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Personal genome service is launched in UK

Midwife led delivery is safer than a labour ward for low risk pregnancies, says latest NICE guidance

Ingrid Torjesen LONDON

Giving birth in a midwife led birthing unit or at home with the support of a midwife is safer than giving birth in a traditional hospital ward for women with straightforward, low risk pregnancies, an updated guideline from the National Institute for Health and Care Excellence (NICE) has said.

It added that a home birth is as safe for the baby as delivery in a midwife led unit or in a traditional labour ward under the supervision of obstetricians, provided the mother has a low risk pregnancy and has had at least one child before.[1]

The guideline said that women should be given information on the safety of different places of delivery to help them decide where to give birth. It highlighted that the use of episiotomy, caesarean section, or instrumental birth (forceps or ventouse delivery) is far more likely when women choose to give birth in an obstetrics unit rather than in a midwifery unit or at home.

Of every 1000 multiparous women who choose to give birth in an obstetrics unit 56 have an episiotomy, 35 a caesarean, and 38 an instrumental birth. Among those who choose a midwifery unit located alongside an obstetrics unit these figures are 35, 10, and 23, respectively; in a community midwifery unit they are 23, 8, and 12; and among home births they are 15, 7, and 9.

In low risk multiparous women the choice of place of delivery was not found to affect outcomes for the baby. However, in women with low risk pregnancies giving birth for the first time, a home delivery was less safe for the baby: serious medical problems occurred in 9 of 1000 births at home, compared with 5 in 1000 births in hospital or at midwife led units.

PICTURE PARTNERS/ALAMY

For low risk multiparous women, having a baby at home was as safe as giving birth in hospital

Of nearly 700 000 babies born in England and Wales last year, 9 in 10 were delivered in hospital under obstetrician supervision, even though around 45% of women giving birth are considered to be at low risk of complications.

NICE also found that women who opt for a midwife led unit or a home birth express higher satisfaction levels, and midwife led care is cheaper for commissioners. But Susan Bewley, professor of complex obstetrics at King's College, London, who chaired the guideline development group, emphasised that "the updated guidance isn't about saving money; it's about ensuring the best outcomes for mothers and babies."

At a press conference on 1 December Bewley said, "Some women may prefer to have their baby at home or in a midwife led unit because they are generally safer—that is their right and they should be supported in that choice."

Cite this as: *BMJ* 2014;349:g7421

Doctors' leaders applaud NHS cash injection

Gareth Iacobucci THE BMJ

Doctors' leaders have welcomed the government's commitment to boost spending on the UK health services by £2bn next year and to ringfence £1bn to improve general practice premises over the next four years. The funding injection was announced by the chancellor of the exchequer, George Osborne, ahead of his autumn statement this week.

The chancellor said that the money was a "down payment" on the recent *Five Year Forward View* from NHS leaders, which called for an extra £8bn a year above inflation for the NHS in England by 2020.[1]

Around £1.5bn will be invested in frontline care across the United Kingdom (including around £300m for Wales, Scotland, and Northern Ireland). In England the £1.2bn will be allocated by NHS England to clinical commissioning groups and specialised commissioning budgets. A further £200m will be set aside to help local areas make service changes mapped out in the five year plan. Of this £1.7bn, £750m will come from the existing budget of the Department of Health for England, with the remainder reallocated from other government departments.

An additional £250m will be used to invest in general practice premises and infrastructure outside hospitals. This portion of the money will be recurrent for the next four years, creating a total investment of £1bn. The government said that this portion of the money would be funded through fines imposed on banks for financial misconduct.

Maureen Baker, chair of the Royal College of General Practitioners, said that the announcement was "excellent news for GPs, the NHS, and most importantly our patients."

Mark Porter, the BMA's chair of council, said, "The chancellor's announcement is an encouraging step forward as it does appear that politicians of all parties are starting to get the message about the dire state of the NHS finances."

But he added, "Despite this announcement the NHS continues to face a number of challenges, with staff shortages, especially in emergency care, remaining a cause of concern. We need this announcement to be the start of a long term programme of investment in the NHS."

