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bmj.com
Attendance rates at emergency departments are 65% higher in London

US newspapers choose to report weaker studies, researchers discover

Michael McCarthy SEATTLE

Major US newspapers tend to cover weaker medical research studies, favouring observational studies over randomised controlled trials (RCTs), a new study in *PLoS One* has found.[1]

Senthil Selvaraj, of the Department of Medicine at Brigham and Women's Hospital in Boston, Massachusetts, and colleagues compared 75 original medical articles covered by the US papers with the largest circulations—*Wall Street Journal*, *USA Today*, *New York Times*, *Los Angeles Times*, and *San Jose Mercury* News—with 75 original medical articles published by the five general medical journals with the highest impact factors: *New England Journal of Medicine*, *Lancet*, *JAMA*, *Annals of Internal Medicine*, and *PLoS Medicine*.

They found that although the most commonly cited medical journals in the news articles were the *New England Journal of Medicine* (16%), *JAMA* (7%), and *Health Affairs* (5%), overall the newspapers tended to cover articles published by journals with lower impact factors (median 5.4 *v* 30.0; P<0.001).

The newspapers were less likely to write about randomised controlled trials than the journals were to publish them, with such trials making up just 17% of the studies the newspapers elected to cover, compared with 35% of the studies that appeared in the journals (P=0.016).

Instead, the newspapers favoured observational studies, which made up 75% of the articles covered, compared with 47% of the papers appearing in the journals (P<0.001).

The observational studies chosen by the newspapers also tended to have weaker methodologies, being more likely to have smaller sample sizes (median 1984 *v* 21 136; P=0.029) and to be cross sectional (71% *v* 31%; P<0.001).

The authors refer to how a large observational study that noted a link between statin use and decreased cancer mortality led to headlines such as "Statins may lower risk of cancer death." Health News Review, an organisation that evaluates healthcare journalism, concluded that most of the news coverage on the article was "botched."

The authors concluded: "Newspapers preferentially cover medical research with weaker methodology."

Cite this as: *BMJ* 2014;348:g1099

Personal health budgets are good for the few but not for the many

Matthew Limb LONDON

A researcher has questioned UK government claims that personal health budgets would significantly improve patient outcomes, saying that the evidence had been misrepresented.

Peter Beresford, a social policy professor who heads Brunel University's Centre for Citizen Participation, said studies showed that a small number of people making the largest direct payments had been successful in meeting their needs and improving their quality of life.

But he said it was wrong to argue that this meant personal health budgets would work for most people as proposed.

"They tend to work for the most confident, assertive, more experienced and able people," said Beresford. He said that claims being made in support of the policy were selective and ignored the experience of most people with personal budgets, whose outcomes had not improved.

Beresford said that extending the policy in England was not consistent with an NHS based on universal principles and warned that people would be left vulnerable to budget restrictions and service cuts.

From April 2014 all people who are eligible for NHS continuing healthcare—currently some 56 000 people—will have the right to request a personal health budget.[1]

And from October clinical commissioning groups will have to provide these budgets to anyone with a long term condition who asks for one.

The budgets are designed to support the health and wellbeing of individual patients and will form part of personal care plans that they or their representatives agree with the NHS.

The case for extending personal health budgets came under scrutiny at a Westminster Health Forum seminar in London on 23 January.

Julie Stansfield, chief executive of the community network charity In Control, said, "The process can be life changing if done properly."

Vidhya Alakeson, deputy chief executive of the Resolution Foundation, said that people should be able to use their budgets to employ their own staff, such as personal assistants, to set pay rates, and to have access to training. "It's crucial to allow people to use budgets creatively," she said.

Angela Coulter, a senior research scientist at Oxford University's Health Services Research Unit, said that accounts of how some people had benefited were "inspirational." But she said that personalised care planning was a vital component and that it was "depressing" that this wasn't happening extensively enough.

