and the different systems and bits of software it uses—is difficult to discern, partly because of the piecemeal way in which the health service is run.

I've had to re-enter the same details repeatedly, only to be logged out minutes later Deborah Eastwood

"There are a vast number of pieces of software that are used across the entire NHS," says Phil Booth, coordinator at MedConfidential, a non-partisan organisation that looks at how the health system uses data. "I wouldn't be surprised if it was over 100 000 pieces of software."

Not every staff member in the NHS uses every one of those systems, but the average employee could struggle to count on both hands the number of apps and tools they use—and each one may have different login credentials.

That number of apps or tools will only increase as the NHS goes more digital and adopts wearables and app based treatment as standard—meaning that the corresponding number of usernames and logins becomes difficult to juggle, besides slowing down professionals as they root around to find the right combination for the right services.

Mistry says, "Depending on their roles and responsibilities, staff will regularly have a dozen or two dozen-plus sign-ons to different tech platforms and tools that they need to use."

Patients affected

Surveys by the Royal College of Surgeons have shown that two thirds of consultants "always" or "frequently" work beyond their contracted hours, with 41% of respondents saying that the level of administrative work is the main reason.

Switching between systems and having to log in each time can quickly add up. "I've had to re-enter the same details repeatedly, only to be logged out minutes later," says Deborah Eastwood, a consultant paediatric orthopaedic surgeon and Royal College of Surgeons of England council member.

"In operating theatres, where I may need to refer to an x ray intermittently throughout a procedure, this isn't just frustrating—it's disruptive and slows operations down."

The BMA survey found that more than 13.5 million hours of doctors' time was lost every year because of dodgy IT, with some doctors reporting spending half an hour or more simply logging onto a system.

"Outdated NHS IT systems and fragmented platforms are piling administrative burden onto already overstretched clinical teams," says Eastwood. "We want to be with patients, not battling slow computers and clunky logins."

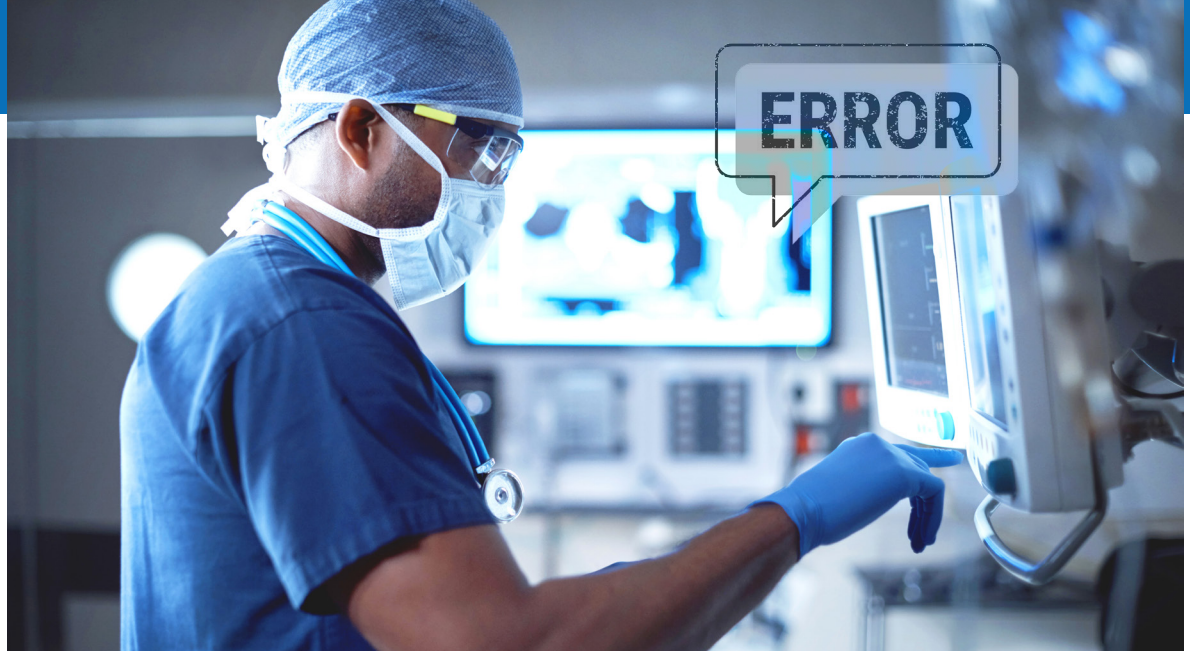
The NHS 10 year plan suggests that SSO could "liberate staff from their current burden of bureaucracy and administration, freeing up time to care and to focus on the patient."

