NEWS

▶ References and full versions of news stories are on **thebmj.com**

thebmj.com
▶ US Supreme Court throws out law that forced doctors to deliver antiabortion message

Half of UK hospitals lack essential services for managing acute GI bleeds, inquiry finds

Susan Mayor LONDON

Patients with acute gastrointestinal (GI) bleeds should be admitted only to hospitals with 24/7 access to endoscopy, interventional radiology, GI bleed surgery, and the critical care facilities needed to optimise their care, a UK inquiry has recommended,[1] saying that half of hospitals currently managing these patients lack some of these services.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) collected data on the care and outcomes of patients admitted to hospitals in England, Wales, Northern Ireland, the Isle of Man, Guernsey, and Jersey with GI bleeding in the four months from 1 January to 30 April 2013.

The inquiry analysed the care of 1077 of the 4780 patients with a severe GI bleed managed at 227 hospitals. NCEPOD peer reviewers assessed clinician questionnaires and case notes from 485 cases against evidence based guidelines and recommendations. The reviewers considered that just under half (44%; 210/476) of these patients had received good care on the basis of what they would have accepted from their own teams. They judged that the clinical care of 45% of patients needed improvement.

"The problem of poor case [management] for the very many patients who suffer a GI bleed must be addressed if it is not to become the next NHS scandal," warned Bertie Leigh, chair of the inquiry. "Our detailed examination of GI bleed care and treatment reveals a situation of which we should be ashamed."

Recognition that a GI bleed had occurred was delayed in 21% (35/170) of people who developed the problem as an inpatient. And just over 25% of all patients with a GI bleed (138/595) had a re-bleed.

Lack of recommended services for managing GI bleeds was identified as a problem in many hospitals. One third of hospitals admitting GI bleed patients (32%; 60/185) did not have a 24/7 endoscopy service. Intraoperative gastroscopy was unavailable in 18% of hospitals, and intraoperative colonoscopy was unavailable at 33% of hospitals.

More than two thirds (70%) of hospitals did not provide 24/7 embolisation of GI bleeding onsite, although 45% had a formal network to deal with this.

Only 59% (99/167) of hospitals submitting data to the inquiry had a clinical lead for upper GI bleeds, and 38% (57/151) of hospitals had a clinical lead for lower GI bleeds.

Simon McPherson, NCEPOD report coauthor and a clinical coordinator in radiology, said, "Recognising and treating GI bleeds as quickly as possible can be more urgent than caring for a patient with a serious heart condition.

"The sooner the GI bleed is recognised and the patient is seen by the specialist, the better. But, without 24/7 access to GI bleed specialists, delays in recognition and treatment will continue—and continue to put lives at risk."

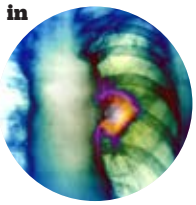
Cite this as: *BMJ* 2015;351:h3488

A| PHOTO / BSIP SA / ALAMY

Recognition that a GI bleed had occurred was delayed in 21% of people who developed the problem as an inpatient

IN BRIEF

RCP launches physician associates faculty: The UK Association of Physician Associates, the Royal College of Physicians, and Health Education England have worked together over the past two years to set up a Faculty of Physicians Associates at the royal college. Faculty members will be able to access the college's membership benefits, and work is now under way to enhance education and training for physician associates.



Lung cancer cases in UK women reach new high: The annual number of diagnoses of lung cancer in UK women surpassed 20000 for the first time in 2012, reaching 20483. Despite a falling smoking prevalence, the incidence of lung cancer in women is still rising because women's smoking rates peaked in the 1970s, while men's peaked in the 1940s. Men's incidence of lung cancer is falling, but around 24000 cases are still diagnosed every year.

Most children report good experiences of hospital care: The Care Quality Commission's first survey of children and teenagers who stayed in hospital overnight or were treated as day patients found that 87% of 19000 rated their overall experience as seven or above out of 10.