Cite this as: *BMJ* 2014;349:g7432

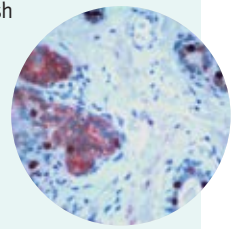
IN BRIEF

Rochdale couple jailed for £229 000 NHS fraud conspiracy: Two NHS managers who defrauded the North West Strategic Health Authority of £229 000 between 2003 and 2008 have been jailed for a total of over five years. John Leigh and Deborah Hancox, who worked at the North Western Deanery, were arrested in December 2013 in Cyprus and extradited to the UK, having fled the country in 2009. The pair used three companies as a front to disguise their ongoing fraud selling IT equipment to the deanery at inflated prices.

Excess winter deaths reach all time low: An estimated 18 200 excess deaths occurred in England and Wales in winter 2013-14, the lowest number of excess winter deaths since records began in 1950-51 and a 22% fall from 23 340 in 2012-13.[3] As in previous years there were more excess winter deaths among women than among men in 2013-14. Most deaths were in people aged 75 or over.

GP to challenge Tory held seat in general election: Oxford GP Helen Salisbury is to stand for the National Health Action Party in the next general election, challenging the Conservative MP Nicola Blackwood, who has a slim majority in the seat of Oxford West and Abingdon. Blackwood won the seat from the Liberal Democrats by just 176 votes in 2010.

Population based screening detects more BRCA mutations in Jewish women: The Genetic Cancer Prediction through Population Screening Study has found that family history based testing failed to pick up 56% of Ashkenazi Jewish women carrying a BRCA mutation but that they were identified by population testing.[1] Screening all Ashkenazi Jewish women aged 30 or over could cut the number of ovarian and breast cancers and potentially save the NHS in England £3.7m, the researchers concluded.[2]



Beijing passes bill to ban smoking in public places: Beijing passed draft antismoking legislation on 26 November to ban smoking in all indoor public places, workplaces, and public transport vehicles. The law is scheduled to become effective on 1 June next year. The bill will also ban smoking in open air space in kindergartens, schools, child welfare institutions, women's and children's hospitals, sports venues, and cultural sites.

Cite this as: *BMJ* 2014;349:g7391

EMA is accused of weakening its conflict of interest policy

Rory Watson BRUSSELS

Critics have claimed that the European Medicines Agency has watered down its rules on conflicts of interest among committee members and experts, under a new policy that is due to come into effect at the end of January.

The EMA said that the revised policy, which was endorsed by its management board in March 2014, was designed to ensure a more balanced approach than its earlier stance and to ensure that it had access to the best possible expertise.

Noël Wathion, the agency's chief policy adviser, explained that past experience had shown that an overly rigid approach could limit access to the expertise needed to ensure the robust scientific assessment of drugs. "The updated policy should now allow a level of involvement better tailored to the interest profile of each expert," he insisted.

Although rules are strict for experts on scientific committees, they are more relaxed for those participating in advisory bodies or ad hoc groups. Moreover, although a three year cooling-off period is foreseen for the majority of experts with declared interests, during which an expert's involvement would be restricted, there will be no cooling-off period for some interests, notably financial ones, as soon as an expert disposes of his or her interests.

The new arrangements were condemned by a group of public health organisations, who said that the changes would weaken the agency's existing policy. "In reality, this revised EMA COI [conflict of interest] policy relaxes EMA's position in relation to the conflicts of interest of

Australia's proposal for a copayment to see a GP is set to fail amid confusion

Melissa Sweet SYDNEY

The Australian government's plan to introduce a deeply unpopular copayment for GP and other medical services looks set to fail, amid confusion and disarray within government ranks.

In a briefing to journalists this week staff of Prime Minister Tony Abbott said that the proposed $A7 (£4) copayment would be dropped in the face of opposition in the Senate, where the Conservative government does not hold power. However, other ministers, including the federal treasurer, Joe Hockey, later said that the measure had not been shelved, while the health minister, Peter Dutton, said that it could be introduced through regulation rather than legislation. Health and medical leaders doubt, however, whether this would be possible or pursued, particularly as it could result in a system likely to be even harsher on poor and sick people than the original proposal.

Uncertainty now also surrounds the future of the Medical Research Future Fund, which was to have been partly funded through the copayment measure.

