this week

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GETTY IMAGES

Call for minimum alcohol price

Pressure is growing on the government to change its mind and approve a minimum price for a unit of alcohol in England after a comprehensive evidence review commissioned by Public Health England backed the policy.

After the report was published on 2 December, 43 organisations and experts wrote to the chancellor, Philip Hammond, calling on him to implement measures such as a minimum unit price for alcohol and higher taxes on high strength white cider, to tackle the alcohol burden on people, the NHS, and public services.

The report sets out evidence that a minimum alcohol price can reduce the prevalence of drinking. The Scottish government has adopted such a policy but not yet introduced it because of repeated legal challenges from the alcohol industry. The former coalition government, despite having pledged to introduce the policy in England in 2012, reversed its decision in July 2013 and was accused by the BMA and others of bowing to pressure from the drinks industry.

The report warned that alcohol was now the leading risk factor for ill health, early death, and disability among people aged 15 to 49 in England and the fifth leading risk factor for ill health across all age groups.

People are drinking twice as much as they did 40 years ago, resulting in a "substantial" burden on health, and costing around £21bn a year in social and economic harm. Alcohol caused more years of life lost to the workforce than from the 10 most common cancers combined, said the report, with 167 000 years of working life lost in 2015.

The authors found that raising the price of the cheapest alcohol brands was the "most powerful tool" available to the government to tackle the issue.

In its letter to the chancellor, the Alcohol Health Alliance UK, a group representing more than 40 organisations including the Royal College of Physicians, the BMA, and Alcohol Concern, asked him to accept and act on the review's "compelling" evidence.

Ian Gilmore, chair of the alliance, said, "Increased duty on the cheapest drinks, alongside minimum unit pricing, would make a real difference to the lives of some of our most vulnerable groups and ease the burden on our health service."

Adrian O'Dowd, London

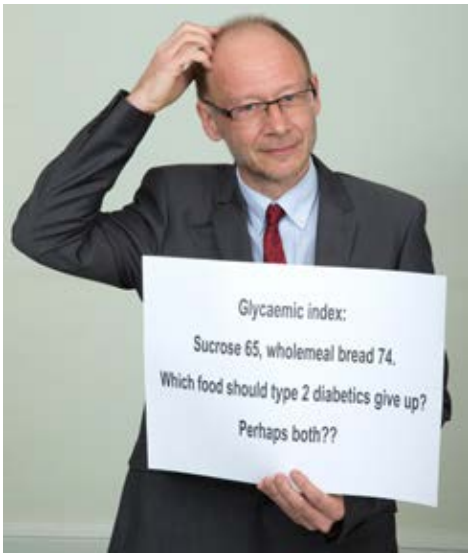
Cite this as: *BMJ* 2016;355:i6546

Alcohol is now the leading risk factor for ill health, early death, and disability among people aged 15 to 49 in England, says the report

LATEST ONLINE

- Johnson & Johnson is ordered to pay $1bn over faulty hip implants
- Scientists welcome government climbdown on "anti-lobbying" clause
- Hospitals must do more to help patients quit smoking, British Thoracic Society says

SEVEN DAYS IN



Type 2 diabetes advice should include diet warnings

GPs have been urged to help patients with type 2 diabetes make informed treatment choices, including advice that cutting sugar and starchy carbohydrate intake could reverse the disorder.

"I have spent 25 years failing patients with type 2 diabetes whose blood sugar levels got worse as they got heavier—and nothing I could say or do made any difference," said David Unwin (left), a GP partner in Southport since 1986, who has been appointed national champion for collaborative care and support planning in obesity and diabetes at the Royal College of General Practitioners. He was speaking at a meeting at the King's Fund in London last week.

Around 3.2 million people in the UK have had type 2 diabetes diagnosed, but this rises by 5% a year, at a cost to the NHS of £9.8bn, 10% of its total budget. Over the past five years, Unwin has published case studies on supporting patients to eat a low carbohydrate diet. "I'm always being told this evidence is anecdotal, but it mounts up," he said. "So often, people are unaware of the amount of glucose that results from the digestion of starchy foods like bread."

On average, said Unwin, his patients lose 9 kg after following his advice. "And my practice now spends £50 000 less each year on insulin and type 2 diabetes drugs than is average for our area." He added: "Above all, these patients are so proud of taking control of their condition. I've never had anyone thank me for putting them on metformin, but many thank me for helping them change their diet."

Jane Feinmann, London Cite this as: *BMJ* 2016;355:i6543

HIV

Tests offered through routine NHS contact

Anyone living in an area with a high prevalence of HIV infection (two or more diagnosed infections per 1000 people) should be offered a test for the virus when they register with a GP or have a blood test, joint guidelines from NICE and Public Health England said. In areas of extremely high prevalence (five or more diagnosed infections per 1000 people), patients should be offered HIV testing on admission to hospital, including to emergency departments. (doi:10.1136/bmj.i6518)

First vaccine trial in seven years starts

A new HIV vaccine trial in 5400 people began in South Africa. It builds on the strongest vaccine candidate tested to date—the RV144 vaccine regimen tested in Thailand in 2009, which was 31% effective at preventing HIV infection. The vaccine contains two immune stimulating components: Sanofi Pasteur's ALVAC-HIV, which uses viral vectors; and a protein vaccine supplied by GlaxoSmithKline. Results are due in 2020. (doi:10.1136/bmj.i6501)

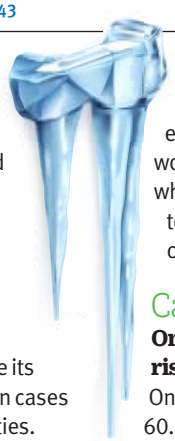
PrEP trial launched ahead of full roll-out in England

A large scale clinical trial on the use of pre-exposure prophylaxis (PrEP) for HIV will start next year ahead of its national roll-out, NHS England announced. The three year clinical trial will include at least 10 000 participants and cost as much as £10m. Last month the Court of Appeal ruled that NHS England has the power, but not the obligation, to fund PrEP. Despite strong evidence on PrEP's clinical effectiveness Public Health England highlighted outstanding questions to answer before implementing it on a substantial scale. (doi:10.1136/bmj.i6537)

Abortion in Ireland

Woman denied abortion is offered €30 000 award

The Irish government offered €30 000 (£25 300) in compensation to Amanda Mellet (below), who was denied an abortion when carrying a fetus with Edwards syndrome (trisomy 18) that would die in the uterus or shortly after birth. Mellet subsequently travelled abroad for a termination. She complained to the UN Human Rights Committee, and it ruled last June that Mellet had experienced "discrimination" and "cruel and inhuman or degrading treatment," demanding that the government offer her compensation and counselling and change its laws to allow abortion in cases of fatal fetal abnormalities. (doi:10.1136/bmj.i6530)



Soft drinks

Treasury publishes legislation to set levy

The Treasury published draft legislation confirming a two band levy for sugar sweetened soft drinks from April 2018. The levy, aimed at fighting obesity, will be 18 p/L on soft drinks with more than 5 g of sugar per 100 mL and 24 p/L on drinks with more than 8 g/100 mL.

