NEWS

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Screen name matters in the online dating game

US panel proposes new name and diagnostic criteria for chronic fatigue syndrome

Michael McCarthy SEATTLE

The condition known as myalgic encephalitis (ME) or chronic fatigue syndrome (CFS) is a serious, chronic multisystem disease that can cause significant impairment and disability, an expert panel convened by the US Institute of Medicine has concluded in a new report.[1] "In its most severe form, this disease can consume the lives of those whom it afflicts. It is 'real,'" the committee wrote.

The institute commissioned the committee to develop evidence based diagnostic criteria for ME/CFS but not to investigate the causes, pathophysiology, pathogenesis, or treatment of the syndrome.

It found that ME/CFS is a debilitating condition characterised by profound fatigue, pain, sleep disturbances, and post-exertional malaise, often accompanied by secondary depression or anxiety. Neurocognitive symptoms are common, it found, as are autonomic symptoms, including orthostatic intolerance, a state in which symptoms worsen when patients are upright and improve when they are recumbent.

The diagnosis of ME/CFS can be frustrating to patients, the committee notes, because there is no known cause or cure and because many clinicians are sceptical that the condition is serious, often thinking that the symptoms are the result of psychogenic illness or a "figment of the patient's imagination."

The committee proposed a new set of diagnostic criteria (below) and a new name for the condition: systemic exertion intolerance disease (SEID).

"The symptoms should persist for at least six months and be present at least half the time with moderate, substantial, or severe intensity to distinguish ME/CFS from other diseases," the committee said.

The criteria, which are more focused on the central symptoms of ME/CFS than other definitions of the condition, "will make it easier for clinicians to recognize and accurately diagnose these patients in a timelier manner," the committee said.

The committee rejected the term "chronic fatigue syndrome" because it is widely unpopular among patients, who believe that it leads others, including clinicians, to think that patients are malingering and that their symptoms are not real.

The committee also rejected the term myalgic encephalitis because the committee found insufficient evidence of brain inflammation in patients with ME/CFS.

Cite this as: *BMJ* 2015;350:h775

BRUCE ADAMS/PA AND FRANK TEWKESBURY/GETTY IMAGES

Politician Yvette Cooper (left) and yachtswoman Clare Francis have both struggled with the disorder

Diagnostic criteria for ME/CFS or SEID as defined by the IOM committee

A patient should have three core symptoms:

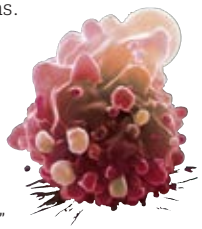
- A substantial reduction or impairment in the ability to engage in pre-illness levels of activity that persists for more than six months and is accompanied by fatigue, which is often profound, of new or definite onset, not the result of ongoing excessive exertion and not substantially alleviated by rest
- The worsening of symptoms after any type of exertion, such as physical, cognitive, or emotional stress—known as post-exertional malaise, and
- Unrefreshing sleep.

In addition the patients should have at least one of two other manifestations:

- Cognitive impairment
- Orthostatic intolerance

IN BRIEF

Canadian court backs physician assisted suicide: Canada's Supreme Court has struck down a century old law imposing up to 14 years' imprisonment on doctors who help patients end their lives. The court accepted the argument that the ban on assisted suicide violated the guarantee of equality in Canada's Charter of Rights and Freedoms.



Public attitude to cancer screening doesn't match reality: Nine in 10 people think cancer screening is "almost always a good idea," despite the fact that a smaller proportion of people actually undergo screening—58% for bowel screening and 77% for breast screening—shows a study by Cancer Research UK published in the *British Journal of Cancer*.

UK response to Ebola was too slow: A report from the Public Accounts Committee says that the Department for International Development was too slow to react to the outbreak of Ebola virus disease in west Africa and relied on the view of WHO rather than organisations on the ground. Had it responded sooner, at least in Sierra Leone, lives and money would have been saved.

China proposes strict anti-tobacco controls: China's government has published draft regulations for banning smoking in public places, which, if implemented, would become the strictest antismoking law in Chinese history. They also propose that warnings about the harms of tobacco should cover at least half the packaging of tobacco products and prohibit all cigarette advertising, promotion, and sponsorship.

