NEWS

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

thebmj.com
NICE calls for end to postcode lottery on fertility treatment

Responsibility for NICE has moved from Health to Business, Innovation and Skills under George Freeman

Insiders say NICE is being told to be more favourable to industry

Deborah Cohen THE BMJ

Committees of the UK National Institute for Health and Care Excellence (NICE) are being encouraged to be more favourable to the drug and device industries, *The BMJ* has been told.

The concerns have been raised since a change in the minister with responsibility for NICE. On 15 July this year George Freeman took over this role when he was appointed as parliamentary undersecretary of state for life sciences at the Department for Business, Innovation and Skills and the Department of Health for England. It is a new ministerial post with a remit to accelerate innovation.

NICE sources are concerned that the change in minister responsible for the institute could lead to greater pressure to allow doctors to prescribe drugs before NICE has appraised them. The sources also told *The BMJ* they were worried about pressure to be more lenient in the interpretation of evidence. In the past the minister with responsibility for NICE has sat within the medicines and pharmaceutical industry branch of the Department of Health.

James Raftery, professor of health technology assessment at Southampton University, told *The BMJ* that there were risks attached to the new appointment. "The new minister having joint responsibility to BIS [Department for Business, Innovation and Skills] as well as the Department of Health runs the risk of giving greater weight to industrial policy within health policy," he said. "This, I fear, would impose costs on the NHS. Promotion of innovation is a matter for industrial policy rather than the NHS. The NHS Constitution emphasises that the function of the NHS is to provide appropriate healthcare to all who need it without payment."

Freeman's other responsibilities will include the Medicines and Healthcare Products Regulatory Agency and the Cancer Drugs Fund, and he will be responsible for a new scheme involving the uptake of new drugs and medical technology, including adaptive licensing and early access. The scheme is, said Freeman in a House of Commons debate on 1 September, a "new fast track runway to get a new generation of innovative medicines to the patients for whom there is no alternative treatment, to give them a chance."

Before becoming a Conservative MP Freeman had a long career in biomedical venture capital and ran the specialist translational medicine consultancy 4D Biomedical. He was also chief executive officer of the Cambridge start-up company Amedis Pharmaceuticals.

Sources say it is as yet unclear how he will interact with NICE. In September this year Freeman told the Commons debate that it was "vital" for people to have access to new and promising drugs. "In drug discovery, time is money, and accelerating assessment and approval is the single most important reform that we have to make. I am absolutely committed to it," he said.

Cite this as: *BMJ* 2014;349:g6387

WHO will review its response to Ebola once the outbreak is under control

Zosia Kmietowicz THE BMJ

The World Health Organization has said it will review how it responded to the outbreak of Ebola virus disease in west Africa once the infection is under control. Media reports had said that an internal WHO document had concluded that poor communication and incompetent staff led to delays in containing the outbreak.

News agencies reported the document as saying that WHO staff "failed to see some fairly plain writing on the wall."

WHO figures from 17 October reported 9191 cases of Ebola virus disease in Liberia, Guinea, and Sierra Leone and 4546 deaths.

WHO recieved reports of the outbreak in March, but by April the charity Médecins Sans Frontières warned the disease was out of control.

The draft report from WHO is said to include a timeline of the outbreak. News agencies that have seen the document have said that problems included WHO experts on the ground failing to report what was happening to headquarters in Geneva, bureaucratic hurdles stopping $500 000 (£300 000) reaching the response effort in Guinea, and doctors not being able to visit the area because of a lack of visas.

WHO said that the document was a draft chronology of the Ebola outbreak that had not yet been "fact-checked or reviewed by WHO staff involved in the initial response." The agency said that it would be analysing its response and publishing the review when the outbreak was under control.

In a statement it said, "WHO believes in transparency and accountability and will release this review when it is fact-checked. For now, WHO's focus is to obtain the resources needed to successfully fight this Ebola outbreak."

EBOLA IN WEST AFRICA
9191 CASES
4546 DEATHS

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IN BRIEF

Girls at risk of genital mutilation get new protection: Victims, potential victims, or third parties in the UK, including teachers, carers, or friends, who believe a girl is at real risk of genital mutilation will be able to apply to the court for a new civil protection order, which could mean the girl's passport being surrendered to prevent her going abroad. Other measures included in the Serious Crime Bill also mean that failing to protect a girl from genital mutilation would be an offence.

