# NEWS


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**bmj.com**
Obesity rates rise substantially worldwide

# Small falls in weight can improve health, says NICE

**Nigel Hawkes** LONDON

Weight loss programmes that focus on diet, activity, and lifestyle are cost effective even if the weight loss is small, so long as the improvement is maintained for the rest of life, the National Institute for Health and Care Excellence (NICE) has concluded.[1]

In new guidance on lifestyle weight management programmes, NICE says that £100 spent on putting an individual through a 12 week course is cost effective if at least 1 kg of weight is lost and if this achieves a permanent change in the person's weight trajectory—that is, for the rest of that person's life, his or her weight is 1 kg less than it otherwise would have been. For programmes costing £500 per head to be cost effective, the weight loss must be 2 kg; for £1000 programmes, 3 kg.

But the programmes are not likely to be cost effective if the weight is regained within two to three years or less, regardless of the weight lost. The group that produced the guidance said that such long term evidence was limited—only seven of the 29 randomised controlled trials it considered reported outcomes at three years or longer, and none beyond five years.

Such evidence as does exist suggests that commercial programmes run by groups such as Rosemary Conley, Slimming World, or Weight Watchers might be more effective than primary care led services, but it was unclear why. One possibility is that NHS services might target poorer people who are less motivated or less able to make the changes needed in diet and lifestyle.

BSIP SA/ALAMY

**Commercial weight loss plans may be more successful than primary care led services, but it is unclear why**

The guidance provides recommendations for commissioners, health professionals, and providers of weight management programmes. It urges all involved not to adopt a censorious or lecturing tone when dealing with those who need or want to lose weight because many avoid treatment for fear of being stigmatised. The remit of the group was narrow, and excluded other approaches such as public health interventions over the content or cost of food, or surgery which is covered by existing NICE guidance.

The average weight loss achieved by the lifestyle programmes the group considered is 3% of body mass, although their target is generally 5%. But this should not put anybody off. "Even at 3% there will be health benefits," said Gill Fine, an independent nutritionist who chaired the group, at a London press conference.

Mike Kelly, director of the Centre for Public Health at NICE, said: "If you weigh in at 18 stones, you may want to lose six stones, but that's very difficult and very difficult to sustain. We're talking about things that work. If you set the goal too high, people will give up. This guidance isn't about quick fixes—there is no magic bullet. It's about ensuring effective services are there to support people in the long term."

Cite this as: *BMJ* 2014;348:g3576

## Scottish independence could threaten medical research, warn scientists

**Bryan Christie** EDINBURGH

Arguments have broken out in Scotland over the future of medical research if the country votes to separate from the UK in September's independence referendum.

A group of leading doctors and scientists warns that independence will "jeopardise Scotland's present success in the highly competitive arena of biomedical research." However, these fears have been dismissed by a group of academics campaigning for a yes vote.

Scotland has 9% of the UK population but in 2012-13 received just over 13% of grants from the UK Research Council. It also received a greater than population share of research funding distributed by UK public and charitable organisations. This has helped to provide state of the art research facilities across Scotland's five medical schools.

If Scotland becomes independent, it is proposed that the country establishes common research funding arrangements with the rest of the UK. However, such an agreement is "fraught with difficulty and unlikely to come to fruition" according a group of 14 doctors and scientists which includes former chief medical officer David Carter, biochemist Philip Cohen, and geneticist Adrian Bird.

In an open letter to the *Scotsman* newspaper they say it is highly unlikely that the remaining UK would contribute research funds to an independent "competitor" country.[1] They warn of the danger of Scotland sleepwalking into a situation that puts its current success in scientific research in jeopardy. "Life sciences research provides thousands of high technology jobs; it is now and can undoubtedly remain a cornerstone of the Scottish economy. We contend that Scotland's research interests will be much better served by remaining within the common research area called the UK," they said.

But a group called Academics for Yes believes Scotland will benefit from independence. In a statement it said that arrangements between the UK and the Republic of Ireland could be replicated if Scotland gained independence.

