NEWS

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bmj.com
Choose and Book appointment service is to be replaced

General practice needs investment to provide more services, says BMA

Gareth Iacobucci BMJ

The BMA has launched a new campaign to lobby for greater investment in UK general practice and raise awareness of the "unprecedented strain" currently facing the service.

The Your GP Cares campaign[1] will highlight to patients how the pressures of escalating demand and a shortage of funding are affecting GP services and public access. It will urge politicians and policy makers to commit new investment to expand the overall number of GPs and practice staff and to improve premises, to enable surgeries to provide an enhanced range of services.

Launching the initiative this week, the BMA said that GPs were seeing a greater number of vulnerable patients and providing more care for those with chronic diseases in often inadequate premises despite receiving no extra funding.

The growing demand was leading to appointment delays and causing morale to plummet in the profession, said the BMA.

The launch comes after Simon Stevens, the new chief executive of NHS England, recently acknowledged the imbalance in workforce numbers that stemmed from an almost 76% increase in the number of hospital consultants since 2000, compared with just a 21% increase in the number of GPs in the same period.[2]

As well as calling for more resources, the BMA's campaign will aim to highlight the unique strengths of UK general practice and demonstrate the role that it can play in managing the growing pressure on the wider NHS.

Chaand Nagpaul, chairman of the BMA's GP committee, said, "The environment in which we work is becoming increasingly challenging. GPs across the country tell us that they are constantly firefighting to provide the services their patients need, leading to exhaustion and stress.

"All of this can have a detrimental effect on the services that practices can provide, leaving patients frustrated as more and more are left waiting for appointments. It is time we addressed these issues head on, which is why our campaign aims to bring to people's attention the true picture of general practice; and it calls for investment in GPs, practice staff, and premises so that we can deliver the care our patients deserve."

Cite this as: *BMJ* 2014;348:g3285

Care of dying review shows shortcomings in palliative care

Ingrid Torjesen LONDON

Most hospitals have not put in place some of the fundamental elements needed to help ensure a "good" death for patients, such as seven day access to specialist palliative care and mandatory training for staff caring for dying patients, an audit led by the Royal College of Physicians has found.

The audit was funded by Marie Curie Cancer Care and Public Health England, and its findings, published on 15 May, showed that just one in five hospitals (21%) had face to face palliative care services available seven days a week, despite a longstanding recommendation that they be provided.[1] Most hospitals (73%) provided face to face services on weekdays only.

Mandatory training in caring for dying patients was a requirement for doctors at only 19% of trusts and for nurses at only 28%. In the past year, 18% had provided no such training at all.

The audit's report, *The National Care of the Dying Audit for Hospitals*, recommended that hospitals should provide face to face specialist palliative care services at least from 9 am to 5 pm, seven days a week.[2]

To improve services the report said that a local audit of the care of dying patients—including assessing bereaved relatives' views—should be done at least annually. It added that trust boards should formally receive and discuss this local audit and should have a designated board member and a lay member with specific responsibility for the care of dying patients. Currently, only 53% of trusts had a board member with this responsibility. In the past year just 56% had carried out a formal audit.

Jane Collins, chief executive of Marie Curie Cancer Care, said, "There's only one chance to get people's care at the end of their lives right, but we know that our hospitals do not always provide the high quality care and dignified death that we all have the right to expect. The recommendations of the audit are clear. In particular, more needs to be done to improve governance, staff training, and access to pastoral and specialist palliative care teams."

The national audit, carried out by the Royal College, in collaboration with the Marie Curie Palliative Care Institute in Liverpool, assessed the quality of care given to 6580 people who had died in 149 hospitals in England between 1 and 31 May 2013, in cases where the death was expected.

The audit included a review of the case notes of a sample of patients; a questionnaire completed by 858 bereaved relatives or friends about the treatment of the patient, their involvement in decision making, and the support available to them; and details about the organisation of care, including the availability of palliative care services, staff numbers and training.