One trust's success story

"Like many others, I had many passwords in my notepad," says Bruno Botelho, director of digital operations and innovation at Chelsea and Westminster Hospital NHS Foundation Trust.

Botelho's trust has SSO as standard across a core suite of around 10 IT systems. The process took time, but it now helps him work more efficiently.

A single biometric scan of



It really depends on your tech stack and understanding that tech stack
Bruno Botelho

Botelho's fingerprint gets him into his IT systems at a speed that would be the envy of many in the health service. (The Darzi review says that "parts of the NHS are yet to enter the digital era.") The benefits are clear to Botelho but, while his trust has raced ahead in enabling SSO, many others have not.

So, how realistic is the goal of SSO around the country? NHS England didn't respond to *The BMJ*'s request for an interview, but experts suggest that it's an uphill climb to succeed. "Simply the coordination of that amount of software is going to be quite tricky," says Booth.

Chelsea and Westminster's progress is difficult to replicate elsewhere, says Botelho, as trusts have different staffing levels and IT deployment points—as well as running different combinations of software and systems. "It really depends on your tech stack and understanding that tech stack," he says.

His trust managed to get to this more manageable point with its IT but, he adds, "This is not something that happens overnight. I think this is something that happens gradually—but it has to come with a group of chief information officers, chief clinical information officers, IT colleagues, and others, understanding what the pain points are at the local organisation."

THE BMA survey found that more than 13.5 million hours of doctors' time was lost every year because of dodgy IT

Getting the different elements of the NHS to work together in lockstep can be tricky, Mistry points out. "There's a huge level of variation across the healthcare system," he says. "It depends on which part of the healthcare system you're looking at."

Patchy history—and no silver bullet

The NHS's history with large IT undertakings is patchy at best, with some successes among the failures. The National Programme for IT, instigated in 2002 and abandoned in 2011 after more than £10bn of unsuccessful investment, is perhaps the highest profile example of the latter.

NHS England's Care.data programme, which was meant to aggregate patient data, was abandoned over privacy concerns in the mid-2010s after £10m of investment. And, as health service staff well know, an ambition announced in 2013 by the then health secretary Jeremy Hunt, for the NHS to be paperless by 2018, didn't work.

Yet the NHS does have some success stories in digital infrastructure. "I started as a GP in 2000—that's 25 years ago—and I've always had EMIS [a clinical software system]," says Amir Hannan, a GP and champion of technology in the NHS. "So, from the day I started 25 years ago as a GP, I had a clinical system, I had a keyboard, and I'm banging away on the keyboard now."

One concern is that SSO isn't a silver bullet to solve the NHS's IT problems. Mistry points out that some issues are more fundamental, such as trying to find out basic information about patients.

"Just because it's single sign-on, you still have multiple windows and multiple apps to juggle," he says. "If you imagine how busy a clinician's clinic is—and how much they need to try and engage with the patient and have that good experience with the patient, but then they're also typing notes—that's hard."

But SSO could be a start, Eastwood believes. She says, "It could be a very good first step in reducing the admin burden for clinicians, freeing up time to be with patients, and improving productivity."

Chris Stokel-Walker, freelance journalist, Newcastle upon Tyne

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WHAT OTHER DIGITAL DEVELOPMENTS ARE IN THE NHS 10 YEAR PLAN?

Alongside plans for single sign-on, the NHS 10 year plan includes other innovations in digital healthcare. While staff will have single sign-on capabilities, the NHS plans to develop a single patient record, accessible to service users.

The NHS App will also become "a full front door to the entire NHS" by 2028, if all goes to plan. And continuous monitoring of health conditions—presumably through tech wearables—aims to turn the NHS into a preventive, rather than reactive, healthcare system.

The digitisation of the NHS is just one plank of the 10 year plan, which also includes steps to develop a "neighbourhood health service" that will see patients away from hospitals and closer to home, while giving more power to foundation trusts over their budgets and spending.