Coulter said that there were challenges in implementing the policy at scale and in measuring its effectiveness. She also highlighted potential risks to NHS services and concerns about money being spent on "non-approved" complementary therapies.

"Some see personal health budgets as a Trojan horse that will introduce payments and vouchers. Some see it as the end of the NHS," said Coulter.

She added that the practice whereby some people held both direct personal social and personal health budgets at the same time was "bonkers."

Beresford warned of greater commercialisation, saying that large multinational companies would move in to offer services, edging out smaller community providers.

Cite this as: *BMJ* 2014;348:g1149

Peter Beresford (left) said budgets worked for assertive people, while Angela Coulter (right) said more planning was needed

Appeal court to rule on patient role in "do not resuscitate" notes

Clare Dyer BMJ

Three judges of the Court of Appeal for England and Wales are to decide whether a patient has a right in law to be consulted before a "do not attempt cardiopulmonary resuscitation" direction is placed in the patient's medical notes.

The judges, headed by the master of the rolls, John Dyson, ruled that a judicial review hearing into the issue should go ahead, overturning a ruling by a High Court judge throwing it out as academic.[1]

The decision means that the court will hear arguments by David Tracey, whose wife, Janet, died after two "do not attempt cardiopulmonary resuscitation" (DNACPR) notes had been put in her records, that Cambridge University Hospitals NHS trust breached her human rights in failing to consult her before writing the first note and failing to explain its policy on resuscitation.

The appeal court decided to hear the case itself, rather than taking the usual step of sending it back to the High Court, because any judgment there was likely to be appealed. No date has yet been set.

Tracey's counsel, Philip Havers QC, will also argue that the health secretary for England, who is a party to the case, should have a national policy on DNACPR rather than leave it to the BMA to make recommendations and to encourage each NHS trust to have its own policy. He contends that the policy should include the right to a second opinion if the patient disagreed.

Janet Tracey was given a diagnosis of lung cancer on 5 February 2011 and a prognosis of nine months to live, but on 19 February she was admitted to hospital with a cervical fracture after a major road crash. She was placed on a ventilator, and attempts to wean her off it were unsuccessful.

After speaking to one of her daughters, who said that her mother would want "full active treatment," and an oncologist, an intensive care specialist wrote the DNACPR note. In the event, she was successfully weaned from the ventilator, and the note was cancelled on 2 March after the family discovered it and objected.

Her condition deteriorated, and a second DNACPR note was written, to which the High Court found that members of the family had agreed, although Mrs Tracey did not want to discuss resuscitation. She died on 7 March, aged 63.

The appeal court judge Andrew Longmore said the issue was not academic. Mrs Tracey was distressed to discover the note was in her records partly because she thought her family had agreed to it. In addition, the points on consultation and a second opinion were "matters of some general importance," he said.

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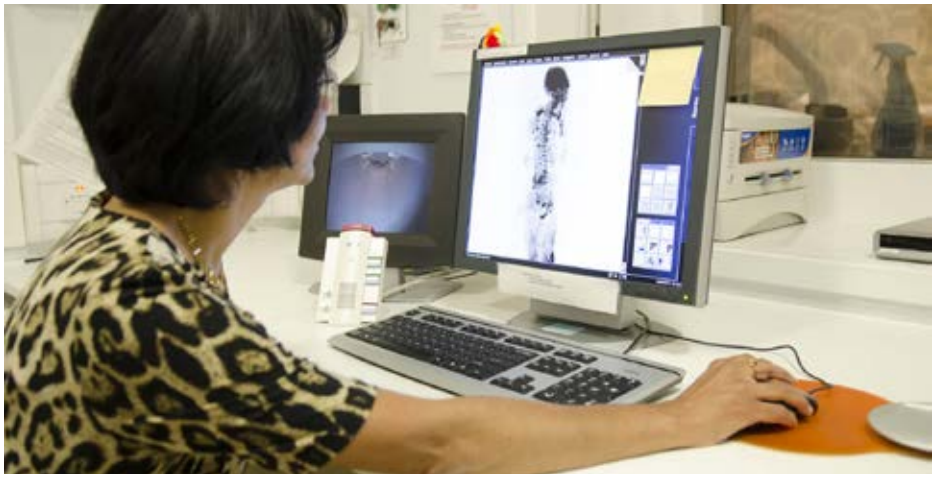