Winter pressures

NHS becomes less prepared each winter

Over three quarters (78%) of doctors believe that the NHS's ability to cope in the winter has worsened in the past three years, a BMA survey showed. Most of the 457 doctors surveyed said that they had experienced an unmanageable workload in previous winters, which had hampered their ability to give high quality patient care.

Cancer

One year cancer survival rises in England

One year survival has risen from 60.6% in people with cancer diagnosed in England in 1999 to 70.4% in 2014, the Office for National Statistics found. Variation in one year survival between clinical commissioning groups with the best and worst survival rates closed slightly, from 13.8% to 9.8%. However, variations were far greater in colorectal and lung cancers. (doi:10.1136/bmj.i6522)

Medicolegal

Misconduct doctor is reinstated

A doctor, struck off seven years ago by the GMC for dishonesty in a job application, has been reinstated by the Medical Practitioners Tribunal Service. Mohamad Kataya is the 10th doctor in five years to be reinstated after erasure for misconduct. (doi:10.1136/bmj.i6504)

MEDICINE

Tobacco

Supreme Court may rule on plain packaging

Tobacco companies challenging the plain packaging law are considering taking the case to the Supreme Court, after the Court of Appeal upheld a High Court ruling that the government was entitled to introduce regulations intended to limit the potential of packaging to entice new smokers. (doi:10.1136/bmj.i6506)

End of life care

Doctors need more support for emotional impact

The BMA called for more support for doctors caring for patients at the end of life, after a poll of more than 450 doctors found that only 18% thought they had sufficient help. Most (93.9%) said that caring for such patients had an emotional impact, but only 14.7% had accessed any support networks.

Antibiotics

Government must tackle AMR, says O'Neill

Jim O'Neill (below), who chaired the government's review on antimicrobial resistance, told MPs on the Science and Technology Committee that the government had not acted on its recommendations. "The single most aggressive recommendation was that antibiotics should not be prescribed without state of the art diagnostic tests by 2020," said O'Neill, who questioned the view of Paul Cosford, medical director of Public Health England, that diagnostic tests should have a secondary role. (doi:10.1136/bmj.i6517)

Men are advised to use condoms for up to six months when returning from areas where Zika is active

Zika virus

First UK case is spread through sexual contact

The first UK case of Zika virus transmission through sexual contact has been detected, Public Health England confirmed. The case concerns a woman, who has since made a full recovery, being infected by her partner, who had been on holiday where the virus was active. PHE reiterated its advice that men travelling to areas of active virus transmission should use condoms for six months after returning and that women should avoid conception and use barrier methods for eight weeks. (doi:10.1136/bmj.i6500)

Hepatitis C

Wales approves drug as England deliberates

Epclusa (sofosbuvir with velpatasvir), the first single tablet regimen licensed to treat all hepatitis C genotypes, was approved for use in Wales ahead of its appraisal by the National Institute for Health and Care Excellence for use in England. Epclusa has been under appraisal by NICE since March 2016, and final guidance is scheduled for January 2017. The All Wales Medicines Strategy Group would not normally assess a drug that NICE was appraising, but in June the Welsh government asked the group to provide accelerated advice on Epclusa because of unmet patient need. (doi:10.1136/bmj.i6499)

Cite this as: *BMJ* 2016;355:i6552

CARE HOMES

Care Quality Commission inspections between 1 January 2015 and 7 November 2016 found that **312** care homes were not providing service users with adequate nutrition and hydration

SIXTY SECONDS ON . . . SCURVY

STEPPING BACK TO A LIFE ON THE OCEAN WAVES?

You might think so. Scurvy was blamed for the deaths of at least two million sailors between the 16th and 18th centuries. James Lind, a Royal Navy surgeon, is credited with carrying out the first ever controlled trial, with a study published in 1753 showing that scurvy could be treated with citrus fruit.

PROBLEM SOLVED?

Not quite. Physicians were unconvinced by the evidence and took no action until the end of the 1800s, when lemon juice was finally issued to naval ships because more sailors were needed to fight a war. Scurvy largely disappeared, but recent newspaper reports suggest it is re-emerging on terra firma.

BUT ISN'T THAT COMPARING APPLES AND PEARS?

We're not talking sailor numbers, that's for sure, and data are scant. A recent survey of Australians found that only half of the 1000 respondents ate at least two servings of vegetables a day, with most (93%) not eating the recommended five a day. Anecdotally, Australian clinicians have reported scurvy among people eating a low carbohydrate diet with little fruit, but said that numbers were low. And hospital admissions in England for a primary diagnosis of scurvy rose from six to 14 cases between 2010-11 and 2014-15 and as a secondary cause from 82 to 113 admissions.

WHAT ARE THE SYMPTOMS OF EATING FRUITLESSLY?

Vitamin C is needed to maintain the fibrous integrity of collagen. When collagen can't be replaced, tissue breaks down, causing muscle and joint pain, bleeding and swelling of the gums, dry skin, and poor wound healing. Australian diabetologists say that long running unhealed wounds have been cured with a simple course of vitamin C.

ORANGES ARE NOT THE ONLY FRUIT (OR VEG)

We need to eat vitamin C every day as it can't be made or stored in the body. A large orange provides around twice the recommended adult daily dose of 40 mg, but half a raw red pepper contains more vitamin C than an orange. And 50 g of Brussels sprouts or broccoli will provide the daily requirement, but over-cooking destroys the vitamin.

Susan Mayor, London Cite this as: *BMJ* 2016;355:i6540

FIVE MINUTES WITH . . .

Lucy Obolensky

The GP talks expeditions, David Attenborough, and *Planet Earth II*

"I was very lucky in that I got to go along to support David [Attenborough] on his trips, not that he really needed much support. I was there just in case. He was amazing, and I was so honoured to meet and work with someone who is so knowledgeable and passionate yet humble about what they do.

"When I work with television film crews I do a lot of the pre-medical questionnaires. I answer any questions that the crew might have and talk to them about any issues they might want to discuss with their own GP.

"I also put together the medical kits, based on the amount of kit you are able to take and the environment you will be working in. For instance, when I went up in a hot air balloon with Sir David [filming for *Planet Earth II* over the Swiss Alps] I took things like airway adjuncts and resuscitation equipment, because we were in a European country with a high quality healthcare system and retrieval service.

"Whereas in Antarctica [her next trip] there is not much point in taking defibrillators or ventilators, because you're so remote that it would be challenging to evacuate to definitive medical care in time in an emergency situation.

"For longer filming trips I act as a standard GP who will tend to the team's needs while we're away. People think that expedition medicine is this big, high octane job, but actually it's just about keeping people healthy. It's very public health based: it's about making sure people remain healthy, physically and mentally, during the trip. On the rare occasions that there are emergencies you have to be able to deal with a trauma situation in austere environments and make the most appropriate interventions and decisions as you would anywhere."