More UK students studying in Sudan head to Syria: The Foreign Office has confirmed that seven British students studying at a private medical school in Sudan travelled to Turkey last week, believed to be trying to enter Syria. A group of students and doctors, including five Britons, from the same school in Khartoum went to Syria in March (Features, p 20).

Cite this as: *BMJ* 2015;351:h3559

IN BRIEF

Government plans to cap legal fees in clinical negligence claims: The UK government is proposing to fix legal costs for claimants' lawyers in cases of claims up to £100 000 so that the lawyer's fee reflects a percentage of the patient's compensation. Currently there is no limit on legal fees that can be charged, meaning that lawyers can be paid far more than the patient gets in compensation. The plan, which the government says will save the NHS up to £80m a year, has been welcomed by the Medical and Dental Defence Union of Scotland and the Medical Defence Union.

WMA appeals to Israel to reconsider force feeding bill: The World Medical Association's president, Xavier Deau (pictured), and chair, Ardis Hoven, have written to Israel's prime minister, Benjamin Netanyahu, urging him to reconsider legislation before the Knesset that would explicitly allow the force feeding of detainees on hunger strike.[2] The association said that force feeding was a "degrading, inhumane treatment, amounting to torture" and that doctors should not be involved in any way. The association said that Israeli doctors had treated dozens of hunger strikers very successfully over the past two decades and were able to deal with the situation if allowed to establish a good relationship with them.

FDA won't restrict sales of contraceptive implant: The US Food and Drug Administration will not move to restrict sales of the Essure contraceptive implant, after two reviews of the maker Bayer's postmarket surveillance data found no conclusive evidence of complications beyond those already mentioned in the patient information booklet. But in response to a continuing high volume of complaints from patients the FDA's obstetrics and gynaecology devices panel will hold a meeting to review the device's "safety and efficacy" on 24 September, at which members of the public may raise concerns.

More people in England now die at home: Latest figures on care at the end of life from Public Health England show that the proportion of people dying at home or in care homes rose from 35% (166 749) in 2004 to 44% (207 764) in 2013.[1] The number of people dying in hospital fell by 50 000 over the same period, accounting for less than half of all deaths (227 748) in 2013.

Monitor sets up team to tackle high spending on agency staff: Monitor has set up a team of experts to reduce the amount of money the NHS in England spends on agency staff. Its figures show that spending on temporary staff rose by 29% to £2.4bn in 2013-14 and that NHS foundation trusts spent £1.8bn, more than double what they had planned. The team will run a three month trial at three foundation trusts to provide trusts with support in action planning and a diagnostic tool to identify weaknesses in how trusts manage staff. It also plans a series of workshops designed to spread good practice.

Cancer Research UK invests £15m in major new centres: The charity Cancer Research UK has launched its first major new research centres in Oxford, Manchester, and Cambridge. Each centre will receive £5m to boost work in personalised cancer medicine and early research into detection. The centres will act as research hubs for Cancer Research UK, drawing together expertise and encouraging collaborative research.

Cite this as: *BMJ* 2015;351:h3559

Cochrane group reviews evidence on surgery for stress incontinence after controversy

Nigel Hawkes LONDON

Surgery for urinary stress incontinence in women that involves mesh slings to support the muscles of the bladder is effective and has low rates of complications, an updated Cochrane review has found.[1]

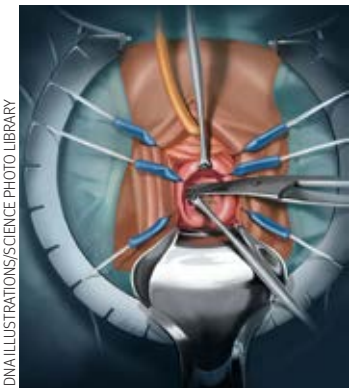
A year after the operation more than 80% of women were cured, though the benefits declined slowly with time. At five years the cure rate fell to around 70%. Two common operations were used, differing in the way the sling was supported: either behind the pubic bone (the retropubic route) or side to side (the transobturator route). Both had similar success rates, the review found.