Professor Nandita deSouza, of the Institute of Cancer Research, studies a new style scan

High tech body scans help detect spread of myeloma to bones

Zosia Kmietowicz BMJ

A new type of magnetic resonance imaging (MRI) scan may help to detect whether cancer cells have spread to the bones of patients with myeloma, avoiding the need for painful and repeated bone marrow biopsies, a small study has found.

The scan could also help doctors decide whether patients are responding to treatment, say the researchers, from London's Institute of Cancer Research and Royal Marsden NHS Foundation Trust.

Myeloma is currently diagnosed and staged with radiography and regular MRI scans, but gauging the response of the disease to treatment often involves bone biopsies. However, even biopsies cannot pinpoint the severity of the cancer or its location in bones.

In soft tissue tumours the new whole body, diffusion weighted MRI scanning provides high contrast between normal and pathological marrow, and the researchers wanted to study the technique for assessing response to treatment. They reported their results in *Radiology*.[1]

Altogether 26 patients underwent whole body, diffusion weighted MRI before and after treatment. Experienced doctors trained in imaging correctly identified 18 of 21 patients who were responding to treatment and four of five patients who weren't responding to treatment.

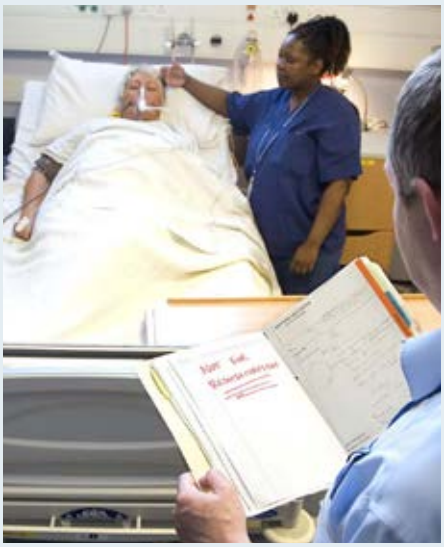
The new scan was able to visualise cancer in almost all bones in the body, with only the skull remaining difficult to image, partly because of the frequency of metal dental implants and fillings.

The researchers also assessed visible changes on the MRI scans by using a measurement called the apparent diffusion coefficient (ADC), which records restriction of water movement within tissues. They found that mean ADC rose in 19 of 20 patients who responded to treatment (mean increase 19.8% (SD 21.5%)) and fell in all five patients who did not respond (mean decrease 3.2% (SD 2.2%)). In one patient ADC analysis was not possible because of lack of visible bone marrow both before and after treatment. There was a significant correlation between change in ADC and change in laboratory markers of response (r=0.614; P=0.001).

Nandita deSouza, professor of translational imaging at the Institute of Cancer Research and honorary consultant at the Royal Marsden, said, "This is the first time we've been able to obtain information from all the bones in the entire body for myeloma in one scan without having to rely on individual bone x rays. It enables us to measure the involvement of individual bones and follow their response to treatment.

"The results can be visualised immediately: we can look on the screen and see straight away where the cancer is and measure how severe it is. The scan is better than blood tests, which don't tell us in which bones the cancer is located. It also reduces the need for uncomfortable biopsies, which don't reveal the extent or severity of the disease." Because of the small size of the study the next step is to test the technology in more patients, said the researchers.