Lucy Obolensky, a GP in southwest England, leads the global and remote healthcare master's degree at Plymouth University. As an expedition doctor she supported David Attenborough during filming for BBC One's *Planet Earth II*. BBC iplayer

Abi Rimmer, BMJ Careers Cite this as: *BMJ* 2016;355:i6533

NICE advises new troponin tests to rule out MI

All patients with acute chest pain who are assessed as having medium or high risk of a myocardial infarction (MI) should be given high sensitivity troponin blood tests, guidance from the National Institute for Health and Care Excellence (NICE) advises. This will allow doctors to make a diagnosis more quickly and should allow many patients to be discharged earlier.

Standard tests for troponin—proteins released when the heart muscle is damaged—are already used routinely in emergency departments. They are usually repeated 8-10 hours apart so that a change in troponin levels can be detected, meaning that most patients have to stay in hospital. The new high sensitivity troponin assays can detect much lower levels of troponin in the blood than the older troponin assays.

"[Doctors] will be able to confirm the diagnosis within three hours of presentation when previously you had to wait up to 12 hours"

The updated guidelines say that patients at high or moderate risk of MI, as indicated by a validated tool, should have the high sensitivity troponin test on arrival at hospital, along with an electrocardiogram (ECG). Patients assessed as having low risk—for example, because of their age—should have a standard troponin test, which, if positive, should be followed by a high sensitivity troponin test.

The guidance adds that, when interpreting high sensitivity troponin measurements, doctors should consider other factors including the clinical presentation, the time from onset of symptoms, and ECG findings.

Adam Timmins, professor of clinical cardiology at Barts Heart Centre in London, said that the new guidance would have a huge impact.

"You will be able to confirm the diagnosis within three hours of presentation when previously you had to wait up to 12 hours," he said. "That will mean far fewer patients hanging around in casualty departments or being kept in overnight.

Jacqui Wise, Kent Cite this as: *BMJ* 2016;355:i6503

Third of partners have vacant GP posts for 12 months or more

Almost a third (31%) of partners in general practices in England said they had vacancies for GPs that they were unable to fill for more than 12 months, a survey by the BMA has found.

The responses from 3567 GP partners were part of a survey sent to all GP members of the BMA. It found that:

- The areas with the most vacancies for 12 months or longer were the West Midlands, the east of England, and the East Midlands.
- One in five partners (18%; 642) said it took three to six months to fill a vacancy.
- Only one in eight GP partners (13%; 464) had no vacancies.
- Around a third of GP partners who hire locums do so to cover long term vacancies (31%; 1106) or to continue providing a full range of services (30%).

Chaand Nagpaul, chair of the BMA's GP committee, said that the "permanent holes" in the workforce were "deeply concerning" and called for the government to fulfil its pledge outlined in the *Five Year Forward View,* to "properly staff and resource general practice."

Zosia Kmietowicz, *The BMJ* Cite this as: *BMJ* 2016;355:i6535

When the price is right: drug costing and NICE approval

Price discounts are leading to a flurry of NICE approvals. **Nigel Hawkes** investigates

After years of standoffs and angry words, drug companies are cutting prices of cancer treatments in a bid to gain approval for use in the NHS in England.

This change of policy, unpredicted when the old Cancer Drugs Fund was wound up in July, has analysts puzzled. Has the industry finally recognised that its products are not worth as much as it once claimed? Or is there a subtle plan to clear the decks of unapproved drugs to make room in the revamped Cancer Drugs Fund for yet more expensive ones coming down the pipeline?

Whatever the reason, the result has been to allow the National Institute for Health and Care Excellence to approve, at the draft or final guidance stage, seven of the first nine drugs it has reviewed from the old Cancer Drugs Fund list. In November NICE approved three drugs for breast cancer in as many weeks and reversed its earlier rejection of the leukaemia drug ibrutinib.

Good news for patients

Commenting on these decisions, Andrew Dillon, NICE's chief executive, made it clear that price discounting was the main reason. "Sensible pricing and in some cases better data are helping to secure access to important cancer medicines as they move out of the old Cancer Drugs Fund," he said. "As reappraised drugs now move to routine commissioning, funding in the CDF can be freed up and used for newer, innovative cancer treatments. This is good news all round for patients."

Richard Sullivan, director of the Institute of Cancer Policy at King's College London, said, "For many pharmaceutical companies trying to get access to the UK market, the view now is we've got the process—we've just got to go through it. Now that the old CDF has come to an end—and thank goodness it has, because it was a dreadful waste of time and taxpayers' money—they know what these drugs are worth, and they are putting them through at a price they know will meet NICE's threshold."

One of two leading drug company executives has begun to admit that prices have been too high. Speaking last month at a conference organised by the *Financial Times*, Andrew Witty, chief executive of GlaxoSmithKline, said that even the United States was reaching a plateau in its ability to pay. "Recent years have been dominated by price, but from a payer point of view those days are coming to an end," Witty said. The last six drugs GSK had launched in the US had been at or below the cost of drugs they were replacing.

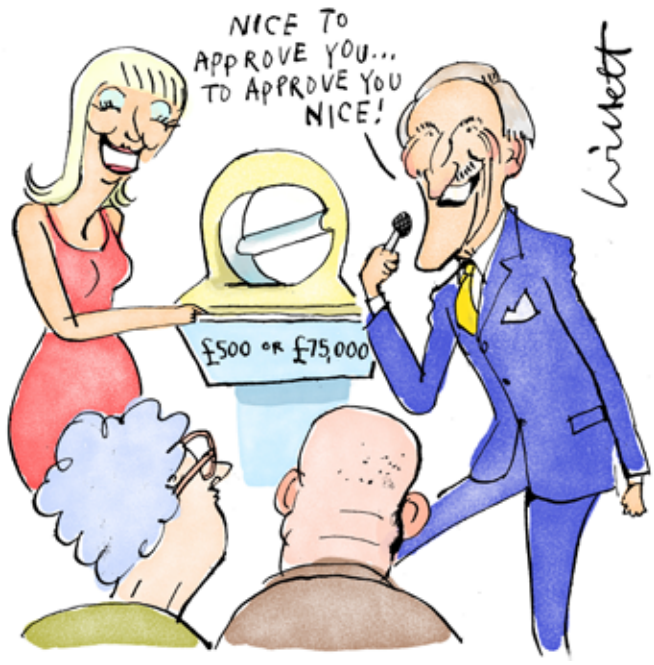
Olivier Brandicourt, chief executive of Sanofi, said that predatory pricing, where a product is priced so low that other firms are forced out of the market, is unacceptable and that the industry needed to rebuild trust. He did not see Donald Trump's victory in the US election as an escape for the industry. "Make no mistake, the pricing debate will continue," he said.

