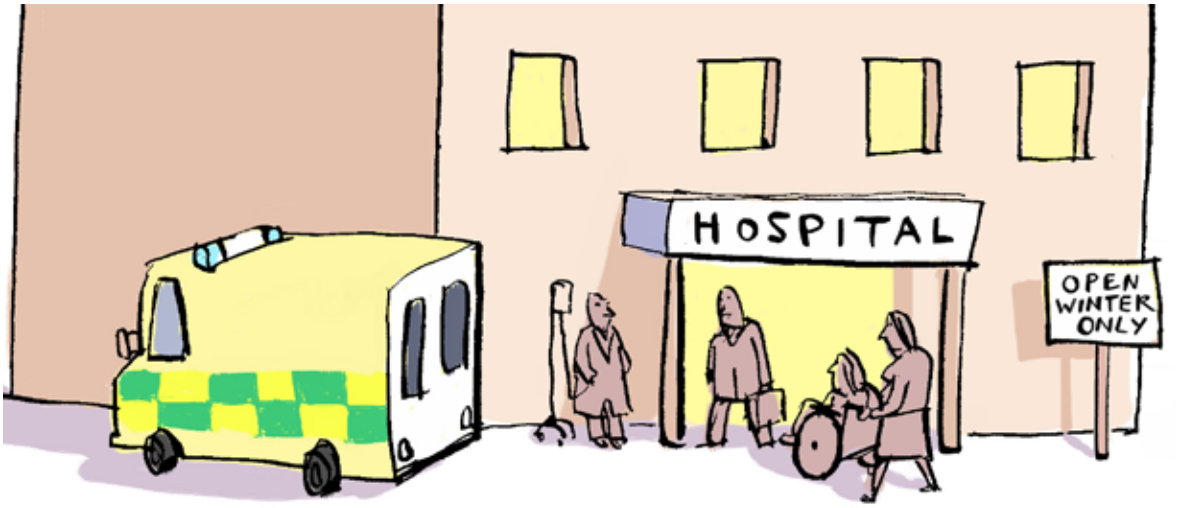
this week

ANAESTHESIA EFFECTS page 380 **CLOSING HOSPITAL BEDS** page 382



NHS must plan for next winter now

The body that represents NHS service providers is calling on the government to start planning for next winter now, after an analysis showed hospitals struggled to cope this winter.

NHS Providers analysed the performance of 152 trusts in England between December 2016 and February 2017 and found that in the week beginning Monday 30 January an extra 32 558 beds were opened to provide more capacity, up from 20 760 additional beds opened in the week beginning 5 December. That figure dropped over the following weeks and in the week beginning 20 February stood at 26 762 extra beds.

NHS Providers said that because the average hospital has around 3850 beds available each week "this is the equivalent of opening an additional eight hospitals to cope with winter demand."

Its analysis also showed how bed occupancy rates remained well above the recommended safe level of 85% for the 13 weeks studied. The week beginning 30 January saw the highest average occupancy, at 96%.

The figures also showed the number of times a week that emergency departments in England have had to divert patients to neighbouring hospitals. The number peaked over Christmas at 57.

The report said that, while the British Red Cross's warning in January that the NHS faced a "humanitarian crisis" was an exaggeration, "We believe it is true to say that the NHS has experienced unprecedented pressure this winter. The NHS has, by and large, coped with this pressure but there have been a number of instances where, for short periods of time, individual trusts have failed to cope, despite their best efforts."

NHS Providers warns that the situation is "unsustainable" and that planning for next winter must begin now. It says that there must be a formal review of how the NHS has managed this year, including whether the NHS should revert to having dedicated winter funding.

Mark Porter, the BMA's chair of council, said, "As a doctor it certainly felt like one of the worst winters on record, and this report demonstrates the reality of what the entire profession had to deal with over the last few months. Instead of outlining a credible plan to deal with that crisis, the government tried to play down the pressure that services were under."

Anne Gulland, London

Cite this as: *BMJ* 2017;356:j1213

The number of extra beds opened by NHS hospitals this winter was equivalent to eight entire hospitals

LATEST ONLINE

- Government forces blamed for attacks on health facilities in Afghanistan and Syria
- Medical practitioners' tribunal criticised for 57 day hearing resulting in a three month suspension for a doctor
- What the budget means for the NHS and social care

SEVEN DAYS IN

REX/SHUTTERSTOCK

Anaesthesia causes discomfort for one in three

A third of patients report severe discomfort after anaesthesia, and women are three times more likely to than men, a study published in the *British Journal of Anaesthesia* found.

The SNAP-1 study, the largest of its kind ever carried out in the UK, included 15 040 patients undergoing non-obstetric surgery requiring anaesthesia care over a 48 hour period. The patients were recruited from 257 hospitals in England, Scotland, Wales, and Northern Ireland. The patients completed questionnaires within 24 hours of surgery about postoperative discomfort and their satisfaction with anaesthesia care.

Severe discomfort in at least one domain was reported by 35% of those surveyed. The most common symptom was severe thirst, reported by 18.5%, followed by pain at the surgical site (11%) and drowsiness (10%). Women were 2.7 times more likely than men to experience severe cold or nausea and vomiting, and they were almost twice as likely as men to experience severe pain and drowsiness after surgery. Anxiety was most frequently cited as the worst element of having an operation, reported by 34% of women and 26% of men.

But respondents said that they were very satisfied with the care they received, and 99% said that they would recommend their hospital's anaesthesia service to friends and family.

Jacqui Wise, *The BMJ* Cite this as: *BMJ* 2017;356:j1154

Care of elderly

Uber to transport elderly patients

The app based taxi firm Uber has signed a partnership deal with the technology company Cera to transport elderly patients. Drivers will receive training in disabilities and access to cars that can accommodate wheelchairs. Cera has also joined forces with Barts Health NHS Trust and three clinical commissioning groups to deliver home care to patients, including those with dementia and cancer.

Devolved nations

Welsh GPs to get rise in pay and expenses

GPs in Wales will share in an extra £27m as part of the new GP contract for 2017-18. The extra funding includes an increase of 2.7% for pay and expenses, comprising a pay rise of 1%, a general expenses increase of 1.4% to cover practice costs, and contributions to the rising costs of professional indemnity and pensions administration. It also includes an increase in funding for maternity leave, parental leave, and sickness absence and a contribution towards the business improvement levy.

New health minister urged to work with GPs

At the annual conference of Northern Ireland's local medical committees in Belfast, Tom Black, chair of the BMA's Northern Ireland GPs committee, urged the incoming health minister to decide whether he wanted to "work with us or work against us." GPs in Northern Ireland threatened to leave the NHS after the province's government failed to commit to an urgent financial rescue package for general practice.

Pressure on NHS

Trusts issue many high level alerts this winter

Some 37 NHS trusts had to declare high level alerts this winter, show data from NHS England. Between December 2016 and February 2017, 37 trusts reported one or more Opel 4 alerts (the highest level), meaning that patient safety might be compromised, the *Guardian* reported. In addition, 93 trusts issued level 3 alerts, meaning that the local health and social care system was seriously compromised. Salisbury NHS Foundation Trust issued 47 alerts, six of which were at the highest level. University Hospitals of Leicester NHS Trust issued 42 alerts, 27 at the highest level.

Stroke services

A fifth of stroke units offer "world class service"

An audit of stroke services has found that 19% of 228 inpatient stroke units in England, Wales, and Northern Ireland achieved the top A score, indicating that they offer a world class service. The Sentinel Stroke National Audit Programme, run by the Royal College of Physicians, also shows that a further 60 teams (28%) achieved a "B" score. The figures, covering August to November 2016, also show that only four stroke services were in the lowest "E" banding, the lowest number since the audit began.