Cite this as: *BMJ* 2014;348:g3262

BURGER/PHANIE SARL/CORBIS

Only one in five dying patients capable of discussing their condition are asked about their spiritual needs

IN BRIEF

Only two in five people return bowel screening test kits regularly: A study of over 60 000 people in southern England aged 60-64 years found that 70% sent back at least one bowel screening test kit over six years but that only 44% sent back all three tests.[1] It also found that people from more deprived backgrounds were less likely to take part in bowel cancer screening than those from affluent backgrounds. Tests need to be done every two years to maximise the chance of detecting cancer.

NICE advises on nurse staffing levels: The risk of harm is higher on wards where a registered nurse cares for more than eight patients during the daytime on a regular basis, NICE has said in draft guidance. It recommends that the lead nurse consider any "red flag events" as indicators of the ward becoming in danger of being understaffed and allocate available nursing staff as needed. Hospital boards and senior managers should take greater responsibility for nurse staffing, said NICE.[2]

Midwife led units are best for most pregnant women: Women who are healthy and experiencing a straightforward pregnancy should be encouraged to give birth in a midwife led unit rather than a traditional labour ward, say draft proposals from NICE. The proposals also say that home birth may be just as safe as hospital for low risk pregnant women who have already had at least one child and that midwives should discuss all options with the women.[3]

MHRA warns about buying herbal medicines online: The UK Medicines and Healthcare Products Regulatory Agency is warning people not to use several herbal medicines that can be bought on the internet after they were found to contain undeclared ingredients. In one case the herbal medicine Shwasa Sanjeevani, used to treat the symptoms of asthma, was found to contain dexamethasone without it being declared on the label. Herbal slimming pills and a treatment for sexual dysfunction were also found to contain undeclared drugs.

Wales reaches its millionth registered organ donor: The number of registered organ donors in Wales is expected to reach a million for the first time this month — a third of the population. Despite the high registration rate, someone dies every 11 days in Wales while waiting for a suitable organ. From December 2015, anyone who has lived in Wales for more than 12 months will be considered as an organ donor unless they opt out.

Cite this as: *BMJ* 2014;348:g3277

JONATHAN BANKS/REX

Nigel Edwards (left) said plans produced by Jeremy Hunt (centre) and Eric Pickles were "wildly optimistic"

Government denies that introduction of Better Care Fund will be delayed

Nigel Hawkes LONDON

The future of the Better Care Fund is under discussion after a report that the Cabinet Office has ordered a review[1] and a damning criticism of the plans by a leading health policy analyst.

The fund, announced in June 2013, is designed to promote greater integration between health and social care by transferring money from NHS allocations in England to local authorities to create a £3.8bn fund. By producing better care in the community, the fund aims to save the money it will cost by reducing admissions to hospital.

The *Guardian* newspaper reported on 7 May that the plan had been delayed after a Cabinet Office review concluded it would not work, citing a lack of detail about how the savings would be generated. The paper said that the departments of health and communities and local government had been told to produce sufficient evidence to make the plan credible.

The Department of Health issued a statement saying: "Successive governments and leading health professionals have talked about joining up health and social care for decades— the Better Care Fund is a major step to making this a reality. We have set aside time to make sure all areas have developed comprehensive plans for joined up care. The Better Care plans start from April 2015, and we asked for early versions to be completed a year in advance so we could review them. This is what is happening now."

That seems to confirm that a review is taking place but also that it is all part of the original plan. The fund is supposed to start full operation in April 2015, but to prepare the ground NHS England sought to "build momentum" by using money already transferred from the NHS budget to local authorities to put two year plans in place by March this year. That left local NHS bodies and local authorities little time to come up with evidence that money could be saved by reducing admissions.

Nigel Edwards, chief executive of the Nuffield Trust, a health policy think tank, responded to the *Guardian*'s report by saying that the Better Care Fund was based on flawed logic and that the government was right to review it. "The fund assumes that hospitals can quickly achieve a 15% reduction in emergency admissions and that these reductions will result in savings in the same year, at full cost," he said. "But reducing admissions takes time, and lowering the types of admissions targeted by the Better Care Fund costs money. These assumptions are therefore wildly optimistic."

Cite this as: *BMJ* 2014;348:g3185

Waste in medical academia must be addressed, Chalmers urges at The BMJ Awards ceremony

Tom Moberly BMJ

Medical academia is wasting "massive" amounts of taxpayers' money, and the public must put it under pressure to change, Iain Chalmers told the audience at The BMJ Awards ceremony in London on 8 May.

