NEWS

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Switch to diesel engines is significantly to blame for poor air quality in UK cities

WHO declares polio a public health emergency

Anne Gulland LONDON

The World Health Organization has declared the spread of polio a global public health emergency, which, if left unchecked, could derail efforts to eradicate the disease.[1]

The 14 members of WHO's international health regulations emergency committee met at the end of April alongside representatives from the nine states where wild poliovirus has been found in the past 12 months: Afghanistan, Cameroon, Equatorial Guinea, Ethiopia, Israel, Nigeria, Pakistan, Somalia, and Syria.

The committee presented its findings to Margaret Chan, WHO's director general, informing her that the cross border spread of wild poliovirus in 2014 was an "extraordinary event." On 5 May Chan declared the situation a global public health emergency under international health regulations. The last such declaration was made in 2009 over the H1N1 influenza pandemic.

Bruce Aylward, WHO's assistant director general for polio eradication and emergencies, told a press conference that about two thirds of cases of wild poliovirus seen this year were caused by the international spread of the virus and that evidence showed that adult travellers were contributing to this spread.

The virus has spread from Pakistan to Afghanistan, from Syria to Iraq, and from Cameroon to Equatorial Guinea, which is also battling an outbreak of the Ebola virus.

There have been 74 cases of type 1 poliovirus reported so far in 2014, compared with 24 for the same period in 2013.

Pakistan has tightened security for its vaccine workers (above) following several murders of staff

GETTY IMAGES

Pakistan reported 59 of the 74 cases, four cases occurred in Afghanistan, and three occurred in each of Cameroon and Equatorial Guinea. Nigeria has reported two cases, and Iraq, Syria, and Ethiopia each reported one case.

Somalia had 194 cases of the disease in 2013, the last case being reported on 20 December. Wild poliovirus has been found in sewage in Israel, but no human cases have been reported.

WHO declared that the three countries exporting the virus—Pakistan, Cameroon, and Syria—posed the greatest risk, and it said that these states should take a number of measures, including ensuring that all residents and long term visitors receive a dose of oral polio vaccine (OPV) or inactivated polio vaccine (IPV) between four weeks and 12 months before international travel and that they carry an international certificate of vaccination or prophylaxis.

Cite this as: *BMJ* 2014;348:g3124

Commissioners in Bristol face legal challenge for failing to involve patients

Zosia Kmietowicz BMJ

A clinical commissioning group (CCG) in southwest England is the first in the country to face a legal challenge for failing to consult patients and the public about proposed changes to the services for which it is responsible.

Protect Our NHS, a web based group that monitors changes to health services in Bristol, north Somerset, and south Gloucestershire, has applied for a judicial review into how Bristol CCG is operating.

It says that the CCG's procurement policy is illegal because it does not state that patients will be consulted at all stages of the decision making process to purchase new services. It is a legal requirement to consult the public about planned changes to services under the 2012 Health and Social Care Act.

Bristol CCG controls a budget of £500m. Protect Our NHS is concerned that part of that sum will be spent on services from private companies and says it is vital that the public has a chance to comment on the proposals.

Rosa Curling, a solicitor at the firm Leigh Day, which is representing the action, said that the CCG had responded to an earlier letter about the omissions in the policy by saying that it would make arrangements to consult the public when it considered that this was necessary. However, Curling said that this approach to public consultation "was not good enough."

She said, "The law is very clear on this. CCGs have a legal duty to put in place arrangements that if they are making decisions that affect services and who is providing those services then they must consult the public.

"Patients' voices are crucial. CCGs have to recognise that involving and listening to what patients think has to be integral to everything that they do."

Bristol CCG has said that it would fight the claim. It said in a statement, "Our [procurement] policy is robust and we are active in engaging and involving local people and organisations."

Cite this as: *BMJ* 2014;348:g3110

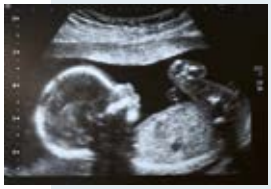
IN BRIEF

London NHS trust tests critical care patients for HIV: Barts Health NHS Trust, which has six hospitals in London, is to test patients in critical care units for HIV in an effort to ensure early diagnosis. The move follows a successful pilot at the Royal London Hospital in which all patients in the adult critical care unit were offered a blood test for HIV. Of the 899 patients, 465 (52%) agreed to the test, three of whom tested positive and have now started treatment.

