Six professors back NICE guidance on extending the use of statins

Nigel Hawkes  LONDON

The so-called statins war triggered by two papers in The BMJ and new guidance from the UK National Institute for Health and Care Excellence (NICE) recommending wider use of the drugs shows no signs yet of a ceasefire.

At a press briefing in London organised by the Science Media Centre, six leading professors of cardiology and epidemiology stated their conviction that the evidence from trials amply justified their confidence that the benefits of statins outweighed any risks. The authors of the two papers in The BMJ had been wrong, they said, and NICE had been right to suggest that statins should be offered to patients who didn’t have a high risk of cardiovascular events.

The Oxford University academic Rory Collins said that the authors of the two papers in The BMJ had withdrawn their claim that 18-20% of statin users experienced side effects. But they had not withdrawn a claim that 5% of users have myopathy. “Actually it’s 100 times less,” he said. He had earlier called for a full retraction of the papers and criticised The BMJ’s appointment of a panel chaired by Iona Heath, former president of the Royal College of General Practitioners, to decide whether that demand should be met.

“My main concern is about the effect that misrepresenting the evidence will have on people who are at high risk of cardiac events,” he said. “It’s perfectly reasonable to debate whether patients at lower risk should get statins or not, but it’s inappropriate to misrepresent the evidence.” Asked whether the panel members, all strong supporters of statins, would be prepared to debate the issue with others who were more sceptical, Peter Weissberg, medical director of the British Heart Foundation, said such a debate was already going on. “But the critics are wrong,” he said. “They’ve retracted, they’re wrong.”

Fiona Fox, director of the Science Media Centre, defended her decision to invite only pro-statins experts to the briefing. The “vast majority” of cardiac and statin experts believed that the evidence was overwhelming, she said, and it was not the centre’s job to platform a minority view.

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Treating type 2 diabetes in older people can do more harm than good

Ingrid Torjesen  LONDON

Drugs to reduce blood sugar levels can do more harm than good in elderly patients with type 2 diabetes, a study has reported.

Researchers from University College London and the University of Michigan in the United States used data from the UK Prospective Diabetes Study, a 20 year study of type 2 diabetes treatments involving more than 5000 people in the United Kingdom. They modelled the net gains or losses to quality of life associated with treatments for lower blood sugar and calculated additional impacts on quality of life from published medical evidence on the burden, safety, and efficacy of different treatments.

Specifically, the researchers looked at the effectiveness of diabetes treatments in preventing associated diabetes complications such as kidney, eye, and heart disease, and they compared the reduced risk of such complications with the increased risk of side effects and the burden of taking pills or injections. They published their findings in JAMA Internal Medicine.

The results showed that, for many people, the benefits of taking diabetes medications were so small that they were outweighed by the minor harms and risks associated with the treatment. The benefits of treatment declined with age, and by age 75 the harms of most treatments were likely to outweigh any potential benefits.

John S Yudkin, emeritus professor of medicine at University College London, emphasised that the aim of treatment was not to lower blood sugar for its own sake but to prevent debilitating or deadly complications. “If the risk of these complications is suitably low and the burden of treatment correspondingly high, treatment will do more harm than good. The balance between the two can never be defined by a simple figure like blood sugar level,” he said.

Diabetes is usually diagnosed at HbA1c above 6.5% (48 mmol/mol), although the patients at greatest risk of morbidity have an HbA1c above 8.5% (69 mmol/mol). Typically, glucose lowering therapies will reduce HbA1c by around 1%.

While someone with type 2 diabetes who begins treatment at age 45 and reduces their HbA1c by 1% may gain up to 10 months of healthy life, if their diagnosis comes at age 75 they may gain as little as three weeks of healthy life. Yudkin noted, “Whether this is worth 10-15 years of pills and injections with potential side effects is ultimately up to the patient.”

The impact of different treatments on quality of life depends not only on their particular side effect profiles but also on the perceptions of patients. In particular, patients will consider that insulin has a more detrimental effect on quality of life than oral therapies because of the need to inject daily and the propensity for weight gain.

“In many cases, insulin treatment may not do anything to add to the person’s quality of life expectancy,” said Yudkin. “If people feel that insulin therapy reduces their quality of life by more than around 3-4%, this will outweigh any potential benefits gained by treatment in almost anyone with type 2 diabetes over around 50 years old.”