At the event Chalmers was presented with the Lifetime Achievement award 2014, sponsored by GlaxoSmithKline (GSK). The ceremony took place at the Westminster Park Plaza Hotel, London, and the evening was hosted by the broadcaster Gyles Brandreth and sponsored by the Medical and Dental Defence Union of Scotland (MDDUS). Awards were also presented in another 12 categories.[1]

Chalmers said that his work had been motivated by the realisation that patients were suffering because clinicians had no ready access to research results that would change their practice. "Although things have improved some-

Newborn babies will be tested for more disorders

Nigel Hawkes LONDON

Four new genetic disorders will be added to those already screened for in newborn babies, the UK National Screening Committee has announced.

The decision followed a 12 month pilot study at six centres in England, which found 12 confirmed cases of these four rare conditions in just under 440 000 births, using blood samples taken from the "heel prick" blood test given to all newborns at 5 to 8 days of age.

The test is already used to screen for phenylketonuria, hypothyroidism, sickle cell disease, cystic fibrosis, and medium chain acyl-CoA dehydrogenase deficiency. To these five conditions four more will now be added: homocystinuria, maple syrup urine disease, glutaric aciduria type 1, and isovaleric acidaemia.

Babies will be tested for homocystinuria, maple syrup urine disease, glutaric aciduria type 1, and isovaleric acidaemia

CROZSTUDIOS/ALAMY

The study ran from July 2012 to July 2013, but screening for the four new conditions continued and the final reported total was 20 positive cases in more than 700 000 births. The study committee believed that a national extension was justified because early detection of these conditions would give the affected children a better chance of avoiding death or disability.

Jim Bonham, who led the pilot study and is director of newborn screening at Sheffield Children's NHS Foundation Trust, said, "This is fantastic news, and everyone who has been involved in the pilot should be really proud of the part they have played in this development.

"As a result of this study 20 children with serious but treatable disorders were discovered. We are delighted with the results because it shows how we can make an enormous difference for these children and their families—in some cases giving them the gift of life."

The pilot scheme included one further condition, long chain hydroxyacyl CoA dehydrogenase deficiency; but this was not recommended for national rollout because screening did not detect any cases that had not already been identified through clinical symptoms.

Cite this as: *BMJ* 2014;348:g3267

Women from Northern Ireland have no right to free abortions in England

Clare Dyer BMJ

England's health secretary, Jeremy Hunt, did not act unlawfully in failing to provide for women from Northern Ireland to have free abortions on the NHS in England, a High Court judge has ruled.

A teenager from the province, named only as A, and her mother argued that Hunt's failure to allow free abortions was perverse and discriminated against Northern Ireland women in exercising their human rights.

The girl was aged 15 in October 2012 when she had to pay £600 plus £300 travel costs for a termination at a Marie Stopes clinic in Manchester. She and her mother contended that Hunt should have made abortions available on the state for women who reside outside England in wider circumstances than at present.

Abortion law is much stricter in Northern Ireland than in England, and Mr Justice King said that the difference in law had led to a "steady stream" of women from Northern Ireland travelling to England to get a termination.

But the system of healthcare in the UK was largely based on residence, said the judge. "There can. . . be no objection in principle to a residence based system of qualification for, among others, abortion services, regardless of the particular sensitivities associated with abortion." He said that Hunt must be entitled to make the judgment that the needs of Northern Ireland residents for abortion services were not reasonable requirements that ought to be met by the NHS in England.

Cite this as: *BMJ* 2014;348:g3211

what, patients and clinicians still lack ready access to the results of research relevant to their decisions in healthcare, and that's unacceptable," he said.

"Medical academia has a great deal to answer for in this deficiency. Medical academia, I believe, is unduly complacent—complacent about the massive waste of resources provided by the public for the research that they do. This state of affairs is unlikely to change without public pressure, and I hope to play my part in fostering that pressure."