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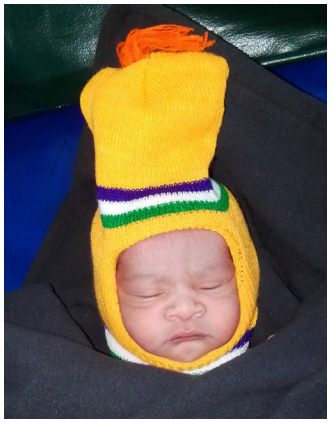
Malik Abakar, born at Zalingei Hospital, Central Darfur, Sudan

Unnamed boy born at MSF Khost Maternity Hospital, Afghanistan

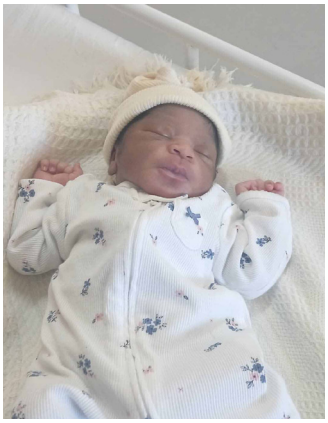
Marium Khatun welcomed her daughter (left) and Mamori Barua her newborn at Kutupalong Hospital, MSF refugee camp, Cox's Bazar, Bangladesh

Happy Roduro, born at Goyalmara Hospital, Cox's Bazar, Bangladesh

Baby born to Omma Habiba at the Rohingya refugee camp in Cox's Bazar



Mohammed Ismail, born at Jamtoli camp, Cox's Bazar, Bangladesh



Unnamed baby born at an MSF supported unit, Port-à-Piment, Haiti

THE BMJ ANNUAL APPEAL

New year, new life

Just after midnight on 1 January, Médecins Sans Frontières teams across the world stood ready, not only to welcome the new year but to greet the first babies of 2026.

Just five minutes into the new year, Mohammed, weighing 3 kg, was born at the MSF supported Boost Hospital in Helmand, Afghanistan.

Meanwhile, in Central Darfur, Sudan, Malik was born at Zalingei Hospital, a fourth child for Sara. Five months ago Sara and her husband decided to flee El Fasher, one of Sudan's war hotspots, to find a safer place for their children. They long for the day when El Fasher is safe again so they can return and be reunited with their family.

Many women living in areas of conflict are left with no option but to give birth in crowded camps, without access to maternity services and with very little privacy.

Birhanu Amare, a midwife at Korem General Hospital and its surrounding communities in Ethiopia, says that "every day [she] has the profound privilege of ensuring that the mother can give birth with safety and dignity in the most challenging circumstances."

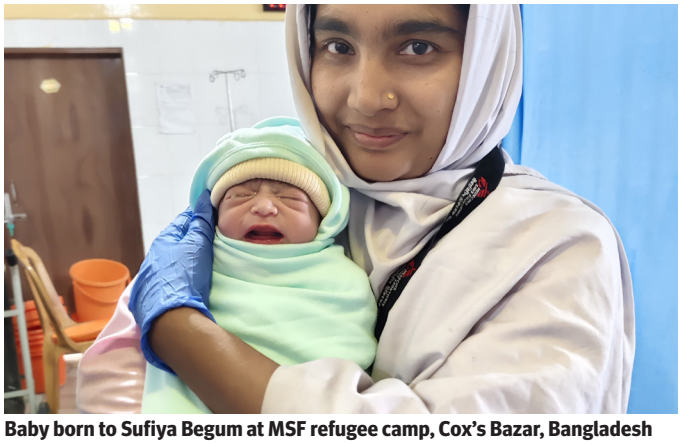
Your donations will support and allow MSF to continue providing maternity care to women in areas of conflict, today and in the future.

