NEWS

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bmj.com
Teen fitness is linked to reduced risk of myocardial infarction in later life

Consultation on introducing a minimum price for alcohol was a sham, *BMJ* investigation shows

Jonathan Gornall LONDON

The *BMJ* has uncovered evidence that the government's consultation last year on the promised introduction of a minimum price for alcohol in England and Wales was little more than a sham.

David Cameron, the prime minister, pledged in March 2012 that the policy would be introduced, in his words, to save hundreds of lives a year.

Yet internal emails from the Department of Health show that as the subsequent consultation on the level at which the price should be set was under way the alcohol industry was arguing successfully against the principle of the policy in a series of meetings with ministers.

Industry representatives had access to health minister Anna Soubry (left), but Sarah Wollaston MP had access to Prime Minister Cameron blocked

The revelations have emerged as part of an investigation by the *BMJ* that has found extensive evidence of the influence on public health policy of an industry granted easy and open access to all departments of government.

Documents released under a freedom of information request show that the health department alone had 130 meetings with representatives of the alcohol industry between the coalition taking power in May 2010 and the end of 2013.

Details of the meetings will come as a shock to public health lobbyists, who at the time had been led by the government to believe that the battle to introduce minimum pricing was won.

On 6 February 2013, the day the consultation on minimum pricing ended, the public health minister, Anna Soubry, met seven representatives of the industry to discuss their "deep concern" about a regulation that, they threatened, would damage the government's voluntary public health "responsibility deal" with the industry.

The industry representatives told Soubry they would prefer a different measure, "a ban on below-cost sales," which was exactly what the government delivered five months later.[1]

The decision to scrap minimum pricing was "absolutely shameful," said Sarah Wollaston, a GP and Conservative MP who has campaigned long and hard for the policy. "The influence of industry, within media and government, is too great," she said.

When rumours began to circulate in parliament that minimum pricing had been scrapped, Wollaston confronted Cameron during prime minister's questions in March 2013, asking for a meeting at which she could "explain to him the evidence base."

Although he said that he was "happy to meet my hon[orary] friend," Wollaston found that doors that always seemed open to the alcohol industry were closed to her.

When the Home Office minister Jeremy Browne announced the U-turn in the House of Commons on 17 July, he told MPs it was because "we do not yet have enough concrete evidence that its introduction would be effective in reducing harms associated with problem drinking . . . without penalising people who drink responsibly."[1]

However, the *BMJ* has discovered that the government had had evidence to the contrary for at least five months. A draft version of a report commissioned from Sheffield University on this specific point and delivered to the Home Office, Department of Health, and Treasury in February 2013 had concluded that "moderate drinkers would experience only small impacts from MUP [minimum unit pricing] policies."[2 3]

FEATURE, p 18; EDITORIAL, p 7

Cite this as: *BMJ* 2014;348:g72

Thousands of patients visited A&E units more than 10 times in 2012-13

Zosia Kmietowicz BMJ

A BBC investigation has found that nearly 12 000 people in the UK attended the same accident and emergency unit more than 10 times in 2012-13. Just over 150 patients attended more than 50 times each.

Cliff Mann, president of the College of Emergency Medicine, said that repeated use of hospital emergency services for non-emergencies was adding to pressure on the NHS.

Mann said the findings raised questions about "the interface between health and social care and how to manage those who might best be dealt with by social services."

The number of people going to emergency departments in England has increased by 50% in the past decade, from 14 million in 2003-04 to 21.7 million in 2012-13.

Mann said that people often turned to emergency departments when they believed they had nowhere else to go for help. The issues affecting these patients included mental health or social problems, drug addiction, and alcoholism. Some patients returned to the emergency department because they had a good experience in the past, he said.

For its investigation the BBC asked 175 UK hospital trusts and boards for figures on repeat attendances during 2012-13. Of these, 106 responded, covering 183 emergency units.

Among the worst cases was a patient at Luton & Dunstable Hospital who went to the emergency department 234 times.

Just over 372 000 people attended emergency units in England between 22 and 29 December, and 96.4% were dealt with in under four hours.[1] The waiting time target is to see 95% of patients within four hours.