MARK THOMAS

Iain Chalmers holds his award from The BMJ

Presenting the award, Ben Goldacre, an open data campaigner, said that Chalmers had "spent his life shining a bright, and often very unflattering, light on the imperfections in evidence based medicine," fighting with an ire "proportionate to the scale of the problems."

Goldacre added, "There are huge numbers of patients who suffer and die unnecessarily because of our failure to perfect evidence based medicine. Iain fights with a fury and passion that is commensurate with the scale of that suffering. If there are those out there who fail to feel that in their belly, who think that these problems are too abstract and too irrelevant, then they are wrong—and Iain, as always, is right."

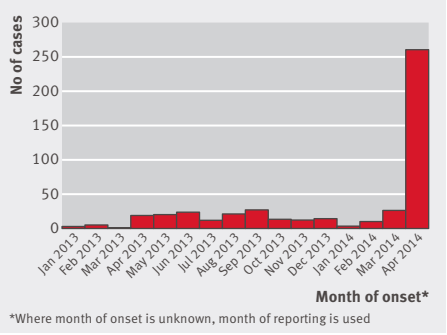
Chalmers commended GSK for being the first global company to sign up to the AllTrials campaign, "in contrast to the Academy of Medical Sciences, for example, which is still havering about whether it can support the principles of registering and publishing all trials." He also praised the work of *The BMJ* and its editor, Fiona Godlee. "I'm grateful to Fiona and *The BMJ* for being a beacon of moral leadership for a medical profession which is sorely in need of good moral leadership," he said.

Cite this as: *BMJ* 2014;348:g3235


Everyone who works with camels in Saudi Arabia has been advised to wear masks

FAYEZ NURELDINE/AFP/GETTY IMAGES

No of cases of MERS by month of onset*



*Where month of onset is unknown, month of reporting is used

ECDC

tion control standards in the Saudi hospitals she had visited were good. "There's no reason to believe that things would happen differently in a North American or European hospital."

A sharp rise in cases was also seen in April 2013, and the first known case of MERS-CoV occurred in March 2012. One theory links this phenomenon to the birthing of camels at this time of year. The dromedary camel has been identified as the main animal host, with almost all mature adults carrying antibodies. A camel MERS-CoV vaccine is currently under development and expected later this year.

A handful of April's reported cases involved direct contact with camels, while about three quarters were from person to person transmission. But in other new cases there was no reported exposure to either camels or infected people, suggesting a still unknown vector, possibly camel milk or meat products. Another, more alarming, explanation for the sudden surge in cases is that the virus has mutated to become more transmissible. But the one viral isolate so far sequenced from April showed no obvious changes that would suggest mutation.

Cite this as: *BMJ* 2014;348:g3186

Labour would divert £100m from NHS revamp into primary care

Zosia Kmietowicz BMJ

A Labour government would ensure that all patients could get an appointment at their GP surgery within 48 hours and see their doctor on the same day if necessary, the party leader, Ed Miliband, has said.

In a speech in Manchester on 12 May, Miliband put the NHS at the heart of the Labour Party's campaign to win the 2015 general election.

He promised to invest an extra £100m a year in primary care by scrapping competition rules in the NHS and cutting bureaucracy created by the coalition government. He said that this money could fund three million more GP appointments every year and take pressure off hospital emergency departments.

Miliband spelt out three ways that Labour planned to improve the NHS: ensuring that physical health, mental health, and social care services work together; making the NHS more preventive; and replacing the principles of competition and privatisations with cooperation and integration.

As well as guaranteed prompt GP appointments, Miliband promised that under Labour patients would have the right to book ahead with the GP of their choice. "This will be better for patients, because they have better access to their GP surgery; better for the NHS, because it will save money currently spent in [accident and emergency departments]; and better for Britain, because it is the kind of health service we need," he said.

Labour said studies had shown that a 5% increase in patients seeing their preferred GP could reduce emergency admissions by as many as 159 000 a year and could save the NHS £375m.

Miliband also promised to repeal the "terrible" Health and Social Care Bill that the coalition government had passed in "a top-down reorganisation [of the NHS] that nobody voted for."

