NEWS

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Malaria vaccine is partly effective in young children, study shows

Leading academics condemn government undermining of NICE to support industry

Jacqui Wise LONDON

Two academics have written a damning critique of UK government policy, which they said supported the drug industry but undermined the National Institute for Health and Care Excellence (NICE) and pushed up drug prices.

The health economists Alan Maynard and Karen Bloor have written in the *Journal of the Royal Society of Medicine* that current government policy lacked accountability, was not based on evidence, and had added billions to NHS costs.[1]

In 2009 NICE was instructed to increase its cost threshold for drugs it recommends to above £30 000 per quality adjusted life year (QALY) for drugs used at the end of life, such as anticancer drugs. Maynard and Bloor, from the Department of Health Sciences at the University of York, said that this resulted in the drug industry virtually being able to set its own prices.

"This system is inflationary and has added billions to NHS costs since 1999, partly because the cost-per-QALY threshold is relatively high, contentious and is not evidence-based," they wrote. Despite work commissioned by the Department of Health for England in 2013 saying that a threshold of less than £13 000 would be appropriate, the government has guaranteed the higher cost per QALY cut-off until 2018.

The article criticises England's Cancer Drugs Fund, which allocates £280m a year to drugs not approved by NICE on a case by case basis. Under the scheme drugs such as ado-trastuzumab emtansine (which is marketed as Kadcyla), which NICE rejected because it cost £166 000 per QALY, can be funded individually.

Maynard and Bloor said that this policy garnered votes from public interest groups and subsidised the drug industry but was inequitable and inefficient. "It is inefficient because [it] subverts NICE processes. It is inequitable because it discriminates against other diseases which may be equally in need of additional funding."

They said that the government's policies supported the drug industry and enhanced export income but at a considerable opportunity cost to the NHS. For example, switching patients with age related macular degeneration from ranibizumab (Lucentis) to the much cheaper bevacizumab (Avastin) could save the NHS in England over £100m each year. Bevacizumab is licensed for the treatment of colorectal cancer, but a Cochrane review found that the cheaper drug was just as effective as the more expensive one.

A recent investigation by *The BMJ* showed that ophthalmologists in the United Kingdom were reluctant to prescribe bevacizumab out of fear of legal action.[2 3] Maynard and Bloor wrote, "Under patent legislation and due to PPRS [Pharmaceutical Price Regulation Scheme] price freedom, the government is powerless, or quietly condones excessive pricing as a means of supporting companies."

The article concluded, "Government continues to subvert the efficiency of technology appraisal work carried out by NICE in order to subsidise industry. Does this benefit the UK taxpayer and NHS patients? Or does government tacitly wish to tax the NHS with high pharmaceutical prices of sometimes inefficient drugs and, in so doing, increase the wealth of industry?"

IF I RULED THE NHS, p 27

Cite this as: *BMJ* 2015;350:h2311

IN BRIEF

Report on sexual health provision postponed indefinitely: A report on the effect of Andrew Lansley's changes to sexual health service provision in England, which was due last November, has been postponed indefinitely. The Department of Health has refused to explain the delay.

Paediatric expertise needed in community: GPs assessing or treating children with unscheduled care should have access to immediate telephone advice from a consultant paediatrician, new standards say (www.rcpch.ac.uk/facing-future-together-child-health). The recommendation is one of 11 standards in a report designed to improve health outcomes in children by improving connections between primary care, hospitals, and the community.

Monoclonal antibodies effective in dyslipidaemia: A meta-analysis of 24 trials of 10 159 adults with hypercholesterolaemia found that treatment with a new class of drug, PCSK9 inhibitors, led to a 47% (95% confidence interval 25.4% to 69.6%) reduction in LDL cholesterol concentrations when compared with no monoclonal antibody treatment (doi:10.7326/M14-2957).

Drug firms urged to reduce vaccine costs: The charity Médecins Sans Frontières has urged drug companies GlaxoSmithKline and Pfizer to cut the price of the pneumonia vaccine in poor countries to less than $5 (£3.30) a child. Figures show that in 2001 the average cost of giving a child six vaccinations was $0.67. By 2014, when there were 14 vaccinations, the price had gone up to between $32 and $45.

IN BRIEF

European drug agency advises on codeine in children: Codeine should not be used to treat coughs and colds in children under 12 or in children aged 12-18 who have respiratory conditions, the drug regulatory body for the European Union has said. A committee of the European Medicines Agency said that codeine is contraindicated in women during breast feeding and in patients known to be CYP2D6 ultra-rapid metabolisers. The committee identified 14 cases of codeine intoxication in children related to the treatment of cough and respiratory infection, four of which had a fatal outcome.