Cite this as: *BMJ* 2014;348:g98

MPs call for publication of full results of past trials



From left: Richard Bacon, MP for South Norfolk, who chaired the inquiry, and witnesses Fiona Godlee, *BMJ* editor in chief, and campaigner Ben Goldacre

Adrian O'Dowd LONDON

The methods and results of all past clinical trials in the United Kingdom, as well as future trials, should be made available to doctors and researchers to ensure the safety of drugs being prescribed by clinicians, MPs have said.

MPs on the parliamentary public accounts committee have also called for further scrutiny of Tamiflu, Roche's branded form of oseltamivir, which had been used to treat pandemic flu, before more supplies are bought and stockpiled by the government.

A report published by the committee on 3 January on access to clinical trial information and the stockpiling of oseltamivir raises many concerns over how the current system operates.[1]

It says that information is routinely withheld from doctors and researchers about the methods and results of clinical trials on treatments that are currently prescribed in the UK.

Although the problem has been known about for many years, says the report, action taken by the government, industry, or professional bodies to tackle it has been inadequate.

The MPs recommended that the Department of Health take action to ensure that full methods and results were made available to doctors and researchers from all trials on all uses of all treatments currently being prescribed—from now on and retrospectively.

They criticised regulatory bodies, saying that, although drug manufacturers had to submit evidence on products they wanted to market in the UK to the Medicines and Healthcare Products Regulatory Agency (MHRA) or the European Medicines Agency, the system still had gaps.

The National Institute for Health and Care Excellence (NICE) and the MHRA did not routinely share information provided by manufacturers during the process for licensing drugs, said the MPs, who recommended that the two bodies put in place a formal information sharing agreement.

Between 2006-07 and 2012-13 the health department bought nearly 40 million units of oseltamivir, costing £424m, said the report, but only 2.4 million units were consumed, mostly during the flu pandemic in 2009-10.

The report says that consensus over how well the drug worked was lacking and that the case for stockpiling the drug at current levels was not based on evidence of effectiveness.

The MPs, therefore, recommended that once the Cochrane Collaboration had completed its review of oseltamivir, using information from all clinical study reports, the health department, the MHRA, and NICE should consider whether it was necessary to revisit previous judgments on oseltamivir.

Richard Bacon, a committee member and the Conservative MP for South Norfolk, said, "The full results of clinical trials are being routinely and legally withheld from doctors and researchers by the manufacturers of medicines.

"This has ramifications for the whole of medicine. The ability of doctors, researchers, and patients to make informed decisions about treatments is being undermined. Regulators and the industry have recently made proposals to open up access, but these do not cover the issue of access to the results of trials in the past."

Ben Goldacre, author of *Bad Pharma* and Wellcome research fellow in epidemiology at the London School of Hygiene and Tropical Medicine, who gave evidence during the inquiry,[2] said, "We cannot make informed decisions about which treatment is best when vitally important information is routinely and legally kept secret."

Fiona Godlee, the *BMJ*'s editor in chief, said, "Congratulations to the Public Accounts Committee for fully comprehending how absurd and damaging the current situation is and for making these important recommendations.

"If the Department of Health does what the committee asks—ensures access to the full methods and results for all trials on all treatments in current use—this will be a huge contribution to improved public health and patient care."

Cite this as: *BMJ* 2014;348:g13

Meniscal tear surgery is no better than sham surgery, study says

Susan Mayor LONDON

Arthroscopic surgery to repair a meniscal tear is no better than sham surgery in improving knee pain in patients with a degenerative meniscal tear and no knee arthritis, show results from a randomised controlled trial that questioned the use of this common procedure for this type of knee problem.

Arthroscopic partial meniscectomy is one of the commonest orthopaedic procedures, yet rigorous evidence of its effectiveness has so far been lacking, said the Finnish research group that carried out the trial.

The procedure aims to relieve symptoms attributed to a tear in a meniscus, one of the two pads of cartilage that cushion the knee joint, by removing torn meniscal fragments and trimming the meniscus back to a stable rim.

The study included 146 patients aged 35-65 years who had had knee pain for at least three months that was not responding to conservative treatment and where clinical findings were consistent with a tear of the medial meniscus.