Caitlin Shortall, *The BMJ*

Cite this as: *BMJ* 2026;392:s26

Mohammed Hares, born in Jamtoli camp, Cox's Bazar, Bangladesh

Ahmad Bilal, born at the MSF run Quetta hospital, Pakistan



Baby born to Sufiya Begum at MSF refugee camp, Cox's Bazar, Bangladesh

Baby born to Khadija at an MSF supported hospital in Baidoa, Somalia

NATALIA ROMERO PEÑUELA/MSF

EDITORIAL

Smoking and vaping trends in young people

New tobacco and vapes legislation requires targeted follow-up actions

Young people are a prime target of the tobacco and nicotine industries as replacement customers.[1 2] Globally, available data indicate children aged 13-15 years are on average nine times as likely to vape as adults.[3 4] Vigilance in detecting slowing progress on youth smoking and strong action in response are central to effective tobacco control.

In recent years, two long running population surveys—the Smokefree Great Britain Youth Survey run by YouGov for Action on Smoking and Health (ASH) and the Smoking Toolkit Study (STS) in England—have shown concerning simultaneous shifts in smoking and vaping trends among both adolescents and young adults. The ASH survey estimates that the prevalence of current smoking among 11-17 year olds in Great Britain rose from 3% in 2021 to 4.8% in 2022 and 5.4% in 2025.[5 6] Similarly, ever smoking increased sharply from 13% in 2021 to 21% in 2025—the highest recorded in the 13 year survey. Current vaping more than doubled from 3.2% in 2021 to 7.2% in 2025; ever vaping rose from 11% to 20%.

STS estimates show similar shifts among 18-24 year olds in England, but two years earlier.[6-9] Current smoking rose from 19.3% in 2019 to 24.1% in 2020, and remained raised at 19.9% in 2024. Ever smoking rose sharply from 24.3% in 2019 to 33% in 2024—higher than in 2011, when vaping levels were trivial. This is against a background of consistently declining daily smoking, suggesting an increase in non-daily smoking. The prevalence of current vaping increased 4.3-fold in just four years, from 5.6% in 2019 to 24.2% in 2023.

Nicotine use increased in both surveys, with around a third of 18-24 year olds (2024) and 10% of 11-17 year olds (2025) smoking or vaping, or both.[6]

Young people who vape are around three times as likely to start smoking as those who don't

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Charlotta Pisinger, professor in tobacco prevention, Bispebjerg-Frederiksberg University Hospital, Copenhagen

Sam Egger, research biostatistician, Daffodil Centre, University of Sydney

Although many factors can influence population smoking prevalence, the elephant in the room is the possibility that recent shifts in youth smoking are at least partly causally linked to rises in vaping. This idea—commonly known as the "gateway hypothesis"—is supported by consistent evidence from prospective cohort studies from different countries, showing that young people who vape are around three times as likely to start smoking as those who don't, even after accounting for risk factors (common liabilities) for both vaping and smoking.[12]

In New Zealand and Australia, falls in adolescent smoking prevalence significantly slowed after vaping emerged,[13-15] while in Ireland, falls in smoking prevalence among 15-24 year olds also slowed amid rapid rises in vaping.[16] In Britain, falling trends in both adolescent and young adult ever and current smoking reversed direction, with prevalences rising when vaping increased rapidly. However, interpretations of these coinciding shifts have varied, with limited weight given to the possibility that vaping is contributing to apparent rises in smoking.[5-9]

Stricter controls

Key to the UK's tobacco-free future is prioritisation of concerted action to reduce youth (and adult) smoking and vaping. This might include reducing the access, appeal, and addictiveness of tobacco, e-cigarettes, and other commercialised nicotine products.

The World Health Organization (WHO) recommends integration of e-cigarette and tobacco control[17 18] and that, at a minimum, tobacco control measures be applied to e-cigarettes, including the WHO Framework Convention on Tobacco Control (FCTC) provisions.[18 19] UK FCTC obligations include preventing and reducing nicotine addiction, reflecting its central role in perpetuating the tobacco epidemic.[20]

The UK Tobacco and Vapes Bill, which aims to create a "smoke-free generation," is currently moving through parliament. It includes several crucial actions such as legislation for advertising bans, licensing, and greater enforcement powers. However, further action on youth will be required because many of the bill's provisions are enabling powers that require secondary legislation to operate.[21 22] The UK's existing ban on disposable vapes recognises their importance in increasing youth use. But further regulation is urgently needed on other factors driving youth vaping, including flavours, affordability, widespread availability, attractive and addiction enhancing product features, and social media promotion.[17 18]

Limited available evidence on regulation indicates lower youth vaping under stronger rules, including bans on commercial sales.[23] Systematic reviews link flavour bans, retail licensing, and higher prices with reduced youth vaping,[24 25] and some evidence indicates that warning labels reduce initiation intent.[26 27] E-cigarettes are often promoted in the UK for adult smoking cessation, but this should not occur at the expense of protecting young people. Youth have the right to grow up free of tobacco, nicotine, and addiction,[28] and must be shielded from tobacco and vaping industry targeting.