Cite this as: *BMJ* 2014;348:g1170



MARK THOMAS/SPL

Judge Andrew Longmore said the issues around DNACPR notes were "matters of some general importance"

Mix-up led to brain damage

Clare Dyer BMJ

A 13 year old girl left with serious brain damage after her right internal carotid artery was mistakenly injected with glue in a mix-up over unlabelled syringes has received what will be one of the biggest medical negligence settlements in the history of the NHS in England.

Maisha Najeeb, aged 10 at the time, was undergoing angiography and embolisation treatment for an arteriovenous malformation in her brain when the incident occurred at Great Ormond Street Hospital for Children in London.

Cite this as: *BMJ* 2014;348:g1202

Doctors widen access to gene test

Sophie Arie LONDON

Cancer experts at the Royal Marsden Hospital in London have proposed a new "oncogenetic" pathway that could allow more patients to have genetic tests to find out if they are susceptible to ovarian cancer.

During a six month pilot from July to December 2013, oncologists at the hospital offered 114 patients with ovarian cancer the test to establish whether they carried the BRCA1 or BRCA2 gene mutation, which increases a woman's susceptibility to the disease.

Identifying these gene mutations can influence decisions about patients' treatment and can lead to their relatives taking action to prevent future cancers. But until now most centres have offered this test on the NHS only if patients have a strong family history of the disease, and only after they have had counselling from a genetics expert.

Under the pilot scheme, oncologists explained the implications of the test and secured patients' consent usually during the first consultation. Only those with a positive result were then referred to a genetics expert for counselling.

"The system's gone very well," said Nazneen Rahman, who led the pilot scheme and trained the oncologists to explain the use and implications of the test without entering into lengthy discussions. "It is a faster, more flexible, cost effective way of dealing with this. It's a system we want to roll out," she said.

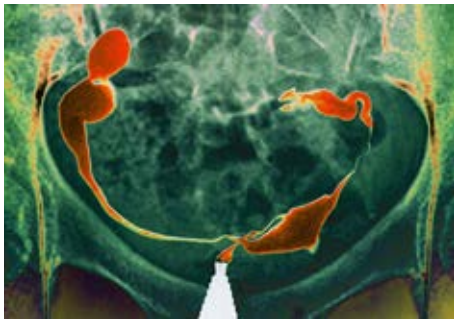
All 114 patients took up the offer of a test, none thought that they had not been given enough information to decide, and none of those who tested positive reported undue distress in informing their relatives about their risk.

Martin Gore, medical director at the Royal Marsden NHS Foundation Trust and one of the oncologists who participated in the pilot, said, "Knowing whether a patient has a gene mutation is an important part of making personalised treatment plans. Patients are also increasingly aware of the value of gene testing, and more and more patients are requesting testing."

Of the 7000 women who get an ovarian cancer diagnosis in the United Kingdom each year, some 15% (1050) have BRCA gene mutations. Patients with these mutations respond better to platinum therapy, and there are also drugs in development that target the BRCA gene mutations and may prove more effective for these patients than existing treatments.

Until now, the NHS had offered testing only to patients whose family history gave them a 20% or higher chance of having BRCA mutations.

Cite this as: *BMJ* 2014;348:g1179



SOVEREIGN ISM/SPL

Genetic testing is usually offered only to women with a 20% or higher risk of having the BRCA mutations

Serco penalised by £81 000 a month over failings in Suffolk contract

Jane Deith OXFORDSHIRE

NHS commissioners have started to impose financial penalties on Serco for missing key targets in its contract to provide community health services in Suffolk.

The commissioners had given Serco until the end of 2013 to improve its services, but the company was unable to make adequate improvements, leading to fines.

GP commissioners are withholding 2% of the value of the £140m Serco contract, equal to £81 000 a month. The financial penalty concerned problems with the Suffolk community equipment store, which supplies people with equipment such as wheelchairs and hoists.

Patients have complained about long delays, and GP commissioners have raised an official contract query, concerned about issues including a lack of equipment and infection control.