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# 5 million UK children stuck in poverty by 2020

**Ingrid Torjesen** LONDON

The number of children in the UK trapped in poverty is expected to climb to a record five million by 2020, research by Save the Children has estimated.

In its report *A Fair Start for Every Child*, the charity examines the impact of poverty on the lives of children in the UK, what is driving child poverty and how many children are likely to be affected by poverty in the future.[1]

Although child poverty levels fell between 1998 and 2004, the report shows that ahead of the financial crisis they stalled. There is a cross party commitment to end child poverty by 2020, but Save the Children's projections suggest that the number of children living in poverty is actually likely to increase by 1.4 million—a 41% rise on the 3.5 million children living in poverty now.

Save the Children is calling for every child to have access to high quality and affordable childcare, a minimum income guarantee for the families of children under five, and a national mission for all children to be reading well by 11.

For its report, Save the Children also surveyed 4000 parents on a range of incomes. The findings showed that half of low income families had seen their incomes decrease in the past five years, around seven in 10 had found it difficult to meet payments and that more than four in 10 had got into debt as a result.

A triple whammy of years of flat wages, cuts to benefits, and the rising cost of living has made life tough for families and children, the report says. But on top of this, low income families also have to pay a "poverty premium" for many goods and services because of their restricted access to affordable credit and banking services.

**Helena McKeown backed fees, but Laurence Buckman (centre) and Chaand Nagpaul disagreed**

# GPs vote against charging patients for their services

**Abi Rimmer** BMJ CAREERS

GPs have rejected a motion put to their annual conference proposing that the BMA should work with UK governments to introduce a mechanism to charge patients for GP services.

Representatives at the BMA's conference of local medical committees in York voted against the parts of the motion that called on the BMA's General Practitioners Committee to "explore national charging for general practice services with UK governments" and "to consider alternative funding mechanisms for general practice."

However, the sections of the motion stating that "general practice is unsustainable in its current format" and that urged UK governments "to define the services that can and cannot be accessed in the NHS" were passed.

Presenting the motion, Helena McKeown, from Wiltshire Local Medical Committee, said that general practice had suffered from years of underfunding, causing "immense damage." Practices were unable to recruit and retain GPs, and increasing workloads were becoming "unmanageable and unsustainable," she said. "The time has come to lead our profession to putting a true price on the value of general practice."

McKeown said that if "the cornerstone of the NHS is to remain firm," then money had to be put into general practice. "A fee for some services to some people would sustain us whilst we build up a workforce who wants to join us and make general practice more attractive than retirement or general practice abroad. We need an honest government to say who and what will be completely covered by GPs as an NHS service," McKeown said.

She said that a fixed fee for some services for some patients would emphasise the "value" of general practice and that the increased funding generated would help practices take on more GPs.

McKeown emphasised that any system of charging patients should not "profit the private sector but would directly support general practice." Practices "would still have a registered list of patients, and our patients would have a usual GP," she added.

Speaking against the motion, Laurence Buckman, a member of the BMA's General Practitioners Committee, said, "This motion links unsustainable general practice with charging patients and is therefore mistaken as well as dangerous." It was not possible to control demand by making patients pay, he added. "You then get survival of the richest, not treatment of the sickest."

Buckman said, "It is not for the [committee] to consider alternative funding mechanisms unless the NHS is threatened with closure . . . [The committee] would be offering the privateers a way out by doing it to ourselves and our patients.

Chaand Nagpaul, chairman of the committee, advised delegates to vote against charging for services. He said that the introduction of charges could destroy the trust between GPs and their patients, Nagpaul warned. "If this motion is passed I think this would put us in a very difficult position in promoting the trust agenda."

Cite this as: *BMJ* 2014;348:g3498

# Australian doctors' leader attacks plan to charge patients $A7 to see a GP

**David Brill** SYDNEY

Australians would have to pay $A7 (£3.8) to see their GP under a controversial new scheme that would spell the end of universal free access to primary care.

Announced in May's federal budget, the copayment would apply to all GP consultations and out of hospital imaging and pathology services from 1 July 2015, if passed by parliament.