Patient safety

Trust to be prosecuted over patient's injuries

Southern Health NHS Foundation Trust will be prosecuted over an alleged failure to provide safe care and treatment after a patient fell from a low roof, sustaining serious injuries. The incident happened in December 2015 at Melbury Lodge, Royal Hampshire County Hospital, Winchester. The case, brought by the Care Quality Commission, is expected to be heard later in the year by Basingstoke Magistrates' Court. An NHS England report published in December 2015 found that there were 722 "unexpected" deaths at the trust between 2011 and 2015. The investigation was sparked by the death of Connor Sparrowhawk (pictured), an 18 year old with learning disabilities who died while in the trust's care.

Pharmaceuticals

Drug firms breach competition rules

The drug companies Concordia and Actavis UK have been found to be in breach of competition rules after Actavis persuaded Concordia not to enter the market with its own competing version of hydrocortisone tablets. The UK Competition and Markets Authority found that Actavis supplied Concordia with a fixed supply of its own tablets for a very low price for Concordia to resell to its own customers. Actavis UK remained the sole supplier of the tablets in the UK during most of this period, when the cost of the drug to the NHS rose from £49 to £88 for a pack.

MEDICINE

Cancer

Charity warns over popularity of fast food

Cancer Research UK has warned that fat and sugar content in takeaways and ready meals is too high, as new figures show their popularity. A poll commissioned by the charity shows that 79 million ready meals and 22 million fast food and takeaway meals are eaten every week by UK adults. Regular consumption of food higher in fat and sugar than home cooked food raises the risk of weight gain and obesity and therefore cancer, the charity warns.

Environment

1.7 million child deaths linked to poor environment

Environmental risks such as indoor and outdoor air pollution, secondhand smoke, unsafe water, and poor sanitation and hygiene lead to the deaths of 1.7 million children under the age of 5 every year, says the World Health Organization. Two WHO reports outline the range of environmental risks facing children and warn that indoor and outdoor air pollution and secondhand smoke kill 570 000 children under 5 every year. Another 361 000 children under 5 die from diarrhoea, because of poor access to clean water, sanitation, and hygiene. And 200 000 under 5s die from unintentional injuries attributable to the environment, such as poisoning, falls, and drowning.

Research news

Dementia linked to tooth loss

A study of 1566 elderly Japanese people found that those with fewer teeth had a higher risk of developing dementia. People with 10-19, 1-9, and no teeth had 62%, 81%, and 63% higher risks of dementia, respectively, than those with more than 20 teeth. "Our findings emphasize the clinical importance of dental care and treatment, especially in terms of maintenance of teeth from an early age for reducing the future risk of dementia," said Tomoyuki Ohara, coauthor of the study in the *Journal of the American Geriatrics Society*.

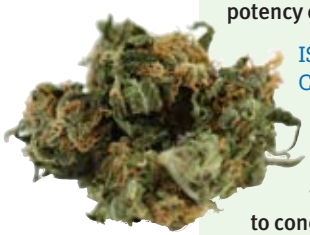
Education good for allergy control

A professional pest management service was no better at reducing asthma symptoms in children allergic to mice than teaching families how to reduce the allergens themselves. The study, published in *JAMA*, compared professional pest management treatments combined with education with education alone and found no significant differences between the two groups in asthma symptoms or mouse allergen exposure.

Cite this as: *BMJ* 2017;356:j1208

SMOKING

17.2% of UK adults smoked in 2015, down from 20.1% in 2010. The number of smokers falls to lowest level since records began in 1974



SIXTY SECONDS ON . . . SKUNK

IS THAT A NEW DANCE CRAZE?

You're such a square. It's a form of high potency cannabis, and researchers from the Institute of Psychiatry, Psychology and Neuroscience at King's College and University College London are warning of its harms.

I THOUGHT THE DRUG SCENE HAD MOVED ON FROM CANNABIS?

Despite cannabis use falling in the UK, particularly among young people, rates of treatment for addiction are increasing. Most cannabis used in the UK is skunk rather than the milder hash that the cool kids would have used when you were a student in the 1960s.

HOW DARE YOU! IT WASN'T THAT LONG AGO. SO WHAT'S THE DIFFERENCE?

The main active compounds in cannabis are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). High potency cannabis such as skunk is high in THC and low in or without CBD. Cannabis resin (hash) has a low potency, generally consisting of equal quantities of THC and CBD. THC gets you high, but CBD can offset some of its harms.

BUT CANNABIS ONLY MAKES YOU GIGGLE AND GIVES YOU THE MUNCHIES

Today's high potency cannabis can lead to cognitive and educational impairment and psychosis. It's also more addictive. Robin Murray, professor of psychiatric research at the Institute of Psychiatry, told a press conference that a quarter of cases of psychosis seen at the institute in south London occurred in people using high potency cannabis or skunk.

IS THERE A SAFE FORM OF CANNABIS?

Increasing the ratio of CBD to THC may be a solution. King's College London has just received funding from the Medical Research Council to conduct a study on healthy volunteers who will get CBD and THC in different ratios. Researchers will look at the volunteers' cognitive outcomes to work out whether there is a right mix.

TO BE FRANK, I DIDN'T SMOKE CANNABIS AS I COULDN'T STOMACH THE TOBACCO

Help may be at hand in the form of vaping devices, which can be filled with cannabis oil. Tobacco increases the addictive potential of cannabis, although few studies have looked at the links between the two.

Anne Gulland, London

Cite this as: *BMJ* 2017;356:j1184

DH unveils plan to speed up payments for birth injuries

Children who experience severe avoidable injuries at birth could be compensated more quickly under a new out-of-court redress scheme proposed by the Department of Health for England.

The rapid resolution and redress (RRR) scheme also aims to reduce the number of such injuries by adopting a learning culture, improving the experience for clinicians and families, and making more effective use of NHS resources.

The proposals, which are out for consultation until 26 May, come as the NHS litigation bill for maternity claims reaches nearly £500m a year. The average payout in cases of severe birth injury, around 100 of which are settled each year, is £6.25m, and the average case takes 11.5 years from incident to resolution.

The RRR scheme is based on a similar scheme in Sweden that has seen the number of severe avoidable birth injuries drop since it was introduced in 2007. The new scheme would apply only to England and would be voluntary, allowing families to opt out and take their cases to court instead.

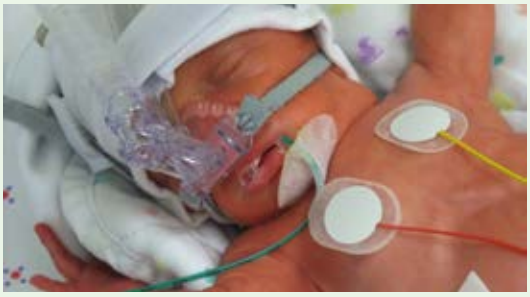
In the first stage of the two stage scheme, cases that met the Royal College of Obstetricians and Gynaecologists' criteria for markers of severe brain injury at birth would be subject to an independent root cause investigation within 90 days. Investigations would focus on systems failures rather than attributing harm to an individual. Families would be given early access to counselling and support in accessing state services.

In the second stage, once eligibility has been established families would receive an upfront payment of around £50 000 to £100 000. This would come at the point when the child is old enough to enable the prognosis, the source of the injury, and its avoidability to be established, typically around age 4, although in some cases much sooner.