New health app guidance aims to protect patients: The Royal College of Physicians has produced a factsheet on using medical apps, to help doctors protect patients.[3] The factsheet explains what is and what is not a medical app, what to do if you are using or developing a medical app, and how to report problems with apps. It advises doctors not to use medical apps, including web based apps, that do not have a CE mark and to always exercise professional judgment before relying on information from an app.

College issues criteria for diagnosing infant death: New guidance from the Royal College of Paediatrics and Child Health recommends that the neurological clinical examination used to diagnose death in older children and adults is appropriate for infants aged between 37 weeks' gestation and 2 months.[1] Previously the college had said that it was "rarely possible" to confidently diagnose death by neurological criteria in a comatose and unresponsive young child. Instead UK doctors waited for the heart to stop to diagnose death in unresponsive infants.

Cigar smoking has similar risks to cigarette smoking: People who exclusively smoke cigars increase their risk of all cause mortality, oral cancer, oesophageal cancer, pancreatic cancer, laryngeal cancer, lung cancer, coronary heart disease, and aortic aneurysm, a review of 22 studies has found.[4] The risk of death from oral, oesophageal, and lung cancers was found to increase with full inhalation of cigar smoke. Even people who reported not inhaling the cigar smoke had an increased risk of death caused by oral, laryngeal, and oesophageal cancer.

Hinchingbrooke improves but remains in special measures: Hinchingbrooke Health Care NHS Trust has been rated as requiring improvement after its latest inspection by the healthcare regulator in January, after its "inadequate" rating given in September 2014. The trust remains in special measures after private company Circle withdrew from the 10 year contract to manage the hospital in March, saying that it was not viable.[2]

Ecuador is urged to change abortion law: The campaigning group Human Rights Watch has written to Ecuador's government calling for it to decriminalise abortion in line with UN recommendations, which says that women should be able to access abortion in cases of rape, incest, and severe fetal impairment. Ecuador allows abortion only when there is a threat to the life or health of a pregnant woman that cannot be averted by other means and in cases of pregnancy resulting from the rape of a woman with a mental disability.

Cite this as: *BMJ* 2015;350:h2242

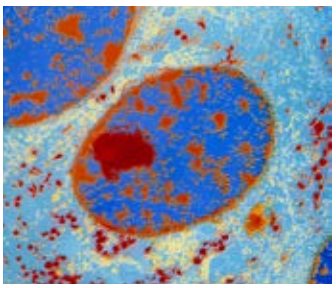
Fresh pair of eyes may speed up bowel cancer diagnosis

Jacqui Wise LONDON

Researchers have found that symptoms of bowel cancer tended to be identified slightly more quickly when patients consulted an unknown doctor rather than their usual GP.[1]

The study, published in the *British Journal of General Practice*, included data for 2000 to 2009 from the General Practice Research Database. The study included 18 500 patients with breast, bowel, or lung cancer whose relevant cancer symptoms were identified up to 12 months before the eventual diagnosis.

Having the same doctor in the 24 months before diagnosis was associated with a slightly later diagnosis of colorectal cancer (time ratio 1.01 (95% confidence interval 1.01 to 1.02)) but not of breast or lung cancer. However, the maximum delay was small, at around seven days. Although seeing a known GP may slightly delay diagnosis, following up new worrying symptoms with the same doctor was found to result in a quicker diagnosis of around 14 days for colorectal cancer and 18 days for lung cancer. The time to diagnosis of breast cancer was not affected by whether the patient saw the same doctor either before or after potential cancer symptoms were identified.



SPL

Having the same doctor for 24 months before diagnosis was associated with later diagnosis

For all cancers the greatest delay in diagnosis of all three types of cancer occurred after the patients had been referred.

The authors said that GPs should be cautioned against overlooking potentially worrying symptoms or signs among patients whom they know well.

Cite this as: *BMJ* 2015;350:h2232

Physician associates are as good as GPs in treating same day patients but cost less

Zosia Kmietowicz THE BMJ

Physician associates could be a solution to overburdened general practices, researchers have said, after they found that outcomes in patients seen by these health professionals were similar to those in patients seen by GPs and that they cost less to practices.