Experienced surgeons at five centres in Finland carried out diagnostic arthroscopy to confirm a degenerative meniscus tear and that there was no knee osteoarthritis before randomly assigning patients to arthroscopic partial meniscectomy or sham surgery, in which the knee was manipulated as if the actual procedure were performed.

"Because the act of performing surgery itself has a profound placebo effect, a true treatment effect is impossible to distinguish from nonspecific placebo effects without a sham comparison group," argued the research group, led by Teppo Järvinen of the University of Helsinki.

The results showed that improvement in knee pain from baseline to 12 months among patients who underwent partial meniscectomy was similar to the improvement shown in the sham surgery group.

Cite this as: *BMJ* 2014;348:g4

NHS must move on from failures of past in 2014, say healthcare leaders

Zosia Kmietowicz BMJ

Leaders of organisations representing frontline NHS staff in England have called for "a new page to be turned" as 2014 begins, by focusing on making the NHS fit for the future rather than on the mistakes of the past.

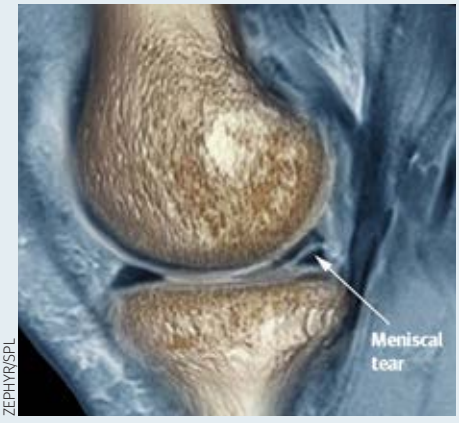
In a letter to the *Guardian* the nine organisations say that the high quality care provided by the NHS to millions of people every day often got lost in headlines in 2013 over failures of the service.[1] While these failures must be dealt with, says the letter, it is time to move on.

The letter quotes Don Berwick, president emeritus and senior fellow of the US Institute for Healthcare Improvement, who published a review into patient safety in the wake of reports on failings at Mid Staffordshire NHS Foundation Trust.[2] As Berwick said, tackling the failures in the NHS meant leaving "'fear, blame, recrimination and demoralisation' behind, and going forward with energy and optimism," says the letter.

Signatories include the BMA's Mark Porter, Richard Thompson, president of the Royal College of Physicians, and Maureen Baker, chairwoman of the Royal College of General Practitioners. They say that "a more measured view of how the NHS is performing" was needed.

They add, "We must strike the right balance between recognising the extraordinary achievements that NHS staff deliver every day and the need for improvement highlighted by the Francis report [of the inquiry into Mid Staffordshire]. Rather than looking back to the failures of the past, we now need to devote our time and energy meeting the very real challenges we face to secure a sustainable NHS for the future."

Cite this as: *BMJ* 2014;348:g5



ZEPHYR/SPL

Improvement in pain was similar in those with real surgery and those with sham surgery

GP commissioning failures deny obese patients access to surgery

Zosia Kmietowicz BMJ

Patients across England are being denied access to bariatric surgery because GPs in some parts of the country are not commissioning intensive weight loss programmes, a prerequisite to surgery, surgeons have warned.

Since April 2013 NHS England, which is responsible for commissioning bariatric surgery, has said that patients should be operated on only after they have been through intensive "tier 3" weight management services before surgery. These can last up to two years and can also help patients control their diet after surgery.

Guidance from NHS England states that it is the responsibility of clinical commissioning groups (CCGs) to commission and fund these services.[1]

But the delivery of tier 3 programmes is fragmented and is putting patients' lives at risk, doctors have told the Royal College of Surgeons.

Sean Woodcock, a surgeon in northern England, told the *BMJ* that only one of the CCGs that replaced the three former primary care trusts in his area currently funded tier 3 services, meaning that a large number of obese patients in the area would no longer be eligible for surgery.