IN BRIEF

Pressure grows on mental health beds: The Mental Health Act was used to detain 23 531 people in England in 2013-14, a 6% rise on the previous year, a report from the health regulator the Care Quality Commission has found.[2] The number of NHS mental healthcare beds fell by 8% between the first quarter in 2010-11 and the last quarter in 2013-14. The mental health charity SANE said that pressure on psychiatric beds was forcing doctors to use the act when most patients were admitted voluntarily.

College advises women to avoid alcohol in pregnancy: Women trying to conceive and those in the first three months of pregnancy are advised not to drink any alcohol, states updated information for patients from the Royal College of Obstetricians and Gynaecologists.[1] The college said a safe limit for alcohol consumption during pregnancy has not been proved and that the only way to be certain that the baby was not harmed by alcohol was not to drink at all during pregnancy or while breast feeding, although small amounts of alcohol after the first trimester did not seem to be harmful.

Faith groups back law to ban abortion on grounds of sex: An alliance of more than 25 organisations, including the Muslim Women's Network, the Hindu Council, and the Sikh Council, has backed an amendment to the Serious Crime Bill that would outlaw abortion on the grounds of sex. The bill, which contains new measures to combat domestic violence and female genital mutilation, is on course to become law before the general election in May. The amendment, tabled by the Conservative MP Fiona Bruce, has been signed by 73 MPs.

Police cells are not appropriate places of safety, MPs say: MPs on the House of Commons Home Affairs Committee have called for a change in the law so that police cells are no longer considered a "place of safety" under the Mental Health Act.[3] In 2013-14 a total of 6028 adults and 236 children were detained in police cells because there were no beds in hospital. There was a "clear failure" of NHS clinical commissioning groups to provide for children with mental health problems, said MPs.[3]

Belgian prisoner denied euthanasia: Frank Van den Bleeken, who has served 30 years in prison for rape and murder, will not become Belgium's first prisoner to undergo euthanasia despite his request being granted last year. Instead, he is being transferred to a psychiatric centre in Ghent before being moved to a specialised care facility in the Netherlands. He had asked for the right to euthanasia because he claimed he was not receiving any mental healthcare in the prison.

Ebola incidence rises: The number of new cases of Ebola virus disease in all three of the worst affected countries has risen for the first time this year. There were 124 new cases in the week up to 1 February, up from 99 the previous week. The United Nations' special envoy on Ebola, David Nabarro, said that another $1bn was needed to fight the disease and that the rise proved that Ebola still posed a grave threat.

Cite this as: *BMJ* 2015;350:h771

Panel finds headache specialist guilty of dishonesty in research misconduct case

Andrew Dowson: the panel is yet to decide whether he is fit to practise

Clare Dyer THE BMJ

A headache specialist who jointly led a clinical trial that sparked a celebrated libel action was dishonest in signing a "materially false" statement in a clinical trial agreement and in not telling a research ethics committee that he had breached the research protocol of a previous trial, a UK regulatory panel has held.

The Medical Practitioners Tribunal Service panel found two charges of dishonesty proved against Andrew Dowson, who was joint principal investigator with the cardiologist Peter Wilmshurst on the Migraine Intervention with STARFlex Technology (MIST) trial. The case is seen as the most important to feature allegations of research misconduct by the General Medical Council since that of Andrew Wakefield, whose work resulted in an international scare over the measles, mumps, and rubella vaccine.[1]

The panel will go on to consider whether Dowson's fitness to practise is impaired and, if so, what sanction he should face. The hearing is scheduled to conclude by 19 February.

NMT Medical, the US manufacturer of the STARFlex device, sued Wilmshurst for defamation over comments he made about trial results. He refused to back down and ran up large legal costs before the company went into liquidation.[2]

Cite this as: *BMJ* 2015;350:h709

Antibiotic research needs funding to make it more attractive and viable, says report

Zosia Kmietowicz THE BMJ

A global fund is needed to bolster basic and innovative research into antibiotics, to cultivate new solutions to tackle resistance, and to elevate the status of the specialty to attract new scientists, a UK report has proposed.[1]

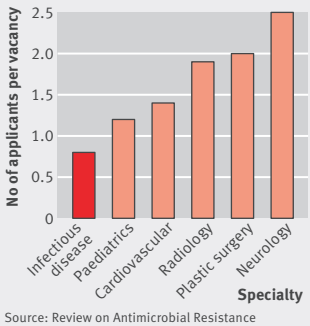
Jim O'Neill, an economist who was appointed last July by the UK prime minister, David Cameron, to chair the review on antimicrobial resistance, said that such a fund would also pay for scientists to re-examine existing drugs and whether new doses or combinations could help restore their effectiveness and to improve diagnostics to ensure that the right antibiotics were used only when they were needed.