The researchers looked at the medical records of 2086 patients presenting for same day appointments at 12 general practices in England over four weeks in 2011 and 2012 (two weeks in winter and two weeks in summer) who were seen by a physician associate or GP.

The study, published in the *British Journal of General Practice*, found no differences between physician associates and GPs in how many patients had another consultation about the same problem (rate ratio 1.24 (95% confidence interval 0.86 to 1.79)), numbers of diagnostic tests ordered (1.08 (0.89 to 1.30)), referrals (0.95 (0.63 to 1.43)), prescriptions issued (1.16 (0.87 to 1.53)), or patients' satisfaction (1.00 (0.42 to 2.36)).[1]

The study also found that physician associates made more thorough records of consultations than GPs did: independent GPs judged 79% of physician associates' records and 48% of GPs' records to be appropriate.

The average time for a physician associate consultation was 17 minutes, compared with 11 minutes for GPs. But because of salary differences physician associates' consultations cost £6.22 less than those of the GPs (£28.14 versus £34.36).

Cite this as: *BMJ* 2015;350:h2230

Alternative providers perform worse than usual GP practices

Zosia Kmietowicz THE BMJ

Researchers have warned that the quality of care in the NHS in England may suffer from the influx of private and voluntary sector providers, after finding that the performance of alternative providers of GP services was worse than that of traditional practices on a range of indicators.

The researchers examined all general practices in England operating between 2008-09 and 2012-13. Reporting in the *Journal of the Royal Society of Medicine*, they found that 4.1% of practices (347 of 8300) held an alternative provider contract in at least one year in the study period.[1] Overall these alternative providers performed worse than traditional general practices on 15 of 17 quality indicators, including all measures of clinical quality and patients' experience, though they had more patients who were satisfied with opening hours.

Cite this as: *BMJ* 2015;350:h2184

NHS trust is charged with corporate manslaughter over woman's death

Clare Dyer THE BMJ

Prosecutors have launched a corporate manslaughter prosecution against an NHS trust in the case of a 30 year old primary school teacher who died after an emergency caesarean section.

Maidstone and Tunbridge Wells NHS Trust has been charged with manslaughter over the death of Frances Cappuccini, who had a cardiac arrest after haemorrhaging and died within hours of the birth of her second son at Tunbridge Wells Hospital in Kent in October 2012.

Two doctors involved in Cappuccini's treatment have also been charged with gross negligence manslaughter: Nadeem Azeez, 52, who qualified at the University of the Punjab in Lahore, Pakistan, and Errol Cornish, 67, who qualified at the University of Cape Town in South Africa. An international warrant has been issued for the arrest of Azeez, who is thought to have returned to Pakistan.

The charge is the first of its kind against an NHS trust since the Corporate Manslaughter and Corporate Homicide Act 2007 created a new statutory offence of corporate manslaughter, making it easier to prosecute large organisations for the crime. An organisation is guilty of the offence if the way in which its senior management organises or manages its activities causes a death, and this amounts to a gross breach of the duty of care it owed to the victim.

An inquest into the death was opened last year but was adjourned while Kent Police investigated the possibility of criminal charges. At a pre-inquest review a lawyer for Cappuccini's husband said that the couple had planned an elective caesarean but were persuaded to try a vaginal delivery.

A spokeswoman for the trust said that it had no comment to make at this stage. The case will have its first court hearing at Sevenoaks Magistrates Court on 1 May.

Cite this as: *BMJ* 2015;350:h2181

Frances Cappuccini (left) died after the birth of her son. Nadeem Azeez is one of the doctors charged with manslaughter

Surgeon is struck off for punching patient in the face to try to repair fracture

Clare Dyer THE BMJ

A consultant oral and maxillofacial surgeon has been struck off the medical register after a fitness to practise tribunal heard that he repeatedly punched an anaesthetised patient in the face during surgery in an effort to reduce a fracture.

Nurses and other staff at Ipswich Hospital told the Medical Practitioners Tribunal Service of their shock when Ninian Peckitt, who had been subcontracted to Ipswich for three months by Norfolk and Norwich University Hospitals NHS Trust, suddenly made his hand into a fist and repeatedly struck the patient hard on the side of the face.

Peckitt, 63, had operated on the patient, who had sustained an industrial injury, two weeks previously, repairing several fractures in his face. But the patient later fell from his hospital bed, displacing his cheekbone.

Erica Rapaport, an associate specialist, told the tribunal that Peckitt was attempting to reduce this fracture when "he made his hand into a fist, and he hit the patient in the face on the left side of his cheek," drawing gasps from those present. He then instructed her to hold the patient's head while he struck again, she said.