Nigeria is declared free of Ebola virus transmission: The World Health Organization has declared that Nigeria is officially free of Ebola virus transmission 42 days after the last infectious contact with a confirmed or probable case occurred. The agency put the "spectacular success story" down to strong leadership, effective coordination of the response, rapid diagnosis, and effective tracing, isolation, and monitoring of contacts.

UK perinatal mental health services are poor: Perinatal depression, anxiety, and psychosis cost society £8.1bn for each one year cohort of births in the United Kingdom, a report has found.[1] Most (72%) of this cost is related to the adverse effects on the child. Less than 15% of healthcare and social services provide the level of recommended treatment, while 40% provide no care. Around £340m would bring NHS services up to the scratch, the report said.

Petition urges action to return British man to UK: A petition with over 70 000 signatures was presented to Downing Street on 16 October calling on the prime minister, David Cameron, to secure the return of Mohammed Asghar to the United Kingdom. Asghar, who is 70 and has paranoid schizophrenia, was arrested in 2010 on blasphemy charges and was sentenced to death earlier this year.[2] He was shot in the back by a guard in September and has been held in hospital since.

India will introduce bigger warnings on tobacco products: Packaging of cigarettes and tobacco sold in India will have to show graphic warnings and text covering 85% of packets, up from 15%, from next April, the government has said. Warnings will need to be displayed on the front and back of cigarette packs, with highly visible pictorial warnings, including the information that "tobacco causes mouth cancer."

Cite this as: *BMJ* 2014;349:g6327

Surgeon who swore at colleagues is suspended

Clare Dyer THE BMJ

A surgeon who had to be ordered out of the operating theatre after shouting and swearing at colleagues and throwing a tissue collection bag in anger has been suspended for 12 months by a fitness to practise panel.

Moudar Maximilian Mahfoud, 49, was also found to have become so aggressive with a patient's husband that hospital security guards were called, an incident which prompted his resignation from the Princess Alexandra Hospital in Essex and led the hospital trust to report him to the General Medical Council.

Mahfoud, a native of Syria, has left the United Kingdom and waived his right to attend the Manchester hearing of the Medical Practitioners Tribunal Service, but he continued to communicate with GMC officials by emails, some of which were acerbic. In one he wrote, "ISIS cuts innocent people's throats in the name of God. The GMC destroys a doctor's life and says: it is in the public interest. What is the difference?"

Mahfoud's anger led to a hospital investigation after he exploded at colleagues during a routine laparoscopic appendectomy in October 2012. Mahfoud, employed as a registrar in general surgery, was performing the operation while a consultant, Fouad Kaldas, held the camera. Mahfoud asked Kaldas several times to stop "jiggling" the camera. A joke from Kaldas that Mahfoud judged inflammatory triggered an outburst of shouting and swearing.

Mahfoud became so distracted that the clinical director of surgery was called to the theatre. She judged him to be in no state to continue and ordered him to leave and let Kaldas take over. Mahfoud then tried to grab the camera from Kaldas, saying he would complete the operation himself, but was eventually persuaded to leave.

Mahfoud's supervising consultant Howard Bradpiece told the panel that his default position when faced with adversity was to become angry and frustrated but that he was a highly skilled surgeon who operated at the level of a consultant, and part of his frustration stemmed from working in a post below his capabilities. He was also troubled by the situation in Syria.

The panel rejected the GMC's call for Mahfoud to be struck off, opting instead for the next most severe sanction. In a case where aggravating and mitigating factors were finely balanced, said Heenan, a reasonable person "would conclude that these matters, whilst serious, are not so grave as to be fundamentally incompatible with continued registration."

Cite this as: *BMJ* 2014;349:g6349

Living with a smoker is equivalent to living in a heavily polluted city, say researchers

IMAGE SOURCE/REX

The particulate matter inhaled by someone in a smoking home was similar to that inhaled in Beijing

Jacqui Wise LONDON

Non-smokers who live with smokers are typically exposed to three times the recommended level of fine particulate matter, new research has found.

A study published in *Tobacco Control*[1] found that particulate matter concentrations in smoking households were on average 10 times higher than those found in non-smoking homes.

The researchers included data from four linked studies carried out in Scotland from 2009 to 2013 involving real time measurement of fine particulate matter. Three of the studies used a personal aerosol monitor placed in the main living area of the participants' home for 24 hours, and the other study used a low cost particle counting device.