The operation became controversial after some women reported pain and injury, leading to court actions. In Scotland the chief medical officer asked hospitals to consider suspending mesh operations while an independent review looked at their safety. The review will report later this year and will be informed by the findings of the Cochrane review, Cathryn Glazener of the University of Aberdeen told a briefing at the Science Media Centre in London.

She is a member of both review groups but declined to anticipate the outcome of the Scottish review. "If it presents evidence in an unbiased way, then it will be up to women to decide, and the doctor's job will be to counsel them," she said.

Choosing between the two surgical routes is not straightforward. Both had identical risks of vaginal tape erosion, which occurred in around 20 in 1000 cases. The transobturator route has a lower risk of bladder perforation and voiding dysfunction but a higher risk of groin pain and of the need for repeat surgery. "Both are highly effective and remain effective for five years and beyond and have similar low rates of complications," Ford said.

The team examined 81 randomised controlled trials to reach their conclusions and said that this was one of the most often investigated procedures in medicine.



DNA ILLUSTRATIONS/SCIENCE PHOTO LIBRARY

In Scotland the chief medical officer asked hospitals to consider suspending mesh operations pending an independent review

Cite this as: *BMJ* 2015;351:h3578

Man with locked-in syndrome challenges GMC ruling on doctors' involvement in ending his life

Clare Dyer BMJ

A man with locked-in syndrome has launched a legal challenge to the General Medical Council's guidance limiting the extent to which doctors may help him in ending his life.

The man, referred to as Martin, asked the High Court in London to rule that GMC guidance on assisted suicide unreasonably prevents doctors from helping patients who want to die.

Martin, 50, who is almost totally paralysed after a stroke, tried to kill himself by refusing food and water, but the attempt failed "in distressing circumstances," the court heard. He is now considering the option of an assisted suicide at Dignitas in Switzerland.

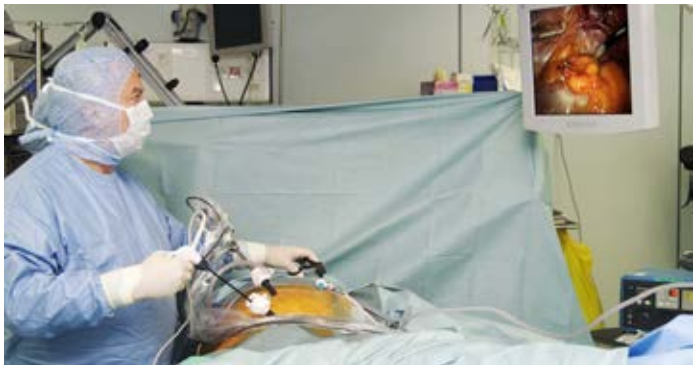
To access Dignitas's services Martin needs a doctor's report covering his medical history, including diagnosis, treatment,

Five times more patients die after emergency bowel surgery as after high risk elective surgery

Jacqui Wise LONDON

The death rate in emergency bowel surgery is up to five times greater than that in high risk elective surgery, shows an audit carried out by the Royal College of Anaesthetists.[1]

The first national emergency laparotomy audit included data on over 20 000 patients (83% of those eligible) from 192 NHS hospitals in England and Wales between 1 December 2013 and 30 November 2014. It found that 11% of patients who underwent emergency laparotomy died within 30 days of the operation. Although this figure was lower than the 15% reported in other studies, it was nevertheless still much higher than the death rate among patients who underwent high risk planned operations such as cardiac, cancer, and vascular surgery, found in various studies to be 2-3%.



AJ PHOTO/SPL

The death rate varied, with 18% of those over 70 years dying within 30 days

The death rate varied with patients' age, with 3% of patients aged under 50 years but 18% of those over 70 years dying in hospital within 30 days. More than a quarter of patients needed hospital treatment for more than 20 days. The report's authors said that one problem was underinvestment in key resources. In particular, patients who undergo emergency bowel surgery benefit from consultant delivered care and admission to critical care units after surgery. The audit found that only 60% of patients were admitted to critical care directly after emergency bowel surgery, whereas it is routine practice for 100% of patients undergoing much lower risk planned cardiac surgery to be admitted to critical care units.