"I am calling on international funders, philanthropic or governmental, to allocate money to a fund that can support blue sky science and incubate ideas that are more mature," said O'Neill in a press statement.

The report highlighted the fact that the world's biggest funder of biomedical research, the US National Institutes of Health, allocated just 1.2% ($341m (£225m)) of its annual $30bn budget each year over the past five years to antimicrobial research. Over the same period it spent $5.2bn a year, or 18.5% of the total, on cancer research.

Cite this as: *BMJ* 2015;350:h700

Applicants per vacancy for US residencies and fellowships



Source: Review on Antimicrobial Resistance

Review rejects claim of 45% higher hospital death rates in England than in United States

Jacqui Wise LONDON

Hospital standardised mortality ratios (HSMRs) are an unreliable method for comparing the quality of hospitals in the United States and England, an investigation by the Academy of Medical Royal Colleges has concluded.[1]

The independent inquiry was commissioned after Brian Jarman, former professor of primary care at Imperial College London, who developed the HSMR index, said in media reports in September 2013 that the likelihood of dying in NHS hospitals in England was 45% higher than in hospitals in the United States.[2]

The academy's review, commissioned by Bruce Keogh, NHS England's medical director, found four main reasons why US and English hospital mortality rates cannot be directly compared. Firstly, in England patients are less likely than in the US to be categorised as being at high risk. For example, septicaemia is the primary diagnosis in 4.5 per 10 000 hospital admissions in England, but the number is eightfold in the US, at 35 per 10 000. This is because in the US there are greater financial incentives to put patients into a higher risk category, as hospitals receive more money from health insurers for patients who are more seriously ill.

Secondly, comorbidity and underlying conditions are under-reported in England, again, because of financial incentives in the US.

Thirdly, the report said that there was some evidence that patients in England may be sicker on admission to hospital. For example, the acute physiology score of patients admitted to critical care is 16.7 in England but 10.6 in the US. And the proportion of patients ventilated within 24 hours is 68% in England and 27% in the US.

Finally, a higher proportion of patients die in acute care hospitals in England and Wales (56%) than in the US (45%), mainly because of a lack of alternatives such as hospices. Whereas in England 5% of patients in acute care hospitals are transferred to alternatives such as domiciliary care and hospices, in the US 30% of patients are transferred.

Proportion of patients transferred from acute hospitals to alternative venues to die

Cite this as: *BMJ* 2015;350:h787

Health services outsourced to private sector increased from £6.9bn to £12.2bn in three years to 2013

Gareth Iacobucci THE BMJ

The private sector increased its financial yield from medical services outsourced from the NHS by three quarters from 2010 to 2013, a new audit has shown.

A report published by Oxford Economics for the Business Services Association (BSA)[1] showed that the UK-wide market for "frontline health services" that are outsourced from the NHS is now worth £12.2bn and employs 261 000 staff. When the audit was last carried out in 2012 the market was worth £6.9bn and employed just 98 000 staff.[2]

The research measured the NHS's purchase of services by healthcare providers classified as the "market sector."

Cite this as: *BMJ* 2015;350:h768

Woman with IQ of 70 and six children should be sterilised for her own safety, court rules

Clare Dyer THE BMJ

A mother of six with an IQ of 70 and an "extraordinary, tragic, and complex" obstetric history should be sterilised for her own safety, a High Court judge has ruled.

Mr Justice Cobb held that the 36 year old, DD, who has an autistic spectrum disorder, lacked the capacity to decide for herself and should be sterilised rather than have an intrauterine device (IUD) inserted. All six of her children, who range in age between 6 months and 12 years, are being raised by permanent substitute carers, and she has no contact with them. Four were born within the past five years.

DD has a history of concealing her pregnancies,[1] and her doctors told the court that a future pregnancy, particularly if hidden, could kill her. When her last baby was delivered by caesarean section her uterine wall was found to be "tissue paper thin," with the baby visible through it, the judge said. Doctors warned that a further pregnancy would put dangerous pressure on it. It would be likely to rupture, causing the almost certain death of the baby and significant bleeding that would materially threaten DD's life.