The rest of the compensation package, a lump sum and periodical payments, would follow. The total package would equal 90% of the compensation that would have been awarded by a court.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;356:j1181



Hospitals must prove beds aren't needed before closing them, says NHS England

Local healthcare leaders in England will not be allowed to cut numbers of hospital beds unless they provide evidence that suitable alternative provision is available in the community, the head of NHS England has said.

The requirement is enshrined in three new conditions that local NHS organisations will have to meet if they are planning major hospital bed closures as part of sustainability and transformation plans (STPs). Subject to the current rules that require formal public consultation on service changes, NHS England said that it would approve bed closures only if one of three new conditions is met.

The announcement comes amid concern that some of the 44 STP areas in England plan to cut numbers of hospital beds despite increasing demand for care, in moves branded "lunacy" by the College of Emergency Medicine.

Announcing the measures at the Nuffield Trust's health policy summit this week, NHS England's chief executive, Simon Stevens, explained that the first condition would require areas to prove that they had increased GP or community services alongside or ahead of bed closures and that the required workforce would be there to deliver them.

The second condition requires local leaders to show that specific new treatments or therapies, such as new anticoagulation drugs used to treat strokes, would reduce specific categories of admissions to hospital.

The third is that where a hospital has been using beds less efficiently than the national average it has a credible plan to improve performance without affecting the care of patients.

Stevens told the Nuffield summit, "Hospitals are facing contradictory pressures. On the one hand, there's a huge opportunity to take advantage of new medicines and treatments that increasingly mean you can be looked after without ever needing hospitalisation. So, of course there shouldn't be a reflex reaction opposing each and every change in local hospital services.

"But on the other hand more older patients inevitably means more emergency admissions, and the pressures on A&E are being compounded by the sharp rise in

NHS leaders announce new measures to cut locum costs

NHS leaders are stepping up efforts to curb hospital spending on locum doctors after new figures showed that around 100 are each earning more than £200 000 a year from agency work.

New measures announced this week by the regulator NHS Improvement (NHSI) include blocking NHS trusts from employing agency workers who hold substantive roles at other trusts and clamping down on the use of personal service companies, which can often reduce agency workers' tax bills.

The regulator will also push for greater transparency on pay and is considering asking trusts to publish rates paid to high earning locum doctors earning more than £150 000.

Outlining the plans in a letter to NHS chief executives on 17 February, the NHSI chief executive, Jim Mackey, said that high rates paid for temporary staff were "a major problem for substantive staff performing the same duties."

The regulator added that the NHS's total spending on agency staff was set to fall from an estimated £3.7bn in 2015-16 to around £3bn in 2016-17.

But Mackey said that further progress was needed to reduce spending on medical locums, estimated at around £1.1bn nationally in 2016-17. Around a fifth of this is incurred in emergency departments.

ALAMY

patients stuck in beds awaiting home care and care home places. So there can no longer be an automatic assumption that it's OK to slash many thousands of extra hospital beds—unless and until there really are better alternatives in place.

"That's why, before major service changes are given the green light, they'll now need to prove there are still going to be sufficient hospital beds to provide safe, modern, and efficient care locally."

NHS England said that under its proposals hospitals would still have the freedom to alter their numbers of beds throughout the year and the responsibility to determine how many beds they could staff safely.

Mark Porter, the BMA's chair of council, said, "While the principle of this move sounds sensible, it is astounding that NHS leaders are still talking about cutting the numbers of beds even though we know that patients are being already unfairly let down by a huge lack of beds in our hospitals."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;356:j1152

"It is clear from the data that we have made the most progress with nursing agency staff, but that there is still a long way to go in tackling excessive costs for medical locums," he wrote.

Mackey said that the "significant differences" in rates paid to locum doctors should be tackled on a collective basis. NHSI would work with groups of local trusts to agree consistent pay escalation rates "that all trusts locally should stand firm on."

The regulator has also set a new national target to reduce medical agency spending by £150m in 2017-18. Each trust will be required to agree an improvement target on medical locum spending with the regulator for the same year.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;356:j1099

LOCUM SPENDING

- Before controls on agency spending were introduced in October 2015, spending was increasing by 25% a year
- In the last year 77% of trusts reduced their agency spending, over half of these by more than 25%
- Medical agency staff prices have fallen by 13% since October 2015
- But around 500 agency staff earn more than £150 000 a year (whole time equivalent), with 100 earning more than £200 000 per year
- The five highest paid locums alone cost the NHS over £2m last year

FIVE MINUTES WITH . . .

Harry Burns

Scotland's former chief medical officer explains why he emphasised social determinants of health at this year's Nuffield Trust health policy summit

"We spend a huge amount of time, effort, and money focusing on treating—and to a certain extent preventing—illness. However, we still find health inequalities widening.

"Continuing to throw money at a health service will not necessarily narrow that gap. On the other hand, over the past few decades it has become very clear that wellbeing and wellness have a very profound scientific basis, associated with the way that children are nurtured and raised. Failure to create a stable environment for children in early life creates definable abnormalities, with stress affecting neurological development.

"If we're serious about reducing inequality in our society we need to focus far more on support for families and children. It's a complex system, and part of the difficulty is trying to provide simple solutions to complex problems. Complex systems are changed by a whole range of methods, and therefore you need to look closely at the determinants of chaos in different areas. Chaotic families produce negative outcomes for children, and they're the families that need support.

"Don't wait for strategies or ministerial pronouncements. If something needs doing, fix it and ask permission afterwards"

"What's very plain from talking to these families is that our social and economic support systems are failing many of them. We need to rethink the way in which perceived need is met.

"Scotland has learnt over the past few years about the use of improvement methods to change outcomes, and we think there's an opportunity to use these methods for families through helping public services work differently with them. My default strategy is always to just get out and do something. Don't wait for permission, strategies, or ministerial pronouncements. If something needs doing, fix it and ask permission afterwards."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;356:j1183

Bullying culture in NHS starts at top, says royal college head

Clare Marx says she doesn't know a chief executive who isn't bullied by more senior colleagues in the health system

A bullying culture in the NHS is being passed down "from the top," the president of the Royal College of Surgeons has said.

Speaking at the Nuffield Trust's Health Policy Summit last week, Clare Marx said that the health service needed to have a "zero tolerance" approach towards poor management behaviour. "I think attitudes and behaviours in healthcare come from the top," she said. "We all hear about bullying cultures. I'm ashamed to say that I don't know a chief executive who isn't bullied from the top, and I think that is passed down."

She added, "They have to be very good leaders not to actually pass on those sort of behaviours.

"So we need to stand up and say, 'I'm not going to have this, and this is what I'm going to do about it. I'm going to ensure that I display the sort of behaviours I would like myself.'"

Honest converstations

Responding to a question about Marx's comments at a later session, Simon Stevens, chief executive of NHS England, said that the NHS had "further work to do" to ensure that honesty concerning gaps in performance did not tip over into inappropriate and bullying behaviour.

"The system is clearly under stress, and stress does not always produce the right kind of behaviours and conversations," he said. "There is also a question about having honest conversations about performance gaps and accountability." These conversations needed to be "calibrated correctly" so that there could be "honest and transparent conversations about where change needs to happen—and hasn't done so far—without that being inappropriate or bullying per se," Stevens said. "Getting that calibration right is a challenge for all of the national bodies, and we've got further work to do."