The benefits of treatment were likely to be greater for around a third of patients with very high blood sugar levels.

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Halve sugar intake to 5% of daily energy, says advisory group

Matthew Limb LONDON

People’s daily consumption of added sugar should be halved so that it makes up around 5% of the average dietary energy intake, a government advisory group has recommended.

The Scientific Advisory Committee on Nutrition said that a reduction from the current recommended level of 10% was necessary to curb obesity. It also recommended that children and adults should “minimise” their consumption of sugar sweetened beverages because of an association with type 2 diabetes.

The committee said that no change was needed to the current recommendation that 50% of the average energy intake should come from carbohydrates, but it recommended proportionate increases in the daily fibre intake for adults and children. It published a 360 page draft report on 26 June for consultation after its review of evidence on carbohydrates and health.1 Public Health England issued a report on how it planned to respond.2

Ian Macdonald, the advisory group’s chairman, said that the review showed “clear evidence” that high added sugar or “free sugar” intake in adults was associated with increased energy intake and an increased risk of obesity. He said that a typical adult would reach the 5% sugar threshold by drinking one average size fizzy drink of 330 mL.

Macdonald, who is also professor of metabolic physiology and director of research in medicine and health sciences at Nottingham University, said that the group had reviewed evidence from prospective, long term cohort studies and randomised controlled trials. These had related to healthy participants, not people with chronic disease.

He said, “Specifically in adults, in cohort studies, there is an association between sugar sweetened beverages and a risk of type 2 diabetes. In children, from trials and cohort studies, there is clear demonstration that sugar sweetened beverage intake is associated with weight gain and an increase in body mass index which is the measure of overweight and obesity. In all age groups, free sugars intake is associated with dental caries.”

Macdonald said that cutting recommended sugar levels from 10% to 5% would reduce the risks from these products to an “acceptable” level.

Quarter of hospital emergency visits are due to inability to get appointments, study finds

Matthew Limb LONDON

Nearly six million attendances at hospital emergency departments in England occur each year because patients cannot get a GP appointment, new research has found. Researchers at Imperial College London said that the figure represented 26.5% of emergency department attendances.

They said that, although a significant number of emergency attendances in England each year could be linked to patients’ access to general practice, it did not necessarily follow that improving this access would reduce emergency department attendances, adding that more research was needed. The analysis was funded by the National Institute for Health Research and published on 30 June in the British Journal of General Practice.1

The lead researcher was Thomas E Cowling, the institute’s doctoral research fellow at Imperial College, who said that the study was conducted because little numerical evidence had so far backed claims that a lack of access to GPs could be a factor in rising emergency hospital attendances.

The researchers estimated that 345.6 million GP consultations took place during the financial year 2012–13, on the basis of estimates from previous years and the trend for this figure to increase over time. They then used patients’ own accounts of their latest attempts to see or speak to a GP or nurse as detailed in the GP Patient Survey 2012–13, to calculate the ratio of these attempts that resulted in emergency department attendance to attempts that resulted in a GP consultation.

The study showed that, for every 100 attempts that resulted in a GP consultation, 1.67 attempts resulted in a visit to the emergency department. The researchers said that, although this ratio was small, in absolute terms it gave a figure of 5.77 million emergency hospital attendances that were preceded by an inability to get an appointment.

In Brief

Public chooses antibiotics for £10m prize: Preventing increased resistance to antibiotics has been chosen as this year’s challenge in the Longitude Prize 2014, signalling the world’s most pressing scientific issue. The decision was based on a vote by the British public, who chose antibiotics ahead of five other categories.1 People can now register an interest in competing for the £10m prize at www.longitudeprize.org. Details of the challenge will be announced this month.

Morecambe trust in special measures: University Hospitals of Morecambe Bay NHS Foundation Trust has been placed in special measures by the healthcare regulator Monitor, over concerns about the quality of care it provides. The decision came after an inspection by the Care Quality Commission’s chief inspector of hospitals, which reported inadequate staffing levels.

UK invests £39m in trachoma care in Africa: The UK government has announced a new £39m investment programme to help eliminate trachoma in Africa. The funding will be used to facilitate the SAFE (surgery, antibiotics, facial cleanliness, and environmental improvements) strategy. The project will be implemented by a consortium from the International Coalition for Trachoma Control and managed by the charity Sightsavers.