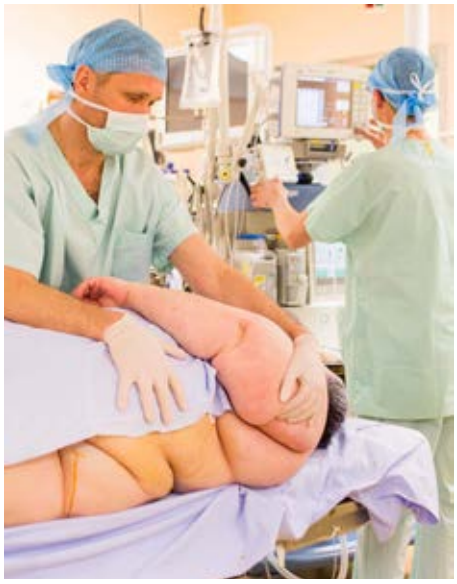
North Cumbria stopped seeing tier 3 patients in September, and North Tyneside will lose its funding for the service from April 2014. Only Northumberland has guaranteed funding until 2015, said Woodcock.

"It is absolutely daft. Here we have something [bariatric surgery] that pays for itself. It treats the medical problems, such as diabetes and sleep apnoea, associated with obesity. It is an absolute joy seeing patients getting their lives back, but now patients are being denied that opportunity," he said.

The problem, said Woodcock, was that CCGs saw tier 3 services as a preventive function that was the responsibility of local authorities, while public health services saw it as a treatment that CCGs should pay for. "It's a bun fight," he told the *BMJ*.

Steve Kell, chairman of Bassetlaw CCG, Nottinghamshire, and co-chairman of the NHS Clinical Commissioners Leadership Group, said that in parts of Nottinghamshire tier 3 services would not be available until August 2014. Therefore with a minimum of six months of presurgery treatment it would be a year before patients in the area could access waiting lists for surgery.

In London, City and Hackney CCG cannot refer patients for bariatric surgery because the tier 3 weight management service offered by Homerton Hospital does not meet criteria laid down by NHS England.



BURGER/PHANIE/REX

Poor access to bariatric surgery is putting some patients at continuing health risk, said surgeons

Kell said that the national rules on eligibility for bariatric surgery should be relaxed until tier 3 services were commissioned nationwide.

He said, "Patients cannot access surgery even though we know there is a clinical benefit. We have units with highly trained surgeons who do not have work to do.

"It is essential that NHS England, as the specialist commissioner, shows some imagination and flexibility so that, where it is deemed clinically necessary, patients who need it can be referred now to a surgical pathway for bariatric surgery."

Richard Welbourn, president of the British Obesity and Metabolic Surgery Society, said, "The benefits of bariatric surgery are well known. It leads to greater body weight loss and higher remission rates of type 2 diabetes than non-surgical treatment of obesity. Poor access to bariatric surgery therefore places some patients at continuing health risk. In the long run this will end up costing the NHS more."

A spokesperson for NHS England said that a working group involving CCGs, local authorities, the Department of Health, Public Health England, and the National Institute for Health and Care Excellence met in 2013 to look at commissioning of obesity services and the pathway to specialist obesity surgery. It is due to report in the next few months.

Cite this as: *BMJ* 2014;348:g57

IN BRIEF

New NHS bodies spent millions on management consultants: England's new clinical commissioning groups spent £17.6m on external management consultants to help implement changes to the NHS in the first six months of the 2013-14 financial year, an information request by the Labour shadow health minister Liz Kendall has shown. In addition, commissioning support units spent £10m on consultants, Monitor spent £8.5m, NHS England spent £1.8m, and the Care Quality Commission spent £2m. These groups and others spent £15m on consultants in 2012-13.

Leaflet explains benefits of sharing healthcare data: England's 26.5 million households are being sent a leaflet from NHS England explaining how the health service uses information on patients. The leaflet says that sharing information helps improve the quality of care and highlights which diseases and conditions need greater investment.

Former surgeon is appointed to reduce premature deaths: Celia Ingham Clark has been appointed as national director for reducing premature deaths for NHS England. Previously she was a consultant general and colorectal surgeon and then medical director at Whittington Hospital NHS Trust in north London. Most recently she was the national clinical director for enhanced recovery and acute surgery for NHS England.