High levels of scarlet fever remain across England: Public Health England has reported a continuing high incidence of scarlet fever across the country, with 405 new cases reported from 21 to 27 April. A total of 8305 new cases have now been reported since the season began in September 2013. An average of 1982 cases of scarlet fever were reported in the same period (September to April) in the previous 10 seasons.

Measures to combat illicit drug trade must be evidence based: A new report from the London School of Economics has called for governments to direct resources for controlling the illicit drug trade towards effective, evidence based policies that are underpinned by rigorous economic analysis.[1] The report, which is backed by five Nobel prize winning economists, says that regressive drugs laws cost billions and don't work.

Tennessee criminalises drug use in pregnancy that harms baby: Tennessee has become the first US state to pass a law that allows prosecutors to charge a woman with criminal assault if she uses illegal drugs during her pregnancy and her fetus or newborn is considered harmed as a result.



The Republican governor, Bill Haslam, ignored the advice of doctors, experts on addiction, and reproductive health groups urging him to veto the measure. Opponents are concerned about the lack of addiction treatment facilities.

Governments urged to do more to protect doctors in conflict zones: Margaret Mungherera, president of the World Medical Association, has made a plea for health professionals and medical facilities to be protected in times of armed conflict. She referred to Nigeria, Syria, Ukraine, and other countries where doctors and other health professionals had been killed or injured in fighting and where hospitals and other health facilities had been destroyed.

Cite this as: *BMJ* 2014;348:g3113

Two thirds of deaths from asthma are preventable, confidential inquiry finds

Ingrid Torjesen LONDON

Two in three deaths from asthma could be prevented by better management of the condition, including personal asthma plans for patients, timely reviews of asthma care, and the prescription of more appropriate drugs, says the first confidential inquiry into asthma by the Royal College of Physicians.[1]

The inquiry looked in depth at the circumstances surrounding 195 asthma deaths in the UK in the 12 months from February 2012. The reviewers identified primary care failings in the routine care of 70% of the deaths studied: in 59% of deaths asthma guidelines were not fully adhered to, and in 47% of deaths avoidable factors were evident in prescribing.

Mark Levy, a GP and the Royal College of Physicians' clinical lead for the National Review of Asthma Deaths, said, "We identified major avoidable factors in two thirds of those who died, so it is fair to say that at least two thirds of the deaths could have been avoided."

Kay Boycott, chief executive of Asthma UK, said, "Parents of children with asthma will be especially horrified that the confidential inquiry showed that children fared worse than adults in multiple aspects of care." Of the deaths investigated, 28 occurred in children and young people aged under 20.

The inquiry, commissioned by the Healthcare Quality

Acute heart failure patients should be seen by specialist teams—NICE

Jacqui Wise LONDON

All hospitals admitting patients with suspected acute heart failure should provide a specialist heart failure service based on a cardiology ward, say new draft guidelines from the National Institute for Health and Care Excellence (NICE).[1]

There are over 67 000 admissions for acute heart failure in England and Wales each year, and it is the leading cause of hospital admission in people aged 65 and over. Current practice is not standardised across hospitals, however. Patients with suspected acute heart failure are usually admitted through emergency departments, and those who are very sick go to intensive care units, high dependency units, or coronary care units, while the rest are admitted to general medical wards or cardiology wards.

Mark Baker, director of the Centre for Clinical Practice at NICE, said, "The treatment patients with acute heart failure receive, and how successful that treatment is, differs depending on the unit they were admitted to. We would like to see all patients who are admitted to hospital with suspected acute heart failure seen by specialists through a dedicated service, regardless of the configuration of the hospital."

The draft guidelines also recommended that the cardiac biomarkers BNP (B-type natriuretic peptide) and NT-proBNP (N-terminal pro-B-type natriuretic peptide) should be measured if acute heart failure is suspected. Normal results would rule out a diagnosis of heart failure, whereas higher levels of these markers are often associated with a worse prognosis.

They said that transthoracic Doppler cross sectional echocardiography should be performed in people with higher than normal natriuretic peptide levels. This should occur within 48 hours of admission to enable early specialist management.

The draft guidelines are now released for consultation, and the final version is expected to be published in September.

Cite this as: *BMJ* 2014;348:g3072

Improvement Partnership, found that during a fatal asthma attack 45% of patients had not called for or obtained help, suggesting that they were not aware of how ill they were until it was too late. In addition, 70% of children and 83% of those aged 10 to 19 died before they reached hospital.

Levy said, "It might be that many of these cases were complacent about their asthma, and we feel that the majority of these people did not know what to do: they did not recognise the danger signs and did not know how or when to call for help." Only 23% of patients who died had received a personalised asthma action plan, which would have provided this information.