"He applied about 10 punches like a boxer. He took aim and then punched. The first punch was unexpected, and then he explained what he was doing. He spoke as he punched again and again. I can remember a feeling of total shock."

Ninian Peckitt punched the patient 10 times

Cite this as: *BMJ* 2015;350:h2214

NHS faces biggest challenge "for many years" amid mounting deficits and declining morale

Gareth Iacobucci THE BMJ

Hospitals and other NHS providers in England are set to post a record deficit of more than £800m in 2014-15, says an analysis by the King's Fund think tank.

In its latest quarterly monitoring report the fund warned that mounting deficits, worsening performance, and declining staff morale had left the NHS facing its biggest challenges "for many years."[1] It said the deficit is still being projected despite nearly £900m provided by the Treasury or switched from capital budgets to plug "the growing black hole in NHS finances."

In the regular survey of trust finance directors that accompanied the report, almost 60% said that they had depended on additional financial support or had drawn down their reserves in 2014-15. In a separate question two thirds of trust finance directors and 40% of clinical commissioning group (CCG) finance directors were concerned about staying within budget over the next financial year (2015-16).

Trust finance directors raised specific concerns about the feasibility of attaining productivity targets—less than half (45%) saying that they were confident of achieving efficiency targets in 2015-16. Also, three quarters (75%) of trust directors and 68% of CCG directors predicted a "high" or "very high" risk of failing to achieve £22bn in productivity gains over the next five years as outlined by NHS England's *Five Year Forward View*.[2]

Morale was the top concern raised by finance directors.

Cite this as: *BMJ* 2015;350:h2180

EPA/ALAMY

Migrants on board an Italian navy vessel after being shipwrecked

MSF launches lifesaving mission in Mediterranean

Sophie Arie LONDON

The charity Médecins Sans Frontières is launching an independent mission to save lives of migrants because it says Europe is still not doing enough to rescue them as they try to cross the Mediterranean from Africa.

From early May the medical charity, working jointly with a small Maltese charity called Migrant Offshore Aid Station, will operate rescue missions across the Mediterranean. The European Union stopped doing similar missions last year out of concern that they were encouraging migration and, despite agreeing to triple spending on its rescue efforts, it still plans to save only those who reach its territorial waters. Over 1700 people have drowned so far this year trying to make the crossing, including 750 people on a single boat in April.

Loris De Filippi, president of MSF Italy, said in a statement, "This humanitarian tragedy is now under everyone's eyes, but Europe is not willing to address it. This is why we will begin first hand operations at sea, in an attempt to save as many lives possible. Only creating safe and legal channels to protection in Europe will truly prevent thousands more deaths. But as a medical-humanitarian organisation we simply cannot wait any longer."

Two MSF doctors and a nurse will be part of a team of 20 on board Migrant Offshore Aid Station's 40 m rescue ship, *MY Phoenix*, which will provide healthcare on the ship.

Cite this as: *BMJ* 2015;350:h2236

Firm "was paid to keep drug out of market"

Owen Dyer MONTREAL

A big manufacturer of generic drugs has had to pay $512m (£340m) to settle a claim that it took payments in various guises from the drug company Cephalon in exchange for not producing a cheap generic version of the company's drugs.

Teva was one of four generic drug makers named in an antitrust suit brought by a large group of bulk drug buyers, pharmacies, and US health insurance plans over an alleged scheme to avert generic competition for the sleep disorder drug modafinil (marketed in the US as Provigil).[1]

Provigil's main patent expired in 2003, but the drug's maker, Cephalon, still held minor patents related to particle size of the active ingredient. Generic manufacturers, including Teva, had prepared versions that skirted around these other patents by modifying the particle size. But Cephalon challenged them, claiming patent infringement. Cephalon's suit had little chance of success, the drug buyers alleged, but the court filing automatically triggered a 30 month hold on the FDA's approval of generic rivals. Cephalon hoped meanwhile to switch patients from Provigil to Nuvigil, a successor modafinil drug with a new patent that would insulate it from generic competition.

But the FDA's approval of Nuvigil lagged, and by 2005 Cephalon faced imminent entry of the generic competitors. At this point Cephalon reached an agreement with the generic makers in its patent infringement suit. The settlement was of a type that has become a specialty of the drug industry: a reverse payment settlement, sometimes called a pay to delay agreement, in which the patent holding plaintiff pays the defendant.