The copayment, announced on 13 May in an austerity budget,[1] faced fierce and wide ranging opposition, including from the indigenous health sector and many health, medical, consumer, and welfare groups, which argued that it would exacerbate health inequalities. The Australian Medical Association also warned that the proposed copayments for general practice, pathology, and diagnostic imaging would be "a costly red tape nightmare" for medical practices.

Tim Senior, a GP, columnist, and critic of the policy, said in a blog that he expected the copayment would not go ahead.[2] He told *The BMJ*, "The most likely outcome is that the copayment will not be implemented. The Senate will block changes to legislation or regulation. The public and health professionals do not support a mandatory copayment, and the government is losing support because of this policy, among others."

The Australian Healthcare and Hospitals Association urged the government to shelve the policy and to look for alternative savings, such as reducing spending on low value care. "It's time to move on from a policy that is clearly unacceptable to much of the Australian electorate."

Cite this as: *BMJ* 2014;349:g7374

experts with pharmaceutical companies," said a statement from the Association Internationale de la Mutualité, the International Society of Drug Bulletins, the Medicines in Europe Forum, and the Nordic Cochrane Centre.

In particular, the four groups insisted, "The evaluation of the efficacy and harms of medicines must be free from undue influence and be based on scientific data, so that the agency's work can benefit health. The agency's integrity is at stake."

The critics maintained that the agency "artificially" distinguished between experts with "direct" and "indirect"' interests, "though there is no evidence that such a distinction affects the influences exerted on the decision-making process." They also targeted the agency's rating system, which aims to mitigate, rather than avoid, conflicts of interest. "Such a system allows key opinion leaders and patient organisations that are heavily sponsored by pharmaceutical companies to act as 'experts,' sometimes in very strategic positions," they complained.

The four organisations urged the EMA to ensure that patient representatives and healthcare professionals sitting on its scientific committees and its management board were independent, to step up monitoring to avoid "revolving doors," and to stimulate more transparent decision making.

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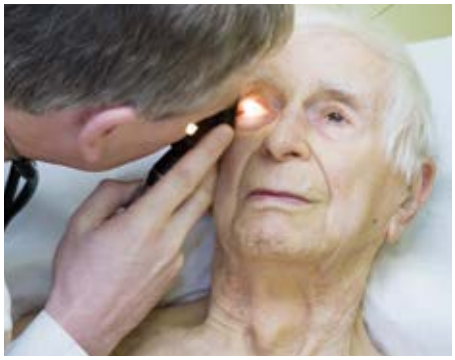

ANTONIA REEVE/SPL/MODEL RELEASED

A quarter of clinical commissioning groups do not commission early supported discharge

Stroke care audit shows major staff shortages

Jacqui Wise LONDON

A quarter of hospitals in England, Wales, and Northern Ireland have an unfilled consultant stroke physician post, and not enough trainee doctors are available to fill them, a national audit has shown.

The organisational audit,[1] carried out by the Royal College of Physicians and published as part of the Sentinel Stroke National Audit Programme, found that, despite steady progress in the care of stroke patients in the United Kingdom, considerable concerns remain about the consultant stroke physician workforce. Almost half of hospitals wish to expand their consultant stroke physician clinical time in the near future, and this shortfall needs to be tackled immediately through training programmes in geriatric medicine and neurology, the report said.

Average staffing levels among nurses and care assistants on stroke units have increased from a median of eight for every 10 stroke beds in 2012 to nine in 2014. But only 50 of 183 hospitals had the recommended three qualified nurses on duty at all times for every 10 acute stroke beds.

Tony Rudd, chair of the Intercollegiate Stroke Network, said, "Clearly care is improving but we must not be complacent. There are still too many patients receiving suboptimal care."

The audit said that the reorganisation of acute stroke services had been a great success, as nearly all hospitals now provide 24/7 access to thrombolysis.

Stroke specific early supported discharge has also improved, such that three quarters of units now have access to it. This enables patients to return home, supported by the same level of expertise that they would receive in hospital.

But Rudd said some groups needed to change. "The 25% of recalcitrant clinical commissioning groups not commissioning early supported discharge have to somehow be persuaded of the hard scientific arguments that such services produce better outcomes at lower cost."