Marx also argued that senior doctors needed to recognise what they should do to improve morale in the workforce. "As leaders, as consultants in secondary care, we need to wake up in the morning and smell the coffee," she said. "We need to realise that we've had the most incredible careers, and now it's actually the time for us to pay back into that system, and we need to stand up and be counted."

She said that leaders in the profession needed to do more to recognise the contributions of doctors in training. "You actually say to them, 'You've done a fantastic job,'" she said. "You really draw them into the whole team ethos. You listen to them and you make them feel valued. I'm ashamed to say that too often

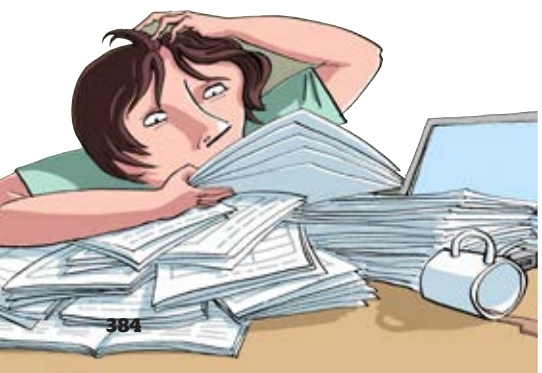
senior clinicians are passing up that opportunity."

Martin Green, chief executive of Care England, a charity that represents independent care service providers in England, said that the health service needed to be better at recognising good work. "We've also got to get much better at validating good practice: telling people what they've done well and doing that in real time, if possible," he said.

"If we're not careful, we spend a lot of our time telling people what they do wrong but not telling them how they delivered a really good service—and that really helps to give people an understanding of what good looks like."

EXPERIENCES FROM THE NHS FRONT LINE

The Royal College of Physicians has published a report collating doctors' experiences of working in NHS hospitals. Here is a selection of quotations, which the college has anonymised



1 Burnout risk

"I have never before known a time when consultant colleagues are constantly exhausted, trainees so disillusioned. As director of medical education, I receive daily visits and emails from trainees who want to talk about leaving medicine—and hospitals under unremitting clinical and financial pressures."

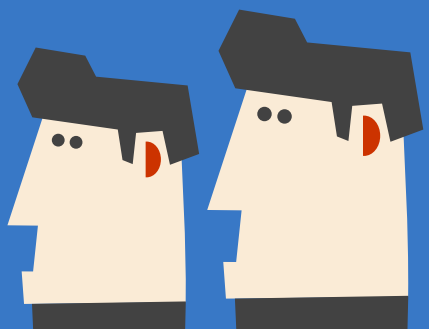
2 Patients in danger

"As a regional hospital, it is almost impossible to get patients transferred in for specialist services. Patients are dying as a result of not accessing specialist care, as the hospitals are jam-full. It is also impossible to get patients transferred back to district general hospitals once patients have received specialist input."

3 Pressure across system

"Of the people I saw this morning, not a single one had been referred by the GP, despite several having primary care amenable problems—they had bypassed primary care and defaulted straight to A&E. It's an environment where all colleagues . . . are stressed with little in reserve."

We spend a lot of our time telling people what they do wrong but not telling them how they delivered a really good service



Praise excellence

In the same session, which focused on "energising your workforce in the face of adversity," Helen Stokes-Lampard, chair of the Royal College of General Practitioners, said that the NHS needed to get the basics right where motivating the workforce was concerned.

"Relationships with my colleagues are fantastic. I know all my colleagues. They are wonderful," she said. "What we're all struggling with is the whopping great elephant in the room, which is the time and the resource [needed] to do a safe job. It has to be a safe environment, and [we have to have the] ability to practise effectively and safely. We've got to get that right."

Tom Moberly, *The BMJ*

Cite this as: *BMJ* 2017;356:j1192

4 Corridor wards

"We have a policy to help each ward—not just the acute admissions wards, but each ward in the hospital—decide who is the 'least bad' patient to approach to ask to sleep on a bed in the corridor."

5 Raising awareness

"I feel strongly that we continue to have a duty to try to ensure that those members of the public who don't witness the current stress the NHS is under are made aware of just how bad the current situation really is."

Consultants vote against automatic ballot on new contract

Consultants have voted against automatically holding a collective ballot of consultants and senior trainees on a new contract.

Instead, consultants could decide individually whether they wish to accept the new contract or remain on the existing consultant contract. Likewise, senior trainees, once they became consultants, could choose between the 2003 consultant contract and the new contract.

At the BMA's consultants' conference in London on Tuesday 28 February, delegates voted against a motion calling on the association's Consultants Committee to neither approve nor accept any new contract "without balloting appropriate branches of the BMA membership."

In his opening speech to the conference, Keith Brent, chair of the committee, said, "A scenario has arisen whereby the best possible terms for both present and future consultants would involve an individual choice of contract rather than a collective ballot."

Brent explained that the Consultants Committee had decided at a special meeting in January that it would consider putting a contract choice to individual members rather than to a ballot.

The BMA has been in discussions with the government about a new consultant contract since 2013. Talks stalled in 2014 but resumed in September 2015. Negotiations are ongoing, and an agreement on a new contract has not yet been reached.

Commenting on the proposed motion, Brent said, "The reality is if you ask us to go for a vote on a ballot, I don't think there will be a ballot anyway because we won't get an offer. It's not that the offer will be worse: there simply won't be an offer, [and] the negotiations will cease."

He added, "Employers will then release local trusts to implement whatever contract they wish for new starters, and of course there is nothing that can be done, unless you feel that existing consultants will take indefinite industrial action to stop a contract being imposed on people that are not them."

Keith Brent, chair of the BMA consultants committee

Nick Flatt, chair of the BMA North West Consultants Committee, proposed the motion that called on the BMA Consultants Committee not to accept a new contract without a ballot of consultants and ST3 (third year of specialty training) juniors and above. He warned that if consultants voted against the motion they would disenfranchise current and future consultants, as well as junior doctors, "but most ironically of all you will be voting against democracy."

However, Rob Harwood, deputy chair of the Consultants Committee, warned that NHS Employers had said that any contract offer would be "downgraded if we decide to go in favour of a ballot rather than an individual choice."

A spokesman for NHS Employers said, "NHS Employers and the BMA remain in formal negotiations on the options updating the consultant doctors' contract.

"Although agreement has not yet been reached, NHS Employers remains committed to continuing to work with the BMA to reach a mutually acceptable outcome to this process. It is unwise for any party to prejudge the outcome of these ongoing and constructive discussions."

Abi Rimmer, BMJ Careers

Cite this as: *BMJ* 2017;356:j1207K

MARK THOMAS

THE BIG PICTURE

Protesters march to stop NHS from being "hung out to dry"

Thousands of NHS staff and patients joined a march in London to protest at continuing cuts to England's health service.

The organiser, Health Campaigns Together, an umbrella organisation of NHS pressure groups, said that around 250 000 people joined the march from Tavistock Square in Bloomsbury, where protesters hung T-shirts, to Parliament Square.

The health service union Unison said that the march was called to highlight increased pressure on NHS staff as "patient demand rises but resources dwindle."

One of the issues raised was the sustainability and transformation plans, which have seen organisations come together locally to draw up plans to transform local services. But the march organisers said that the plans were simply a "smokescreen for further cuts" and the "latest instruments of privatisation."

Jeeves Wijesuriya, chair of the BMA's Junior Doctors Committee, told marchers, "What is sustainable about debts that can only be paid with our patients' health and yet still won't be settled? Where is the transformation when the money to build new hospitals and health centres is being siphoned off to pay debts?"