RCP backs e-cigarette regulation: The Royal College of Physicians has released a new position statement on electronic cigarettes, which says that the devices could help to reduce smoking prevalence in the United Kingdom.2 It said that regulation should ensure “that products deliver nicotine effectively and safely; that advertising and promotion do not target young people or other non-smokers; and that advertising and use (e.g. in public places) do not undermine smoking prevention policies.”

Call for stricter rules on drugs and driving: The European Monitoring Centre for Drugs and Drug Addiction has argued for tougher action against combined drug and alcohol use by drivers. The call accompanied the publication of its latest report on drug use, impaired driving, and traffic accidents.3

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GPs’ workload climbs as coalition government’s austerity agenda bites

Since 2010 the UK government has brought in a raft of changes to the welfare system in a bid to reduce the national deficit. In the first of a two part investigation, Gareth Iacobucci looks at the effects of stricter rules on disability benefits.

Nearly all general practitioners in a new survey carried out by *The BMJ* said that their workload had risen in the past year as a result of their patients’ financial hardship.

Over 1000 GPs responded to the survey, the results of which showed that doctors working in the country’s most deprived inner city areas were the worst affected by the recent reorganisation of the benefits system and other austerity measures. The findings also indicate that people receiving welfare support because of illness or disability are struggling to cope with cuts to their financial support and are turning to their GPs for support.

The findings come after a recent analysis published by the think tank the High Pay Centre said that the poorest fifth of British households were now among the most economically deprived in western Europe.1

This first part of *The BMJ*’s investigation focuses on how changes to the employment support allowance (ESA), introduced by the Labour government in 2008 to replace the old incapacity benefit, have affected patients with long term illnesses or disabilities. Many doctors in our survey said that the ESA had increased their workload in the past 12 months, after the coalition government introduced stricter criteria for receiving benefits in the Welfare Reform Act 2012.

As well as being asked more often to provide medical information for their patients’ work capability assessments (WCAs), GPs are also being asked to help an increasing number of patients appeal against the removal of their benefits under the new system, which many believe has wrongly judged them as fit for work.

WCAs are carried out by medical advisers, often nurses, employed by the private company Atos. The firm has been contracted to run the assessments since 2008, but it recently negotiated an early withdrawal from the contract after criticism of its operation of the assessments. A new provider is due to be appointed early next year.2

Alongside its survey *The BMJ* interviewed doctors, advisers, and patients at general practices in three towns and cities, who raised major concerns about the way the system was working (box 1).

What *The BMJ*’s survey found

Of 1056 GPs who responded to the survey (see box 2 for details of the survey methods), 94% said that their workload had risen to some degree in the past 12 months because of financial hardship among their patients (fig 1).

The impact seemed to be deepest in inner city areas. Nearly half (46%) of GPs who identified themselves as working at an inner city practice said that their patients’ financial problems had “significantly increased” their workload. The proportion was 39% in towns, 38% in suburban areas, and 33% in rural areas.

Overall, 91% of GPs said that the ESA had increased their workload to some degree in the past 12 months. Within this, more than a quarter (27%) said that the ESA had “significantly increased” their workload, 41% said it had “increased” their workload, and 23% said it had “slightly increased” their workload.

More than half of GPs (57%) said that they had filled in more WCAs for their patients in the past 12 months than in the previous year, while 15% said that they had not filled in more. This increased workload included providing medical information for initial assessments, as well as helping patients with appeals. A further 28% said they were not sure if the number had increased.

The findings reflect the most recent statistics published by the Department for Work and Pensions, which show that the number of appeals against WCA rulings that were subject to a tribunal hearing rose from 181 137 in 2011-12 to 327 961 in 2012-13.3 Of the 224 375 appeal tribunals concluded in 2012-13, 43% were overturned in favour of the claimant.

To compound the surge in workload, many GPs thought that their professional opinion was regularly disregarded by the agencies assessing people’s ability to work. More than half of the GPs surveyed (52%) said that the advice they supplied was either “often” or “usually” ignored by Atos and the Department for Work and Pensions (fig 2).
AUSTERITY INVESTIGATION

Box 1 | What GPs, other staff, and patients told us

The Lawson Practice serves 13 000 patients in Hackney, one of the most deprived local authorities in England. The population is ethnically diverse, and most of the practice’s patients are from low income households. The practice has seen a growing number of patients requesting help with the ESA.