The plan includes a massive boost to Australia's investment in medical research, with $A5 of every $A7 copayment going into a multibillion dollar research "Future Fund." General practices would get the remaining $A2, but there would be an accompanying $A5 cut in Medicare rebates for GP services, meaning that practices would be likely to lose money overall.

The government has insisted that copayments were necessary to make healthcare spending sustainable, but critics fear this would come at the expense of society's poorest and most vulnerable.

The Royal Australian College of General Practitioners has labelled the copayment a "GP tax" that would drive patients to emergency departments, at greater cost to the system. The college's president, Liz Marles, said, "In this model the government has widened the healthcare gap to favour a two tiered system that leaves the 'have nots' and the unwell even further disadvantaged."

**Liz Marles: charging would widen the healthcare gap**

Cite this as: *BMJ* 2014;348:g3495

Two thirds of poor children now live in working families—an increase of 20% since 2003

DAVID HOFFMAN/ALAMY

Unemployment has fallen among low income families, and two thirds of poor children now live in working families—an increase of 20% since 2003—because the UK now has one of the highest rates of low pay in the developed world.

Between 2007 and 2011, food prices rose by 19% more than the prices of other goods, the report says. Childcare costs have also soared. The cost of a nursery place for a child under two rose by 77% between 2003 and 2013.

Justin Forsyth, chief executive of Save the Children, said, "Far too many of our children are living in cold and damp homes, without healthy food, with parents who can see no end to their situation. If we ignore the rising toll of poverty we are blighting the future of a further 1.4 million children. In one of the world's richest countries there is simply no excuse."

He added, "Unless there is a dramatic change of course we're at risk of writing off the future of millions of British children, giving them an unfair start in life."

Only a third of the poorest children go on to achieve five good GCSEs, including maths and English, and while 60% of well off families expect their young children to go to university, only one third of parents on low and modest incomes expect their children to do the same.

Cite this as: *BMJ* 2014;348:g3541

# Judge authorises trust to treat minor for paracetamol overdose

**Clare Dyer** BMJ

A High Court judge has made an order in the middle of the night authorising a hospital trust to give an antidote to a paracetamol overdose to a seventeen and a half year old girl who was refusing her consent.

The girl, named only as P, was admitted to hospital at 3.20 pm on May 13 but firmly resisted all treatment. Her mother consented to the antidote, but a psychiatrist had concluded that P had the capacity to take her own decisions, and the trust was reluctant to administer the treatment without a court order.

Unless the overdose is treated within around eight hours serious liver damage and death may result. The situation had reached a crisis point by around 10 pm, said Mr Justice Baker in a judgment which was delivered in private but has now been made public, on condition that the girl and the foundation trust are not identified.

Baker was told that P had a history of self-harming behaviour. She had been briefly detained under the Mental Health Act and discharged the previous week.

On the limited information he had before him, he said he was not satisfied that P lacked capacity to take her own decisions.

A patient aged under 18 who has sufficient maturity and understanding is deemed to have the capacity to give a legal consent to treatment. But where a patient under 18 refuses treatment, the court has jurisdiction to override the child's wishes in her best interests and consent to the treatment.

The judge quoted from an earlier case indicating that the court should override the child's wishes "if the child is seeking to refuse treatment in circumstances which would in all probability lead to the death of the child or to severe permanent injury." He had "no hesitation in concluding that the balance comes down firmly in favour of overriding P's wishes."

The court was "under a heavy duty to take what steps it can to protect P's life which is manifestly in danger tonight," he added. That included sedating or restraining her, although he hoped that would not be necessary.

Cite this as: *BMJ* 2014;348:g3534

# Just 15% of A&E patients could be safely redirected to general practice

**Jacqui Wise** LONDON

Only one in seven people attending hospital emergency departments in England could have been seen by a GP in the community, research carried out by the College of Emergency Medicine has found.

The college said that the finding challenges the much quoted figure that 40% of patients who go to emergency departments are discharged requiring no treatment.

The research was based on analysis of the records of 3053 patients who visited 12 emergency departments across England over a 24 hour period on Thursday 20 March 2014. The emergency departments were representative in terms of geography, age, and case mix.