Cephalon's agreement with the generic makers delayed the entry of their cheaper drugs by six years, until 2012. During that time sales of Provigil grew to over $1bn a year.

All of the parties could earn more from such an agreement than they would have earned competing in the generic marketplace, the lawsuits allege. Cephalon allegedly transferred about $200m in various guises to the generic makers.

Cite this as: *BMJ* 2015;350:h2282

Tobacco industry sought to prevent Islamic fatwas against smoking

Owen Dyer MONTREAL For three decades the tobacco industry has fought a secret battle against Islamic scholars who seek to discourage smoking, show industry documents reported in a new study in the *American Journal of Public Health*.[1]

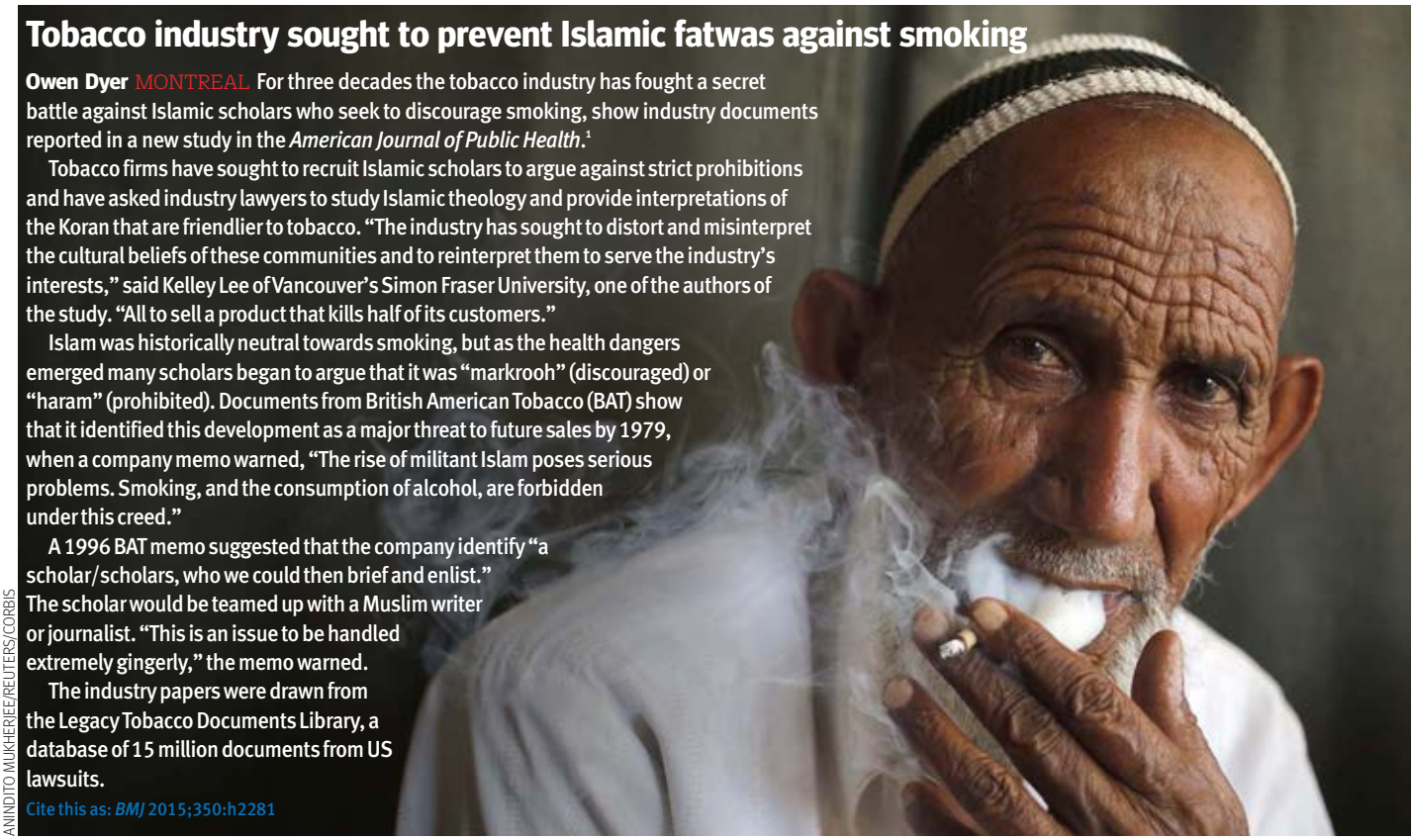
Tobacco firms have sought to recruit Islamic scholars to argue against strict prohibitions and have asked industry lawyers to study Islamic theology and provide interpretations of the Koran that are friendlier to tobacco. "The industry has sought to distort and misinterpret the cultural beliefs of these communities and to reinterpret them to serve the industry's interests," said Kelley Lee of Vancouver's Simon Fraser University, one of the authors of the study. "All to sell a product that kills half of its customers."