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EDITORIAL

Outlook for life sciences in the UK

Strategies to promote investment must not overlook population health

The UK plan for the life sciences sector, published in July 2025, made a case for the UK recovering the country's position as a global leader for pharmaceutical and medical technology industries.[1] Foreign direct investment in the life sciences was second highest globally in 2017, but the UK had fallen to eighth place by 2023,[2] despite the UK investment in pharmaceutical industry research and development remaining the highest in Europe that year.[3]

The plan sets out to support research and development, promote investment, and scale up and promote innovation and reform. Nevertheless, several high profile planned investments by drug companies have been cancelled or put on hold. After cancellation of its £1bn research centre, Merck argued that successive UK governments had not invested adequately in the sector and paid too little for new drugs and vaccines.[4]

However, some analyses suggest that the threshold value for health gain used by the National Institute for Health and Care Excellence (NICE) may be too high, and hence treatments approved on the current threshold may displace other more efficient care.[5-7]

Assessing value

How important are life sciences for improving population health? New treatments have undoubtedly helped many individual patients, but their effects on overall population health are not always positive. Trials, for example, may estimate treatment effects not realised in practice because of restrictive selection criteria and subtle changes in management that do not reflect real world practice.[9]

Furthermore, there may be an optimism bias if clinicians and patients overestimate benefits and underestimate harms of treatment.[11 12] Taken together, the assumption that greater and faster adoption of novel medications and treatments is a priority for population health is questionable. Indeed, an analysis of all drugs newly approved by NICE between 2000 and 2020 concluded that coverage of new drugs reduced population health because of the opportunity cost of existing treatments that were forgone.[7]

Belgrove House, London, was earmarked as Merck's £1bn research centre, until the drug company cancelled

Assuming that greater and faster adoption of novel medications is a priority is questionable

Is increasing NHS expenditure on drugs necessary to incentivise the life sciences industry? The UK pays less for medication than some but not all comparable economies, with the US being a notable outlier in paying much higher prices.[13] NHS expenditures look set to rise following US government pressure to increase prices as part of a US-UK trade agreement.[14] But from a healthcare perspective, the rationale for increasing expenditure is undermined when decision rules may actually reduce population health.[7]

The UK constituted only 2.4% of the global pharmaceuticals market in 2022,[16] which raises questions about the extent that UK spend is a major factor in decision making around where to invest. Perhaps more important is the role the UK has in informing policies in other countries. The Association of British Pharmaceutical Industry has stated: "In many global boardrooms, the UK is now viewed as a contagion risk with practices that, if adopted by other markets, would threaten the sector's ability to invest and innovate globally."[8]

It is unclear how much power the UK has to shape other countries' policies, and the extent to which this would be disrupted by changing investment decisions. Probably more important are international factors outside the UK government's control, such as pressure on the sector to invest more heavily in the US.

High quality infrastructure

Less debatable is that the UK and the NHS have high quality clinical research infrastructure and unique data resources. Actions in the life sciences sector plan to capitalise on these and so support the sector are welcome. As the plan recognises, the byzantine and fractured processes required to take a technology from bench to bedside are challenging, especially for small to medium size businesses, from which many medtech innovations originate.

Plans to speed up research, such as commitments to reduce trial set-up times to under 150 days and the creation of the £600m Health Data Research Service, may help tackle these issues. The NHS should also enable greater use of electronic health records for health research. However, previous experience of failed data sharing initiatives (such as care.data) highlight the need for coordinated action to proactively address public concerns.

Ultimately, NHS decision making should prioritise improving population health given available resources.[18] New technologies will help but are not the best way of maximising health in an equitable way at the lowest cost. Instead, we should prioritise the social determinants of health, such as tackling poverty and improving poor quality housing.

At a time when even highly cost effective interventions are being reduced,[21] increasing expenditure on any treatment that offers poorer value for money is hard to justify.