Cite this as: *BMJ* 2014;349:g7375

Diabetes in midlife increases cognitive decline 20 years later

Susan Mayor LONDON

People who have diabetes diagnosed in midlife have a higher risk of cognitive decline over the following 20 years than people with normal glucose levels, a prospective US study has shown.

Type 2 diabetes has previously been associated with dementia risk, but until now evidence of a link to cognitive decline has been limited.

DIABETES IN MIDLIFE was associated with **19%** GREATER DECLINE in cognitive function

Researchers followed up 13 351 adults who were aged 48 to 67 at the start of the study in 1990-92.[1] The participants all lived in four US communities in Maryland, North Carolina, Minnesota, and Mississippi and were taking part in the community based Atherosclerosis Risk in Communities study.

All participants had their diabetes status assessed at baseline—defined as self reported diagnosis by a doctor, use of diabetes medication, or having an HbA_{1c} level of 6.5% or greater. Cognitive function was assessed at baseline and then every few years until 2011-13—the 20 year follow-up period making this the longest study yet to investigate its possible links with diabetes.

Results showed that having diabetes in midlife was associated with a 19% greater decline in cognitive function over 20 years (adjusted global z score difference −0.15 (95% confidence interval −0.22 to −0.08)) than not having diabetes. This meant that having diabetes aged cognitive function by about five years more than the normal effects of ageing.

People with poorly controlled diabetes (HbA_{1c}>7.0%) showed greater decline in cognitive function than those whose diabetes was well controlled. And longer duration of diabetes was associated with a greater cognitive decline in later life.

"The lesson is that to have a healthy brain when you're 70 you need to eat right and exercise when you're 50," said Elizabeth Selvin, lead author and associate professor of epidemiology at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland.

The research group argued that "maintaining cognitive function is a critical aspect of successful ageing," adding that preventing diabetes and improving glucose control in people with diabetes offered important opportunities for preventing cognitive decline and delaying progression to dementia.

Cite this as: *BMJ* 2014;349:g7386

Exercising at 50 increases the chance of a healthy brain at 70

Many oesophageal and gastric cancers are detected too late

Zosia Kmietowicz THE BMJ

The number of patients surviving surgery for oesophageal and stomach cancer has reached its highest ever, but many cases are being diagnosed too late for patients to benefit from treatment, an audit has found.

The national oesophagogastric cancer audit found that 30 day mortality after surgery fell from 4.1% in 2008-10, when the audit started, to 2.3% in 2011-13.[1] Similarly, 90 day mortality fell from 6.5% to 4.5% over the same period.

The audit collected data on all 22 832 patients in England and Wales who were diagnosed with oesophageal or stomach cancer between 1 April 2011 and 31 March 2013. The proportion of patients who were considered for curative treatment has risen in five years from 35.9% to 37.3%, meaning that most patients still present with incurable disease.

Richard Hardwick, consultant surgeon and president elect of the Association of Upper Gastrointestinal Surgeons, said that the reasons why curative plans had increased only slightly were unclear. He added, "Some of the increase relates to more patients being offered definitive chemoradiotherapy without surgery as treatment for oesophageal cancer. We will need to follow these patients carefully, as high quality randomised trials of this strategy are currently unavailable. It would appear that multidisciplinary teams are increasingly deciding to exclude surgery from radical treatment for patients with squamous cancer of the oesophagus; we do not know whether salvage oesophagectomy is being offered to these patients if the tumour recurs without distant metastases."

Every year about 15 500 people in England have oesophageal or gastric cancer diagnosed. But the proportion of patients surviving for five years is low, at 13% for oesophageal cancer and 18% for gastric cancer.

The poor outcomes are partly a result of late diagnosis. Only one in 20 cases was diagnosed at an early stage, when three quarters can potentially be cured. The completeness of the cancer resection at surgery is also key. The report found that the proportion of patients with residual tumour after surgery for oesophageal cancer has fallen and that the same needs to happen for gastric cancer.

Cite this as: *BMJ* 2014;349:g7340

Royal College of Physicians holds firm on opposition to assisted dying

Jacqui Wise LONDON

The Royal College of Physicians has reaffirmed its position against assisted dying after a survey of its fellows and members showed that most did not support a change in the law.