Just how deep the cancer drug discounts have needed to be to gain NICE approval has not been disclosed, but Sullivan said that the drug companies know very well where to pitch prices. "There are only two things they can do," he said. "They know what the efficacy of the drugs is, and they have to set a price. They either set a price which is over the threshold or one that is near the threshold and will get approval.

"A company going to NICE knows it will get rejected if it sets a certain price for the sort of outcomes it's delivering. And it does this because it wants to get premium pricing in another market, like the US. The prices asked are unrelated to actual value."

Realistic pricing

The new, more realistic attitude is, Sullivan believes, related to a growing realisation that the value offered is not good enough. He was one of the authors of a scale to measure the clinical benefit of cancer drugs developed for the European Society for Medical Oncology, published last year. "This showed that 71% of cancer medicines given market authorisations showed insignificant benefit," Sullivan said. "Drugs are getting approval from the US Food and Drug Administration or the European Medicines Agency with enormous amounts of uncertainty. In many cases the benefit is actually very, very small or it's buried in a tiny population within a much bigger population. The companies can smell that clinical uncertainty just round the corner."



The new, more realistic attitude is related to a growing realisation that the value offered is not good enough

But he warns that immuno-oncology drugs, on which most future hopes are now placed, are still "off the radar" in price. "You've got cancer regimens costing $150 000 [£120 000] to $200 000 in the US, and the NHS can't afford that.

"There are some incredible responses that we've never seen before with any drugs, but most patients don't benefit, and the side effects are so dreadful they do more harm than good. A lot of these drugs should still be in the research arena, not the marketplace."

Nigel Hawkes, London

Cite this as: *BMJ* 2106;355:i6519

NHS PROVIDERS CONFERENCE

Return of the "firm" wins wary approval

Hunt's proposal is broadly supported by doctors, but some say the world has moved on. **Abi Rimmer** reports

Among the initiatives announced last week as part of work to improve junior doctors' morale was a plan to reintroduce the medical "firm" system.

Speaking at the NHS Providers conference, the health secretary Jeremy Hunt, said that by dismantling the firm system when doctors' working hours were reduced "we may have thrown the baby out with the bathwater." He asked, "Can we bring back the firm or at least the best bits?"

Hunt said that Health Education England would work with the Royal College of Surgeons, teaching hospitals, and education providers to explore if a modern firm structure could enhance medical teams and make junior doctors feel more valued.

"This pilot will take the best parts of the traditional 'firm' into the modern hospital," he said. With an emphasis on multidisciplinary learning and longer placements for trainees, the aim of the pilots was "to allow for more meaningful relationships to improve training and supervision and foster a genuine sense of mentorship," he said.

"There aren't enough doctors to go back to the old firm. We have to build a team that is fit for the NHS"

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Need for inclusion

Richard Montgomery, honorary treasurer of the Royal College of Surgeons of Edinburgh, said a modern firm structure that included all members of the multidisciplinary surgical team could help to make junior doctors feel more valued.

"Nowadays the surgical team incorporates a lot more nurses with special skills and professions allied to medicine, so the surgical team is much broader based," he said. "What we would like is to get more junior doctors feeling like they are an integral part of this rather than being somebody who's just being used to plug gaps in rotas and doesn't really feel part of a team."

Jane Dacre, the Royal College of Physicians president, welcomed the plan—in principle. "There is a lot of evidence that trainees feel that they are not properly supported in the hospital, and anything that brings in a better social network for them—people to talk to, people to ask a question of—is likely to improve their morale. Whether we can turn back the clock 20 or 30 years is probably more difficult."

The college's registrar, Andrew Goddard, said that it was important not to try to replicate the firm structures of the past. "We know there aren't enough doctors to go back to the old firm of consultant, senior registrar, registrar, senior house officer, and houseman," he said. "We must be careful that we don't aim for something that is unachievable. We have to build a team that is fit for the NHS. The modern team is going to include (as well as doctors) nurses, advanced care practitioners, and physician associates. So the new firm has to acknowledge the part that all of those health professionals can play."

No return to old system

Jeeves Wijesuriya, joint deputy chair of the BMA's Junior Doctors Committee, said plans to bring back the firm "indicate an acknowledgment of some of the issues that juniors have been talking about." But he said it would be a mistake to want a return to a system that was based on old ways of working, with doctors putting in very long hours.

"When Hunt talks about firms, what I hope he is referring to is the sense of community, the sense of mentorship

JEREMY HUNT'S KEY ANNOUNCEMENTS

Leadership

- New NHS approved MBA degree at top British universities, with first students enrolling in September 2017
- New fast track leadership programme for doctors and nurses to send 30 a year to world's top universities, starting with Yale (left) in 2017
- Look at whether doctors should be able to choose clinical leadership as a specialty in its own right
- Improve professional regulations to encourage rather than discourage transition to management roles, by end of March 2017
- Increase NHS graduate scheme places for non-clinicians from 100 to 200 next year, aiming for 1000

Morale

- Pilot a modern version of the "firm" structure from next year, emphasising multidisciplinary learning and longer placements, with the aim of improving training, supervision, and mentorship (see above)
- Review assessment and appraisal process to make it simpler, less stressful, and more helpful

MARK THOMAS/SPL

that trainees should experience. And the ability to work with people for more than just a transient period—people who invest in your training, in your career progression and who take on the roles of mentors," he said.

"That is the kind of thing that I think trainees want to see. So "firm" isn't really the best term: we want to see some of its aspects while maintaining the things that we have put in to protect against the damaging aspects of the old firm system."

Clare Gerada, medical director at the NHS Practitioner Health Programme, said Hunt's announcement was a sign that he was listening to the profession and represented a positive change for many trainees who currently felt isolated.

"One of the problems we have got with the current NHS is that junior doctors feel like itinerant workers. What we've lost is the relationship between teams and, in particular, medical teams," she said. "We've created a whole series of isolated doctors and even senior doctors identify juniors by their position and not their name."

Abi Rimmer, BMJ Careers

Cite this as: *BMJ* 2016;355:i6556

BMJ BLOG FROM THE CONFERENCE Gareth Iacobucci

Firm hand casts a shadow

The health secretary caught a few people off guard at last week's NHS Providers conference when he unexpectedly announced a flurry of new policies.

Those who have heard him give dozens of speeches over the past four years had their usual game of "Jeremy Hunt bingo." The key watchwords are patient safety, technology, and Virginia Mason (the award winning Seattle hospital that Hunt loves to name check). But his latest speech also contained a spate of announcements geared towards tackling the low motivation and morale among NHS staff and enhancing opportunities for leadership training and flexible working (box below).

Plans to encourage more clinicians into senior management positions and boost low morale among junior doctors by piloting a modern version of the old "firm" structure in hospitals were well received by clinicians.