Giving judgment in the Court of Protection in London, the judge said, "This case is not about eugenics. This outcome has been driven by the bleak yet undisputed evidence that a further pregnancy would be a significantly life threatening event for DD."

He said that it would be a rare case in which the more radical alternative of sterilisation would be preferable to the insertion of an IUD, but this was such a case. DD could pay for pregnancy with her life; if the IUD were expelled or removed there was reason to believe that she would not disclose this to professionals.

Cite this as: *BMJ* 2015;350:h728

Gulp and think of your waistline

Zosia Kmietowicz THE BMJ

A new campaign called Gulp (Give Up Loving Pop) takes to the road in half term week to tell the truth about the harmful effects of sugary drinks.

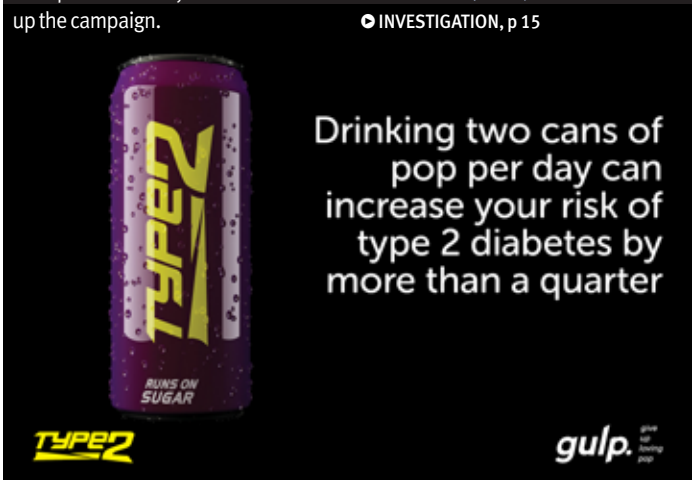
There is a chronic lack of awareness among adults and young people about the effect of sugary drinks on weight and a range of associated health conditions, says the Health Equalities Group, a social enterprise in Merseyside that set up the campaign.

Robin Ireland, the group's chief executive, said, "As well as damaging your teeth, overconsumption of these drinks can lead to weight gain, type 2 diabetes, and poor heart health. Unless we start to take action on sugary drinks we will be storing up problems for future generations."

Gulp is running a series of road shows, featuring advertisements, such as the one below.

Cite this as: *BMJ* 2015;350:h772

INVESTIGATION, p 15



Surgeon acquitted of carrying out FGM in a prosecution criticised by obstetricians

Clare Dyer THE BMJ

An NHS trainee obstetrician who faced the first prosecution in the United Kingdom for female genital mutilation has been acquitted after the jury deliberated for less than half an hour.

Dhanuson Dharmasena, then a junior registrar in obstetrics and gynaecology at the Whittington Hospital in north London, was accused of reinfibulating a Somali woman by sewing her labia together after the birth of her first child in 2012. But he told the jury that he had put only a small suture at the top of a cut he had made to deliver the baby, to stop bleeding, in an emergency situation.

The verdict of not guilty came after Mr Justice Sweeney told the jury at Southwark Crown Court in his summing up that they would have to consider whether the doctor had been made a "scapegoat" for systemic failures by the hospital.

Dharmasena's lawyers argued that he had been "hung out to dry" and made to pay for the "ineptitude" of the hospital, where the woman, named only as AB, should have been placed on a female genital mutilation pathway months before her due date. Instead, it emerged only when she came to hospital in labour at 8 am on a Saturday morning in November 2012 that she had undergone the procedure as a child in Somalia.

PHILIP TOSCANO/PA

Dhanuson Dharmasena said he regards FGM as "abhorrent"

The court heard that AB, who underwent genital mutilation at the age of 6 or 7, had had surgery in 2011 at a hospital in south London to facilitate sexual intercourse. She told a community midwife about this but, against Whittington Hospital policy, was not referred to a specialist female genital mutilation team antenatally.

Dharmasena was bleeped at 10 am because the fetus was showing signs of distress. He told the jury that he had to make a cut through scar tissue to deliver the baby safely and put in a single figure of eight stitch afterwards to stem the bleeding. He told the jury that he regarded female genital mutilation as an "abhorrent practice."