The four studies together collected air quality

More than 1700 FGM cases seen in past six months

Susan Mayor LONDON

More than 1700 girls and women treated at acute NHS hospital trusts in England were identified over the past six months as having undergone female genital mutilation (FGM), the first official figures[1] in a national data programme have shown.

From 1 September 2014 all acute care trusts in England have had to report any patients that they identify as having been subjected to FGM, which is illegal in the United Kingdom. Clinicians are required to record in a patient's clinical notes that they have identified FGM and its type.

IN SEPTEMBER 2014 HOSPITALS IDENTIFIED
467 PATIENTS as having had FGM

The Female Genital Mutilation Prevalence Dataset is collecting monthly figures as a first step towards understanding how many girls and women undergo the procedure, to inform measures to prevent it. The latest monthly figures from September 2014 showed that 467 patients were newly identified as having undergone FGM when they were seen at acute hospitals. Another 1279 were previously identified from 1 April, when hospitals began recording FGM data voluntarily. Patients that health professionals identify as having undergone FGM are included in the figures, whether they are being treated for a related problem or for another reason.

More than half of all FGM cases were reported by London hospitals: 740 of 1279 up to 1 September, and 252 of 467 during September. The numbers were otherwise evenly spread across the remaining three commissioning regions: Midlands and East of England, North of England, and South of England.

Kingsley Manning, chair of the Health and Social Care Information Centre, which is working with the Department of Health to collect the data, said, "Having accurate data about this crime is an important step in helping prevent its occurrence in the future. The information will support the Department of Health in its FGM prevention programme, and we hope to expand the dataset over time so that it provides a more complete picture across a wider variety of care settings."

The centre said the NHS was in a unique position to identify women and girls who have undergone FGM and that the data would be used to improve the NHS's response to FGM.

Cite this as: *BMJ* 2014;349:g6302

ADRIAN SHERRATT/REX

Fahma Mohamed (left) and Caitlin Moran: campaigners for FGM action

data from 93 smoking households and 17 smoke-free homes. Homes that were likely to have a significant additional source of particulate matter, such as a coal fire, were excluded.

The World Health Organization's guidance on annual exposure to fine particulate matter (PM2.5) is 10 μg/m³. The smoking homes had average PM2.5 concentrations of 31 μg/m³ (10 to 111), compared with 3 μg/m³ (2 to 6.5) in the non-smoking homes. Around a quarter of the smoking homes had 24 hour average concentrations in excess of 111 μg/m³, more than 11 times the recommended level.

The researchers estimated that the overall mass of fine particulate matter inhaled over an 80 year period by a person living in a typical smoke-free home was about 0.76 g, whereas a person living in a smoking home would inhale about 5.82 g. This is equivalent to living in a non-smoking home in a heavily polluted city such as Beijing.

Sean Semple, of the University of Aberdeen and the study's lead author, said, "These measurements show that secondhand tobacco smoke can produce very high levels of toxic particles in your home.

"Making your home smoke-free is the most effective way of dramatically reducing the amount of damaging fine particles you inhale."

Cite this as: *BMJ* 2014;349:g6318

GP recruits are offered £20 000 "golden hello" to work and remain in Leicester city

Abi Rimmer BMJ CAREERS

GPs are being offered a £20 000 incentive to take up posts in Leicester. The scheme, a joint initiative of Leicester City Clinical Commission Group, NHS England's Leicestershire and Lincolnshire area team, and Leicester City Council, is using £250 000 of non-recurring primary medical care funding from the area team.

The money will be available to GPs who are new to the area and who take at least a part time post for a minimum of two years. If the GP leaves the post before the end of the two years, the incentive funding will have to be repaid on a sliding scale.

A spokeswoman for the area team said that recruitment had been a problem across Leicester, with many practices failing to fill posts despite advertising the roles widely and offering salaried and partnership positions. Many practices were having to rely on locums to cover unfilled permanent positions, she said.

In a board paper presented to Leicester City Council's Health and Wellbeing Board earlier this month, Leicester City CCG highlighted the recruitment problem, especially GP partners. It said that around 50% of the 121 GP partners in the area were likely to retire in the next five to 10 years.

Recruitment has been a problem across Leicester, and many practices are having to rely on locums

The paper said, "The current structure of practice-based primary care provision is likely to undergo severe instability if new partners cannot be attracted into the system to take their place." Lesley Harrison, the pharmacy and medical lead for NHS England's Leicestershire and Lincolnshire area team, said, "Our priority is to ensure that all patients have good access to GP services."