But Hunt employed a very different kind of "firm" when responding to criticism of the chancellor's decision to ignore the pleadings for extra cash for NHS and social care in the recent autumn statement. Alongside his bevy of new announcements, Hunt took a moment to censure NHS Providers' own chief executive, Chris Hopson, for having the temerity to warn that NHS trusts could not deliver everything that was being asked of them under the current funding.

Hunt, brazenly admonishing Hopson at his own party through the medium of Charles Dickens, told the audience of senior NHS managers that it was "a misjudgment" for the NHS to adopt a tone of "please Sir, can I have some more," given that health had received a bigger funding boost from the Treasury than every other government department last year.

Hospital bosses, traditionally more reserved than clinician audiences, maintained poker faces as Hunt delivered his telling off. But Hopson's argument that the NHS cannot continue to meet stiff performance targets and maintain standards of care with inexorably rising demand and restricted funding will have resonated strongly with those present.

And while the overall noise at the conference was one of sleeves being rolled up, NHS leaders may also have wondered whether Hunt's plans to bolster morale and enhance leadership can truly succeed while the service remains under such huge and sustained pressure.

Gareth Iacobucci is senior reporter, *The BMJ*

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- Ensure doctors get better notice of rotation schedules, through new code of practice
- Manage training and rotations more effectively to help couples in training or with caring responsibilities
- Make £10m available to support trainees returning to training after time out

Low paid staff

- Allow nurses to train on job rather than at university from September 2017, via a nursing degree apprenticeship
- Continue to develop apprenticeship standard for role of nursing associate and work towards legislation to regulate them
- Ensure a clear progression path for nurses to reach advanced level practice and beyond, so they can develop their scope of practice
- Review, with professional bodies, feasibility of creating a smooth career path for advanced nurse practitioners who wish to become doctors
- Consult on possible regulation of physician associates

Flexible working

- New funding to ensure all hospital trusts adopt best practice in using e-rostering, so that it is flexible, personalised, and needs based

GEOFF OLIVER BUGBEE/ORBIS

THE BIG PICTURE

Appeal for sight

Pinki's cataracts had gone unnoticed until her grandfather recognised them because he had had cataract surgery himself. They visited the Sadguru Netra Chikitsalaya Hospital, which is supported by the eye care charity Orbis, in Chitrakoot, Madhya Pradesh. Pinki was assessed and scheduled for surgery. Both eyes were operated on, and her sight was restored. Left untreated, cataracts can cause irreversible blindness.

The BMJ's appeal this Christmas is for Orbis, which aims to eradicate preventable blindness. More than eight million people in India are blind. Cataract is the leading cause of blindness worldwide. In 2000 Orbis helped establish the 350 bed eye hospital at Chitrakoot, which each year treats more than 100 000 patients.

Last year alone Orbis's supporters helped fund 65 558 operations worldwide, including 24 177 on children, and 2.13 million screenings or examinations. The charity also trained 1414 doctors and nearly 29 000 other healthcare workers. A donation of £150 could buy six intraocular lenses for cataract surgery. Please give generously.

Richard Hurley, *The BMJ* **Cite this as: *BMJ* 2016;355:i6589**

EDITORIAL

Fair vaccine pricing please, not charity

Vaccines are essential goods produced collectively to safeguard children, wherever they live

Last month, Médecins Sans Frontières (MSF) surprised Pfizer and the world by refusing a donation of one million doses of the company's vaccine against *Pneumococcus*, the leading cause of pneumonia worldwide, killing one million children a year.[1]

Although the need for the vaccine is high—only 37% of children worldwide are immunised[2]—MSF judged it more important to press the company to lower the price, which is the primary obstacle to access.[3] And with success: Pfizer, following the example of GlaxoSmithKline, the other producer of pneumococcal conjugate vaccines, has since announced that humanitarian organisations will get the vaccine at a special price,[4] similar to that it is already offering to Gavi, a public-private partnership that works to increase access to vaccines in some 50 of the poorest countries.[5]

But donations and benevolent price reductions for selected countries or populations remain random acts of charity that do not get to the heart of the problem: the unacceptable commodification of human lives by drug companies using monopoly pricing power to determine who lives and who dies.

Market power

Price discrimination—that is, charging customers differently depending on their ability or willingness to pay—is a sign of market power. In the case of vaccines or other essential health products—public goods that should be generated according to public value considerations—the matter is extremely serious.

Pneumonia vaccines are likely to cost less than a dollar to produce (based on estimates for similar vaccines[6]) but are typically being sold at $120-$160 (£96-£130) per dose in wealthy countries,[7] and at least three doses are required to protect a child. Pfizer's revenue from this vaccine was $6.2bn in 2015.[8]

At $3 a dose, the price which GSK and Pfizer have agreed is still more than profitable,[5] and there is no transparency around the cost structure of vaccine manufacture or company use of tax deductions to assess the true generosity of such offers. Moreover, these widely publicised price reductions are only available to countries covered by Gavi and for humanitarian emergencies, leaving about 82 million children unprotected against *Pneumococcus*, 88% of whom live in middle income countries.[9]

Long considered among the most cost effective health interventions, vaccines now join other vital treatments—including the $1000 per pill hepatitis C drug sofosbuvir, the EpiPen, and new cancer drugs—whose price is becoming a critical barrier to access, with justifiable public outcry.

Traditionally, the vaccine market has been based on high volumes at low prices, with relatively modest profit margins, but it is now clear that drug companies have identified vaccines as the next pot of gold. Old vaccines are being reformulated and sold at higher prices, while new vaccines have entered the market at once unthinkable prices. The average cost to fully vaccinate a child through adolescence in the US rose from $100 in 1986 to $2192 in 2014.[10] Prices for the rest of the world follow suit.

Cynically, drug companies have the pricing power to ask whatever they think the market can bear. Even in the few instances where there are multiple vaccines, companies tend to price their products at similarly high levels; more often, they enjoy monopoly power. Furthermore, there is no real market for vaccines in the sense of an open and transparent system in which supply and demand determine the best value price. Instead, the main buyers are governments and global organisations using taxpayers' money to promote health, with prices being negotiated on a case-by-case basis behind closed doors. Moreover, in contrast to the medicines market, there are no generics for vaccines to drive down prices. This gives even stronger pricing power to a small number of multinational vaccine producers.[11]

Agreeing on a fair price could be a critical step

Development costs

As with medicines, the often cited justification for high vaccine prices is that research and development is expensive and risky—even though vaccines are primarily paid for with taxpayers' money. A detailed estimate of the development cost of rotavirus vaccines suggests that companies could recover all fixed costs quickly and offer these vaccines to all countries at affordable prices.[12]

To achieve the right outcomes markets must be actively shaped by public policy. One critical step could be to agree on a fair price that accounts for research and manufacturing costs, the public research contributions, and the public health importance of vaccines. This, rather than charitable donations meant to mask the system failures of a profit maximising economy, would be a beneficial corrective for public health. The right price for vaccines must take into account the value of their collective creation but also the fact that they are essential goods produced collectively to safeguard the vulnerable—no matter where they live.