Jonathan Gore, GP partner, Lawson Practice, Hackney, northeast London

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Anonymous patient, 58, Lawson Practice

The patient has been “in and out of hospital” since the age of 16 with arthritis and is also a carer to her partner, who has had an amputation. Having previously been classed as having limited capability for work, she was reassessed last year and had her benefits reduced. She believes that she is not fit for work and is currently appealing the sanction on her benefits.

I’m appealing it, but I’m worn out by it. I’m attending the hospital. They’ve said [I have] crumbling arthritis and spurs on the knee. I’m going down all the possible routes to help myself, but, realistically, sending me back to work [would mean] taking every second day off work. I will not be able to maintain a job. It’s unrealistic of them. I’m nearing 60. It has an impact on my life: I am incapacitated. They’re not sensitive enough.

The Hackney WellFamily Service provides “brief emotional and practical support” to patients in this deprived area of London. Yucel spends one day a week working at the Lawson Practice.

Hamra Yucel, family support coordinator, Hackney WellFamily Service

The Hackney WellFamily Service provides “brief emotional and practical support” to patients in this deprived area of London. Yucel spends one day a week working at the Lawson Practice.

There has been a surge in the number of referrals, and it’s actually an ongoing thing. They are sanctioning people a lot here. We are having meetings with job centres. People who are illiterate, or have dyslexia, or mental health issues, or people who don’t have the motivation, are being sanctioned again and again. Those people suffer a lot when they have to deal with job centres, because they [the centres] don’t seem to understand the underlying issue.

When GPs were asked whether they had seen evidence that their patients’ health was being harmed by reductions to their benefits, 68% of those who responded to the question said that they had. The proportion was highest among GPs who identified themselves as working in inner city areas (77%), followed by those in towns (71%), suburban areas (65%), and rural areas (58%) (fig 3).

Changes to disability and work support benefits

Doctors are increasingly being asked to provide medical information for the controversial WCAs, which people who are ill or disabled must undergo to assess their eligibility for ESA. They are also dealing with the effects on health among people who have had their benefit payments cut, many of whom have mental health problems or disabilities.

The WCAs have been heavily criticised by doctors, patients, charities, and MPs, who claim that they are inflexible and punitive towards sick and vulnerable people. Reports have surfaced of people committing suicide after being incorrectly assessed as fit to work. The government and the company it contracted to run the assessments, Atos, negotiated an early end to the contract in 2014 after heavy criticism.

The ESA was first introduced in October 2008 by the then Labour government to replace incapacity benefit, which was paid to those below the state pension age who could not work because of illness or disability. The allowance was initially paid only to new benefit claimants but was extended by the coalition government from 2011, with the aim that all existing claimants would be migrated to the new system and reassessed by 2014.

Stricter assessments

The key difference between ESA and its predecessor was the introduction of the stricter WCAs to replace the personal capability assessment. The Department for Work and Pensions said that the new system would be more rigorous and would help more people into work. In this system claimants who score 15 points or more in WCAs are considered unable to work. These claimants then receive a basic ESA weekly payment of £72.40 (for those aged 25 years or over) or £57.35 (16-24 year olds), plus an additional £35.75 a week for those who attend support groups.

Claimants who don’t meet the 15 point threshold receive less money overall: the same £72.40 or £57.35 basic payment, but with an additional payment of £28.75 a week for attending “work related activity groups.” Claimants in this second group must be seen to be taking immediate steps towards moving into work to avoid sanctions.

Before the coalition’s Welfare Reform Act 2012, claimants in this group who did not comply with this requirement lost 50% of the work related activity component (£28.75) for the first four weeks of non-compliance and all of it for weeks of non-compliance thereafter. None of their basic payment was docked.

Tougher sanctions

But the Welfare Reform Act introduced tougher sanctions for those who breached the terms of their benefits. Claimants can now immediately lose their entire basic rate (£72.40 or £57.35) if they do not demonstrate that they are trying to seek work. Although those in breach now retain the full work related activity component (£28.75), the changes mean many people in this group are now substantially worse off financially.

The BMJ spent three days visiting three centres in England to observe at first hand the effects of austerity policies and the changes to benefits.