Less than half (48%) of patients who were admitted in emergencies and underwent emergency bowel surgery were reviewed within 12 hours of admission by a consultant surgeon, as recommended in national standards. There was wide variation between hospitals in the rate of consultant review.

Cite this as: *BMJ* 2015;350:h3496

Doctors and scientists urge Wellcome Trust to divest from fossil fuels

Zosia Kmietowicz THE BMJ

More than 50 senior doctors and academics have signed a letter to the Wellcome Trust urging it to support action on climate change by pulling all of its investments from the world's 200 largest fossil fuel companies over the next five years.

The call is part of the *Guardian* newspaper's "Keep it in the ground" campaign, launched in March this year. The campaign recognises that to avoid the mean global temperature rising by more than 2°C, 80% of known coal reserves will have to stay underground, along with half the gas and a third of the oil reserves.[1]

The *Guardian* said that more than 200 institutions, worth over $50bn (£31.8bn), have committed to divesting from fossil fuels. It has called on the Bill and Melinda Gates Foundation and the Wellcome Trust—the world's two largest health charities—to do the same.

The BMA, which owns the BMJ Publishing Group, agreed to divest at its annual meeting a year ago.

The doctors' letter said, "Divestment rests on the premise that it is wrong to profit from an industry whose core business threatens human and planetary health, bringing to mind one of the foundations of medical ethics—first, do no harm." The campaign's primary concern is that not divesting legitimises an industry that has made no pledges to act on climate change.[2] "Indeed, many of these companies continue to use their considerable influence to delay political action, as tobacco companies have done."

Signatories of the letter included Fiona Godlee, editor in chief of *The BMJ*. Other signatories included Unni Karunakara, former president of the humanitarian organisation Médecins Sans Frontières; Nick Black, professor of health services research at London School of Hygiene and Tropical Medicine; and Martin McKee, also from the London School of Hygiene.

Cite this as: *BMJ* 2015;350:h3436

and prognosis. But the GMC's guidance says that, when a patient raises the question of assisted suicide, doctors should be prepared to listen and discuss the reasons but must not breach the Suicide Act 1961 by actively encouraging or assisting.

Martin's solicitors, Leigh Day, said that this has a "chilling effect" on doctors' ability to give advice on end of life choices and their willingness to provide the medical reports required by Dignitas.

Although assisting a suicide is a crime in the UK, under guidance issued by the director of public prosecutions (DPP) those who do help are rarely prosecuted. The guidance originally implied that doctors were more likely to face prosecution than relatives who compassionately aid a suicide. But, after a Supreme Court judgment in an earlier case brought by Martin and Tony Nicklinson, the DPP's guidance was amended to state that this should apply only if the patient was in the doctor's care.[1]

The GMC also clarified its initial guidance, telling doctors that no action would be taken against them if they simply provided a patient's medical records in response to a request under the Data Protection Act.[2]

Philip Havers QC, for Martin, argued that the GMC should take the more "compassionate approach" taken by the DPP. He said, "We say the DPP's policy is the starting point and the General Medical Council has failed to explain why it needs to take a different approach in order to protect the public."

Cite this as: *BMJ* 2015;350:h3524

Providing welfare advice in GP surgeries can benefit patients

Jacqui Wise LONDON

Welfare advice provided within healthcare settings results in better health and wellbeing among patients and can reduce demand on the NHS, a new report concludes.[1] It says that advice on social welfare can deliver a range of health related benefits such as lower anxiety, and more stable relationships and housing situations.

The report by the Low Commission, an independent body on the future of social welfare advice pulls together the existing evidence about welfare advice and gives examples where it has worked.