Labour Party's leader, Jeremy Corbyn, told the crowd, saying, "The NHS is in crisis, in crisis because of the underfunding in social care and the people not getting the care and support they need. It is not the fault of the staff. It is the fault of a government who has made a political choice."

Anne Gulland, London

Cite this as: *BMJ* 2017;356:j943

EDITORIAL

STPs for the NHS in England: radical or wishful thinking?

Greater commitment from the government is vital

Planning is back in fashion in the NHS. Over the past 15 months, NHS England has overseen the production of sustainability and transformation plans (STPs) for health and care services in 44 geographical areas or "footprints" covering the whole country.[1] They have been produced by local NHS organisations, with varying levels of involvement from local authorities, senior clinicians, professional associations, patient groups, and the public.

We have had almost three decades of health reforms in the English NHS emphasising competition and markets, patient choice, provider autonomy, and the like.[4] A journey that started in the early 1990s with Kenneth Clarke's introduction of NHS trusts, GP fundholding, and the internal market concluded with Andrew Lansley's abolition of strategic health authorities, primary care trusts, and much of the organisational infrastructure of the NHS.[5]

Five Year Forward View

All that has changed since NHS England and other national NHS bodies published their *Five Year Forward View* in 2014, articulating a vision for reforming health and social care services and meeting ambitious savings targets set by government.[6] Competition and autonomy are out of favour—integration, collaboration, and planning are now the order of the day. STPs are meant to be the key to how the NHS will transform the way health and care services are organised, delivered, and used and to make them financially, clinically, and socially sustainable in the longer term. It is, as they say, a "big ask." So how do the 44 STPs measure up?

STPs are meant to be the key to how the NHS will transform the way health and care services are organised, delivered, and used

There are some eminently sensible common themes across the STPs. They set out proposals for improving prevention and early intervention; strengthening and integrating primary and community care services; integrating NHS provided health services with social care services funded by local authorities; reconfiguring acute care and diagnostic and specialist services; and rationalising supporting "back office" functions. There is a welcome focus on changing services—rather than organisational structures—and on dealing with multimorbidity, chronicity, and frailty.

The main problems

The direction of travel is right, but that is not the whole story. There are four main problems with STPs, which if not resolved make it unlikely that these plans will work.

Firstly, they are being launched at a time of unprecedented levels of financial constraint and challenge in the NHS.[7] The changes that STPs envisage require considerable investment, and any resulting savings from rationalisations, reconfigurations, and better managed demand for health and care services are both hypothetical and some way in the future.

Secondly, the plans have been written in a rush, and professional and public consultation and engagement have been largely neglected. As a result, the response from the medical profession, the public, and the media has defaulted to suspicion and opposition, mostly focused on hospital cuts and closures.

Thirdly, these plans have no statutory force or authority—they are simply agreements among sets of NHS organisations and some other stakeholders. Lansley abolished the organisations—strategic health authorities—that might have carried these changes through, and his Health and Social Care Act 2012 contains a host of provisions on competition and market access that make these changes open to legal challenge and difficult to implement.

Fourthly, these plans are founded on the sound idea that we should bring health and social care services together—but social care services are funded separately by local authorities, whose funding has been cut by 37% in real terms over the past six years,[8] and social care services are means tested whereas healthcare is not. There are many institutional barriers to integrating health and social care, but funding is the most problematic.

Government action required

Fixing these problems and giving STPs a real chance to succeed requires action from government—to provide realistic transitional funding for the changes; to give political backing to the changes and allow for proper consultation at a national and a local level; to enact legislation to remove the competition and market access provisions of the Health and Social Care Act and to allow for statutory bodies to be created to lead STPs; and to tackle the health and social care divide by implementing the recommendations of the Barker commission[9] for a single system of funding to commission health and social care.

The NHS and its leaders have done what they can to map out a sustainable future health and social care system for England. But without a much greater commitment from government, it seems unlikely that these plans will work.

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Cite this as: *BMJ* 2017;356:j1043

Find the full version with references at http://dx.doi: 10.1136/bmj.j1043

EDITORIAL

Patient and family engaged care—going beyond tactical buzzwords

Aim for better care, not simply more engagement

A scientific advisory panel convened by the National Academy of Medicine in the US has released a new framework for building and sustaining patient and family engaged care (PFEC).[1] It described PFEC as "care planned, delivered, managed, and continuously improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and healthcare goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of the care match with patient goals."

PFEC should influence clinical decisions and policy making about the organisation and delivery of care, from the clinical encounter to the boardroom. The authors expect the framework to lower costs and to guide and catalyse collaborative actions to improve healthcare culture, care, and health outcomes. But this useful, hopeful, and potentially seminal report raises some concerns that give us, activists for engaged patient centred care, some pause.

The framework justifies engaged care as a tactic for improving healthcare, from culture to costs. But behind engagement as a tactic, there is the obligation to care, to attend to a human situation of patients and family experiencing illness or the threat of illness. It is healthcare's diminished capacity to engage in caring for people that demands a renewed emphasis on engagement. If we don't acknowledge this angle, engagement tactics are unlikely to succeed. When engagement is used as a tactic for reducing costs, for example, we may find that the costs to start and maintain PFEC programme do not compete favourably with cost containment or profit making programmes.

ADAM GAULT / SCIENCE PHOTO LIBRARY

Patients have been hearing about good intentions like PFEC for years

Neglecting the burden that engagement strategies may place on patients and families can have unintended consequences, such as the silencing of voices made weaker by illness or social exclusion or made discordant by their particular goals and ways of achieving them; the discharge from care of those who are "non-compliant" with engagement; and the under-representation of patients and families for whom it is more practical to engage in the co-production of other services.

Patients have been hearing about good intentions like PFEC for years, hoping for the moment when buzzwords like "patient centricity" become reality.[2] Maybe this report can help catapult PFEC to the top of healthcare agendas and persuade all organisations to fully and respectfully partner with patients and families. Or it may do nothing at all—or worse, make PFEC a promotional talking point for healthcare, bling for a hospital's mission statement, the newest entry into the pantheon of managerial buzzwords that healthcare leaders can use while doing business as usual. Before cynicism sets in, we need a to-do list for PFEC.

The task list for PFEC need not be monumental. The new framework describes systemic and ecological transformations, but smaller, equally important changes can be made almost immediately. Making the clinical visit longer and moving the computer out of the way could help clinicians and patients notice each other, communicate better, and co-produce more effective care plans.[3] Patients and caregivers who need help finding and using their voice could be partnered with others who are already taking control of their healthcare.

Of course, it takes two to partner. Engaged care is not likely to become routine solely by convincing those with all the power to have less of it. The new PFEC framework's focal point lies firmly within healthcare, while patients and families lie on its blurry edges. What should patients and families do to rise up and engage? Where is the evidence about what works, with minimal burden and costs, for patients and families? Moving the central point of the framework from healthcare to the true partnership required in caring for a person and family may bring the challenges and opportunities for both sides into sharper focus.

Ultimately, and the report gets this right, PFEC programmes should not aim at more engagement, but at better care. It is time to partner with patients and families to co-create careful and kind care for everyone.