The study found that 15% of those attending hospital emergency departments could be seen by a GP in the community without the need for emergency department assessment. This would equate to 2.1 million patients a year. Of these, the largest subgroup was young children with symptoms of minor illness.

The study found that 22% of people could be appropriately managed by a GP working in the emergency department with access to the same resources. A further 63% of those attending the emergency department needed the skills of an emergency medicine doctor, and 28% were admitted to hospital. The group for whom redirection was least likely was elderly people.

The college is calling for the establishment of primary care centres alongside hospital emergency departments and A&E based GPs.

JOHN COLE/SPL

**85% of patients need an emergency department assessment, but 22% could be managed by a GP**

Cite this as: *BMJ* 2014;348:g3479

# IN BRIEF

**Doctor will not face charges in UK:** The European Court of Human Rights has ruled that a German court was correct not to extradite Daniel Ubani, a locum doctor who gave a patient, David Gray, a lethal dose of the drug diamorphine. The patient's family argued that criminal proceedings in Ubani's home country were inadequate and that he should face a UK court. Gray's sons said they had not been sufficiently involved in the criminal proceedings in Germany. The family can appeal.

**Tuberculosis cases in England to outnumber those in US by 2016:** Public Health England has warned that unless the rise in tuberculosis is stalled, the number of cases in England will overtake that of the whole of the United States within two years. There were 8130 cases of tuberculosis in England in 2012—or 15 cases per 100 000 of the population, the second highest tuberculosis rate in Western Europe.

**GPs pilot test for patient activation:** NHS England is piloting a new assessment tool, known as patient activation, which measures the knowledge, skills, and confidence patients have to manage their own health and highlight where they need extra support. Patients with higher activation levels have better health outcomes and lower healthcare costs.[1] The pilot will cover 150 000 people.

**Health costs of air pollution are estimated:** A report from the Organisation for Economic Co-operation and Development (OECD) has calculated that the cost of air pollution to its 34 members is about $1.7 trillion (£1 trillion) in terms of premature deaths and ill health.[2] Around half the cost is from road transport, with diesel vehicles producing the most harmful emissions The cost to China is nearly $1.4 trillion and to India nearly $0.5 trillion.

**Antibiotic crisis needs united global response akin to that for climate change:** Growing resistance to antibiotics and other drugs demands a coordinated global response on the same scale as efforts to deal with climate change, Mark Woolhouse, of the University of Edinburgh, and Jeremy Farrar, Director of the Wellcome Trust, argue in a commentary published in the journal *Nature*.[3] They are calling for the creation of an independent body to oversee surveillance efforts and set targets to stem the loss of drug potency and speed new drug development.

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# Mothers are often depressed four years after birth

**Ingrid Torjesen** LONDON

Mothers are more likely to be depressed four years after childbirth than at any point in the first 12 months after giving birth, a study in *BJOG: An International Journal of Obstetrics and Gynaecology* has found.[1] Women with only one child at four years post partum were more than twice as likely to report depressive symptoms as women with more children, the results of the Australian study showed.

The researchers recruited 1507 women to the study who were registered to give birth to their first child at six public hospitals in Melbourne. The women then completed questionnaires at 3, 6, 12, and 18 months, and then at four years after giving birth.

The results showed that almost one in three women reported depressive symptoms in the first four years after birth. The prevalence of symptoms at four years post partum was 14.5%—higher than at any point in the first 12 months post partum (prevalence of depressive symptoms was 8.1% at 3 months, 10.1% at 6 months, 9.5% at 12 months, and 11.3% at 18 months post partum). Furthermore, women with only one child at four years post partum were more than twice as likely to report depressive symptoms at that time than women who had had subsequent children (22.9% and 11.3% respectively; unadjusted odds ratio 2.34 (95% confidence interval 1.63 to 3.37)).

The strongest predictor of depressive symptoms at four years post partum was having reported depressive symptoms either in early pregnancy or in the first 12 months after childbirth. Other factors included abuse by an intimate partner, young maternal age (18-24 years), recent stressful life events or social adversity, and low income.