Jonathan Gore, GP partner, Lawson Practice, Hackney, northeast London

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It [the ESA] has definitely generated more work. It’s not part of NHS work, and you would normally charge a fee, but these are people that are struggling with their money, so you might feel that you couldn’t ask them to pay a fee. It’s really a reduction in our income to provide a service for nothing. Plus, if you do that, you can’t be doing something else. It’s a patient contact that’s generated that would otherwise not have happened. It’s a 10 minute consultation, 15 minutes writing a report and planning it, and the secretary’s time.

There is definitely some truth that not a great deal of attention is given to the information GPs provide. What they [the assessments] are not able to do is to see how cumulative problems—often physical and psychological—interact to create disability.

As a GP, I do see work as a healthy option. It’s probably more use than your “five a day.” Yet, [although] some people may be able to change their outlook and employment, it’s a bridge too far for a lot of people.

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distress to people if money suddenly stops. I'm very keen to get people back to work, where possible, but it can't just happen overnight, and there is very little structured help to get them back to work. We're seeing a lot of quite poor decision making in assessments, particularly for people with mental health problems. I have patients with chronic fatigue who have been I think very poorly treated. I think there's a real lack of understanding of mental health in the benefits system. I think judgments are made inappropriately on very flimsy evidence.

Because people are having problems, we're seeing them more often because of deterioration in their mental health or crisis situations. We can see people several times a week because everything is falling apart for them, which puts quite a strain on it.

I would like a bit of respect as a GP. I do question people before I support them in appeals. On one hand we're being asked to provide reports. But then we're told via a letter from the minister that as an advocate of the patient, the GP "is not in a position to dispense advice to the decision maker on benefit entitlements." Then don't bother asking me for them! It takes quite a lot of time to fill in, I fill them in seriously. But I'd be happy doing other things with my time. For them then not to be taken seriously is slightly dispiriting.

The act also introduced a stricter time limit of one year on claiming ESA for those who were either in work related activity groups or the initial assessment phase. Charities say that this change has resulted in thousands of people losing some or all of their benefit support.

To compound matters, there are lengthy ongoing delays in the initial assessment process, with hundreds of thousands of people waiting in limbo for decisions on whether they are eligible for support.

Against the backdrop of these tougher sanctions, many more patients are appealing against the decision to remove their benefit payments. This has created additional work for GPs, who are often asked to support appeals. But many GPs surveyed by The BMJ thought that their professional opinion was too often disregarded by assessors sticking to a crude scoring system.

Gareth Iacobucci news reporter, The BMJ giacobucci@bmj.com

Next week The BMJ looks at the effects on GPs' workload of the "bedroom tax" and patients' debt and unemployment. Competing interests: None declared. Provenance and peer review: Commissioned; not peer reviewed. Patient consent obtained. Full version and references are on thebmj.com

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AUSTERITY INVESTIGATION

Box 1 \ Investigation background and methods

The BMJ's investigation was prompted by a series of recent trends in UK general practice. As patient demand continues to outstrip available resources, GPs have faced a surge in their overall workload. More than half (54%) of the GPs who responded to a recent BMA survey said that their current workload was "unmanageable" or "unsustainable."11

Alongside this, The BMJ heard numerous anecdotal reports from GPs who told us that a rising number of appointments were being taken by patients presenting with non-medical problems relating to issues such as debt and unemployment.

Against the backdrop of the UK government's austerity programme, The BMJ set out to examine the extent to which recent welfare changes and other austerity measures were contributing to the increase in GPs' workload, as well as affecting patients' health and wellbeing.

The BMJ emailed a link to the online survey to 28 602 GPs. The survey was active from 5 June to 16 June 2014. A total of 7151 recipients opened the email, and 1056 responded to the survey.