New York state expected to legalise cannabis for medical use: Andrew Cuomo, the governor of New York state, is planning to allow cannabis to be used for medical purposes, the *New York Times* has reported.[1] The changes mean that cannabis could be prescribed by 20 hospitals in the state for seriously ill patients. To date 20 states and the District of Columbia have legalised the use of the drug for medical purposes.

Children in central African camps to get measles vaccine: More than 60 000 children in two camps for displaced persons in the Central African Republic are being targeted by an emergency measles vaccination campaign led by WHO and others, after eight cases of measles were found in late December. Doctors are concerned about the conditions at the camps, which shelter 150 000 people who have fled violence.

Cite this as: *BMJ* 2014;348:g41

Task force urges CT lung cancer screening for people at high risk

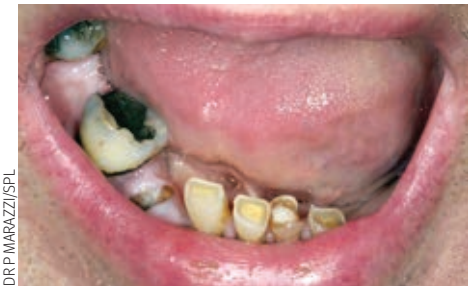
Michael McCarthy SEATTLE

Smokers and former smokers aged 55-80 who have a history of 30 pack-years or more, and who are currently smoking or have quit within the past 15 years, should be screened annually with low dose computed tomography, the US Preventive Services Task Force has concluded.[1]

The panel recommended that screening should be discontinued once a person has not smoked for 15 years or has developed a health condition that limits the person's life expectancy "or the ability or willingness to have curative lung surgery."

The panel's recommendations were published on 31 December 2013 by the *Annals of Internal Medicine*. Task force panels are charged with assessing the effectiveness of preventive care services for patients who do not have signs or symptoms of the screened condition. In drawing up their recommendations, panels weigh the benefits and harms of the intervention but do not consider cost.

In this case the panel graded its recommendations as "B" to indicate that the evidence showed with "moderate certainty that annual screening for lung cancer with LDCT [low dose computed tomography] is of moderate net benefit in asymptomatic persons who are at high risk for lung



DR P MARAZZI/SPL

Evidence to support a cut of 5% was "of very low quality," a recent review said

WHO may advise halving dietary sugar intake to 5% to combat tooth decay

Nigel Hawkes LONDON

The World Health Organization may recommend halving the level of sugar in the diet, prompted by a review of the link between sugar consumption and tooth decay.[1]

The present WHO guidelines say that sugar should not exceed 10% of dietary energy—but the review, led by Paula Moynihan of the WHO Collaborating Centre for Nutrition and Oral Health at Newcastle University, found evidence that a lower limit of 5% may be justified to reduce the risk of caries.

A WHO spokesman confirmed that new guidelines were being drafted but could give no information on timing. Public consultation would be sought when the draft guidelines are published by the WHO Nutrition Guidance Expert Advisory Group, he said.

The sugar industry is expected to strongly oppose any change to the existing WHO guideline, which was set out in 2003. The WHO advisory group had originally planned to finalise its recommendations on sugar intake in relation to weight gain and dental caries at a meeting in March 2013, and it did not expect any change.

A review published in the *BMJ* in January 2013 by Jim Mann and colleagues from Otago University in New Zealand concluded that sugar consumption had a small but significant effect on weight gain.[2] It said that the existing 10% guideline was compatible with the evidence from cohort studies and made no recommendation to reduce it.

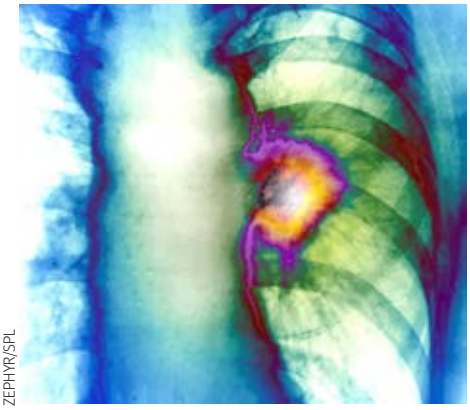
The December publication of the Moynihan review in the *Journal of Dental Research* has reportedly prompted a rethink, or at least a delay in publishing the draft guideline. The review concluded that there was evidence "of moderate quality" to support the 10% guideline and some evidence, "albeit classified of very low quality," to indicate the benefits of a reduction to 5%.