The researchers said that their findings emphasised the need to extend surveillance of maternal mental health to cover the early years of parenting by integrating services into routine primary and antenatal care. Currently, maternal mental health focused on pregnancy and the early months after birth.

Hannah Woolhouse, psychologist and senior research officer at the Murdoch Children's Research Institute in Melbourne, said, "Current systems of maternal mental health surveillance in Australia and the UK will miss more than half the women experiencing depression in the early years of parenting. In particular, women who do not have subsequent children may be especially vulnerable to falling through the gaps."

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# Soft drink health claim referred to trading standards

**Jacqui Wise** LONDON

The Advertising Standards Authority (ASA) has referred two companies to Trading Standards in a bid to tackle advertisers who persistently make misleading health claims.

Critics have previously accused the independent regulator of being toothless. This is the first time that it has used its new legal backstop regime and referred advertisers to Trading Standards. The ASA said that these two cases were a clear warning to others in breach of the code that they could face legal sanctions.

In 2012 the drinks manufacturer Fahrenheit60 was investigated by the ASA and was found to be in breach of the rules for making misleading efficacy claims about its soft drink Aspire. The manufacturer claimed that the drink created a "thermogenic" reaction that could boost metabolism, suppress appetite, accelerate weight loss, and oxidise fat and "burn on average 200 calories per can". The company submitted research carried out on 20 subjects aged 19 to 26, but the regulator said that was not sufficient to support the assertions.


**Manufacturer claimed Aspire could "burn on average 200 calories per can"**

The ASA also referred another company, Electronic Healing, to Trading Standards over misleading health claims on its website about its products Bob Beck Protocol and Liquid Oxygen Drops. Electronic Healing claimed that "the Bob Beck Protocol kills or disables every microbe (virus, bacteria and fungus) in your body." It also claimed that the protocol could amplify the immune system, remove the need for flu vaccinations, increase oxygen in the blood, reduce HIV infection levels, and help people with fibromyalgia. Liquid Oxygen Drops were credited on the website with a number of health benefits including "healthy" energy, immunities, and disease prevention.

In 2012 the ASA said that no evidence supported these claims and that they were misleading. It then placed both companies on a list of non-compliant online advertisers; but because they continued to make misleading claims the ASA has now referred them to Trading Standards, which has the power to seek criminal prosecutions or civil enforcement orders.

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Women at average risk of developing contralateral cancer should understand the risks of prophylactic surgery, said researchers

DAVID JAY/THE SCAR PROJECT

# Majority of double mastectomies are not clinically indicated

**Michael McCarthy** SEATTLE

Nearly seven in 10 women with breast cancer who have contralateral prophylactic mastectomy are not at significant risk of developing a new breast cancer in the contralateral breast, research has found.[1]

Recently, the number of women choosing to have a contralateral prophylactic mastectomy as part of their initial treatment for breast cancer in the US has risen steadily.

However, in most patients removal of the unaffected breast has not been shown to prolong survival, and the procedure is generally recommended only for women with a higher than average risk, such as those with genetic mutations of BRCA1 or BRCA2 or with at least two first degree relatives with breast or ovarian cancer. "It is estimated that fewer than 10% of women with newly diagnosed unilateral breast cancer have one or both of these clinical indications," the researchers note.

To find out what factors were associated with a woman's decision to have the procedure, the researchers surveyed 1447 women with newly diagnosed breast cancer shortly after diagnosis and again four years later. They report their findings in *JAMA Surgery*.

Ultimately, about half of the women (57.6%) had breast conserving surgery, one third (34.4%) unilateral mastectomy, and 7.9% contralateral prophylactic mastectomy, but roughly a fifth (18.9%) of the women surveyed said they had considered having the prophylactic procedure "quite a bit or strongly." Of those who strongly considered contralateral prophylactic mastectomy, a third (32.2%) decided to have it.