Cite this as: *BMJ* 2015;350:h3544

Sir Michael Marmot wrote the introduction to the Low report

Anesthetist is sued after sedated patient recorded insults on phone

Owen Dyer MONTREAL

A Virginia anaesthetist must pay $500 000 (£320 000) in damages to a patient whose smartphone recorded her insulting and mocking him during a colonoscopy and deliberately giving him a false diagnosis.

Expecting to feel groggy after his colonoscopy, the patient, a lawyer identified in court papers only as DB, had turned on his phone's voice recorder to capture the gastroenterologist's postoperative instructions. The phone, in his trousers, recorded the entire procedure.

The anaesthetist, Tiffany Ingham, 42, seemed to have taken a sharp dislike to the patient during their preoperative discussion, when he had mentioned feeling queasy after a previous injection and also disclosed the fact that he was taking a drug for an unidentified rash on his penis.

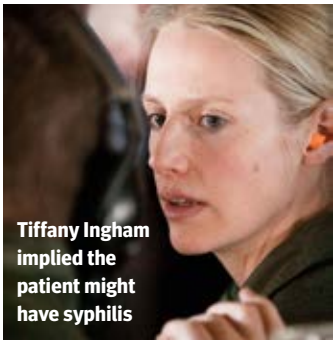
As DB was being anaesthetised he apologised for asking so many questions. Ingham answered when he was unconscious, "After five minutes of talking to you in preop I wanted to punch you in the face and man you up a little bit."

Ingham warned assistants not to touch the rash, saying, "You might get syphilis on your arm or something." She called DB a "retard" and joked about the school he'd attended, once an all girls' school, then wondered aloud whether he was gay.

The gastroenterologist conducting the colonoscopy, Soloman Shah, also made some disparaging remarks about the patient, but these were milder, and he was dismissed from the patient's lawsuit at an early stage.

Ingham mocked DB for needing only a small dose of anaesthetic to be sedated. Calling him a "big wimp," she said, "People are into their medical problems. They need to have medical problems."

Ingham then sang aloud, "Round and round we go. Wheel of annoying patients we go.



Tiffany Ingham implied the patient might have syphilis

Where it'll land, nobody knows."

She then announced, "I'm going to mark 'haemorrhoids' even though we don't see them and probably won't. I'm just going to take a shot in the dark." She then wrote a false diagnosis of haemorrhoids on DB's chart.

Cite this as: *BMJ* 2015;350:h3510

Lawsuit seeks access to data from hepatitis C drug trial

Michael McCarthy SEATTLE

Two health advocacy groups have filed suit to compel the US Food and Drug Administration to release clinical trial data submitted to the agency for the approval of the hepatitis C drugs sofosbuvir and sofosbuvir with ledipasvir. The plaintiffs also seek all FDA records relating to the clinical trials and correspondence between the agency and the US Department of Health and Human Services with companies developing the drugs.

The suit, which was brought by the Treatment Action Group, an HIV and AIDS advocacy group, and the Global Health Justice Partnership, an initiative of the Yale Law School and School of Public Health, was filed in US District Court District of Connecticut on 25 June.[1]

The plaintiffs contended that an independent review of the data was needed because both drugs were approved on an accelerated timeline under the FDA's "breakthrough-therapy" programme. They wrote in their complaint: "While the program aims to streamline approval for promising drugs, it may increase the risk that gaps in drug efficacy will go undiscovered, or that side effects or contraindications will go unnoticed."

The two drugs offer the promise of cure but are costly.

Cite this as: *BMJ* 2015;350:h3564

AXEL HEIMKEN/DPA/PA

Refugees in Hamburg (above) are often sent on long journeys to refugee centres

Refugee policy is criticised after pregnant woman sent on long train trip miscarries

Ned Stafford HAMBURG

The German Medical Association has criticised the state of Hamburg's refugee policy after a 20 year old, high risk pregnant woman from Guinea had a miscarriage after she, her husband, and their toddler son were sent on a 12 hour train and bus trip from Hamburg to a new refugee centre near Dortmund, in North-Rhine Westphalia.