The review looked at evidence regarding the amount of sugar consumed and not the frequency of consumption, which earlier research had shown to be more important. The reason for this, it explained, was to help WHO establish recommendations on the basis of the amount consumed, not the frequency of consumption.

The review found no randomised controlled trials; the only evidence backing the call for a lower limit was three Japanese population surveys, published in 1959 and 1960, showing lower dental decay in children who consumed less than 5% of their dietary energy in the form of sugar.

A commentary on the NHS Choices website concluded that, such was the quality of the evidence, it was "debatable" whether current advice would be altered.[3] All three studies were in populations with low fluoride exposure.

Cite this as: *BMJ* 2014;348:g21



ZEPHYR/SPL

The study was criticised for including in its modelling people up to 80 years old

cancer based on age, total cumulative exposure to tobacco smoke, and years since quitting."

Under the US Affordable Care Act 2013 the panel's "B" grade means that private health plans, but not Medicare, must cover low dose computed tomography screening for these patients at no additional cost. It is estimated that about seven million US residents aged 55 to 75 years have smoked for 30 or more pack-years (a pack-year is packs smoked a day multiplied by the number of years of smoking).

Current evidence does not support screening lower risk patients for whom the harms of screening may outweigh the benefits, the panel said. "It is important that persons who are at lower risk for lung cancer be aware of the potential harms of screening," it said.

Smoking is thought to be responsible for 85% of cases of lung cancer diagnosed in the US. Prognosis is poor, with nearly 90% of patients dying of the disease. There are about 160 000 lung cancer deaths in the United States each year, making the disease the nation's leading cause of death from cancer.

Lung cancer patients have one of the lowest five year survival rates among cancer patients, at 17%. Among those whose cancer is diagnosed at an early stage five year survival is far better, at 52%—but currently only 15% of cases are diagnosed at an early stage, the panel noted.

Using modelling studies the panel estimated that screening high risk smokers from ages 55 to 80 with low dose computed tomography would cut lung cancer mortality by 14%—or an estimated 521 fewer lung cancer deaths per 100 000 people.[2]

In an accompanying editorial Peter B Bach of Memorial Sloan-Kettering Cancer Center questioned the panel's decision to increase the upper age of eligibility for its modelling studies to 80 years—well beyond the limit of 74 years used in the National Lung Screening Trial, on which much of the analysis was based.[3 4]

Cite this as: *BMJ* 2014;348:g56

Plastic surgeon is struck off for errors

Clare Dyer BMJ

A plastic surgeon who worked at a private clinic in Liverpool has been struck off for a catalogue of surgical errors that left patients disfigured or in need of repair by other surgeons.

Olufemi Adeyinka Adeogba also repeatedly failed to record adequate medical histories, to obtain informed consent, to take before and after photographs, and to deal with patients' concerns over poor outcomes.

Adeogba, who qualified in Germany in 1979, was found to have provided deficient care in four breast procedures and two rhinoplasties between March 2008 and August 2010.

One rhinoplasty resulted in a "major and catastrophic" complication, and the patient told the General Medical Council that she was left with a hole at the end of her nose. A second operation on the patient by Adeogba was unsuccessful, and a third operation by a different surgeon was needed.

The Birkdale Clinic in Liverpool, which employed him, offered internet discounts in May 2011. One web advertisement said, "Birkdale Clinic, a quality care commission approved facility, offers the reputable and caring skills of Dr Olufemi Adeyinka Adeogba who is a consultant plastic surgeon specialising in an array of cosmetic surgery procedures and registered with the General Medical Council… GroupOn grippers [users of the online discount website GroupOn] are offered £5000 towards a procedure of their choice for £1999."

A Liverpool plastic surgeon, Kevin Hancock, told the *Liverpool Echo* that the offer was "belittling the risk as well as the profession."