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EDITORIAL

Whole brain radiotherapy for brain metastases

Optimising its use and application in the context of new treatments

A recent large non-inferiority trial reported that whole brain radiotherapy did not improve survival or quality of life in adults with brain metastases from non-small cell lung cancer, when compared with corticosteroids and supportive care.[1]

QUARTZ (Quality of Life after Treatment for Brain Metastases) was a pragmatic trial with broadly inclusive eligibility criteria, but the 538 patients, unsuitable for surgery or stereotactic radiosurgery, were recruited only when the clinician and patient felt uncertain about the potential benefit of whole brain radiotherapy. Many participants had a poor performance status, functioning in their daily lives at a level that would typically would exclude them from clinical trials.

Although reported baseline characteristics were similar between the two groups, several key prognostic factors were not reported, including the presence of symptomatic or asymptomatic metastases, controlled or uncontrolled extracranial disease, and molecular characteristics such as mutations in the epidermal growth factor receptor (EGFR) and anaplastic lymphoma kinase (ALK) genes as more than half of the participants had adenocarcinomas.

Treatment factors may also have affected overall survival.[1] While the study reported no overall difference in survival between treatment groups, whole brain radiotherapy significantly improved survival among patients younger than 60. A non-significant association hinted at survival benefit for patients with better baseline functioning.

Diminishing use

The QUARTZ trial provides further support for the diminishing use of whole brain radiotherapy in adults with brain metastases. Patients with brain metastases from non-small cell lung cancer can expect little benefit, especially if they have asymptomatic brain metastases, poor functional status, or progressive untreatable extracranial disease. In addition, patients treated with whole brain radiotherapy are more likely to report side effects such as drowsiness, hair loss, and nausea compared with those receiving supportive care.

Treatment options are growing, along with the challenge of optimising management for each patient

Patients considered suitable for local targeted treatments were excluded from the QUARTZ trial. Spatially targeted treatments such as stereotactic radiosurgery are increasingly taking the place of whole brain radiotherapy. Stereotactic radiosurgery is minimally invasive and uses precisely focused radiation beams to deliver, often in a single session, a high dose of radiation to individual metastases with minimal damage to surrounding healthy tissue. Several recent trials suggest that stereotactic radiosurgery is better than whole brain radiotherapy at preserving cognition and quality of life in patients with a limited number of brain metastases and good performance status.[2 3]

The QUARTZ trial protocol allowed systemic treatments after randomisation, but only 42 patients received chemotherapy, 29 a tyrosine kinase inhibitor, and seven received both. Several trials have shown the promise of targeted therapies for patients with cancers that express actionable mutations such as EGFR and ALK, including the treatment of patients with small, asymptomatic brain metastases.[4] Recent publications of immunotherapy have also shown promising results in patients with non-small cell lung cancer including responses in brain metastases.[5] Other trials are evaluating combinations of targeted drugs, immunotherapy, and radiosurgery.[6]

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Still relevant

Whole brain radiotherapy still has a role in selected patients. These include patients with decent performance status and treatment options for their extra cranial disease, who have multiple brain metastases, brain metastases that are too close to critical structures to be treated with radiosurgery, or large lesions that are not amenable to surgical resection.

Efforts should be made to minimise the toxicities of whole brain radiotherapy in all patients, particularly cognitive deterioration. Adjunctive medical treatments such as memantine may help to preserve cognitive function,[7] and delivery techniques that avoid the hippocampus have also shown promise in early uncontrolled trials.[8] A further trial is testing both in combination for selected patients who opt for whole brain radiotherapy.[9]

Management of patients with brain metastases is evolving rapidly to exploit the prognostic implications of histology and molecular characteristics. Treatment options are growing, along with the challenge of optimising management for each patient to maximise benefit and minimise harm. To this end, whole brain radiotherapy is no longer the global standard of care for all patients with brain metastases, and although it is still needed in selected patients, its role is diminishing.

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HOMELESSNESS

How to end the endless recycling of patients between the streets and the hospital

Access to primary care is vital to prevent the health of rough sleepers reaching crisis point. **Anne Gulland** reports on the role GPs can play

When she was homeless Gerry Dickson did not see a doctor for five years, and it was only when she collapsed on the street and was taken to the emergency department that she got some medical care.

Dickson now works for homeless charity Groundswell as a case worker and says her experience is typical. "I didn't want to seek help because I didn't want to be known or to be found, and that happens a lot. Some clients can have very serious health issues as health is not their number one priority."

A report by homeless charity St Mungo's estimates that the annual cost of hospital treatment for homeless people in England is at least £85m a year.[1] The report said, "Failure to support homeless people to get the healthcare they need when they need it, before they require urgent hospital treatment, comes at great cost to the health sector, and for homeless people themselves."

A survey of 2000 St Mungo's residents in August 2016 found that in the past year one in four had had an ambulance called at least once and one in five had attended an emergency department at least once.

However, emergency departments often do not record patients' housing status: an audit carried out by the royal colleges of emergency medicine and physicians found that only 52% of departments did so.[2]

Anna Sussex, a sister in the emergency department of the University Hospital of Wales in Cardiff, conducted an audit of what she calls "frequent flyers": anyone who presents four or more times a month. Of the 450 frequent flyers identified in 2015, 11% were homeless.

"When homeless patients come in they are genuinely unwell. They are not misusing the service. We decided that every homeless patient should register with a GP and stay with that GP regardless—this meant there was some kind of stability in their medical treatment," she says.

Ensuring support

GPs at the Urban Village Medical Practice in Manchester, which has a large cohort of homeless patients, were asked by Manchester Royal Infirmary in 2013 to help work with homeless frequent attenders after a survey found that 29 of the 100 patients turning up most often at emergency departments were homeless. These patients accounted for 641 attendances in 12 months, with an average 22 visits each.

The GPs introduced an acute hospital round: five mornings a week, a GP visits every homeless patient in the hospital to support all aspects of care and to help provide a supported discharge. Patients who do not have a GP are invited to register with the practice and attend its drop-in homeless clinics offering access to doctors, practice nurses, leg ulcer dressing services,

MANAGING HOMELESS PATIENTS IN GENERAL PRACTICE

Kay Saunders is a partner at Butetown Medical Practice in Cardiff and has been welcoming homeless patients for 20 years. The practice list of more than 7500 patients includes around 300 who are homeless (mostly in hostels).

She says that, although a knowledge of substance misuse and mental health is important, there are no special skills required to provide a good service for homeless patients.

"It's an attitude and an ethos. There can be multiple problems and sad life histories; this can be quite draining. It is very interesting work, and you can make a big difference.

"We have an open surgery every morning for all patients. People who are homeless and sleeping rough often can be very chaotic and unable to keep appointments, so special clinics are unlikely to work. As people progress they use the booked appointments and learn to use more mainstream systems."