In a press statement Frank Ulrich Montgomery, president of the German Medical Association, said he was "shocked" to hear of the woman's miscarriage,[1] which occurred on 2 March 2015 and was reported in investigative news reports by the regional public radio and television broadcasters NDR in Hamburg and WDR in Cologne.[2 3]

The news reports said that shortly before the train trip the woman, in her fifth month of pregnancy, had been in hospital for two days because of vaginal bleeding. Doctors at the hospital labelled her pregnancy as high risk and advised bed rest and as little movement as possible. But she and her family were subsequently assigned by Hamburg refugee case workers to leave Hamburg by so called "regional trains," widely regarded in Germany as being uncomfortable, bumpy, loud, and slow, with numerous stops.

After news reports emerged of the woman's miscarriage, Hamburg senators demanded a response from Hamburg's interior office, which administers refugee affairs. The office replied, said the news reports, with a written statement that case workers knew that the woman was pregnant but were not aware that she had been in the hospital and that the pregnancy was a high risk one. They said that the family had agreed to the train trip. Those assertions were contradicted by the woman and her husband in news reports, which also said that Hamburg prosecutors were investigating the case for potential wrongdoing.

Montgomery, a Hamburg native who is a radiologist at University Medical Centre Hamburg-Eppendorf, said that the case needed to be "carefully clarified" as it would be a "scandal" if it were proved true that case workers knew of the woman's medical condition before the train trip. Referring to a similar case in 2010, Montgomery said, "It is tragic that once again something so terrible had to happen."

In the 2010 case a woman from Ghana at "the end of her pregnancy" was moved twice from Hamburg to a refugee centre in Mecklenburg-Western Pomerania. She subsequently had a miscarriage.

Cite this as: *BMJ* 2015;350:h3538

RESEARCH NEWS

ORAL ANTICOAGULATION

Patients can self monitor oral anticoagulation

Patients can monitor and manage oral anticoagulation themselves, a UK community based study has shown.[1] The study, in the *British Journal of General Practice*, included 296 patients requiring oral anticoagulation who had bought a device to monitor their international normalised ratio (INR). Most (97%) had warfarin prescribed, and this was for a range of conditions including thrombosis (35.8%), having a mechanical heart valve (32.8%), atrial fibrillation (23.0%), and antiphospholipid syndrome (8.4%).

The median age of participants was 61, and most were professionals or had a university qualification. Less than half (45.9%) had received training on how to use their device, although most (92.9%) had looked at an accompanying booklet or DVD.

Results showed that 90.2% of patients (267) were still self monitoring their INR at 12 months. They were in the therapeutic range for effective anticoagulation three quarters of the time on average (75.3%; standard deviation 16.9). This rate was higher in older patients, reaching 85.0% in patients aged 70-79. During the one year follow-up six serious and two minor adverse events were reported.

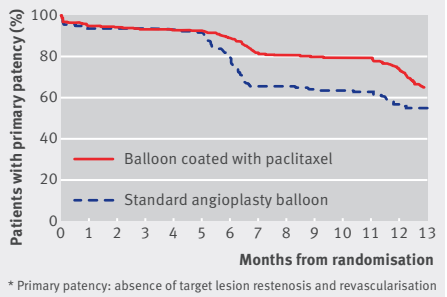
Nearly half the patients met the criterion for successful self monitoring of INR, defined as achieving the target therapeutic range for more than 80% of the time on treatment. However, a third gave different INR target ranges from figures recommended by their GP at the end of the study—which, the researchers said, may show a need for regular input from health professionals.

Cite this as: *BMJ* 2015;350:h3534

ATHEROSCLEROTIC DISEASE

Paclitaxel coated balloon helps angioplasty

Kaplan-Meier curves for primary patency* in patients with femoropopliteal artery disease



* Primary patency: absence of target lesion restenosis and revascularisation

Percutaneous transluminal angioplasty using a paclitaxel coated balloon improves arterial patency at one year compared with standard angioplasty in patients with femoropopliteal artery disease, a study in the *New England Journal of Medicine* has shown.[1] Percutaneous transluminal angioplasty restores blood flow to patients with atherosclerotic disease in the femoral and popliteal arteries, but restenosis occurs in two thirds of patients within a year.