Wendy Tankard, chief contracts officer for the NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG) and the NHS West Suffolk CCG, said, "Serco has failed to agree a remedial action plan to improve the community equipment service. Each month until then [the time that an action plan is agreed] the CCGs will withhold 2% of one month's annual contract value. Once the action plan is agreed, this money will be released to Serco. The honeymoon period is over."

A year into the three year contract, the fine—however temporary—signalled that the GP commissioners were getting tougher. The CCGs have issued two other formal contract queries: these involved a failure to make sure that every patient had a care plan and a care lead, as well as a failure to hit urgent four hour and intermediate 72 hour patient response times to reach clients at home—although the CCGs said that since January Serco had started to meet the targets.

A review of quality commissioned by the CCGs also found "high stress levels" in some teams and that recruitment continued to cause concern. The report said that morale was low and that "most frontline staff still state they have no understanding of where the organisation is going and what needs to happen or change to get there."

Serco won the Suffolk contract by bidding £10m less than the incumbent NHS trust, and fears were expressed that Serco had underestimated the cost of running a community health service. Serco recently said that it was making a £9m loss on the contract.

Cite this as: *BMJ* 2014;348:g1167

IN BRIEF

Ministers plan to ban sale of e-cigarettes to children: The UK government is to introduce amendments to the Children and Families Bill next week to ban the sale of electronic cigarettes to children under 18 years old in England and make it illegal for adults to buy cigarettes for children. England's chief medical officer has warned that no one really knows how safe e-cigarettes are.

GP to stand for European elections: The London GP who led the successful campaign against England's health secretary to save Lewisham Hospital is to stand in the European parliament election for the National Health Action Party, a new political party that opposes the government's privatisation of the NHS. Louise Irvine (above) said that the NHS was under threat from an impending trade deal between the EU and the US, and she called on Londoners to use the election to stop the NHS's destruction.

Drug agency assesses effect of weight on emergency contraceptive: The European Medicines Agency has started a review to assess whether increased body weight reduces the effectiveness of emergency contraceptives. The review follows an addition to the summary of characteristics in November 2013 for Norlevo, an emergency contraceptive containing levonorgestrel, which said that the contraceptive efficacy of Norlevo was reduced in women weighing ≥75 kg and that levonorgestrel was not effective in women weighing ≥80 kg.

People with HIV are treated unfairly by NHS staff, survey finds: A survey of 245 people with HIV by the National AIDS Trust found that 40% of respondents said they had been treated differently or badly in the NHS because of their HIV positive status. Examples included staff asking people how they contracted HIV, blaming them for having HIV, and refusing or delaying treatment.

Patients with cancers of unknown origin are more likely to present as emergencies: More than half (57%) the people in England who received a diagnosis of cancer of unknown primary between 2006 and 2010 presented to hospital as an emergency, compared with 23% of all patients with cancer, shows research by the National Cancer Intelligence Network. These make up 10% of all cancers.

Cite this as: *BMJ* 2014;348:g1160

Romanian health system is in crisis as doctors leave for better working life

Ned Stafford HAMBURG

Thousands of doctors have left Romania in recent years, triggering a healthcare crisis that will worsen unless the government takes action to improve conditions for remaining doctors, says Vasile Astarastoae, head of the Romanian College of Physicians.

In an interview with the *BMJ* Astarastoae said that in 2013 the number of public hospital doctors fell to about 14 500, down from about 20 000 in 2011.

"Romanian doctors are deciding to leave and work abroad to be able to do their jobs as they learnt, to be respected, and to earn more money," he said. He added that new doctors were not being trained quickly enough in Romania to replace those leaving, with only about 2600 new doctors qualifying each year.

The United Kingdom, Germany, and France were key destinations for Romanian doctors, he said, adding that doctors who stayed behind in Romania often worked "exhausting schedules and overtime hours, which are not paid."