However, the survey showed a shift in opinion since the college carried out an identical survey in 2006: the members who opposed a change in the law on assisted dying decreased by 10.7%.

The survey was sent to 21 674 fellows and members of the royal college, including retired members. Of these, 40% (8767) accessed the survey, but not all respondents answered every question. The proportion who completed the survey was 31%.

The survey found that 62.5% agreed with the statement, "We believe that with improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation is not needed." This compared with 73.2% who agreed with the same question in 2006.

When asked the question in a different form 57.5% said that they did not support a change in the law to permit assisted suicide of terminally ill people with the assistance of doctors, and 32% said that they supported a change. A further 10% supported such assistance, but not from doctors.

One in five of those surveyed said that if the law changed they would personally be prepared to participate in assisted dying; 58% opposed this, and 20% were neutral. Very similar results were found in the 2006 survey.

Of the respondents, 44% believed that the college as an organisation should oppose assisted dying, 25% thought that it should be in favour, and 31% said that it should be neutral.

However, Andrew Goddard, registrar and senior officer with responsibility for professional matters at the royal college, said, "Whilst there is still a majority against a change in the law, we recognise there has been a shift in opinion over the past eight years, and we will continue to engage with members and fellows on this issue."

Cite this as: *BMJ* 2014;349:g7335

QUESTIONS ASKED IN THE SURVEY		2006	2014
We believe that with improvements in palliative care, good clinical care can be provided within existing legislation, and that patients can die with dignity. A change in legislation is not needed.	AGREE	73.2%	62.5%
	DISAGREE	26.0%	37.5%
Regardless of your support or opposition to change, in the event of legislation receiving royal assent, would you personally be prepared to participate actively in "assisted dying" as defined in the Royal College of Physicians' consultation document?	WOULD PARTICIPATE	18.9%	21.4%
	NEUTRAL	19.4%	20.1%
	WOULD NOT PARTICIPATE	59.4%	58.4%

Variations in lung cancer care continue to affect survival and quality of life

Zosia Kmietowicz THE BMJ

Nearly two thirds (63%) of patients with early lung cancer in some parts of Great Britain receive surgery, while in others only a third (33%) are offered surgical treatment, the latest audit of lung cancer treatment has found.

"Since surgical treatment represents the best chance of cure of the disease, these data suggest that a substantial number of patients are needlessly dying of lung cancer as a result of local variation in care," said the audit report.[1]

Among patients who have advanced and incurable disease treatment with chemotherapy varied from 48% to 69% across cancer networks, the audit found, despite the fact that chemotherapy is known to extend life expectancy and improve quality of life in this group of patients.

The audit collected data on 39 203 patients seen in hospital with lung cancer in 2013 in England, Scotland, and Wales.

In some areas overall measures of standards of care had marginally improved from previous years, with very small rises in the proportion of patients having their cancer subtyped, in the proportion of patients with small cell lung cancer receiving chemotherapy (from 67.9% to 69.7%), and in the proportion having access to a lung cancer nurse specialist (from 82.3% to 83.9%).

If all organisations provided the same standard of care as that provided in the best performing units, more cancers would be likely to be cured, and those patients whose cancer could not be cured could see improvements in their quality of life.

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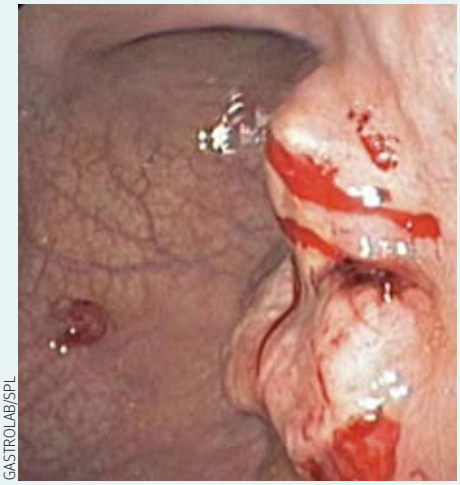

GASTROLAB/SPL

Complete resection needs to improve for stomach cancers, as it has for oesophageal cancers

Action against surgeon is suspended after MDU withdraws funding

Clare Dyer THE BMJ

The Medical Defence Union has withdrawn funding for the rogue breast surgeon Ian Paterson to fight negligence claims by hundreds of patients, causing legal action to be temporarily halted while a solution is sought.