Her reception staff are crucial in establishing a good rapport. Homeless patients often use the practice address for registration purposes. This means the administration staff need to do detective work to find people for any hospital appointments.

She says that having good relations with all the homeless services is vital. "We're known in the hostels and around Cardiff as the practice to come to if you're homeless. We're firm but fair; we listen to people, are flexible and consistent, and do our best for them."

It's an attitude and an ethos. There can be multiple problems but you can make a big difference

INPICTURES LTD/GETTY IMAGES

drug and alcohol services, mental health services, and a dentist. The practice also runs a blood borne diseases clinic in conjunction with an infectious disease specialist for patients with hepatitis C.

Six months after the pilot began an audit found that the number of homeless patients in the top 100 attenders had fallen from 29 to 15, and 12 months later 73% of the 29 high frequency patients had not been to the emergency department in the past three months. More recent analysis showed that from April 2015 to March 2016 the service assessed 410 people who had been admitted to the Royal Infirmary, 73% of all homeless people admitted during this period. The team also managed 77 people who frequently attended the emergency department.

Gerry O'Shea, a partner at the practice, says the initial impetus behind the project was partly economic but also born out of a desire to end the cycle of homeless patients going in and out of hospital.

"Homeless patients come into hospital and get this hi-tech medicine but are then sent back out on to the streets where there's nothing for them. There's this constant recycling of patients between the streets and the hospital," he says.

In hospital the GPs have no clinical responsibility but act as a conduit between the patient and the hospital staff. "One of the purposes for going in is to advocate for people, to prevent premature discharge, to encourage patients to have regular and ongoing treatment," he says.

Better awareness

Ensuring that homeless patients attend primary care is the key to preventing health problems escalating. In an area with a large population of homeless patients there may be general practices that specialise in dealing with homeless people. But in other areas, accessing mainstream practices can be difficult because of poor attitudes from staff or because of mistaken beliefs that patients need a permanent address to register.

NHS England guidance issued last year aimed at reducing health inequalities states that failure to produce a permanent address should not be a bar to registration.[3] Nigel Hewett, medical director of homeless charity Pathway, believes that many GPs and practice staff are unaware of the updated advice.

"Nationally most practices believe that they have to ask people to prove who they are. They have this vague feeling someone is going to tell them off if they don't check up. The current state of the law in this country is that anyone has the right to access primary care," he says.

Pathway is in the process of producing a video in conjunction with the Healthy London Partnership aimed at practice receptionists, spelling out the rights of homeless patients and how they can help them to access their services. The partnership has also produced a leaflet for homeless people to carry with them, which they can show to reception staff if they are told they cannot register.

Before the pilot began 29 of the top 100 frequent hospital attenders were homeless, six months later that had fallen to 15

Hewett says, "Receptionists are unfairly given a hard time, cast in the role of the bad guys when they're simply behaving in a way that's led by the GPs and practice managers. Often when you speak to individual receptionists they want to try to find ways to help."

Homeless patients, particularly those who have been on the streets for a long time, are not always an easy patient group to treat. They have comorbidities and complex needs, and their chaotic lifestyles mean they may not always stick to their appointments.

The key to treating a homeless patient is flexibility, says Hewett. Practices in a small market town or rural area with a small homeless population need to be mindful of enabling a patient to register and being flexible about appointment times. For practices in areas with a larger homeless population or with a hostel nearby there are three things to consider: outreach work, running drop-in clinics at regular times during the week, and being more flexible with appointments.

Jacqui McCluskey, director of policy and communications at Homelessness Link, believes that all practices have a responsibility to homeless patients. "Specialist GPs let mainstream services off the hook. If the mainstream practices have good services for the most vulnerable in society, then their services for the rest of their patients are likely to be good too."

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HEAD TO HEAD

Are nanny states healthier states?

Government regulation is necessary for safety, says **Simon Capewell**, but **Richard Lilford** argues that restricting adults' choice can undermine such aims

yes

A sugary drinks tax is a simple but powerful way of helping children consume less sugar and stay healthy

Simon Capewell, professor of public health and policy, University of Liverpool capewell@liverpool.ac.uk

The term "nanny state" is often used pejoratively but it can also describe a safe and healthy environment for our children and families, as invoked by the use of "nanny" to describe a grandmother or professional carer.

To fulfil our potential, we each depend on Maslow's "pyramid of needs": esteem, love, affection, and belonging to a group. These in turn depend on a foundation of physical safety, shelter, health, food, water, and sleep.[1] In rich countries, we take these health determinants for granted—for example, clean water, drains, car seatbelts, safe aeroplanes, immunisations, and smoke-free environments.[2] However, in nations without such regulation and legislation, these crucial determinants are not guaranteed, and the strong are then free to exploit the weak.

Legislators can choose "upstream" or "downstream" approaches. Downstream interventions include advice or education for individuals, "nudge," voluntary pledges, and "responsibility deals." These approaches are generally ineffective, weak,[3 4] or inequitable.[5]

Conversely, upstream interventions such as regulation, taxation, or mandatory reformulation represent much more powerful structural actions that make the environment safer and healthier. This "effectiveness hierarchy" is evidenced by public health successes in controlling tobacco, alcohol, and harmful dietary nutrients such as salt, sugar, and fats.[6] For instance, use of industrial trans fats in food products has only been modestly decreased in the UK by downstream advice, education, and labelling. In Denmark, however, upstream measures underpinned by legislation have effectively eliminated this food toxin.[7]

The nanny state generally enjoys (sometimes muted) support from scientists, the public, and democratic politicians. Hence the many effective public health interventions supported by legislation and regulation.[2] Every time, an initially sceptical public becomes increasingly supportive, as seen with seatbelts, smoke-free public spaces, and now levies on sugary drinks.[8]

Opposition to the nanny state from free marketeers, libertarians, or vested interests can be aggressive. Five corporations sell most of the world's tobacco, and 10 transnational corporations produce most of our packaged food.[9] They all have just one key objective: to maximise profit for shareholders. These corporations thus drive "the non-communicable disease pandemic" caused by tobacco, alcohol, and processed food and drink.[10]

The World Health Organization's head, Margaret Chan, recently concluded: "It is not just Big Tobacco anymore. Public health must also contend with Big Food, Big Soda, and Big Alcohol. All of these industries fear regulation, and protect themselves by using the same tactics."[11]

Paternalistic, interfering, officious?

Ideological opponents use "nanny state" pejoratively to claim that government involvement in our lives is paternalistic, overbearing, overprotective, officious, interfering, intrusive, coercive, controlling, or excessive. Furthermore, when attacking public health champions, some libertarians conceal their industry funding.[12]

Their three main arguments emphasise the primacy of individual autonomy, dispute the effectiveness of proposed interventions, or allege harms to the economy. However, these arguments are flawed and easily trumped by the four ethical principles of public health: justice, service, community, and knowledge.[13] For instance, a sugary drinks tax is a simple but powerful way of helping children consume less sugar and stay healthy. Despite industry protests, this tax is now supported by some 70% of the UK public.[8] The public thus implicitly endorses these ethical principles and agrees that the government has a duty of care to its citizens, particularly children.