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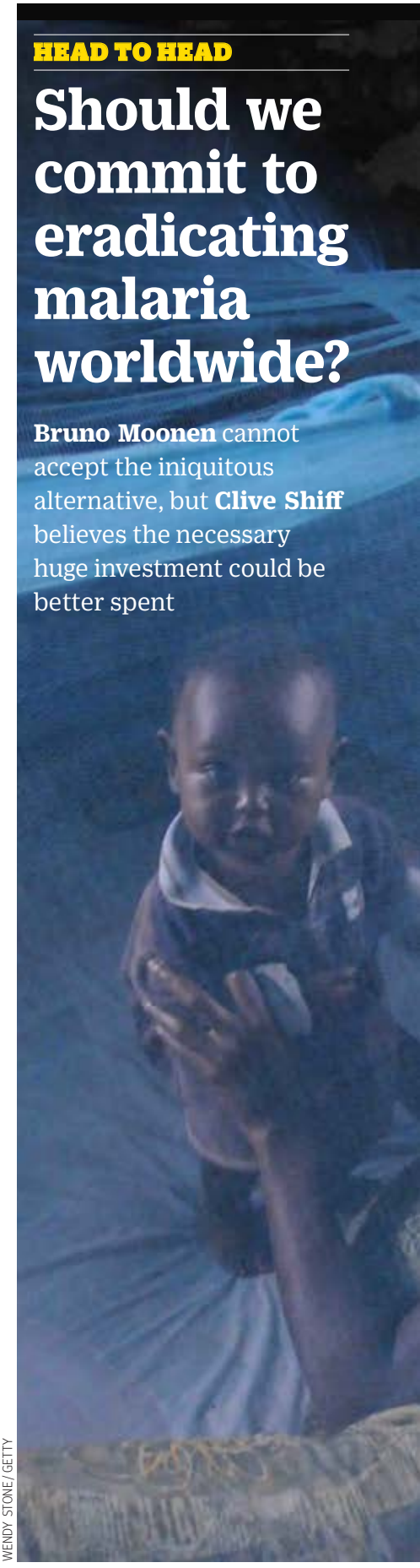
Cite this as: *BMJ* 2017;356:j1155

Find the full version with references at http://dx.doi: 10.1136/bmj.j1155

HEAD TO HEAD

Should we commit to eradicating malaria worldwide?

Bruno Moonen cannot accept the iniquitous alternative, but **Clive Shiff** believes the necessary huge investment could be better spent



WENDY STONE/GETTY

yes

Indefinite control would require constant investment in research and development to stay ahead of an ever evolving parasite

Bruno Moonen, deputy director for malaria, Global Health Program, Bill & Melinda Gates Foundation, Seattle, WA, USA Bruno.Moonen@gatesfoundation.org

The World Health Organization,[1] the Roll Back Malaria Partnership,[2] and the United Nations[3] all have a vision of a malaria-free world. More importantly, malaria endemic regions are setting ambitious elimination targets, showing a clear demand for, and commitment to, regional elimination and, eventually, global eradication.[4-6]

For malaria, eradication is the only equitable and sustainable solution. Half of the world has already eliminated malaria,[7] and, as Melinda Gates put it in 2007: "Any goal short of eradicating malaria is accepting malaria; it's making peace with malaria; it's rich countries saying: 'We don't need to eradicate malaria around the world as long as we've eliminated malaria in our own countries.' That's just unacceptable."[8]

The alternative, indefinite control, is not sustainable. Maintaining financial commitment, especially when the burden becomes low, is challenging, and history has shown that when programmes are not adequately funded malaria will resurge.[9] Indefinite control would require constant investment in research and development to stay ahead of an ever evolving parasite and vector. Countries that eliminate, on the other hand, are more likely to remain malaria-free.[10]

Polio endgame

The challenges in the polio endgame, operationally and financially, are obvious reasons for pause. As Chris Whitty, chief scientific adviser to the UK Department of Health, noted: "Trying and failing [to achieve] eradication is costly, pulls resources from other priorities, breeds cynicism, and may destroy good control programmes. The key, therefore, is not to call for it where we cannot achieve it, and, for most diseases, we cannot."[11]

However, failures in control because of inconsistent funding are equally expensive,[9] and bold and ambitious goals typically mobilise additional resources that otherwise would not have been available. Also, it is important to recognise that a commitment to malaria eradication is not a call for a vertical campaign that would divert scarce resources and replace control programmes. Instead elimination programmes need to build on strong control efforts (not replace them); the currently well funded malaria efforts should form the basis for integrated infectious disease surveillance and integrated vector management, as was the case in Sri Lanka, which is now malaria-free.[12]

In general, a false sense of the feasibility of eradication, often with a single tool, has historically stifled research and development. Funding faltered for the Global Malaria Eradication Programme in the 1960s and the programme ended, and when parasites became increasingly resistant to chloroquine and DDT controlling malaria became challenging.[13]

Investment in innovation

Today's challenges relate to emerging resistance, and the acknowledgment that malaria cannot be eradicated with the current tools alone has spurred investment in innovation, often through public-private partnerships. We now have a robust pipeline of new molecules for treatment and active ingredients for vector control as well as investments in vaccine development and other technologies that either reduce mosquito populations or make them refractory to transmit parasites to prevent transmission sustainably.[14]

Unlike polio, for which routine vaccination continues globally, many previously malaria endemic countries no longer have vertical control programmes for malaria, and failing in one region does not necessarily pose a global risk because regional success has already been shown to be sustainable.

Although the vision of a malaria-free world is already broadly held, a recommitment by the World Health Assembly to malaria eradication would be a strong sign of support for regional elimination ambitions. This should not be a commitment to a campaign that is based on a single tool, effected through an all-in global effort that needs to continue everywhere until the last parasite is exterminated.

Instead it should be a global commitment to support parallel regional elimination efforts combined with sustained investments in research to develop the necessary tools and tackle the yet unknown challenges of the future. Given the impressive progress made in the past 15 years,[19] now is the time to commit to eradicating a disease that has plagued humanity since its origin. And when we are in the endgame, the world should remember that at the end of the last century this disease killed more than a million children every year.

bmj.com
Editorial: Eliminating malaria: following Sri Lanka's lead. *BMJ* 2016;355:i5517

no

Investing to integrate malaria control into functional local public health systems would be sustainable at a manageable expense

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Without doubt the concept of global eradication of a disease is a highly desirable goal. This laudable objective has been achieved only once, with smallpox. Success depended on a vaccine that imparts long lived immunity after a single inoculation. Even this simple vaccination at scale required a huge worldwide commitment in people and supplies until the last person with symptoms was identified and immunologically isolated.

Massive concentrated funding

This is a top-down strategy, dependent on massive concentrated funding until finished. This runs counter to the concept of public health as an integrated, sustained service for the community.

The World Health Organization's global malaria eradication programme of the 1950s also required central monitoring to provide local commitment and oversight.[20] It had great success in eliminating malaria from some 34% of the areas originally assessed as endemic for malaria,[21] but it depended on functional local health infrastructure. Although research projects in Africa generated much epidemiological data,[22] they could not sustain control, foiling global eradication.[23] This resulted in WHO changing its policy on malaria,[24] focusing on drugs to prevent and reduce deaths—and the policy foundered when chloroquine failed. Today's tools are essentially similar to those of 60 years ago, with improvements in diagnosis and predicting outbreaks and new insecticides and bed nets.

We should promote the management of health services rather than commit massive funds to attempt to eradicate malaria in the near future. Eradication of malaria will require major synchronised commitments, but the governments of many endemic countries have other priorities.[25] Local wars as well as unstable, reluctant, or impoverished administrations, mean many cannot commit the concerted effort necessary to achieve eradication. At the Abuja summit in 2000, African heads of state agreed to control malaria, yet few have committed adequate resources.