The loss of funding has prompted the official solicitor for England and Wales, who was acting for Paterson as his litigation friend after the surgeon was judged to lack the mental capacity to take part,[1] to pull out of the case.

Paterson, who was a consultant surgeon at Solihull Hospital, run by the Heart of England NHS Foundation Trust, from 1998 to 2011, is being sued by hundreds of women. He carried out hundreds of unauthorised "cleavage sparing" mastectomies that left breast tissue behind and increased the risk of cancer recurring.

He also operated at two private hospitals, Parkway and Little Aston. He was allowed to go on operating until mid-2011, although an independent review by Ian Kennedy, former chairman of the Healthcare Commission, found that colleagues were "at their wits' end" trying to get the trust to take action.[2]

He is also under investigation by the police, who are looking into whether he benefited financially from carrying out unnecessary procedures.

Lawyers for five women suing Paterson, asked a High Court judge to decide what should happen next. Mr Justice Foskett said that he was taking an "essentially pragmatic" approach in directing an eight week stay of action "with a view to ensuring that these cases can proceed."

Cite this as: *BMJ* 2014;349:g7437

Council leaders almost walked away from Better Care Fund deal

Adrian O'Dowd LONDON

The controversial Better Care Fund, designed to shift care from hospitals in England to the community by encouraging integrated health and social care, almost collapsed as local government leaders considered walking away from the agreement, MPs have been told.

The balance of the fund's priorities tipped towards the NHS too much at one point, and local government had to be persuaded that it was not being unfairly dealt with, witnesses have admitted to MPs on the parliamentary Public Accounts Committee.

The Better Care Fund aims to help older and disabled people be cared for more in the community than in hospitals by creating a single pooled budget to incentivise the NHS and local government to work more closely together. It is now intended that it will pool £5.3bn of existing NHS and local authority funding from April 2015; it was originally set at £3.8bn but has increased after additional local investment. Local health and wellbeing boards have submitted plans on how they will spend their fund allocations in 2015-16.

BETTER CARE FUND
Original total £3.8bn
Revised total £5.3bn

There has been controversy over the level of its original predicted savings and more realistic later calculations.[1] There were also concerns when the fund was announced in the summer that up to £1bn of the fund would be held back to pay for NHS services because of worries that estimated savings from the scheme were wrong.[2]

During an evidence session on 1 December of the Public Accounts Committee's inquiry into planning for the Better Care Fund, the committee's chair, Margaret Hodge, the Labour MP for Barking, asked witnesses to comment on her view that the fund was "not a fair sharing of resources of burdens and risks" for local government, which had already seen cuts to its overall budget, with more planned for next year.

Carolyn Downs, chief executive of the Local Government Association, giving evidence, said, "That was definitely a discussion that did take place within local government about the eventual prize and the principle that we all signed up to and very strongly agree with and whether the conditions were changing to the extent that one would wish to walk away.

"What was very important to us were the words that the savings could not be made without the spend being through NHS commissioned services, and that includes those services which are undertaken through a section 75 agreement, i.e. an integrated service. And if that wording hadn't been agreed then I think perhaps local government might have walked away. However, we didn't, and what we have done is work with colleagues in government non-stop to try to make sure that local areas can bring forward plans."

Hodge challenged this, saying that social care funding was due to be cut and that much of the Better Care Fund was being kept for the NHS.

Simon Stevens, chief executive of NHS England, also giving evidence, said, "The NHS will be making a net transfer, meaning that £900m is shifting from NHS spending to local authority directed [spending] under the health and wellbeing boards. So, yes, it's a pragmatic response to a set of dual pressures on both sides of the fence."

The risks were being shared equally, said another witness Andrew Ridley, the Better Care Fund's programme director. "Within each area, there is a requirement that there are financial risk sharing arrangements put in place between the NHS and social care," he said.