The inquiry's report showed that many of the patients who died were undertreated. Where the condition's severity was recorded it was categorised as severe in only 39% of patients. The report, *Why Asthma Still Kills*,[1] said, "It is likely that many patients treated as having either mild or moderate disease asthma had poorly controlled undertreated asthma," adding that this was evident from the drugs prescribed to patients.

Of the patients who had died 39% had had at least 12 short acting reliever inhalers prescribed in the previous year and 4% had had more than 50. Inhaled corticosteroids to help prevent attacks had been prescribed to 86% of those who died, but 80% received fewer than 12 prescriptions a year and 38% fewer than four. "To comply with recommendations most patients would usually require at least 12 preventer prescriptions per year," the report noted.

There was no evidence of any asthma review in primary care during the past year in 43% of the deaths reviewed by the inquiry.

And when uncontrolled symptoms had led patients to seek help these warning signs had not been acted on. Asthma attacks had led 21% of those who died to attend an emergency department in the previous 12 months, and more than half of those had done so more than once. One in 10 patients died within 28 days of leaving after treatment for asthma.

The inquiry recommended an electronic surveillance system "as a matter of urgency" to alert doctors to poorly controlled asthma, through excess prescription of reliever medication or insufficient prescription of preventer medication.

Cite this as: *BMJ* 2014;348:g3108

Many of those who died were complacent about their asthma and most did not recognise the danger signs or know how or when to call for help, said GP Mark Levy

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Plan for minimum price on a unit of alcohol in Scotland is delayed again

Bryan Christie EDINBURGH

Plans to introduce a minimum price for a unit of alcohol in Scotland have hit another hurdle, after a legal challenge has been referred to the Court of Justice of the European Union.

It is now almost two years since the Scottish parliament passed legislation to introduce the measure, but it has been consistently opposed by the Scotch Whisky Association, which argues that it is uncompetitive and breaches European law.

The Court of Session in Edinburgh has now decided to refer the matter to the European court in Luxembourg in a move that could delay potential implementation by up to two years. The Scottish government wants to introduce minimum pricing to reduce the harm caused by excessive drinking.

Scotch Whisky Association has challenged the policy

Health campaigners applauded a decision by the Court of Session last year that minimum pricing was legal and compatible with European law, in a move that brought introduction a step closer.[1] However, the Scotch Whisky Association appealed, and the Scottish judges have now decided to ask the European court for a preliminary ruling on whether or not the proposals are valid under European Union law.

Ian Gilmore, chairman of the Alcohol Health Alliance UK, said he was disappointed by the delay. "Minimum unit pricing is the fairest and most targeted way of helping those most at risk of damage to their health: young people and the heaviest drinkers. It will have a significant effect on the health of the population of Scotland—we can only hope that such a delay does not last too long."

Scotland's health minister, Alex Neil, heard the news of the delay while in Brussels where he was putting the case for a minimum price. "While it is regrettable that this means we will not be able to implement minimum unit pricing sooner, we will continue our ongoing and productive dialogue with EU officials," he said.

Cite this as: *BMJ* 2014;348:g3054

Parity of esteem between mental and physical healthcare is being ignored

Matthew Limb LONDON

Experts have warned that "discriminatory" funding cuts are damaging mental healthcare in England.

Sue Bailey, president of the Royal College of Psychiatrists, speaking at a conference in London on Tuesday 29 April organised by the Westminster Health Forum, denounced new changes to tariffs that differentially affect mental and physical health services.

She was referring to an announcement earlier this year by NHS England and Monitor that recommended smaller cuts in the tariff for acute care trusts than for other types of trust in 2014-15.[1] The healthcare bodies argued that hospitals would incur "extra" costs to implement recommendations for safety made by Robert Francis QC, including recruiting more staff.

The tariff "deflator" decision has been widely opposed by leading mental health bodies, including the Royal College of Psychiatrists. They protested that the 1.5% cut in tariff proposed for hospitals, compared with a 1.8% cut for non-acute care services including community and mental healthcare, was discriminatory.

Sue Bailey: the cuts run counter to NHS England's commitment

Bailey said signs showed that most clinical commissioning groups were already implementing the 1.8% cut for mental healthcare, even though NHS England had reportedly told the groups to use their discretion in applying it. The findings were confirmed by a recent survey of mental health medical directors by the college.