A combination of donor and scientific entities will be needed for successful eradication efforts. But who will do the integration? What facilities will be needed on the ground? Who will fund and audit the process? Several donors operate in most endemic countries but each with a specific agenda. For example, some donors provide bed nets only for pregnant women or children under 5, whereas others place no such restrictions but do not evaluate their programmes. Eradication would require coordination and only WHO could do this, but many donors will not agree and WHO now lacks funds for the vital expertise to provide successful coordination.

In any programme to initiate eradication, national health ministries will be responsible for the complex interventions, requiring civil servants who are well trained and remunerated and committed to the programme. However, some endemic countries struggle to fill such roles.[26]

Countries also lack local staff trained and experienced in deploying drugs, diagnostics, and insecticides. These experts are essential for global eradication. Foreign scientists are less likely to provide continuity and may be influenced by external perspectives.

Finally, we have no vaccine for malaria. Vector control depends on insecticides. Experiments are under way to try to modify species genetically, but these are unlikely to be introduced soon, and there are over 40 species that are potential vectors.

Invest in public health

Eradication requires elimination of all cases, even of subclinical infection,[27] meaning that however implemented, eradication would be costly. And costs would increase greatly when seeking and curing an exponentially shrinking number of patients.

Proper management of malaria seems the sensible route. Investing to integrate malaria control into functional local public health systems would be sustainable at a manageable expense. It would also help bolster local infrastructure and the local public health service as well as ensuring that malaria is kept under control and no longer of public health importance.[28] To expend huge resources in an unstable world trying to eradicate a vector-borne parasite complex that has dormancy and a zoonotic base seems an irresponsible alternative to improving the management of public health in endemic countries.

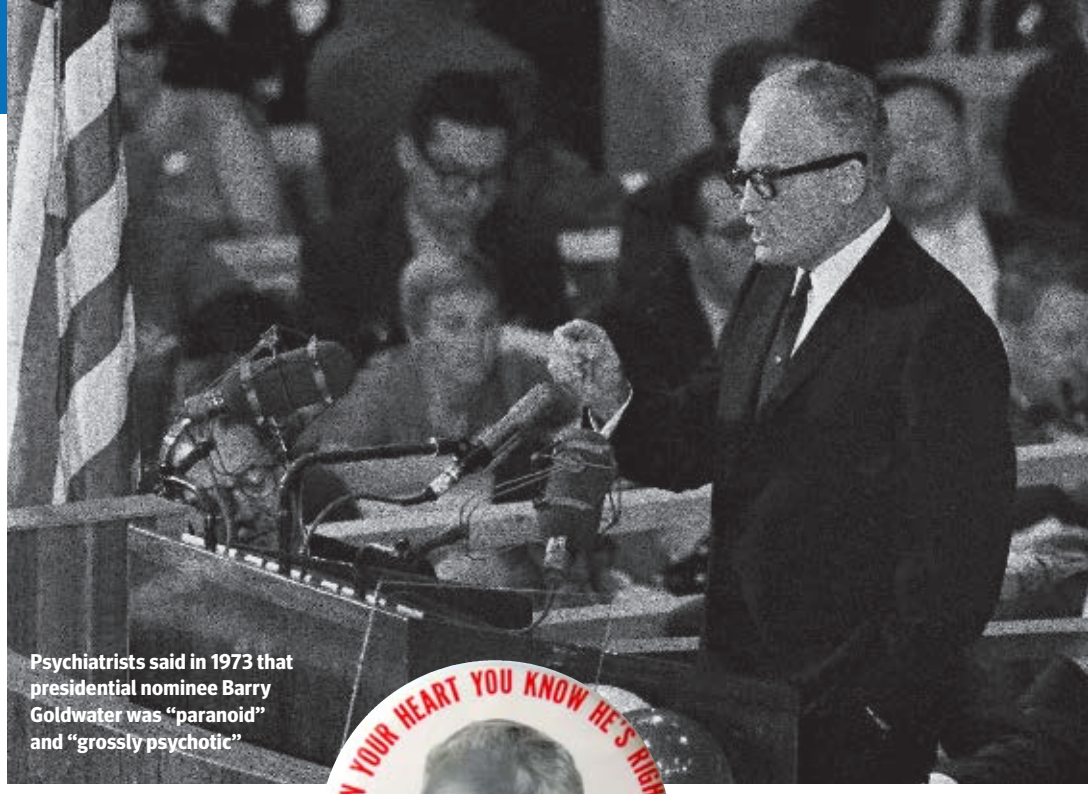
Competing interests: BM declares that the Bill and Melinda Gates Foundation aims to eradicate malaria by 2040.

Cite this as: *BMJ* 2017;356:j916

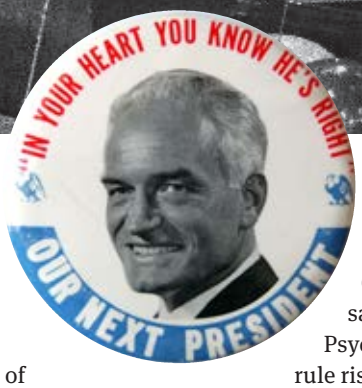
MENTAL HEALTH

Diagnosis from a distance

Jeanne Lenzer explores the debate among healthcare professionals about whether to make public their concerns over Donald Trump's mental health



Psychiatrists said in 1973 that presidential nominee Barry Goldwater was "paranoid" and "grossly psychotic"



Healthcare professionals in the United States are not supposed to comment on patients they have not examined themselves, and they can only discuss their patients with others if they have the patient's consent or consider that a patient is a threat to someone else.

But in recent weeks, debate has raged within the profession about whether, if experts believe US president Donald Trump is mentally ill, they have a duty to inform the public. Many who choose to speak out opine that he has the traits of a sociopath that fall under the diagnosis of narcissistic personality disorder.[1 2]

Two rules

Two rules govern US healthcare professionals and patient confidentiality.

The Goldwater rule states that it is unethical for psychiatrists to diagnose mental illness in people they have not examined and whose consent they have not obtained. The rule was issued by the American Psychiatric Association in 1973 after it surveyed its members about Senator Barry Goldwater, then Republican nominee for president.[3] Nearly half of the responding psychiatrists said he was mentally ill, and some described him as "paranoid" and "grossly psychotic." Goldwater successfully sued *Fact*, the now defunct magazine that published the results of the survey, for libel. The rule does allow psychiatrists to talk to the media about the general traits of an illness an individual not in their care is said to have. The American Psychological Association's code of ethics similarly states that psychologists "should not offer a diagnosis in the media of a living public figure they have not examined."

The Tarasoff rule established that healthcare professionals have a "duty to warn" if they believe a patient in their care may be a threat to others. This rule grew out of a civil suit filed by the relatives of Tatiana Tarasoff, a student at the University of California who was stabbed to death by Prosenjit Poddar, a fellow student who had been stalking her.[4] Tarasoff's family successfully sued the therapist for failing to warn them after Poddar had confided he was planning to kill her.

Since the Tarasoff ruling, depending on the state in the US, health professionals are required by law to warn people (or law enforcement or both) if a patient makes serious threats of harm against them.[5]

But these laws do not give health professionals any responsibility for warning the public about people who are not their patients. And the Goldwater rule specifically says that they should not.

The Goldwater rule states that it is unethical for psychiatrists to diagnose mental illness in people they haven't examined and whose consent they have not obtained

Psychiatrists who violate the rule risk suspension or expulsion from their professional association. Yet growing numbers of doctors are finding they feel a stronger ethical duty to warn the public about Trump than to follow the rule. A group of 35 psychiatrists, psychologists, and social workers has written a letter to the *New York Times* warning that Trump is dangerous. And one psychologist, John Gartner, has launched a petition entitled "Mental health professionals declare Trump is mentally ill and must be removed," which has gathered over 27 000 signatures (though not all from health professionals). Another petition calling for Trump's mental health to be formally examined has gathered 36 000 signatures.