A spokesman for GroupOn.co.uk told the *Liverpool Echo* that "this deal went through considerable checks and considerations—above and beyond our already high standards of quality assurance."

The Medical Practitioners Tribunal Service panel that struck off Adeogba expressed particular concern about his poor procedures for obtaining patient consent. He failed to mention several possible risks and complications, did not give written information, and in some cases had struck out with a pen risks mentioned by the surgical pro forma. He ignored guidance requiring a minimum 14 day "cooling-off" period after an initial consultation.

Patients described Adeogba as considerate and reassuring before surgery but arrogant and unhelpful once complications arose. When one patient asked him after surgery why she had a plaster on her breast, he claimed to have no idea, though the record showed that she had been burned during the operation.

He told another patient that rhinoplasties almost always required a repeat procedure, when in fact even a 20% revision rate is considered unacceptable. Another patient was left with disfigured breasts after he placed implants too low. He told her to wear a supportive bra and did not offer repair, which was eventually done by another surgeon.

Adeogba did not attend his hearing and stopped replying to GMC correspondence in early 2012. "In the absence of insight and remediation," said the panel's chairman, Malcolm Phillips, "Dr Adeogba continues to present a risk to patients… Erasure from the medical register is the only means of protecting patients and the public interest."

The New Birkdale Clinic says it has had a complete change of staff in the past year.

Cite this as: *BMJ* 2014;348:g53

Medicare slashes payment for BRCA test

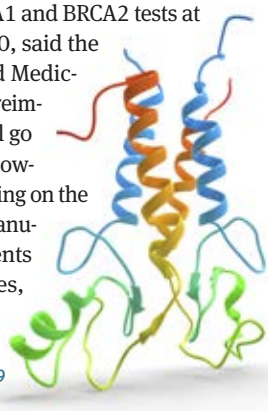
Michael McCarthy SEATTLE

Medicare, the US health insurance plan for elderly and disabled people, will halve its maximum reimbursement for the BRCA1 and BRCA2 breast cancer gene tests to $1440, down from the maximum of $2795 it paid in 2013, the US Centers for Medicare and Medicaid Services announced on 27 December.

The decision came after the US Supreme Court ruled unanimously last June that naturally occurring DNA segments could not be patented.[1] That case involved a challenge to the patent claims of Myriad Genetics, a company based in Salt Lake City, Utah, that held patents on the BRCA1 and BRCA2 genes and used those patents to prevent competitors from producing tests that might challenge its lucrative screening business.

The court found that although the company had discovered the location and genetic sequence of the BRCA1 and BRCA2 genes, it had not created something new that warranted patent protection.

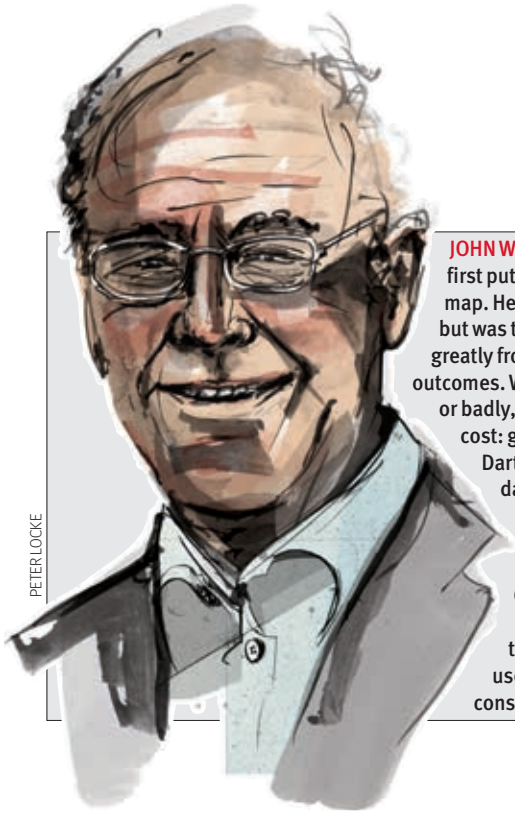
Since the court's ruling, several companies have begun offering BRCA1 and BRCA2 tests at between $900 and $2900, said the Centers for Medicare and Medicaid Services. The centers' reimbursement maximum will go into effect on 1 January. However, the agency is consulting on the new pricing rule until 27 January. Should those comments lead to a change in prices, those prices will take effect on 1 April 2014.