Addressing the conference, Bailey urged the new head of NHS England, Simon Stevens, to change the tariff decision and issue fresh guidance. She said that it ran counter to NHS England's commitments to give mental healthcare "parity of esteem" with all other parts of the NHS.

Sohrab Panday, a general practitioner who co-chairs a working group for NHS England on parity of esteem, told the conference that health service staff should "whistleblow" and oppose a decision that was "going in the wrong direction," as it would mean that funding cuts to mental healthcare were greater than those for physical healthcare.

Cite this as: *BMJ* 2014;348:g3053

UK spending on health is lowest of all G7 countries except Italy

Gareth Iacobucci BMJ

The United Kingdom is spending less on healthcare as a share of its gross domestic product than all other G7 countries apart from Italy, which spends the same, new figures have shown.

The figures from the Office for National Statistics (ONS) show that the UK's total expenditure on healthcare in 2012 was £144.5bn, 9.2% of GDP.[1]

The largest portion of this (£121.3bn or 7.7% of GDP) came from the public purse. The remaining £23.2bn was from private sources, including individual spending on healthcare, private health insurance, and private sector capital.

As a proportion of GDP, healthcare spending was 17.7% in the United States, 11.6% in France, 11.3% in Germany, 11.2% in Canada, 9.6% in Japan, and around 9.2% in Italy.

Although growth in healthcare spending in the UK was strong from 1997 to 2009—with an average annual growth rate of 8%, growth has slowed since 2009 to an average of 1.6% a year.

The ONS analysis also shows that private healthcare expenditure fell by 1.4% from 2011 to 2012 while public healthcare expenditure rose by 2.5%.

The figures come as a report from the health think tank the King's Fund forecasted that NHS spending as a proportion of GDP would fall to 6.1% by 2021, its lowest level since 2003.[2]

Cite this as: *BMJ* 2014;348:g3063

Simon Stevens said he did not want a "one size fits all" solution for clinical commissioning groups

will complete their initial five year "forward views" for local NHS services.

Each proposal will be discussed by the applicant CCG and the local area team of NHS England, which will subsequently make a recommendation for approval by the board of NHS England.

Cite this as: *BMJ* 2014;348:g3086

Financial crisis is inevitable in the NHS by 2015-16, King's Fund says

Gareth Iacobucci BMJ

A significant increase in NHS funding is needed to halt a looming financial crisis that will lead to "damaging consequences" for patient care, the King's Fund has warned.

The NHS Productivity Challenge: Experience from the Front Line,[1] a new report published by the healthcare think tank on 1 May, argued that a financial crisis was "now inevitable by 2015-16 and could arrive sooner," with more than a quarter of NHS trusts already in deficit.

The fund said that drastic action was required in order to deal with the crisis, and it called for honesty from all political parties about the scale of the challenge.

The report—based partly on detailed research carried out on six NHS trusts—said that opportunities existed to improve efficiency in the health service by focusing on areas such as improving procurement and changing clinical practice.

But it warned that the main methods used so far to reduce costs, such as pay freezes for staff and reductions in management costs, "have now almost been exhausted."

The think tank also echoed a warning in its most recent quarterly report[2] that pressure on the NHS budget would be exacerbated by introducing the Better Care Fund in 2015-16, which would divert a further £1.8bn of NHS funding to local government to support shared working with social care. On current projections NHS spending as a proportion of gross domestic product will fall to 6% by 2021, its lowest level since 2003.

But although the report called for new funding for the NHS it said that this should not be used to maintain the status quo or to "disguise the need for change by propping up unsustainable services."

Instead, the fund said that new funding should be used for two key purposes: firstly, to set up a transformation fund to meet the costs of service changes and invest in developing new models of care outside hospitals; and secondly, to provide emergency temporary support for "otherwise sound NHS organisations experiencing difficulties as a result of the unprecedented pressures on their budgets."

Barts' Hospital, London, was facing a projected deficit of £38.3m at the end of March

The report also identified key mechanisms for achieving greater efficiency. These included a stronger national focus on collecting and sharing good practice to improve efficiency; more emphasis on encouraging clinicians and frontline staff to identify and lead changes in clinical practice; stronger regional leadership to plan and implement large scale service change; and a more sophisticated approach to paying hospitals and incentivising NHS organisations.

John Appleby, chief economist at the King's Fund and the lead author of the report, said, "There is still scope to improve efficiency in the health service, and efforts to release savings should be redoubled. However, it is now a question of when, not if, the NHS runs out of money. Without significant additional funding, this will lead to rising waiting times, cuts in staff, and deteriorating quality of care."