Cite this as: *BMJ* 2015;350:h703

Hospitals put into special measures in 2013 have cut their mortality, finds analysis

Gareth Iacobucci THE BMJ

Death rates at the 11 NHS hospital trusts in England that were placed into special measures in July 2013 have fallen since the measures were introduced, a new analysis has found.

The healthcare analysis company Dr Foster, which carried out the study, said that it found a "significant reduction" in death rates when the 11 trusts were taken as a group.[1] But the company said that the figures also showed "significant variation" in performance between the trusts.

The 11 were placed into special measures in July 2013 after they were identified as having higher than expected death rates in a review by NHS England's medical director, Bruce Keogh.[2]

The special measures regime is overseen by England's healthcare regulator the Care Quality Commission, with fellow regulators the NHS Trust Development Authority and Monitor in charge of implementing support packages to help hospital trusts.

Dr Foster's analysis found that the 11 trusts showed a decline of 9.5% in mortality rates from the point they were placed in special measures to the latest available point in August 2014. In the same period there was a 3.3% fall nationally in mortality.

On average, the 11 hospitals still had a higher mortality rate than the national average, but Dr Foster said that the gap had "narrowed considerably" since the measures were introduced.

The researchers used national hospital standardised mortality ratios and summary hospital level mortality indicators. They compared mortality data from the 11 trusts in special measures with thousands of randomised samples from other English trusts to see how they had performed in relation to the average.

Analysts said that it was difficult to know what had driven the change, as the special measures intervention was a managerial rather than a clinical one. But they suggested that changes to the trusts' senior management and the appointment of "buddy" hospitals to provide support to struggling organisations may have contributed. The variation seen between the 11 trusts was consistent with the CQC's August 2014 report that measured improvement at the hospitals.[4]

Roger Taylor, Dr Foster's director of research and public affairs, said, "Our analysis gives us some hard evidence that special measures can be an effective tool for turning around NHS trusts that experience problems."

Cite this as: *BMJ* 2015;350:h744

Food "responsibility deal" has cost 6000 lives, professor tells meeting

Nigel Hawkes LONDON

A "responsibility deal," under which food manufacturers and retailers agree to sell healthier products if the government refrains from legislation, has achieved gains "worth celebrating," a meeting in London heard on 3 February.

The deal has been criticised as being soft on the food industry and easily manipulated, but Susan Jebb, of the University of Oxford, who chairs the deal's food network, put up a stout defence of its record at a Westminster Food and Nutrition Forum held at the Royal Aeronautical Society. "It's a judgement call, but I personally don't buy the case that it would have been better done by legislation," she said. "That's very difficult when you're talking about product composition."

Parliament would have been unlikely to find the time for legislation, which would have been difficult to draft effectively, added Jebb. The risk, she said, would have been passing legislation that put limits only on foods marketed to children—"a tiny bit of partial action, which is not going to change the vast majority of foods which are marketed, which is what we've been trying to do."

Susan Jebb (left) defended the "responsibility deal" against criticism from Graham MacGregor

But Graham MacGregor, a professor who has campaigned on salt in food, disagreed. He said that the responsibility deal formulated by Andrew Lansley, the former health secretary, had been a disaster—delaying progress on salt reduction begun by the Food Standards Agency and costing, by his reckoning, 6000 lives. The responsibility deal was rubbish, he said.

Jebb gave examples of how she thought the deal had worked. She said that 70% of high street chains were now committed to calorie labelling and that two thirds of manufacturers had signed up to salt reductions. A good start had been made in reducing sugar in soft drinks.

INVESTIGATION, p 15

Cite this as: *BMJ* 2015;350:h676

RESEARCH NEWS

AUTISM

Frequent eye movements in babies linked to diagnosis

More frequent eye movements in babies have been linked with a later diagnosis of autism spectrum disorder in research funded by the Medical Research Council.[1] The researchers said that the findings may contribute to better ways of identifying babies with early signs of behavioural difficulties.

The study used eye tracking technology to measure eye movement patterns in 104 babies aged 6-8 months who were at high or low familial risk of autism spectrum disorder. Babies who went on to receive a diagnosis of autism spectrum disorder at 36 months moved their eyes about three times a second, compared with two times a second for those who did not receive such a diagnosis.

The babies at high risk of autism spectrum disorder also showed little variation in the frequency of their eye movements, with highly consistent and repetitive timing.

Hugh Perry, chair of the MRC's Neurosciences and Mental Health Board, said, "This research suggests that eye tracking technology could be used to reveal more subtle changes that might give us some important clues as to what might be causing autism in the developing brain."