Astarastoae said that "great inequalities" existed in Romania's healthcare: larger cities had "centres of excellence" with working conditions

Named doctor will end culture of "brief encounters" in hospitals

Zosia Kmietowicz BMJ

Hospital patients should each have a "whole stay doctor" assigned to them who would be accountable for their care throughout their stay and who made sure that they were handed over to a named GP after discharge, England's health secretary, Jeremy Hunt, has said.

In a speech at St Thomas' Hospital in London on 23 January, Hunt said that the NHS needed new models of care to tackle the "fragmentation of care experienced by patients in hospitals." More generalist doctors needed to be trained in the place of specialists, he said.

IAN WEST/BUBBLES/ALAMY

Hospitals will be rated on whether patients have a named doctor

Hunt said that his vision of whole stay doctors, named consultants, and named GPs "transcends the walls of a hospital—with names above beds inside hospitals as the starting point."

New models of care were needed to reduce ward transfers during a hospital stay, he said, because evidence showed that every change of ward lengthened the average stay of elderly patients in that ward by more than a day. US studies have also found that hospitalists (doctors who carry out whole stay functions) are associated with lower rates of readmission for heart failure, acute myocardial infarction, and pneumonia.

About two fifths of hospital trusts already displayed a doctor's name above a patient's bed, said Hunt. But in the future the Care Quality Commission's ratings of hospitals would include this practice.

Hunt said that his plans on continuity of care mirrored those laid out by the Royal College of Physicians in its "excellent" *Future Hospital* report, published last September.[1] This called for doctors to have responsibility for their patients wherever they were, in or out of hospital, and for care to be delivered wherever was best for the patient, not the medical team, so that moving from ward to ward should be the exception.

Hunt said that his vision was supported by the Care Quality Commission, the Royal College of Physicians, and the Royal College of Surgeons.

Guidance on taking forward the plans would be published by the Academy of Royal Medical Colleges in March, he said.

Hunt referred to a Royal College of Physicians survey that found that nearly a quarter of consultant physicians rated their hospital's ability to deliver continuity of care as poor or very poor. He said that one frontline doctor had told him, "Hospital care today has become a series of brief encounters." Another blamed the European Working Time Directive for undermining team work.

Hunt also called for key patient information to be readily available anywhere in a hospital and for an end to "the referral ping pong that is such a nightmare for patients with complex needs—as well as being expensive for the NHS."

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similar to those in centres in western Europe; but in other areas conditions were difficult, with a lack of drugs and modern technology.

Astarastoae said that the Romanian government must act "to eliminate the causes of migration" among doctors. He said that this action would include "proper financing of the health system," increased respect for doctors from "politicians and society," and improved salaries.

Mihaela Carmaciu, a native of Romania who qualified there in 1986 but who has practised medicine in the UK for nearly 20 years, said, "Brilliant young Romanian doctors are practically being forced to leave the country." She added that salaries were "very low by European standards," at about €200 a month, and that training was unsatisfactory.

Cite this as: *BMJ* 2014;348:g430

VADIM GHIRDA/AP/PA

Romanian health staff march in 2013 to demand an increase in the GDP spent on health from 4% to 6%

Gagging clauses have been used at the expense of patient safety

Clare Dyer BMJ

"Gagging" clauses in settlement agreements with whistleblowers who leave NHS jobs have been used to stop them speaking out on patient care and child safety, say MPs.

The House of Commons Public Accounts Committee heard "shocking examples of using taxpayers' money to 'pay off' individuals who have flagged up concerns about patient or child safety," said the committee's chairwoman, Margaret Hodge. "We are deeply concerned about the use of compromise agreements and special severance payments to terminate employment in the public sector."

She added, "It is clear that confidentiality clauses may have been used in compromise agreements to cover up failure—and this is simply outrageous. It is vital that people feel free to speak out to help prevent terrible tragedies or even deaths; and protecting the reputation of an organisation such as the NHS at the expense of public safety is unacceptable."