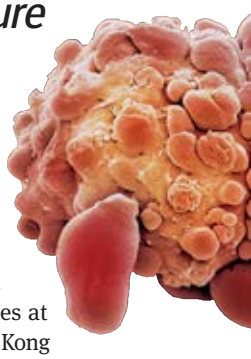
Labour said that the bill, which came into effect in April last year, had led to at least £78m being spent on unnecessary administration and legal fees and that the party would redirect this money to primary care.

Further money for GP services would come from scaling back three quangos—Monitor, the Trust Development Authority, and commissioning support units—which spend more than £3m a month on consultants.

"Why should a hospital have to spend money on competition lawyers instead of patient care?" asked Miliband. "We will stop that happening. We'll stop the regulators from spending their time on free market competition in the NHS."

Cite this as: *BMJ* 2014;348:g3300

Easy stem cell production published in *Nature* "does not work"



STEVE GSCHMEISSNER/SPL

Nigel Hawkes LONDON

A Hong Kong scientist who has tried to replicate a supposedly easy way to generate stem cells has been forced to conclude that the method does not work.

Kenneth Lee and colleagues at the Chinese University of Hong Kong were among the scientific groups that actively followed up what would have been, in his words, "a major game changer in regenerative medicine."

This was the controversial claim published in *Nature* by a team from the RIKEN Centre for Developmental Biology in Kobe, Japan, that subjecting mouse cells to immersion in a bath of warm acid restored them to a pluripotent state—from which, in principle, they could be used to create a wide range of specialised cells for medical therapy.

The existing methods are seen as inefficient, so a simpler way to generate stem cells would have been welcomed. In the online journal *F1000Research*,[1] Lee said that the method did not induce the cells to express the pluripotency marker. "It appears that the method for producing STAP [stimulus acquired transition of pluripotency] stem cells is not as simple and straightforward as has been reported," he concluded.

Cite this as: *BMJ* 2014;348:g3229

First patient with MERS in US recovers, but number of cases shows a sharp rise

Owen Dyer MONTREAL

An American healthcare professional who brought the first case of Middle Eastern respiratory syndrome (MERS) to North America is improving daily and should soon be discharged into home isolation, Indiana health officials said. The man, who worked at a hospital in Riyadh, flew to Chicago via Heathrow airport on 24 April then took a bus to Munster, Indiana. He fell ill three days later.

British and US officials have contacted most of the passengers on the plane and the bus, and testing so far has revealed no transmission. Anne Schuchat, responsible for respiratory diseases at the US Centers for Disease Control, told a media briefing that the importation posed a very low risk to the wider community but "we should not be surprised if additional cases are identified among the healthcare providers who had close contact with this patient before the patient was isolated."

The arrival of the MERS coronavirus (MERS-CoV) in America was expected, said Schuchat. Isolated cases among travellers appeared last month in Egypt, Greece, Malaysia, and the Philippines. But a dramatic increase in cases from Saudi Arabia and United Arab Emirates is worrying experts. Over 250 cases were reported in April—more than in the previous 26 months combined.

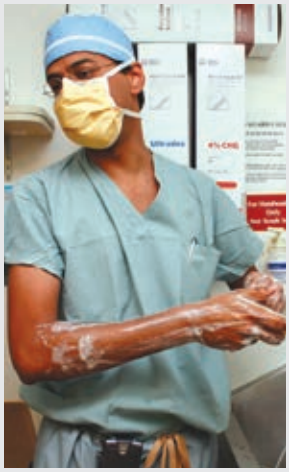
Some of the increase is due to wider testing of suspected contacts. A substantial minority of April's new cases are healthcare workers detected by such screening, some of whom remain asymptomatic or exhibit only mild symptoms. Younger patients often experience much milder disease. As the total number of reported cases rose from 200 on 26 March to 495 on 6 May, the case fatality rate fell from about 42% to about 28%.

But 40% of all deaths in the two year history of MERS-CoV have occurred in the past six weeks.

The death rate may still rise as some of the new cases have yet to run their course, warns Allison McGeer, an infection control specialist at Mount Sinai Hospital in Toronto who studied a MERS outbreak in four Saudi hospitals last year.[1]

McGeer, who worked in Toronto's 2003 severe acute respiratory syndrome (SARS) coronavirus epidemic and caught the disease, said that infec-

Surgeon gives patient a vasectomy by mistake



The hospital said that the surgical checklist developed by US surgeon Atul Gawande, above, was not followed

Clare Dyer BMJ

A surgeon in Liverpool has been suspended from operating pending an investigation, after a man who was booked for a minor urological operation was given a vasectomy instead.