Cite this as: *BMJ* 2015;350:h702

CANCER DEATH

Eight signs of impending death are identified

Eight specific clinical signs associated with death within three days in patients with cancer have been identified in a study published online in the journal *Cancer*. Knowing when death is imminent means that close family members can be informed, investigations and aggressive treatment can be discontinued, and the patient can be made comfortable, the authors noted.

Researchers studied 357 consecutive patients with advanced cancer who had been admitted to acute palliative care units at two tertiary cancer centres in the United States and Brazil.[1] They documented 52 physical signs every 12 hours from admission to death or discharge. During the study 57% of the patients died.

Eight physical signs that were highly diagnostic of impending death were identified. These signs occurred in 5% to 78% of the patients in their last three days of life and had a late onset, as well as a high specificity (>95%) and a high positive likelihood ratio for death within three days. The signs were non-reactive pupils, decreased response to visual stimuli, decreased response to verbal stimuli, inability to close eyelids, drooping of the nasolabial fold, hyperextension of the neck (the head tilting back when the patient lies down), grunting of vocal cords, and upper gastrointestinal bleeding.

The authors said that they now needed to validate their results in other healthcare settings, such as inpatient hospices.

Cite this as: *BMJ* 2015;350:h663

BLOOD PRESSURE IN DIABETES

Targets set for type 2 diabetes should be lower

Recent changes to guidelines on lowering blood pressure in patients with type 2 diabetes should be reconsidered to reinstate the lower target level, researchers have said in *JAMA* after carrying out a meta-analysis of randomised controlled trials.[1] They concluded that people with diabetes who reached a systolic blood pressure below 130 mm Hg had a 25% lower risk of stroke than those with higher blood pressure levels and also had a lower risk of retinopathy and albuminuria.

Until recently most guidelines recommended that people with type 2 diabetes should have a blood pressure target of lower than 130/80 mm Hg, contrasting with a target of 140/80 mm Hg for the rest of the population. But in 2010 the ACCORD trial concluded that a target of 120 mm Hg did not significantly reduce cardiovascular events and was associated with a greater number of adverse effects than a target of 140 mm Hg.[2] As a result, guidelines in the United States and Europe last year changed the recommendation to a less aggressive target of 140/90 mm Hg.[3 4]

The researchers included 40 trials involving 100 354 patients with type 2 diabetes. They found that each 10 mm Hg reduction in systolic blood pressure was associated with significant reductions in death, cardiovascular events, coronary heart disease events, stroke, retinopathy, and albuminuria.

Kazem Rahimi, of the George Institute for Global Health at the University of Oxford and the lead author, said, "We urgently call for these recent changes to guidelines to be modified and for all guidelines around the world to consistently reflect the evidence, so that patients with diabetes can receive the best possible treatment."

Cite this as: *BMJ* 2015;350:h749

TYPE 1 DIABETES

Women have significantly higher risk of dying than men

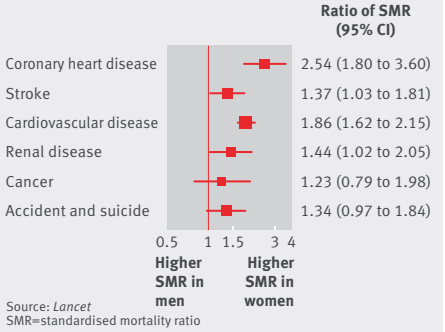
Women with type 1 diabetes are at raised risk of dying from any cause and twice as likely to die from heart disease as men with type 1 diabetes, a meta-analysis has found.[1] It is well known that people with type 1 diabetes have a shorter life expectancy than the general population, but until now it has not been clear whether this excess mortality was the same for men and women, said the researchers.

To investigate they analysed data from 26 studies involving 214 114 people with the disease. Their results, published in the *Lancet Diabetes and Endocrinology*, showed that women with type 1 diabetes have a higher excess all cause mortality than men (ratio of standardised mortality ratio 1.37 (95% confidence interval 1.21 to 1.56)) and higher excess mortality from stroke (1.37 (1.03 to 1.81)), coronary heart disease (2.54 (1.80 to 3.60)), cardiovascular disease (1.86 (1.62 to 2.15)), and renal disease (1.44 (1.02 to 2.05)).