Cite this as: *BMJ* 2014;349:g7433

Chair of Public Accounts Committee Margaret Hodge (left) asked witnesses Simon Stevens (centre) and Carolyn Downs (right) whether much of the Better Care Fund was being kept for the NHS

Sam Everington

Optimistic, extrovert, driven

PETER LOCKE

SAM EVERINGTON is an extrovert GP in east London who believes that treating patients meets only some of their needs. His practice, to which countless pilgrims have beaten a path, provides advice on benefits, employment, arts, and gardening, among 100 different projects at a centre designed as a community hub. As a junior doctor he camped on the street outside the Royal London Hospital to draw attention to long working hours. He chairs the Tower Hamlets clinical commissioning group and is a believer in applied optimism, where every crisis is an opportunity. Everington is 57.

Who has been your biggest inspiration?
"Aneez Esmail, with whom I worked to publish research on racial discrimination faced by doctors. It all started when he told me about a surgeon in the operating theatre who said, 'When it comes to shortlisting doctors who are going to work for me, if the surname is foreign, the applications get filed in the bin.'"

What was your earliest ambition?
To be a woodcarver in Norway. I was an apprentice for a few months.

What was the worst mistake in your career?
Having to complete my training as a barrister while desperately wanting to study medicine.

What was your best career move?
When our partnership joined the team at the Bromley by Bow Centre to create a holistic approach to patient care, looking at the social determinants of health. We have a wonderful team and over 100 different projects on the site, including a pottery, a vegetarian cafe, a stained glass artist, community care, a nursery, job advisers, a community university, social enterprises, and a beautiful park—all in the heart of the east end of London.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
Lansley was the best and the worst. He was the first to recognise primary care's importance in delivering patient care, by creating GP led commissioning. But he was the worst for not recognising that he did not need to achieve this through the most chaotic restructuring in the history of the NHS.

Who is the person you would most like to thank and why?
My mother and father, who sacrificed everything for our education in sending all seven of us to private school. My father died very soon after he retired, and I was never able to thank him properly.

Who has been your biggest inspiration?
George Fielding, the chair of the Whizz-Kidz Ambassadors [a disabled children's charity]; Ian Basnett, director of public health at Barts; all of the paralympians; and Aneez Esmail, with whom I worked to publish research on racial discrimination faced by doctors at all stages of their medical career. It all started when he told me about his parents having to start a new life in the UK with nothing, and about a surgeon in the operating theatre who said to Aneez, "When it comes to shortlisting doctors who are going to work for me, if the surname is foreign, the applications get filed in the bin."

If you were given £1m what would you spend it on?
I'd hold a "dragons' den" and give 100 awards to budding social entrepreneurs. I am blessed with a wonderful wife, children, and family; more money will not change that.

Where are or were you happiest?
On my grandfather's mountain farm in Norway, or on Loch Creran on the west coast of Scotland in a small boat surrounded by seals and otters. Either of those places with all my extended family.

What single unheralded change has made the most difference in your field in your lifetime?
The computerisation of general practice, way ahead of hospitals.

What book should every doctor read?
Something to make us laugh—*What Doctors Really Think* by Phil Hammond.

What is your guiltiest pleasure?
Maltesers, scoffed on my own while watching a world cinema film.

Clarkson or Clark? Would you rather watch *Top Gear* or *Civilisation*? What television programmes do you like?
Clarkson, I'm afraid. I love history, but the naughty boy in me wins out.

What is your most treasured possession?
My Norwegian jumpers, knitted by my mother.

What, if anything, are you doing to reduce your carbon footprint?
I'm an avid user of "Boris" bikes [Barclays Cycle Hire].

What personal ambition do you still have?
Almost by accident I have been a member of the BMA Council (acting chair for six months), a member of the GMC Council and the Commission for Health Improvement, a campaigner on junior doctors' hours, a cadet pilot in the RAF, governor of a local primary school, director of community health partnerships, a log cabin builder, ambassador for social enterprise, a welder in a Norwegian shipbuilding yard, and, most importantly, a GP for 25 years.

Summarise your personality in three words
Optimistic, extrovert, driven.

If you weren't in your present position what would you be doing instead?
I worked in the House of Commons for years and nearly became an MP. I was surrounded by people whose only ambition was to get to the top; they never did, psychologically. I've always loved my present position, and I love seeing my children and colleagues succeed.

Cite this as: *BMJ* 2014;349:g7387