Surgeons performed a reversal, but it is not yet certain whether the procedure, which has a success rate of only around 55%, has been effective.

"This instance of a never event"—identified by NHS England as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented"—was revealed at a board meeting of Royal Liverpool and Broadgreen University Hospitals NHS Trust and picked up by the *Liverpool Echo*.

Aidan Kehoe, chief executive of the trust, told the board that the World Health Organization surgical safety checklist did not seem to have been followed when the operation took place in February.

The trust would not reveal the patient's age or circumstances, but a clinical negligence lawyer told the *Echo* that the mistake could cost the trust a six figure sum in compensation in the worst case scenario of a young man with no children who was rendered sterile.

"We have apologised unreservedly to the patient and we are offering him our full support," said the trust's medical director, Peter Williams. "We greatly regret the distress this has caused him.

"It is our duty in the best interests of the patient to uphold their confidentiality. Therefore we cannot provide any further detail without their agreement. This is a serious incident and we are investigating this fully to understand why it occurred and how we can ensure it does not happen again."

Williams said that the trust had had only one other "never event" since 2011. He added, "We take any incident such as this extremely seriously and report them at the highest level in the trust and to our regulators.

"In addition, we are carrying out routine checks on compliance with the WHO checklist and our surgical teams are compliant."

Cite this as: *BMJ* 2014;348:g3180

Two thirds of British public think spending on NHS should increase

Gareth Iacobucci BMJ

Nearly four fifths of people in Britain believe that the NHS should be protected from further funding cuts, a new poll has shown.[1]

Research by Ipsos MORI asked members of the public which areas of public spending should be exempt from further austerity measures. The NHS and healthcare scored highest (79%), followed by schools (51%), care for the elderly (51%), the police (39%), and social services (21%).

Two thirds of the public (65%) said that NHS funding should be increased to maintain current service provision, while only 14% thought that services should be limited or rationed.

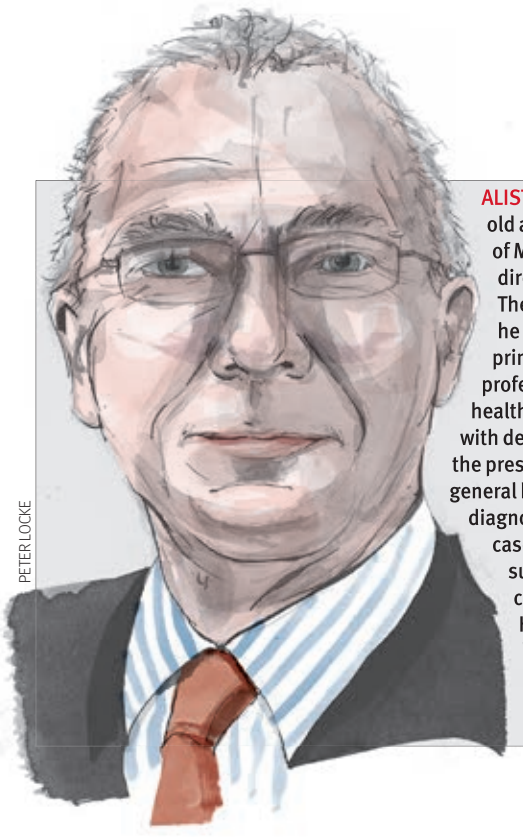
A lack of resources was identified as the biggest problem facing the NHS, with 38% of respondents highlighting concerns over the issue.

The research, commissioned to coincide with Simon Stevens becoming the new chief executive of NHS England, came after a recent report from the healthcare think tank the King's Fund, which warned that a significant increase in NHS funding was necessary to halt a financial crisis.

Some 52% of respondents identified the NHS as the thing that made most people proud to be British—an increase of 7% on 2012, when Ipsos MORI last surveyed the public on this question.