The committee took evidence from the Treasury, Cabinet Office, NHS, Department of Health, and other departments in its inquiry.[1]

Hodge acknowledged that the Public Interest Disclosure Act gives former employees the right to speak out on matters of public interest, even if they have agreed to a confidentiality clause. But she said that people who had been offered or accepted compromise agreements "have clearly felt gagged."

Cite this as: *BMJ* 2014;348:g1101

Access to some NICE approved drugs varies hugely across England

Ingrid Torjesen LONDON

A "postcode lottery" still exists in access to the latest drugs in England, show figures from the NHS Health and Social Care Information Centre.

For the first time the centre's analysis of actual versus expected use of drugs recently approved by the National Institute for Health and Care Excellence (NICE) looked at use by local area.[1] It found wide variation, including a 28-fold difference in use of the newer anticoagulants rivaroxaban and dabigatran for stroke prevention in atrial fibrillation and a more than nine-fold variation in use of denosumab for osteoporosis.

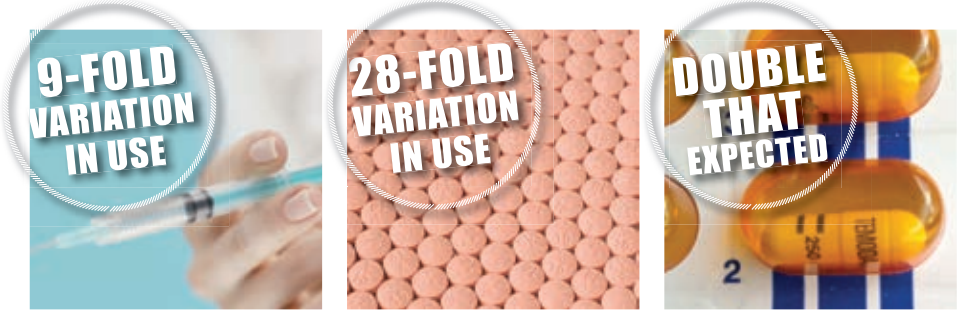
The analysis looked at the actual versus expected use in England of 18 drugs in 10 categories. It found lower than expected use in four groups and higher than expected use in two groups. Overall, across England, drugs for treating Alzheimer's disease (donepezil, galantamine, rivastigmine, memantine) were used 50% more than expected; and the use of temozolomide, a treatment for brain cancer, was double that expected.

Where a patient lived seemed to have a dramatic effect on their access to the latest drugs. In October to December 2012 there was a 28-fold variation across England in prescriptions in primary care of the latest anticoagulants for stroke prevention in atrial fibrillation. Dabigatran and rivaroxaban made up 8.4% of items prescribed for stroke prevention in atrial fibrillation in Bristol, north Somerset, Somerset, and south Gloucestershire but made up just 0.3% of the group of drugs in south London, East Anglia, and Merseyside.

Overall in England dabigatran and rivaroxaban made up just 1.2% of items prescribed for stroke prevention in atrial fibrillation during this time. In new guidance, NICE has advised that newer anticoagulants such as dabigatran and rivaroxaban can be prescribed as alternatives to warfarin.[2]