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CAREERS CLINIC

How do I deal with a difficult colleague?

Staying calm and respectful can be challenging, but could make all the difference, **Elisabeth Mahase** hears

Start with a respectful conversation

Michael El Boghdady, director of education at the Association of Surgeons in Training

"Difficult colleagues are an unfortunate but common feature of some workplaces. If left unresolved they can fuel imposter syndrome, particularly within rigid hierarchies and unsupportive structures, leading to isolation, stress, and declining wellbeing.

"The first step in tackling such behaviour is to understand its root cause. A colleague's hostility or defensiveness may stem from personal insecurity, stress, or a lack of insight into the impact of their actions. When appropriate, start with an honest and respectful conversation, focusing on how their behaviour affects the team and patient care. Clear, non-confrontational communication can sometimes prompt self-reflection and change.

"If the behaviour persists, or if a direct discussion feels unsafe, escalate your concerns through the appropriate channels, such as your supervisor, clinical lead, or human resources. A Datix report can also highlight incidents of poor communication. Document events contemporaneously. Constructive feedback should not only emphasise the behaviour itself but also its consequences for team dynamics, trust, and patient safety.

"The profession is already stressful enough, there is no place for hostility or rudeness. When individuals fail to recognise this, they must face consequences and understand that medicine requires mutual respect and support. While I prefer a friendly and non-hierarchical work environment, in some situations I've chosen to confront or escalate matters. At other times, I've opted to avoid certain colleagues and maintain a strictly professional relationship."

Don't mirror their aggression

Sabena Jameel, professor of medical professionalism at the University of Birmingham Medical School

"Dealing with a difficult colleague is rarely just about them—it's also about you. Sometimes organisational escalation is necessary, but often the challenge lies in exercising contextual judgment. That's not easy. It demands integrity, courage, and reflection from a place of reason rather than emotion.

"Firstly, it can be cathartic to share a 'non-complimentary' version of the situation or colleague with a trusted friend. A problem shared is a problem halved. Research on wisdom suggests that we make better decisions when we imagine advising someone else with the same problem: this self-distancing brings clarity.

"Secondly, consider a 'non-complementary' approach: break the usual escalation pattern. Meet anger with calm and keep the conversation in adult mode. Show mental compassion—recognise the hinterland behind the façade. As Kipling said, 'Prepare to believe the best in people; it saves so much time in the end.'

"Don't mirror their aggression or become defensive. Use open body language and a steady tone. Validate feelings without endorsing poor behaviour. Stay resolute in your own good character—over time, that usually wins.

"Finally, use curiosity to diffuse tension by asking something like, 'What is most important for you in this situation?'

"Non-complementary behaviour interrupts escalation, maintains professionalism, and protects psychological safety and team cohesion. This may sound saintly, but it's worth experimenting with, at least at the outset of difficulty."

Find your calm

Vinayak Mishra, a GP in Ipswich

"During one of my rotations a colleague frequently second guessed my decisions and spoke over me during handovers. I felt undermined and so I dealt with a difficult colleague by becoming one myself—something I wouldn't advise. Difficult colleagues are inevitable, but how we respond to them can make all the difference.

"My first piece of advice is to find your calm. I practise a breathing mindfulness technique where I pause to focus on my breath and allow my difficult feelings to exist in a compassionate and non-judgmental way. This technique has stopped me from saying things in the moment that I'd later regret.

"Marshall Rosenberg's non-violent communication framework has also transformed how I approach conflict. We can often struggle with conflict because we find it difficult to express our anger and frustration in healthy ways. Instead, we might default to passive aggression or blame. Here's how I used this method with my colleague. Firstly, I observed, without judgment, the behaviour factually—'When you interrupt me during handover.' Then I expressed my feeling—'I feel undermined and anxious,' and stated my need—'I need to be heard respectfully.' Finally, I made a request—'Could we please take turns?'

"If direct conversation, as advised above, doesn't help, or if behaviour crosses into bullying or harassment, it's time to escalate.

"Tolerating poor behaviour goes against professionalism and allows toxicity to fester. That colleague and I never became friends, but we learnt to work together respectfully, and sometimes that's enough."

Cite this as: *BMJ* 2026;392:r2594