In the study 476 patients with symptomatic intermittent claudication or ischaemic pain at rest and significant atherosclerotic lesions were randomised to angioplasty with a paclitaxel coated balloon or to standard angioplasty.

Paclitaxel, a taxane drug that inhibits cell division, is used in drug eluting stents to reduce restenosis in cardiac blood vessels. Drug eluting stents have shown varied results in peripheral vessels, but early studies using balloons coated with paclitaxel have suggested an effect by delivering the drug directly to the artery wall.

Nearly two thirds (65.2%) of patients treated with the drug coated balloon were free from binary restenosis and did not require revascularisation of the target lesion at 12 months, compared with just over half (52.6%) with conventional angioplasty (P=0.02). There were no significant differences in functional outcomes or the rates of death, amputation, thrombosis, or reintervention.

Cite this as: *BMJ* 2015;350:h3451

OBESITY AND OVERWEIGHT

Liraglutide improves weight loss in obesity

Liraglutide significantly reduces body weight and improves metabolic control in people who are obese or overweight and have dyslipidaemia or hypertension, a randomised trial reported in the *New England Journal of Medicine* has shown.[1]

The study randomised 3731 people who had a body mass index of at least 27 and dyslipidaemia or hypertension to treatment with once daily injections of liraglutide (3.0 mg) or placebo in addition to counselling on lifestyle changes. Liraglutide is a glucagon-like peptide-1 analogue that mimics the natural gut hormone to stimulate insulin release and reduce food intake by increasing satiety. It is licensed to treat type 2 diabetes, but none of the patients in the trial had diabetes. The study was funded by Novo Nordisk.

Results showed significantly greater weight loss after 56 weeks in patients randomised to liraglutide (mean loss 8.4 kg (standard deviation 7.3)) compared with placebo (2.8 (6.5)). The average difference was 5.6 kg (95% confidence interval −6.0 to −5.1; P<0.001).

Two thirds (63.2%) of patients in the liraglutide group lost at least 5% of their starting body weight, compared with a quarter (27.1%) of the placebo group (P<0.001). A third (33.1%) of patients treated with liraglutide and 10.6% of those given placebo lost at least 10% of their body weight (P<0.001).

Patients taking liraglutide also showed significant, though sometimes modest, improvements in glycaemic control, fasting insulin concentrations, cardiometabolic markers, and quality of life measures.

Cite this as: *BMJ* 2015;351:h3545

CARDIOVASCULAR DISEASE

Five risk factors responsible for half of deaths

If five modifiable risk factors for cardiovascular disease—high cholesterol, diabetes, hypertension, obesity, and smoking—were eliminated in the US, deaths from cardiovascular disease would be halved, a study in the *Annals of Internal Medicine* has found.[1]

Researchers estimated what fraction of cardiovascular deaths would be prevented in 2009 to 2010 under two scenarios: the complete elimination of the five most common modifiable risk factors; and a national reduction of risk factors to the best levels achieved by any state. Their analysis was based on data from the self reported risk factor status of 45 to 79 year olds gathered by the Behavioral Risk Factor Surveillance System, and on relative hazard calculations using data from the National Health and Nutrition Examination Survey linked to the National Death Index.

If all five modifiable risk factors were eliminated, 54.0% of cardiovascular deaths would be eliminated among men and 49.6% among women. Elimination of hypertension would prevent 30.4% of cardiovascular deaths among men and 38.0% among women, and elimination of smoking would prevent 36.4% of cardiovascular deaths among men and 17.4% among women. If all US states met the mean prevalence in the five states with the lowest levels of each risk factor in 2010, less than 10% of cardiovascular deaths would be prevented.