Gartner, a clinical psychologist and former Johns Hopkins professor, argues that Trump is "dangerous," and that his attacks on the Muslim parents of a fallen soldier, his bragging about sexual assault, and other behaviours are manifestations of a "serious mental illness that renders him psychologically incapable of competently discharging the duties of President of the United States."[6]

JIM LO SCALZO / PA

A group of 35 psychiatrists, psychologists, and social workers has written a letter to the *New York Times* warning that Trump is dangerous

Truth or illusion?

Other psychiatrists wrote that Trump has an "apparent inability to distinguish between fantasy and reality" and called for him to submit to a full medical and neuropsychiatric evaluation by impartial investigators.[7]

Bandy Lee, a psychiatrist specialising in preventing violence and Yale professor, and Gartner say a large proportion of mental health professionals agree that Trump is showing signs of mental illness, although they differ somewhat in the next step. Some, like Gartner, think the remedy lies in the 25th amendment to the constitution with a direct appeal to Congress to remove Trump because of impairment, a process allowed under the amendment.

Over-riding obligation

Others, like Lee, say therapists cannot diagnose Trump without examining him and call for an independent assessment. Lee told *The BMJ* that current practice in all US states is such that "if someone shows signs of mental illness and is dangerous even to just one person, and if the person refuses to be evaluated, then detaining him or her is permitted because it is an obligation of health professionals to prevent harm," which, she says, "is an obligation that over-rides all others."

However, other mental health professionals object to labelling Trump as mentally ill. Citizen Therapists, an organisation of psychotherapists, states that it is "alarmed by the rise of the ideology of Trumpism," but nonetheless concludes: "arguing about a mental health diagnosis for a public figure risks 'weaponizing' diagnosis . . . with every candidate for president being subjected to 'partisan diagnosis.'"

Allen Frances, professor emeritus at Duke University, North Carolina, and former chair of the task force for the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, which defines the criteria for narcissistic personality disorder, says Trump is "bad not mad."

"He may be a world class narcissist, but this doesn't make him mentally ill because he does not suffer from the distress and impairment required to diagnose mental disorder," Frances wrote in a letter to the *New York Times*. "Psychiatric name-calling is a misguided way of countering Mr Trump's attack on democracy . . . His psychological motivations are too obvious to be interesting, and analyzing them will not halt his headlong power grab. The antidote to a dystopic Trumpean dark age is political, not psychological."[8]

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Cite this as: *BMJ* 2017;356:j1087

Trish Greenhalgh

What should UK doctors say about Trump?

The General Medical Council's *Duties of a Doctor*—to my surprise—does not explicitly cover the question of a doctor's duty towards a public figure who is not his or her patient. The GMC guidance conveys a general expectation of professional decency and restraint, including but not limited to the use of social media. It also says (paragraph 4) that "You must use your judgement in applying the principles to the various situations you will face as a doctor [and] be prepared to explain and justify your decisions and actions."

My reading of the GMC guidance is that in extreme circumstances, even acknowledging the expectation of how doctors should normally behave, it may occasionally be justified to raise concerns about a public figure (for example, when someone is relentlessly pursuing a course of action that places many lives at risk). Expressing clinical concern in such circumstances seems to involve a comparable ethical trade-off to the public interest disclosure advice (*Duties of a Doctor* paragraphs 53-56) that breach of patient confidentiality may be justified in order "to prevent a serious risk of harm to others."

The two situations—stating that your patient is medically ill and wondering whether a public figure may be medically ill—are not the same

That said, it is important to recognise that the two situations—stating that your patient is medically ill and wondering whether a public figure may be medically ill—are not the same. The former is an informed clinical opinion; the latter is clinically informed speculation. I believe that on rare occasions it may be ethically justified to offer clinically informed speculation, so long as any such statement is clearly flagged as such. There is no absolute bar to a doctor suggesting that in his or her clinical opinion, it would be in the public interest for a particular public figure to undergo "occupational health" checks to assess their fitness to hold a particular office.

But in the case of Donald Trump, I have been most influenced by the distinction made by Allen Frances, an author of the *Diagnostic and Statistical Manual of Mental Disorders*, who explained that while Trump may be a narcissist he does not have narcissistic personality disorder. We must all beware the dangers of diagnosing from afar.

Trish Greenhalgh is professor of primary care health sciences at the University of Oxford

This is an updated version of a blog published on bmj.com on 30 January 2017 (http://bit.ly/greenhalgh2017)

ILLUSTRATION: DUNCAN SMITH

Anne Johnson, 63, rocketed to national prominence in 1990 as the leader of a nationwide sex survey that earned the disapprobation of the then prime minister, Margaret Thatcher. With public funding for it banned, only the Wellcome Trust's backing saved the survey. Since repeated twice, the survey provided the groundwork for many sexual health initiatives such as chlamydia screening and HPV vaccination—as well as showing, in its most recent iteration, that UK women are now more likely than men to have same sex relationships.

Johnson is professor of infectious disease epidemiology at University College London, has served on numerous advisory committees, chaired the recent AMS Working Group on the health of the public in 2040, and was appointed a DBE in 2013.

BMJ CONFIDENTIAL

Anne Johnson
A niche in population health

What was your earliest ambition?
To be able to ice dance in a short frock and tights: I thought it the height of elegance and sophistication. But I had to stick to algebra.

Who has been your biggest inspiration?
Mike Adler, professor of genitourinary medicine at the Middlesex Hospital. He trusted in me enough to throw me in at the deep end of research at the beginning of the HIV epidemic. I learnt to navigate the shark infested waters of academia.

What was the worst mistake in your career?
Thinking that I should give up medicine two years into preclinical studies because the course seemed so distant from human health. My father was furious. I was dissuaded of this plan by a "gap year" in South America, where the barrios of Caracas—a city awash with oil money in the 1970s—were stark, firsthand evidence of the socioeconomic determinants of health inequalities. I now realise that this was when I discovered "public health."

Who is the person you would most like to thank, and why?
The late Jane Wadsworth, a statistician I worked with on the first National Survey of Sexual Attitudes and Lifestyles (Natsal). She taught me how to answer questions with numbers while learning to interpret the outputs with words.

What single unheralded change has made the most difference in your field in your lifetime?
The development of PCR (polymerase chain reaction) for detecting, and sequencing for characterising, infections; and the computing power required to analyse results alongside large scale epidemiological datasets.

What book should every doctor read?
Doctors have to spend too much time reading about medicine, so it would be good to read some novels. I like Gabriel García Márquez's *Love in the Time of Cholera*, about life beyond medicine.

What is your guiltiest pleasure?
Shopping for designer clothes at rock bottom prices in the sales.

What is your most treasured possession?
Yanomami arrowheads, among far too much hoarded memorabilia.

Summarise your personality in three words
Determined, distractable, enthusiastic.

What is your pet hate?
Hazelnuts and pomposity.

What would be on the menu for your last supper?
A large plate of varied shellfish (too late to poison me), real mayonnaise, homemade bread, a good salad (no onions), pavlova, and a fine, cold, white wine.

Do you have any regrets about becoming a doctor/academic?
I might have done if I hadn't realised that there's a niche for almost anyone in medicine. I found mine in epidemiology and population health.

Cite this as: *BMJ* 2017;356:j1095