As Janet Hoek, a marketing professor, said, "Rather than depriving individuals of freedoms, state intervention maintains and defends those freedoms against commercial interests, which potentially pose a much greater threat to free and informed choice."[14]

Cicero asserted: "The welfare of the people shall be the supreme law." Quite so. The nanny state means ensuring a healthy environment for all. It underpins every health determinant in Maslow's pyramid. Only then can we and our families enjoy our health and fulfil our true potential. The nanny state is not a luxury or a naive socialist aspiration. It is essential for the optimal health of every person on this planet.

This Head to Head summarises a debate commissioned by Aileen Clarke, president of the Society for Social Medicine, for its 2016 annual scientific meeting.

PRIYA SUNDRAM

no

Advertising bans infringe individual liberty and taxes are regressive because poor people are the heaviest users of unhealthy products

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No reasonable person thinks that the world should have no safety regulations or that people should be able to act in ways that endanger others; no one thinks there should be no driving speed limit or that smoking should be allowed in crowded spaces.

So the term "nanny state" really only describes state action that is designed solely to prevent people from harming themselves, not others. Once children grow up they have no need for a nanny.

The state can seek to curtail unhealthy behaviour in two ways. For example, it may criminalise the actions of individual citizens, say by banning the use of cocaine. Alternatively, or in addition, the state may legislate to reduce supply, say by banning the production or sale of cocaine.

The state should be reluctant to criminalise individual choice, however, without pressing public concern; setting and enforcing speed restrictions is one justifiable example. Hard won freedoms demand respect for individual autonomy even if what people are doing is risky: they should be free to add lashings of salt, go hang gliding, or gorge themselves on food.

There can be no autonomy if the state, rather than the individual, is the custodian of personal values. It is true that unhealthy behaviours explain higher mortality among poorer people,[15] but it's a travesty to use this fact to restrict the choices open to people.

The situation is subtly different when the state legislates at the supply side of the economy. Firstly, supply side interventions potentially criminalise powerful organisations not individual citizens. Secondly, supply side legislation is often necessary to correct for power imbalances caused by information asymmetry. Thirdly, many people who consume the same product have different preferences, so the state has to arbitrate. Fourthly, children may consume products intended for adults.

Consider the dilemma posed by salt in processed foods. Humans have evolved to crave salt, and exposure causes taste buds to crave ever greater amounts. This physiological phenomenon interacts with commercial logic when companies progressively increase the salt content of processed foods to stay ahead.

Given such a textbook case of market failure, the state has a duty to act. Such action has lowered average salt consumption in the UK (under a voluntary agreement) and Finland (under legislative constraints), the UK reaching a slightly lower level and Finland experiencing a greater fall relative to baseline.[16] You can always add more salt but you cannot easily subtract it from processed food.

The state also has an important role in correcting information asymmetries—for example, by mandating product labelling. Far from over-riding choice, such labels buttress choice by informing it.

Advertising bans

When a product is harmful but neither desirable nor cheap, such as trans fats, it is justified to assume market failure and just ban it on the grounds that no one would knowingly choose such a bad product. Bans on advertising, however, start to infringe individual liberty and taxes are regressive because poor people are the heaviest users of unhealthy products. Moreover, taxes on unhealthy products tend to have ceiling effects beyond which higher prices act like a ban and encourage the emergence of a black market.

The more coercive the method of control, the more societal consent is needed for it to be accepted. But the nanny state is not concerned with such nuance; it says that lives will be lost by procrastinating and that education is not a powerful behaviour change agent in the short term[17]—so tax or ban.

Bans might work in the short term but it is undemocratic to impose them against the will of the majority. And even if coercive bans are effective in the short term, they are prone to backfire in the longer term, as shown by alcohol prohibition in the US in the 1930s, recreational drugs almost everywhere,[18] and externally imposed limitations on sugary drinks in New York.[19]

It is better to educate people and get them on your side before acting, even if it requires patience. If we act against societal opinion, then the nanny state's impatient and sometimes self righteous zeal could do more harm than good.

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ILLUSTRATION: DUNCAN SMITH

Phil Whitaker, 50, is a GP in Somerset and an award winning novelist. Those who have not read his novels, such as his debut, *Eclipse of the Sun* ("a little masterpiece," said the *Spectator*), may have read his column in the *New Statesman*, where he paints a picture of the ins and outs of a GP's life and argues the case for an NHS free of interfering politicians. Born in Kent, he trained at Nottingham and Oxford and then did an MA in creative writing at East Anglia. His fifth and most recent novel, *Sister Sebastian's Library*, was published in September 2016.

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Phil Whitaker
A novel take on medicine

What was your earliest ambition?
When I was a boy I wanted to be a police officer in America. I blame *Starsky and Hutch*. I'd also never heard of the green card.

What was the worst mistake in your career?
Taking a mid-career post as a salaried GP. I'm not temperamentally suited to being an employee, and I was relieved to get back into partnership.

What was your best career move?
After finishing GP training I took a year out to read for an MA in creative writing at the University of East Anglia. It was a brilliant experience, and I wrote a book called *Eclipse of the Sun* there, which became my first published novel and scooped a couple of middle ranking literary awards.

Who has been the best and the worst health secretary in your lifetime?
The best must be Frank Dobson, who was implacably opposed to private sector involvement in the NHS. The worst is, without question, Jeremy Hunt.

To whom would you most like to apologise?
My aunt, Margaret Hotine. She had no family of her own, and when she was terminally ill with breast cancer I should have done far more to help her.

If you were given £1m what would you spend it on?
I'd pay off my mortgage, buy more time for writing, endow an award for fiction written by a medical student, support my church, and travel around Africa.

Where are or were you happiest?
At my word processor, with uncluttered time for writing and a creative buzz from a work in progress that's going well. That's equalled only by striding across open countryside with my wife and our dog.

What single unheralded change has made the most difference in your field?
The "preventing overdiagnosis" movement is slowly bringing the humanity back to medicine—something we desperately need.

Do you support doctor assisted suicide?
Emphatically, provided there are robust safeguards.

What poem, song, or passage of prose would you like at your funeral?
Matthew 25:1-13, followed by *i thank You God for most this amazing*, by e e cummings.

What personal ambition do you still have?
To win a major literary prize.

Summarise your personality in three words
Kind, good-humoured, optimistic (OK, that's four, but that's hyphens for you).

Where does alcohol fit into your life?
I make room for it. Red wine, mainly.

Do you have any regrets about becoming a doctor?
None. Medicine is a rewarding career in its own right, and the security and flexibility of general practice has allowed me time to indulge my passion for writing.

If you weren't in your present position what would you be doing instead?
It's hard to imagine. All I can say is that, green card or no green card, I wouldn't be a police officer in America.

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