Islam was historically neutral towards smoking, but as the health dangers emerged many scholars began to argue that it was "markrooh" (discouraged) or "haram" (prohibited). Documents from British American Tobacco (BAT) show that it identified this development as a major threat to future sales by 1979, when a company memo warned, "The rise of militant Islam poses serious problems. Smoking, and the consumption of alcohol, are forbidden under this creed."

A 1996 BAT memo suggested that the company identify "a scholar/scholars, who we could then brief and enlist." The scholar would be teamed up with a Muslim writer or journalist. "This is an issue to be handled extremely gingerly," the memo warned.

The industry papers were drawn from the Legacy Tobacco Documents Library, a database of 15 million documents from US lawsuits.

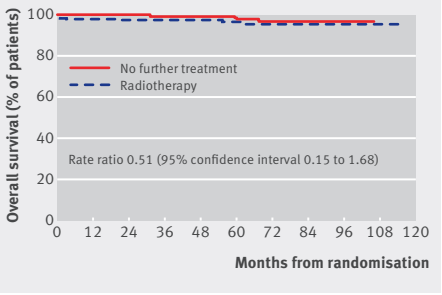
Cite this as: *BMJ* 2015;350:h2281



ANINDITO MUKHERJEE/REUTERS/CORBIS

RESEARCH NEWS

Kaplan-Meier plot of overall survival in patients who underwent radiotherapy or no further treatment after negative PET findings



HODGKIN'S LYMPHOMA

PET identifies patients who can avoid radiotherapy

Positron emission tomography (PET) scanning immediately after chemotherapy for Hodgkin's lymphoma can identify patients who are likely to have good survival without radiotherapy, a study reported in the *New England Journal of Medicine* has found.[1]

The standard treatment for early stage Hodgkin's lymphoma is currently chemotherapy followed by radiotherapy. However, interest has been growing in whether PET scanning can determine those patients who are cured with chemotherapy and who do not need consolidation radiotherapy.

The study included 602 patients with a new diagnosis of early stage Hodgkin's lymphoma who were treated with three cycles of chemotherapy before undergoing PET. Patients with negative findings on PET (n=426) were then randomly assigned to radiotherapy or to no further treatment.

The results showed that 94.6% (95% confidence interval 91.5% to 97.7%) of patients randomised to radiotherapy and 90.8% (86.9% to 94.8%) of those who received no radiotherapy showed no disease progression at three years.

At a median of 60 months of follow-up eight patients in the radiotherapy group showed disease progression and eight patients had died (three with disease progression and one from Hodgkin's lymphoma). Twenty patients in the group who were given no further therapy showed disease progression and four had died (two with disease progression and none from Hodgkin's lymphoma).

The group concluded that patients with early stage Hodgkin's lymphoma and negative PET findings after three cycles of chemotherapy had a very good prognosis either with or without consolidation radiotherapy.

Cite this as: *BMJ* 2015;350:h2190

THERAPEUTIC HYPOTHERMIA

Outcomes in children with cardiac arrest aren't improved

Therapeutic hypothermia, in which the whole body is cooled, does not improve survival or reduce brain injury any more than normal temperature control in infants and children who have had a cardiac arrest out of hospital, shows a study reported in the *New England Journal of Medicine*.[1]

Whole body cooling has been shown to improve survival in comatose adults after cardiac arrest and to improve outcomes in neonates with brain injury at birth. But it has not previously been investigated in infants or children admitted to hospital after having a cardiac arrest.

The study included 295 infants and children who were unconscious after a cardiac arrest out of hospital. Within six hours after the return of circulation they were randomised to therapeutic hypothermia to a target temperature of 33.0°C or to normal temperature control, with a target of 36.8°C.

Results showed no significant difference in survival, and neurobehavioural functioning was good at 12 months. A fifth (20%) of infants and children who underwent cooling and 12% of those whose temperature was controlled to normal levels were alive and functioning well at one year (relatively likelihood 1.54 (95% confidence interval 0.86 to 2.76); P=0.14).