Cite this as: *BMJ* 2014;349:g6343

The BMJ launches seventh annual awards and calls for nominations for achievements in 13 categories

Nigel Hawkes LONDON

Nominations are open for The BMJ Awards 2015, an annual competition now in its seventh year and firmly established as the UK medical profession's Oscar ceremony, celebrating outstanding achievement and leadership and culminating in a gala night in May 2015 when the awards will be presented.

Last year there were over 400 entries, the highest number recorded since entrants were limited to teams based in the United Kingdom—clear evidence of the high profile and unchallenged authority the awards have achieved since their introduction in 2009. More than 70 teams and individuals who have been honoured since then attest to the energising effect of public recognition for exceptional efforts that might otherwise not have been known beyond their place of work.

The main sponsor will once again be the Medical and Dental Defence Union of Scotland (MDDUS), and this year there will be 13 categories. Some will be familiar from previous years, such as the hotly contested UK Research Paper of the Year award and the award for the best primary care team. But others are new and reflect today's medical priorities: there are awards for mental health, palliative care, and dementia care, all of which struggle to achieve greater recognition.

Entry forms are available at www.thebmjawards.com. A shortlist in each category will be announced in February, and judging will take place at the end of March 2015. The awards presentation, which last year attracted an audience of more than 600 of the most influential people in UK medicine, will take place on Wednesday 6 May at the Westminster Park Plaza Hotel in London.

Cite this as: *BMJ* 2014;349:g6311

Giles Brandreth (centre) presented the best respiratory medicine award to a team from the Wirral (left) and the gastroenterology award to a team from Bolton

THE CATEGORIES FOR *THE BMJ* AWARDS 2015: The shortlist for each award will be announced in February

PRIMARY CARE TEAM
This award recognises a team that has made an exceptional contribution to the health and wellbeing of patients in primary care and is sponsored by MDDUS.

PALLIATIVE CARE TEAM
The UK's pioneering role in palliative care often goes unrecognised. Judges will be looking for a team that has set new standards in this important area of care.

MENTAL HEALTH TEAM
A new category this year, the mental health award will recognise excellence in a branch of medicine promised but still not achieving parity of esteem with physical illness.

GASTROENTEROLOGY TEAM
An innovative project or an initiative that has improved care in gastroenterology will provide the winner in this category, sponsored by Takeda.

DIABETES TEAM
This award recognises excellence in the planning or delivery of care in the UK's fastest rising condition.

DEMENTIA TEAM
Prompted by the government and by the growing number of people who live long enough to have dementia, the illness now has a greatly enhanced profile. But who in 2015 has done most to improve dementia care? The judges will decide.

WOMEN'S HEALTH TEAM
This award recognises a team that has made an exceptional contribution to the care of women.

IMAGING TEAM
A new award this year and a reminder of great progress made in medical imaging over the past 20 years, this award will go to a team that has made an exceptional contribution to the field.

CLINICAL LEADERSHIP
Clinicians are often called on to provide leadership as medicine becomes a collaborative activity characterised by multidisciplinary teams. Clinical leadership is also vital to nurture and support changed patterns of care where the evidence indicates that change, however unwelcome, will improve outcomes. This award, sponsored by the General Medical Council and the Faculty of Medical Leadership and Management, will recognise an individual or team whose contribution to clinical leadership has been outstanding.

PATIENT SAFETY
Judges will be looking for a team that can demonstrate it has made an important contribution to improving the safety of patients in the NHS.

INNOVATION
All healthcare systems need to innovate to improve outcomes, cut costs, and replace outmoded approaches. The team that shows it can best meet these challenging objectives will win the innovation award.

UK RESEARCH PAPER OF THE YEAR
A key part of the awards since their inception, this award goes to the research paper that has the greatest potential to improve health and healthcare.

LIFETIME ACHIEVEMENT AWARD
Who has done the most to advance outcomes in medicine or public health? This award is an opportunity to nominate someone whose career exemplifies the qualities most valued in medicine: a pioneer, a champion, or an original thinker who has made a big impact. Nominations are welcomed at www.bmjawards.com, and the winner will be chosen by a panel of judges chaired by *The BMJ*'s editor in chief, Fiona Godlee. GlaxoSmithKline once again sponsors this award.