EDITORIAL, p 9

Cite this as: *BMJ* 2014;348:g3048

CORRECTION Doctor is not to blame for baby left brain damaged

We printed the wrong photo to this News story (*BMJ* 2014;348:g2970, print publication 3 May, p 5). The picture was of Nicholas Phillips (Lord Phillips of Worth Matravers), and should have been of Stephen Phillips. The confusion arose because in the story the judge was simply referred to as Mr Justice Phillips. The present Mr Justice Phillips is Stephen Phillips, but before Lord Phillips was made a lord he used to be referred to as Mr Justice Phillips.

GETTY IMAGES

ALAMY

Since 2000 the number of GPs in England has risen by 21% while consultant numbers have risen by 76%

Ratio of GPs to hospital consultants may need to shift, says new NHS chief

Adrian O'Dowd LONDON

Workforce numbers among general practitioners have not risen as quickly as those of hospital consultants despite a shift in the NHS to provide more care outside hospitals, the new head of the NHS in England has said.

Simon Stevens, chief executive of NHS England, who appeared before MPs on the parliamentary health select committee on 29 April, said that he intended to deal with the issue of GP workforce shortages soon. He also said that he expected health spending to rise between now and 2021 as long as the United Kingdom's economy grew in that time.

As part of their inquiry into the work of NHS England, MPs asked about workforce issues in primary care. These included many GPs being due to retire soon, shortages in newly recruited doctors, and growing workloads.

Stevens, making his first appearance before the committee since he took on his new role at the start of April, said, "GPs are working incredibly hard and are under pressure as a consequence.

"There has been a 21% increase in the number of GPs since 2000 but that is a far smaller proportionate increase than the increase in the number of consultants in hospitals, which has been more like 76%.

"There's an interesting question as to whether we've got the balance out of kilter there, and, if we have, then what are we going to do about it? One of the answers is to enable CCGs [clinical commissioning groups] to have more impact over the decisions that are made about spending in primary care services." Stevens said that he would make an announcement on this subject soon (see below).

MPs asked whether the NHS was facing more years of stagnant funding, to which Stevens replied, "There is no doubt that since we are now in year five of the longest squeeze on NHS finances that there has been in our 65 year history, times are tough.

"There is recognition that the NHS has been in some ways fortunate to have been shielded from some of the impacts that people in local government and elsewhere have had to take as a result of the broader economic situation.

"Equally, it's clear that for the last two or three years, an incredible effort has been put in and that has ensured that standards of care have for the most part remained very high. That is the result of a lot of goodwill and sacrifice on the part of frontline NHS staff who have maintained significant pride and commitment to the services that they are responsible for."

Stevens said that over the next 180 days he would have discussions with national bodies, CCGs, and local government partners to try to answer what the NHS could do to further contribute to "putting itself on a sustainable footing." He said that he would report back in the autumn.

MPs asked whether the quality of care and the breadth of services currently on offer could be maintained without additional funding for the NHS.

"There are significant uncertainties about how well the economy will be doing [by 2021] but it is clear that, for the NHS to thrive, the British economy has to do well," he replied.

"If it is the case that strong economic growth returns, then for medical, economic, and social reasons, most independent commentators would predict that the nation will be spending more in real terms on healthcare by 2021 than it is now."

Cite this as: *BMJ* 2014;348:g3037

GPs will be allowed to jointly commission primary care, NHS chief says

Annabel Ferriman BMJ

Clinical commissioning groups (CCGs) in England will get new powers under an initiative announced this week by Simon Stevens, the new chief executive of NHS England.

He told the annual conference of NHS Clinical Commissioners, the membership organisation of CCGs, that he would be writing to CCGs next week with details of how they could submit expressions of interest in taking on enhanced powers to jointly commission primary care services with NHS England.

CCGs would need to show how they would ensure transparent and fair governance, while NHS England would continue to have an oversight role to safeguard against conflicts of interest, he said. But he added that worries over possible conflicts of interests could not be allowed to stand in the way of this development.

Speaking to GPs and other NHS health professionals at the conference in London, Stevens said, "England has now taken the bold step—unique in the Western world—of putting two thirds of its health service funding under the control of local family doctors and clinicians.

"If we want to better integrate care outside hospitals and properly resource primary, community, and mental health services—at a time when overall funding is inevitably constrained—we need to make it easier for patients, local communities, and local clinicians to exercise more clout over how services are developed. That means giving local CCGs greater influence over the way NHS funding is being invested for their local populations. As well as new models for primary care, we will be taking a hard look at how CCGs can have more impact on NHS England's specialised commissioning activities.