Cite this as: *BMJ* 2015;350:h2245

TYPE 1 DIABETES

Maternal obesity increases risk in offspring, study shows

Overweight and obesity among women increases the risk of type 1 diabetes in their offspring even when neither parent has diabetes, shows a nationwide cohort study of more than 1.2 million children in Sweden.

The results, published in *Diabetologia*,[1] indicate that efforts to reduce overweight and obesity in women before and during pregnancy might reduce the incidence of type 1 diabetes in children of parents without diabetes.

The researchers followed a cohort of 1 263 358 children born in Sweden between 1992 and 2004 from birth until a diagnosis of type 1 diabetes, emigration, death, or the end of the follow-up period in 2009. Information for each child was compared with data on their mother's body mass index (BMI) during the first trimester of the pregnancy that resulted in each child's birth.

Type 1 diabetes was diagnosed in 5771 of the children during the study period. Among children of parents who didn't have diabetes, having a mother who was obese during pregnancy (BMI ≥30) was associated with an increase in risk of developing type 1 diabetes of a third, when compared with children of mothers whose BMI was in the normal range (incident rate ratio 1.31 (95% confidence interval 1.20 to 3.40); P for trend 0.0005).

The risk of a child developing type 1 diabetes was greatly increased if the mother (incidence rate ratio 3.17 (2.80 to 3.58)) or father (incidence rate ratio 5.27 (4.74 to 5.86)) had type 1 or type 2 diabetes, but this risk did not increase further with maternal obesity in pregnancy.

Cite this as: *BMJ* 2015;350:h2252

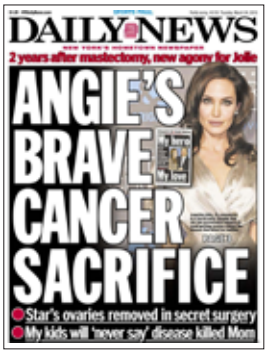
INHERITED BREAST CANCER

Researchers estimate benefit of oophorectomy in women

Removal of the ovaries is associated with a 62% reduction in breast cancer deaths among women with diagnosed breast cancer who carry the BRCA1 mutation, a retrospective analysis published in *JAMA Oncology* has found.[1]

Women who carry a mutation in either the BRCA1 or BRCA2 gene have a lifetime risk of breast cancer of up to 70%, and once they have a diagnosis of breast cancer they face high risks of second primary breast and ovarian cancers. Preventive oophorectomy is recommended to women aged over 35 with a BRCA mutation to prevent breast and ovarian cancer, but it is unclear whether removing the ovaries may also reduce mortality from breast cancer.

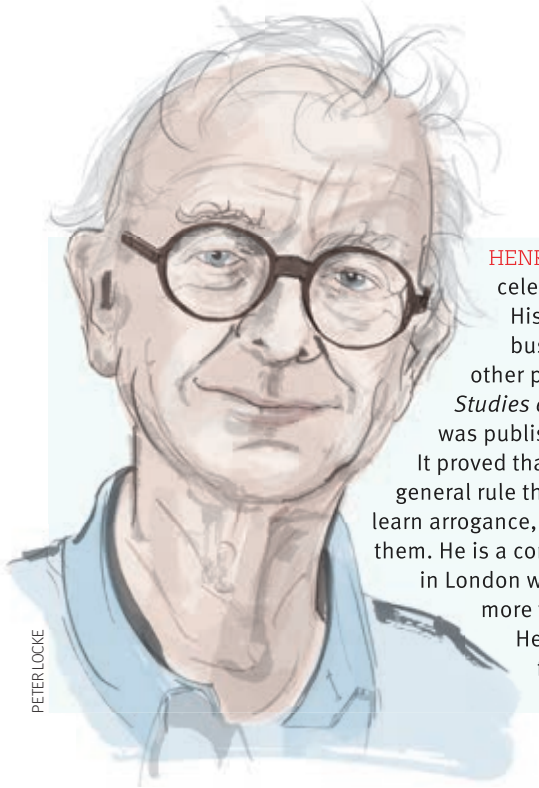
Of 676 women with stage I and II breast cancer who had a BRCA1 or BRCA2 mutation, 345 underwent bilateral oophorectomy after the diagnosis of breast cancer and 331 retained both ovaries.