The BMJ also asked doctors to say which environment best described where they worked. The four options were "inner city," "town," "suburban," and "rural." Of the 863 who responded to this question, 26% (204 people) said "inner city," 27% (229) "suburban," 35% (304) "town," and 18% (153) "rural." Alongside the survey The BMJ interviewed doctors, staff, and patients at three general practices. These took place at Haven Health in Felixstowe, Suffolk (5 March 2014), Endeavour Practice in Middlesbrough (10 April 2014), and the Lawson Practice, Hackney, northeast London (7 May and 20 May 2014).
Jeremy Taylor
From a cog to a doer

From a cog to a doer

Jeremy Taylor is chief executive of National Voices, a coalition of health and social care charities in England that champions the right of patients to be involved in decisions about their care. A former Treasury civil servant with a sharp mind to match, Taylor has become the go-to man for any comment related to patient involvement—now guaranteed by the 2012 Health and Social Care Act, which (at National Voices’ insistence) included the right of patients to be consulted. Sample tweet: “Why are all three parties reluctant to spend more £ on NHS and social care but happy to blow billions on HS2: the white elephant in the room?”

What is your pet hate?
‘Medical language that demeans or objectifies the patient. ‘Bedblocker, frequent flyer, inappropriate attender, DNA, multiply comorbid, admit, discharge,’ etc, etc’

Who is the person you would most like to thank and why?
My wife, for rescuing me from obscure bachelorhood.

To whom would you most like to apologise?
My wife, just to be on the safe side.

If you were given £m what would you spend it on?
Paying off the mortgage and funding a year or two’s sabbatical to write a book.

Where are or were you happiest?
I’m happiest with my family, especially up mountains and in rivers. A natural water slide in the eastern French Pyrenees holds particularly fond memories.

What single unheralded change has made the most difference in your field in your lifetime?
The internet. I find it hard to imagine how we ever managed to learn and communicate before we were online.

Do you believe in doctor assisted suicide?
It makes me feel uncomfortable, because I can see how it could be abused.

What book should every doctor read?
They should read novels—almost any—to stimulate their imagination and their capacity for empathy.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
I would hope that they could have a laugh through the tears and that someone would read out some of the silly verse I’ve composed over the years for family occasions.

What is your guiltiest pleasure?
Hmm. Full disclosure is difficult here, but I will own up to red wine and dark chocolate.

If you could be invisible for a day what would you do?
‘Streak through London!’

Clarkson or Clark? Would you rather watch Top Gear or Civilisation? What TV programmes do you enjoy?
In a straight contest it would have to be Clark over Clarkson, but I don’t watch much TV. I really enjoyed Sherlock, Modern Family, and House of Cards (the Kevin Spacey version—I still need to see season two). I guess I like stuff with wit, clever dialogue, and good characters.

What is your most treasured possession?
Other than that, I’m more interested in doing things than owning things.

What personal ambition do you still have?
To make “putting patients first” something real, not an empty slogan. There is still a long way to go.

Summarise your personality in three words
Passionate, thoughtful, humorous.

Where does alcohol fit into your life?
I like a glass or two of red wine of an evening, along with the chocolate I referred to earlier.

What was your earliest ambition?
To avoid anything stereotypically respectable—especially doctor, lawyer, or accountant. Then I spoilt it all by becoming a civil servant. It took me much longer to work out what I actually wanted to do.

Who has been your biggest inspiration?
Peter Gibson was the inspirational director of the Scottish Consumer Council in the late 1980s, when I was a rookie researcher there. He had a strong sense of justice, a huge intellect, and a wicked sense of fun, enabling a small non-governmental organisation to punch way above its weight.

What was the worst mistake in your career?
Being too cautious and not following my instincts earlier.

What was your best career move?
Throwing caution to the winds, leaving the Treasury, and becoming a charity director. I would find it difficult to go back to being a cog in the government machine.

Bevan or Lansley? Who’s been the best and the worst health secretary in your lifetime?
The best has to be Bevan. He had the guts to introduce a comprehensive health service, free at the point of use, at a time when Britain arguably couldn’t afford it. His inspiration is highly relevant now. Do we have the guts to carry on affording comprehensive healthcare? It is still a matter of choice and conviction, and “austerity” itself is a choice, not an economic inevitability. As for Lansley, his reforms are now clearly revealed as a costly vanity project.

What book should every doctor read?
It makes me feel uncomfortable, because I can see how it could be abused.

What is your pet hate?
Medical language that demeans or objectifies the patient. “Bedblocker, frequent flyer, inappropriate attender, DNA, multiply comorbid, admit, discharge,” etc, etc.

What would be on the menu for your last supper?
Wine, chocolate, and a big cake to hide the nail file.

Do you have any regrets about becoming a patient champion?
None at all.

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