CMO defends decision to stockpile Tamiflu and says she would do it again

Adrian O'Dowd LONDON

The government has said that it would stockpile the antiviral drug oseltamivir (marketed by Roche as Tamiflu) again, despite large amounts of previously bought supplies being written off and questions raised by experts over its effectiveness, MPs have been told.

Government witnesses appearing before the House of Commons Public Accounts Committee on 20 October insisted that oseltamivir, which was used to treat pandemic flu, was worth having. Between 2006-07 and 2012-13 the Department of Health for England purchased nearly 40 million units of oseltamivir, costing £424m. However, only 2.4 million units were consumed, and 10 million units were written off, many because of poor record keeping about their storage during the 2009-10 pandemic.

MPs asked witnesses if the conclusions of a review published in March this year by the Cochrane Collaboration were fair. The review showed that oseltamivir shortened symptoms of flu by only 16.8 hours and that there was no good evidence to support claims that it reduced admissions to hospital or complications of flu such as pneumonia, bronchitis, or sinusitis.[1]

Sally Davies, England's chief medical officer, giving evidence, said, "It is a systematic review . . . done in seasonal flu that underestimates the results because they [the participants] are not, as they would be for licensing [studies], proven to have flu and they are healthy people."

Pressed by the MPs on whether the government wasted public money on stockpiling oseltamivir, Davies said, "I would spend it again. The observational data is strong."

DoH STOCKPILED
40m UNITS
of oseltamivir
costing £424m

"We now have more evidence . . . observational evidence, but real individual patient data meta-analysed in 29 234 patients from 78 studies, and it showed during the pandemic a drop by a half of mortality when it [Tamiflu] was given within 48 hours of clinical symptoms and a drop by a fifth in mortality if it was given later."

Carl Heneghan, director of the Centre for Evidence-Based Medicine at the University of Oxford, also giving evidence, said, "Observational data does have uses. It is important, but many people in this room know it's subject to such bias that you would not want to use it to establish treatment effects."

Cite this as: *BMJ* 2014;349:g6386

THE SUNDAY TIMES/NEWS SYNDICATION

Jean Davies, who starved herself to death, said it was the only legal way for her to end her life

Charges for assisting death are less likely if patients are not known to doctors

Clare Dyer THE BMJ

Doctors who help severely disabled or terminally ill people to end their lives are less likely to be prosecuted, under amended guidance issued by the director of public prosecutions (DPP) for England and Wales, as long as the person who is helped to die is not the doctor's own patient.

The change in the guidelines[1] means that a doctor not currently caring for the patient but brought in to assist will be no more likely than a friend or family member to be prosecuted for aiding a suicide. Under the previous guidance, the fact that the helper was a health professional was a factor in favour of prosecution.

The DPP, Alison Saunders, clarified the guidelines after a UK Supreme Court judgment last June in a case brought by the widow of Tony Nicklinson, a stroke survivor with locked-in syndrome who starved himself to death after the High Court ruled against him. She was joined by Paul Lamb, who was almost completely paralysed after a car crash, and another paralysed stroke survivor named only as Martin.[2]

At that time, the DPP's lawyer told the Supreme Court that a medical professional who was brought in by the patient's family to assist and who was "not profiteering" would be "most unlikely" to be prosecuted, but the justices said that the DPP should revisit the policy to make it clearer.

The new guidance says that the factor in favour of prosecution applies to a healthcare professional "only where there was, in addition, a relationship of care between the suspect and the victim such that it will be necessary to consider whether the suspect may have exerted some influence on the victim." The clarification comes as peers prepare to give detailed scrutiny next month to the Assisted Dying Bill—tabled by the former lord chancellor, Charles Falconer—which seeks to legalise assisted suicide for terminally ill people. The bill's committee stage is scheduled for 7 November.

A majority of the Supreme Court justices, five of nine, warned that the court might rule in a future case that the law making assisted suicide a crime infringes the European Convention on Human Rights, unless parliament tackles the issue. The Assisted Dying Bill covers only terminally ill people, but the majority of justices said that they would expect parliament also to debate whether any change in the law was needed for people like Nicklinson, who are not terminally ill but are suffering unbearably.

Sarah Wootton, chief executive of Dignity in Dying, which campaigns for the legalisation of assisted suicide, said that the change in the guidelines "seems to send a strange message to patients—effectively that they should not seek help from healthcare professionals who know them and their medical history, and who they as patients trust, but instead seek advice and assistance from healthcare professionals they do not know."