Cite this as: *BMJ* 2013;347:f7709

John Wennberg

Tenacious, optimistic, sceptical



PETER LOCKE

JOHN WENNBERG is a US epidemiologist who first put unwarranted variation on the medical map. He showed what is now a commonplace but was then a surprise: that medical care varies greatly from place to place in cost, quality, and outcomes. Where you live determines how well, or badly, you are treated and how much it will cost: geography is destiny. He founded the Dartmouth Atlas of Health Care (www.dartmouthatlas.org) to document these variations, thereby helping to transform the understanding of medical practice in the United States. One solution, he says, is for patients to be far more involved in decisions about their care. Another is to limit overall use of healthcare through budgeting or constraints on capacity.

What is your guiltiest pleasure?
"Showing doctors at Harvard, Yale, and the University of California how much their utilisation rates varied"

What was your earliest ambition?
To become a mountaineer, ski bum, forester, pastor, philosopher, linguist of the Germanic languages, and sociologist. None of these worked out, so I went to medical school.

Who has been your biggest inspiration?
Kerr White, viewed by many as the father of health services research, who taught me to be sceptical and to use the tools of epidemiology to understand the healthcare system. At the time I learnt from him he was professor at Johns Hopkins School of Hygiene and chairman of its Department of Health Care Organization, which he founded.

What was the worst mistake in your career?
My early assumption, picked up in medical school and as a resident, that healthcare delivery was based on sound science.

What was your best career move?
My first job! As director of a well funded regional planning programme at the University of Vermont I worked with Alan Gittelsohn (who had taught me statistics at Johns Hopkins) to develop our method for small area analysis. This uncovered the remarkable differences in healthcare delivery among Vermont communities—and led directly to my career long interest in understanding variation in medical practice.

What book should every doctor read?
My *Tracking Medicine*,* of course.

Bevan or Lansley? Who's been the best and the worst health secretary in your lifetime?
Bevan changed history, and for the better. The effects of Andrew Lansley's policies have yet to be assessed, but I hope the pursuit of "competition" doesn't end up with an NHS that looks more and more like US care.

Who is the person you would most like to thank and why?
Egmont Norregard Wennberg (my dad). He was kind and generous, taught the importance of family, and helped my wife, Corky, become a successful artist.

If you were given £1m what would you spend it on?
Micro-grants to fund innovation in healthcare delivery in developing countries that do not assume that the pathway to better health is more Western-style medicine.

Where are or were you happiest?
With my family, especially when we are in our cabin in western Wyoming.

What single unheralded change has made the most difference in your field in your lifetime?
The relentless increase in the proportion of gross domestic product invested in healthcare has reached the point where the study of practice variations and the influence of physicians and medical capacity on demand for healthcare is an international priority.

Do you believe in doctor assisted suicide?
The real question is whether doctor assisted suicide will play a significant role in helping patients achieve the care they want at the end of life. In Oregon, where enabling patients' preference for end of life care has been widely discussed, the answer appears to be yes, but elsewhere the debate over end of life care seems to be stuck on the assumption that more is better.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Ode to Joy (in Schiller's German, please).

What is your guiltiest pleasure?
Showing doctors at Harvard, Yale, and the University of California how much their utilisation rates varied.

What is your most treasured possession?
If I can count my family as a possession, then the answer is easy.

What personal ambition do you still have?
Among the wide variation in medical practice, to learn which rate is right.

Summarise your personality in three words
Tenacious, optimistic, sceptical.

Where does alcohol fit into your life?
Nicely at the right time of day and with the right company.

What is your pet hate?
Waiting for an obvious answer to an uninteresting question.

What would be on the menu for your last supper?
Not sure I would have an appetite for a last supper.

Do you have any regrets about becoming a doctor?
None whatsoever. After the pain of getting there, the door opened to many interesting things.

**Tracking Medicine: A Researcher's Quest to Understand Health Care* (ISBN-13 978-0199731787)

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