"So today I am inviting those CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path.

"CCGs are still young organisations at different stages of development and with different local needs. So rather than specifying a 'one size fits all' solution, and having listened carefully to what CCGs have been saying, I'm keen to hear from CCGs themselves about what next steps they would like to explore."

He said he would soon be providing details of how CCGs could submit expressions of interest in taking on enhanced commissioning powers and responsibilities.

CCGs' expressions of interest should be developed by 20 June, the same date that the groups

HARAZ GHANBARI/PA

Sabaratnam Arulkumaran
Dreaming of entering politics

PETER LOCKE

SABARATNAM ARULKUMARAN, president of the British Medical Association, is professor emeritus of obstetrics and gynaecology at St George's, University of London. Born and educated in Sri Lanka, he has divided his senior career between the United Kingdom and Singapore. At St George's from 2001 he reorganised and improved education, research, and clinical services—skills that led to key advisory posts for the UK and Irish governments. He has written 32 books and many articles and is president of the International Federation Gynaecology and Obstetrics.

Where are or were you happiest?
"I was surprised and overjoyed when I got a letter from the prime minister in May 2009, asking whether I would accept the appointment of Knight Bachelor for services to medicine and healthcare."

What was your earliest ambition?
To be a pilot; the uniform and the leadership qualities in the advertisements attracted me. My ambitions kept changing, and after entering medicine I wanted to be a GP or an anatomy demonstrator. During my clinical years I wanted to be a consultant, and as a specialty trainee I wanted to be an academic.

Who has been your biggest inspiration?
My parents, who taught me to respect and help others. Their words were "I would rather hear from others that our son is a postal peon [postman] but a good man, than a hospital consultant but a nasty man."

What was the worst mistake in your career?
In my first three months of doing O&G [obstetrics and gynaecology] in Sri Lanka in the early 1970s I managed a case of mitral stenosis in cardiac failure with medication. I did not know that urgent valvotomy could have saved the patient, although the facilities were not immediately available. She died within two hours of admission. From then on I tried to keep up my knowledge and skills and to ask my seniors when in doubt or needing help.

What was your best career move?
Moving to St George's, University of London, in 2001, to "revitalise" the O&G department. I asked the staff to speak well of each other and be proud of their achievements. I created opportunities for them to flourish in their field.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
The best was Bevan, for his foresight—"health is wealth, and all need it." To be politically correct, I think Lansley and others tried, but the financial climate was not conducive.

Who is the person you would most like to thank and why?
Lord Patel (Naren) for being my mentor and supporter, especially during my term as president of the Royal College of Obstetricians and Gynaecologists.

To whom would you most like to apologise?
My wife, Gayatri, for tolerating my obsession with work and letting me leave the family responsibilities with her. Her father was a well respected senior obstetrician in Sri Lanka, who was busy and worked day and night. This may have prepared her mentally to expect the same when she got married to an O&G specialist.

Where are or were you happiest?
I was surprised and overjoyed when I got a letter from the prime minister in May 2009, asking whether I would accept the appointment of Knight Bachelor for services to medicine and healthcare.

What single unheralded change has made the most difference in your field in your lifetime?
There were plenty—ultrasound, in vitro fertilisation, laparoscopy, etc—but embracing evidence based medicine has improved multi-professional team care for the benefit of patients.

Do you believe in doctor assisted suicide?
No, the misuse can be enormous.

What book should every doctor read?
There are several books one could recommend. For a busy doctor, a book that can be read in 30 minutes is *Who Moved my Cheese?* by Spencer Johnson. A short synopsis, in my words, is "do not whinge—get on with your work if you want your 'cheese.'"

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Hindu religious songs and verses that give calm and peace. I have found this soothing when I attend funerals.

What is your guiltiest pleasure?
Malt whisky, if I'm with good friends and don't need to travel after it. I like tasting different varieties, but Glenmorangie has a special place.

What is your most treasured possession?
My three children, in addition to my son in law and daughter in law.

What personal ambition do you still have?
To enter politics! It is a wild dream, but I think I can offer my services beyond medicine.

Summarise your personality in three words
Committed, considerate, and hardworking.

What is your pet hate?
My inability to say no to requests to give lectures, when friends ask me from all over the world.

If you weren't in your present role what would you be doing instead?
Humanitarian voluntary work—maybe in Sri Lanka, where I come from.

Cite this as: *BMJ* 2014;348:g3069