Cite this as: *BMJ* 2014;348:g3273

Alistair Burns
Slippery when wet



PETER LOCKE

ALISTAIR BURNS 55, is professor of old age psychiatry at the University of Manchester and national clinical director for dementia at NHS England. The profile of dementia is such that he has to navigate the interests of the prime minister, the health secretary, professional colleagues, and the many health and care organisations involved with dementia. He balances issues such as the prescription of antipsychotics, improving general hospital care, the need for timely diagnosis, and the question of screening or case finding. He must have scored some success, as nobody doubts his genuine commitment to better dementia care. He recently re-tweeted a picture of himself being kissed (in front of an audience of 150) by an attractive younger woman who had pledged to become a Dementia Friend.

What personal ambition do you still have?
"To retire before being reported to the General Medical Council, and to have a full page obituary in *The BMJ*."

What was your earliest ambition?
To be served in an over 18 pub when I was 16.

Who has been your biggest inspiration?
Robert Boyd (my first dean in Manchester) for leadership; David Jolley (senior consultant colleague in Manchester) for industry; and Tony David (psychiatrist at the Maudsley Hospital, best friend, and best man) for integrity.

What was the worst mistake in your career?
Seeing a bright red bloodstained fluid clot on draining a pleural effusion and realising it was probably from the aorta, or at least a major artery. I spent a harrowing few hours hanging around the patient waiting for something to happen, but everything was all right in the end.

What was your best career move?
They've all been rewarding, and it's hard to pick one out. Moving to and from the Maudsley were the two best.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
Jeremy Hunt is the best—he's incredibly supportive of the work we are doing in dementia and has an energy, enthusiasm, and emotional intelligence that is infectious. I have not met the worst.

Where are or were you happiest?
"Most happy" is a trait rather than a state marker for me. But most content—as a young surgical house officer in Dumfries, without a care in the world.

Who is the person you would most like to thank and why?
Personally: my family. Professionally: Raymond Levy (professor of old age psychiatry at the Maudsley) for my first break; David Goldberg (professor of psychiatry in Manchester when I arrived) for my second; and David Behan (director general at the Department of Health, now at the Care Quality Commission) for my third.

To whom would you most like to apologise?
The patient whose aorta I tapped.

If you were given £1m what would you spend it on?
I would pay off the family mortgages and go out for a curry.

What single unheralded change has made the most difference in your field in your lifetime?
The availability of treatments for Alzheimer's disease. That, and the mobile phone.

Do you believe in doctor assisted suicide?
No.

What book should every doctor read?
The Nazi Doctors: Medical Killing and the Psychology of Genocide by Robert Jay Lifton.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Always Look on the Bright Side of Life by Eric Idle, from Monty Python's *Life of Brian*. One of the few times I have laughed so much it hurt.

What is your guiltiest pleasure?
Gently pressing the accelerator of my Bentley to 120 mph (NB I've never done this on a public road).

If you could be invisible for a day what would you do?
Listen to what people said about me and try to work out if I was very clever or very stupid (I keep on wondering this myself). As Robert Burns said, "O, wad some Power the giftie gie us, To see oursels as others see us."

Clarkson or Clark? Would you rather watch *Top Gear* or *Civilisation*? What TV programmes do you enjoy?
Clarkson, for sure. Making people smile is important—presumably a defence from my bullied schooldays.

What personal ambition do you still have?
To retire before being reported to the General Medical Council, and to have a full page obituary in *The BMJ*.

Summarise your personality in three words
I could not choose between "batteries not included," "subject to availability," and "slippery when wet."

Where does alcohol fit into your life?
Seamlessly.

What is your pet hate?
People who take themselves, and BMJ Confidential, too seriously.

What would be on the menu for your last supper?
Onion bhaji, chicken tikka masala, pilau rice, naan bread, lashings of lager.

Do you have any regrets about becoming a doctor?
None at all. I'm fortunate, in that work is one of my hobbies.

If you weren't a doctor what would you be doing instead?
Probably a lawyer—I remember filling in the form for Glasgow University (for personal reasons I had to stay at home), and the pen was poised over "Law" and "Medicine." It landed almost randomly on Medicine.

Cite this as: *BMJ* 2014;348:g3202