Factors associated with deciding to have the procedure included higher educational attainment (relative risk ratio 5.04 (95% confidence interval 2.37 to 10.71)); having had a genetic test, regardless of the result (10.48 (3.61 to 30.48)), for women with a positive result and 2.17 (1.13 to 4.15) for those with a negative result); having a strong family history of breast or ovarian cancer (5.19 (2.34 to 11.56)); having had magnetic resonance imaging (2.07 (1.21 to 3.52)); and reporting that worry about a recurrence played an important part in the decision (2.81 (1.14 to 6.88)).

Although clinical indications, such as genetic risk factors and strong family history, were factors in some women's decision to have a contralateral prophylactic mastectomy, most women having the surgery (68.9%) did not have such risk factors, and one in five (20.8%) of those who had been tested for genetic risk factors had negative results.

Of women who had the operation, 80% said that it was done to prevent breast cancer from developing in the other breast.

The findings bolster other research showing that clinical and non-clinical factors, including fear of recurrence, motivate many patients to consider contralateral prophylactic mastectomy.

Patients at average risk of developing contralateral cancer should clearly understand the risk of the procedure "including lengthy recovery time and increased risk for serious operative complications, and should weigh them against the lack of empirical evidence that the procedure improves disease-free survival from the cancer, which is already present." write researchers.

Cite this as: *BMJ* 2014;348:g3512

# Funding shortfalls could result in services closing

**Gareth Iacobucci** THE BMJ

NHS England is failing to fulfil its commitment to support general practices facing huge funding cuts and possible closure under new contractual arrangements, Chaand Nagpaul, the leader of the BMA's GP committee has warned.

He called for greater support to practices facing huge funding shortfalls following the abolition of the minimum practice income guarantee (MPIG), which NHS England has admitted will leave some practices at risk of closure.

Nagpaul said he had written to the chief executive of NHS England, Simon Stevens, to warn of the "serious threat" to patient care.

The MPIG was introduced as part of the 2004 GP contract to protect the income levels of general practices that would otherwise have lost out from the new arrangements. But as part of the agreement on the GP contract in England for 2013-14, the government decided to begin phasing out the payment over seven years from April 2014 and reinvest the money into the core global sum payments.[1]

Nagpaul claimed that NHS England and its regional area teams have failed to deliver on their pledge to support affected practices—including 98 identified as being at risk of closure.[2]

In his letter to Stevens, Nagpaul said the situation was "a critical issue for our members" that posed "a serious risk to the delivery of services to patients."

Nagpaul added: "If this situation is allowed to continue there will be a real and imminent threat to services provided to patients, with some practices at risk of closure."

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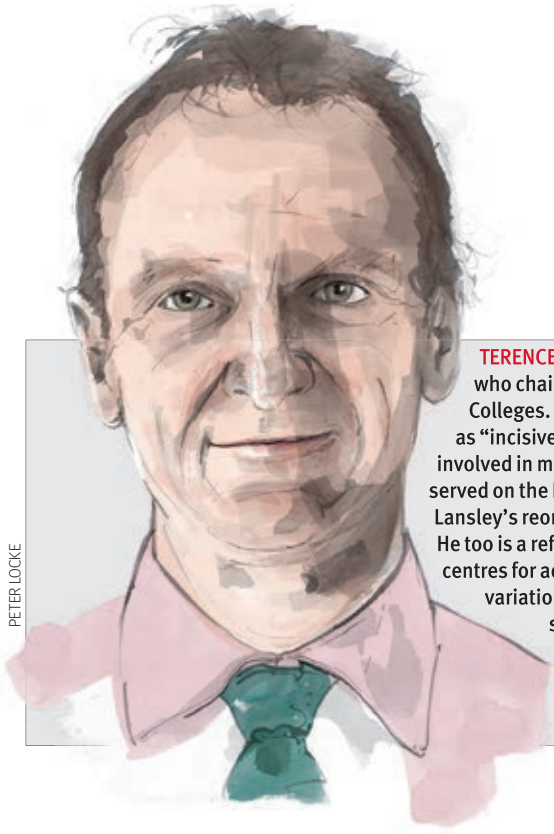
# Terence Stephenson
## Honest, conscientious, fair



PETER LOCKE

**TERENCE STEPHENSON** is a paediatrician who chairs the Academy of Medical Royal Colleges. Described by the *Guardian* as "incisive and articulate," he is heavily involved in medical policy making, having served on the Future Forum set up amid Andrew Lansley's reorganisation of the NHS in England. He too is a reformer—keen to see fewer, better centres for acute services and less unjustified variation in care. He supports a tax on sugary drinks to combat obesity and recently promised to lose 5 lb (2.3 kg)—although he is not overweight—to prove that he is serious.