Removal of ovaries was associated with a significant reduction in breast cancer death in women with a BRCA1 mutation (adjusted hazard ratio 0.38 (95% confidence interval 0.19 to 0.77); P=0.007). There was a 43% reduction in women with a BRCA2 mutation, but this was not statistically significant. In the entire group oophorectomy was particularly effective for survival benefit in women with oestrogen receptor negative breast cancer (hazard ratio 0.07 (0.01 to 0.51); P=0.009).

Cite this as: *BMJ* 2015;350:h2182

Henry Marsh
Thinking fast and slow



PETER LOCKE

HENRY MARSH is a neurosurgeon celebrated for a work of literature. His candid reflections on the risky business of poking his nose into other people's heads, *Do No Harm: Studies of Life, Death and Brain Surgery*, was published to huge acclaim in 2014. It proved that there are exceptions to the general rule that surgeons are born arrogant, learn arrogance, or have arrogance thrust upon them. He is a consultant at St George's Hospital in London who remembers his mistakes more vividly than his successes. He has refreshingly little time for bureaucratic interference, however well meant it may be.

What single unheralded change has made the most difference in your field in your lifetime?
"Endovascular treatment of intracranial aneurysms, wonderful for patients but not for neurosurgeons"

What was your earliest ambition?
To be a poet. Fortunately, unlike the Vogons in the *Hitchhiker's Guide to the Galaxy*, I abandoned this early on.

Who has been your biggest inspiration?
Raoul Wallenberg, the Swedish diplomat who saved thousands of Hungarian Jews from the Nazis but was afterwards arrested by the Russians and disappeared in Stalin's Gulag.

What was the worst mistake in your career?
There are so many mistakes I don't know where to start—mainly patients I have failed. My favourite surgical quotation is by the French surgeon René Leriche: that all surgeons have an inner cemetery that they have to visit regularly to contemplate their mistakes.

What was your best career move?
Becoming a neurosurgical senior house officer at the Royal Free Hospital in London in 1981.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
The best was Nye Bevan for starting the NHS, the worst Kenneth Clarke for introducing the wholly untried idea of the internal market. The NHS has many faults, but I suspect (though cannot prove) that the "competition" of the internal market has not helped in any way other than further to drive up costs.

Do you support doctor assisted suicide?
Yes, very strongly. I think bicycles and euthanasia are signs of higher civilisation.

Who is the person you would most like to thank?
My parents.

To whom would you most like to apologise?
The many patients I have failed.

If you were given £1m what would you spend it on?
Half to my three children and half to obscure charities, mainly for the war wounded in Ukraine, where I have been working in my own time for more than 20 years.

Where are or were you happiest?
In my family's cottage in rural mid-Wales, bought by my parents many years ago and one of the many reasons for my gratitude.

What single unheralded change has made the most difference in your field in your lifetime?
Endovascular treatment of intracranial aneurysms, wonderful for patients but not for neurosurgeons. Aneurysm surgery defined neurosurgery 20 years ago, being delicate, dangerous, and difficult, but modern interventional radiological techniques are slightly safer and much less traumatic for the patients and in the United Kingdom are performed by radiologists.

What book should every doctor read?
Daniel Kahneman's *Thinking, Fast and Slow*. Doctors make many serious decisions about their patients every day, and we are prone to all the "cognitive biases" that Kahneman so brilliantly describes. We are much less rational than we like to think. Kahneman's critical conclusion is that other people are better at seeing our mistakes than we are ourselves. Although clinical meetings can be trying, they are a very important part of medical practice, and having good colleagues who feel able to criticise you is very important for the safety of your patients.

What is your guiltiest pleasure?
Gin and tonic.

If you could be invisible for a day what would you do?
Prowl around the Department of Health to see whether my many prejudices are justified.

What television programmes do you like?
I don't have a television.

What is your most treasured possession?
My woodworking tools.

What, if anything, are you doing to reduce your carbon footprint?
I have cycled almost every day in London since 1973 and try to keep driving to a minimum. That and cold showers.

What personal ambition do you still have?
To write another book before my wits start to fade.

Summarise your personality in three words
Impatient, driven, easily frightened.

Where does alcohol fit into your life?
More than it probably should, which is why I am trying to wean myself on to green tea in the evenings.

What is your pet hate?
Political correctness.

Do you have any regrets about becoming a doctor?
None whatsoever. I have been incredibly spoilt, fortunate, and privileged to have had the career and colleagues that I have had.

Cite this as: *BMJ* 2015;350:h2233