She added, "Despite the best efforts of successive DPPs to provide a more compassionate approach, the law is broken and ultimately it is parliament's job, not that of the DPP, to fix it. Lord Falconer's Assisted Dying Bill is currently going through parliament, and this seeks to create a safeguarded law which would give dying people choice, while better protecting vulnerable people."

Cite this as: *BMJ* 2014;349:g6326

David Oliver

Pet hate—privatisation by stealth

PETER LOCKE

DAVID OLIVER is a geriatrician and former national clinical director for older people, who has little truck with the idea that most admissions of elderly people are preventable. It is "absolute La La Land to think we're going to be in a position any time soon when older people don't still keep piling through the doors of general hospitals," he asserted in 2013, arguing that the challenge was to improve hospital care, not pretend that it can be avoided. He is president of the British Geriatrics Society, senior visiting fellow at the King's Fund, and visiting professor at City University London.

If you could be invisible for a day what would you do?
"I'd find out what management consultants and IT companies with public sector contracts really say about their duped and gullible clients behind their backs"

What was your earliest ambition?
To pass the entrance exams for Manchester Grammar School and to get a season ticket for Maine Road.

Who has been your biggest inspiration?
Finbarr Martin, consultant geriatrician at St Thomas' Hospital and professor of clinical gerontology at King's College London; and John Young, who is consultant geriatrician and professor of geriatric medicine at Bradford Hospitals Trust, as well as being my successor as the national clinical director for older people (though his official title is "NHS England national clinical director for frail older people and integration").

What was the worst mistake in your career?
As a young doctor, not having the emotional intelligence or life experience to realise that, if patients or their relatives are unhappy, it's not always your fault and you can't always fix it. Walk a mile in their shoes.

What was your best career move?
Choosing internal medicine and specialising in geriatrics, and then broadening my skills—getting qualifications in research, management, leadership, ethics, and law and getting involved in policy work. Doctors and medicine are often too inward looking to be influential.

Who is the person you would most like to thank and why?
My wife, Anne, for her tireless support from my medical student days onwards.

To whom would you most like to apologise?
The same lady, for my obsession with my job and for my endless stream of groan-worthy puns.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
In my own career the best was Frank Dobson before he was pushed into running for London mayor to oppose "Red Ken." The worst by a country mile was Lansley, who promised "no more top-down reorganisation" but then reneged and sent an already decent and improving service into three years of chaos before Cameron "the delegator" belatedly woke up. Ministers in all parties are too fond of trying to make their mark by introducing change for change's sake.

If you were given £1m what would you spend it on?
Pay off the mortgage and give myself enough financial security to run for parliament. It may be unfashionable to say so, but if we want MPs with real life experience from mid-career professions, we need to pay them more.

What single unheralded change has made the most difference in your field in your lifetime?
The belated realisation by non-geriatricians that older people with frailty, dementia, and complex comorbidities are the NHS's core customers.

Do you support doctor assisted suicide?
As British Geriatrics Society president I don't want my personal view to be construed as the society's view, so I'll "plead the fifth."

What book should every doctor read?
The Citadel by AJ Cronin: seeing what healthcare was like in poor areas before the NHS existed should make us eternally grateful for it.

What is your guiltiest pleasure?
There is enough guilt in the job of a practising doctor without borrowing more guilt when relaxing.

If you could be invisible for a day what would you do?
I'd find out what management consultants and IT companies with public sector contracts really say about their duped and gullible clients behind their backs.

Clarkson or Clark? Would you rather watch *Top Gear* or *Civilisation*?
Clarkson and all that he stands for are an abomination, so that's easy.

What is your most treasured possession?
My house and garden—even though we are near the river and were flooded on Christmas Day.

What, if anything, are you doing to reduce your carbon footprint?
Driving an ordinary car, not a gas guzzling mobile building à la Clarkson. And token recycling, when Anne reminds me.

Summarise your personality in three words
I asked my wife: she said, "Loquacious, energetic, and kind." I'll settle for that, although others might be less charitable!

What is your pet hate?
Privatisation by stealth of the NHS, especially the scandalous spend on consultancy. And cheap, trite comments by journalists or politicians, based on no experience in the NHS and no understanding of the evidence base.

Cite this as: *BMJ* 2014;349:g6297