Cite this as: *BMJ* 2015;350:h3539

Suzy Lishman
Grateful to the air bubble

PETER LOCKE

SUZY LISHMAN, 47, consultant in cellular pathology at Peterborough City Hospital, has been the president of the Royal College of Pathologists since November 2014. She has her hands full overseeing the college's move from London's swanky SW1 to the grittier environs of Whitechapel—once Jack the Ripper territory but now manifestly on the up. She is vocal in promoting the cause of women in science, extolling pathology (under the Twitter name @ilovepathology), and asking with increasing exasperation why, 15 years after Harold Shipman was sentenced, death certification has yet to be reformed by the creation of medical examiners.

What is your pet hate?
"It's always frustrating when people think that pathology is only about dead bodies. I spend a lot of time putting them straight"

What was your earliest ambition?
I always wanted to be a ballerina; in fact, I still do. I attended ballet classes for many years, but it was never more than a hobby. Luckily, I also wanted to be a doctor, having come from a medical family, and I turned out to be better at that than at ballet.

Who has been your biggest inspiration?
My aunt Gilly, now a retired respiratory physician, who showed me that women can have good careers in medicine. I followed Gilly to Girton College, Cambridge, and then the London Hospital Medical School. As a student I spent occasional holidays with her at work, watching my first bronchoscopies. I always wondered what happened to the biopsies she took; I never thought that I'd be interpreting them one day.

What was the worst mistake in your career?
I took my part 1 FRCPath [fellowship of the Royal College of Pathologists] exam at the first opportunity and failed it. I'd read lots of journals and books but hadn't spent long enough looking down a microscope, and it showed. I'm sure that it was good for me not to sail straight through my training, but it didn't feel like it at the time.

What was your best career move?
Applying to University College Hospital to study histopathology: I had five years of excellent training, which has stood me in good stead for the rest of my career. I didn't know very much about histopathology when I applied, but I quickly realised that I was born to be a pathologist and have never looked back.

Who is the person you would most like to thank and why?
My parents, for their unconditional support and encouragement. My father, a GP, showed me the importance of hard work and how fulfilling a career in medicine could be. My mother, who died seven years ago, taught me the value of kindness.

To whom would you most like to apologise?
My family and friends, for never having any spare time and forgetting to send birthday cards (which I used to be very good at). I'm quite good at buying cards well in advance but not so good at writing and posting them.

If you were given £1m what would you spend it on?
An Aston Martin for my husband, a painting for me, and research grants for medical students and pathology trainees. Funding for academic pathology has recently been cut drastically, but it's essential that the next generation of doctors has the opportunity to learn more about the specialty and to contribute to its advancement.

Where are or were you happiest?
I'm happiest with my family, anywhere, but ideally at home in Rutland.

What single unheralded change has made the most difference in your field in your lifetime?
It's difficult to pick just one—particularly something that hasn't been chosen before. In 2012 the college published *A History of Pathology in 50 Objects*,[1] which highlighted the pathology related objects that members thought had made the greatest contribution to healthcare. If I had to pick one of those I'd choose the air bubble—something so simple and cost-free that made a huge difference to the ability to analyse multiple blood samples in rapid succession rather than one at a time.

What book should every doctor read?
The Bright Side by Kate Granger—essential reading to understand what it's like being a patient and what a difference doctors can make, not just with their knowledge and skill, but by being kind and seeing the person behind the illness.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Dancing Queen by ABBA—it's been my favourite song for nearly 40 years. I'd have it playing as people walked out at the end, to make them smile.

What is your guiltiest pleasure?
Salted caramel puddles from Hotel Chocolat.

What television programmes do you like?
I don't watch much television, but I enjoy Sunday evening period dramas such as *Downton Abbey* and *Mr Selfridge*. And I enjoy *Silent Witness* from time to time, even if I do find myself shouting at the television when it takes the occasional artistic liberty!

What is your most treasured possession?
My mother's gold Tiffany heart necklace.

Summarise your personality in three words
Enthusiastic, determined, and optimistic.

What is your pet hate?
It's always frustrating when people think that pathology is only about dead bodies. I spend a lot of time putting them straight.

The full version is on thebmj.com.

Cite this as: *BMJ* 2015;351:h3458