**What book should every doctor read?**
"*Pride and Prejudice*. To be a good clinician, doctors have to be good listeners and assiduous observers of people, as Jane Austen was. I was taught that history is 95% of the diagnosis. As Osler said, 'Listen to your patient, he is telling you the diagnosis.'"

**What was your earliest ambition?**
To be a bin man (aged 5).

**Who has been your biggest inspiration?**
David Weatherall, then Nuffield professor of medicine at Oxford. He was the first to show me that a doctor can be a clinician and a scientist.

**What was the worst mistake in your career?**
Being called to see an ill baby and asking the exhausted carer on the postnatal ward whether she was the infant's grandmother—a mistake I made only once. Thereafter I always erred on the safe side and made innumerable new grandmothers happy by asking if they were the mother.

**What was your best career move?**
Taking up a clinical lectureship with David Hull, professor of child health at Nottingham. He was a fantastic role model and a wonderful mentor.

**Bevan or Lansley? Who has been the best and worst health secretary in your lifetime?**
Richard Crossman wrote the best diaries, which I read as an undergraduate. However, he demonstrated that an intelligent person can also be an intellectual bully and that being offensive is not necessary in speaking truth to power.

**Who is the person you would most like to thank and why?**
My father, for demonstrating that merit and integrity matter more than birth.

**To whom would you most like to apologise?**
My son and daughter, for not spending more time with them—a hazard of a medical career.

**If you were given £1m what would you spend it on?**
Endowing a prize, through the Royal College of Paediatrics and Child Health, for the best PhD by a UK paediatric trainee. Getting an initial award is very hard for young researchers.

**Where are or were you happiest?**
In Dublin when Ireland beat France on their way to the 2009 rugby Grand Slam.

**What single unheralded change has made the most difference in your field in your lifetime?**
The reduction in meningitis through immunisation.

**Do you support doctor assisted suicide?**
For patients in severe pain with a terminal illness, doctors need to be able to give enough analgesia to minimise suffering as much as possible—if cessation of breathing is a side effect, it should be clear that this was not the doctor's primary intention. The situation when the patient is very distressed by profound disability, but not in acute pain, is more difficult, and not just for doctors. Depending on the case, nurses, pharmacists, and relatives could all be capable of assisting a suicide, and it will be for parliament to clarify whether they would be immune from prosecution.

**What book should every doctor read?**
*Pride and Prejudice*. To be a good clinician, doctors have to be good listeners and assiduous observers of people, as Jane Austen was. I was taught that history is 95% of the diagnosis. As Osler said, "Listen to your patient, he is telling you the diagnosis."

**What poem, song, or passage of prose would you like mourners at your funeral to hear?**
The gavotte from Bach's D Major cello suite and *Danny Boy*.

**What is your guiltiest pleasure?**
Chocolate.

**If you could be invisible for a day what would you do?**
Go back to the Namibian desert and get really close to the wildlife, though still downwind from them of course!

**What is your most treasured possession?**
My piano.

**What personal ambition do you still have?**
Lots, but I am a great believer in never counting your chickens—let's wait and see what happens.

**Summarise your personality in three words**
Honest, conscientious, fair.

**Where does alcohol fit into your life?**
I am on record as saying that I sometimes drink enough to sing but not enough to fall over.

**What would be on the menu for your last supper?**
Grilled monkfish in lime juice, tournedos Rossini, "death by chocolate" pudding. If I were to eat all that, it probably would be my last meal.

**If you weren't in your present role what would you be doing instead?**
I enjoyed all of medicine as a student and could have been happy in most specialties. If not medicine, I would have become an engineer (or a bin man).

Cite this as: *BMJ* 2014;348:g3465