The authors speculated that poorer glycaemic control and difficulties in insulin management, which are more common among women, could be contributing to the increased risk of vascular related death in women with type 1 diabetes. In a linked comment David Simmons, of the University of Western Sydney, New South Wales, wrote that the extra investment that can help reduce hyperglycaemia needed to start immediately.

Cite this as: *BMJ* 2015;350:h678

Pooled women to men ratios of SMRs associated with type I diabetes



Source: *Lancet*
SMR=standardised mortality ratio

Celia Ingham Clark
Enthusiastic and determined

PETER LOCKE

CELIA INGHAM CLARK is the NHS England director for reducing premature mortality. She qualified at Cambridge and the Middlesex universities, then trained as a general surgeon and was a consultant and medical director at the Whittington Hospital in north London. Her interest in health policy began as a member of the BMA's Junior Doctors Committee in the 1980s, and her focus is on improving the quality of patient care. In 2013 she was awarded an MBE for services to the NHS.

What book should every doctor read?
"*Better: A Surgeon's Notes on Performance* by Atul Gawande. It gives examples of simple, low tech changes that, if systematically implemented, can greatly improve patient care. The best example is perhaps the systematic application of proper handwashing"

What was your earliest ambition?
To be an astronaut, until I realised that I had been born at least 50 years too early for this to be realistic.

Who has been your biggest inspiration?
My father, Ken Parsons, who was a rural GP who showed me the difference good doctors can make to their patients' lives; and Richard Wood, who supervised my surgical research and taught me to keep asking questions and how to speak to an audience with confidence. Sadly, neither of them is still with us.

What was the worst mistake in your career?
Applying for something that I thought was a general surgical registrar post but turned out to be based in another specialty. I had to back out at interview.

What was your best career move?
Taking up the post of medical director at the Whittington Hospital. I really enjoyed being a colorectal surgeon, but in that role I could help only one patient at a time. In medical management, if you get it right, you can improve the quality of care for many more patients.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
From what I have seen it's a very difficult job: there will always be a demand for more resources than are available because of new technologies and drugs, demographic changes, and increasing public expectation. A good health secretary has to ensure a balanced approach, taking into account public and professional views and the changing trends in society.

Who is the person you would most like to thank and why?
John Marks, director of studies for medicine at Girton College, who was my tutor at Cambridge. Among many other things, he taught me to use lists to get organised, and this advice is increasingly valuable in a world of instant messaging.

To whom would you most like to apologise?
To the patients and their families for whom my surgery failed to produce the outcome we wanted.

If you were given £1m what would you spend it on?
I'd give it to one of the big health charities and let it decide. They have sound processes for selecting where the money can have the greatest effect.

Where are or were you happiest?
Walking in Pembrokeshire with my husband, sons, and dog on a fine, sunny day. Actually, it's quite fun even when it rains.

What single unheralded change has made the most difference in your field in your lifetime?
In medical management, the recognition that management skills, like clinical and teaching skills, can be learnt and then used by many more doctors to improve the quality of care for patients.

Do you support doctor assisted suicide?
I can see a theoretical argument for it in extreme cases, but I don't think that I'd ever be able to put it into practice.

What book should every doctor read?
Better: A Surgeon's Notes on Performance by Atul Gawande. It gives examples of simple, low tech changes that, if systematically implemented, can greatly improve patient care. The best example is perhaps the systematic application of proper handwashing.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
It would have to reflect my Welsh roots; both of my parents were Welsh, and I represented Wales at lacrosse a long time ago. Probably the hymn "Guide Me, O Thou Great Redeemer."

What is your guiltiest pleasure?
Probably cheese.

What is your most treasured possession?
My cat (if you can call it a possession, which is doubtful).

What, if anything, are you doing to reduce your carbon footprint?
Whenever possible I try to walk between meetings in London. I use a pedometer and usually manage over 10 000 steps a day.

What personal ambition do you still have?
Professionally, I want to be part of a team that reduces premature mortality in England. Personally, I would like to become a grandmother (but not just yet, thank you, boys).

Summarise your personality in three words
Enthusiastic, determined, organised (at least at work).

What is your pet hate?
One of my old teachers said that if you didn't know something he didn't mind if it was from ignorance, but he did if it was from laziness. I think that professionals in medicine have a responsibility to keep learning and to keep asking questions throughout their professional lives.

Cite this as: *BMJ* 2015;350:h677