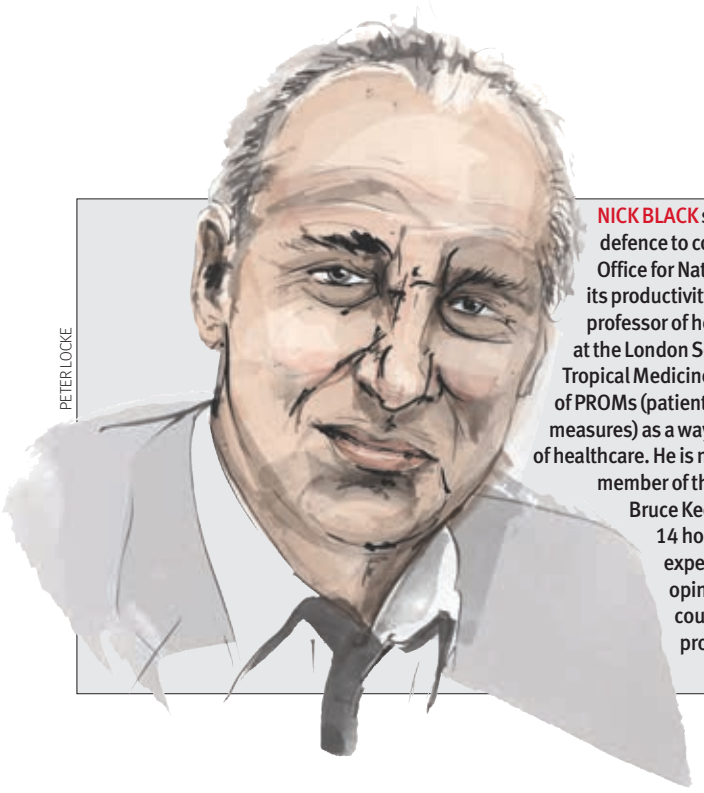
However, despite positive technology appraisals by NICE, some areas restrict their prescribing of the drug contrary to its guidance, and funding for warfarin clinics creates perverse incentives to prescribe it.

Cite this as: *BMJ* 2014;348:g465



Wide variation was found in the use of denosumab for osteoporosis (left), new drugs used for stroke prevention in atrial fibrillation (centre), and temozolomide for brain cancer

Nick Black
Arsenal's next manager?



PETER LOCKE

NICK BLACK sprang to the NHS's defence to contest a claim by the Office for National Statistics that its productivity was in decline. He is professor of health services research at the London School of Hygiene and Tropical Medicine and a champion of PROMs (patient reported outcome measures) as a way to measure the quality of healthcare. He is no Dr Pangloss—as a member of the advisory panel for Bruce Keogh's 2013 review of 14 hospitals with higher than expected death rates, he opined that other hospitals could have similar or worse problems.

If you could be invisible for a day what would you do?
"See what my elderly mother is actually eating."

What was your earliest ambition?
To be a film director (preferably Swedish, French, or Italian).

Who has been your biggest inspiration?
Phil Strong, one of the leading medical sociologists of his generation, who, despite his early death at 49, offered me a unique and challenging perspective that has influenced much of my thinking.

What was the worst mistake of your career?
It might prove to be answering these questions. I regret none of the knight's moves I've made, and I would encourage people not to be dissuaded from pursuing less predictable options.

What was your best career move?
Spending three years as a lecturer at the Open University. Working intensively with a biologist, economist, and sociologist, it allowed me to learn how to write, teach, and understand the perspectives of other disciplines.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
The best was Ken Clarke, who understood the key underlying and enduring issues that make healthcare so challenging to get right. The worst was Andrew Lansley, for not understanding those issues and for wasting two precious years with unnecessary and distracting structural change.

To whom would you most like to apologise?
Future generations, for what our generation has done to the environment.

If you were given £1m what would you spend it on?
Helping establish tidal energy projects, such as the Swansea Tidal Lagoon, in the hope of persuading politicians and the public of its potential contribution to saving the planet.

Where are or were you happiest?
26 May 1989: Liverpool 0 Arsenal 2.

What single unheralded change has made the most difference in your field in your lifetime?
Recognition of the essential role of the patient, without which the effectiveness of healthcare is limited and health systems will never meet the needs and expectations of the public.

Do you believe in doctor assisted suicide?
If we're serious about recognising patients' preferences and helping them make informed decisions, then we must be prepared to offer this. But perhaps more importantly, we must improve our assistance to those who are dying.

What book should every doctor read?
Anthony Powell's *A Dance to the Music of Time* (actually 12 books). As well as sharp observation of people and relationships and wonderful writing, it provides a view of the long, slow trajectory of time, which is increasingly necessary to counteract the misplaced and increasing tyranny of 24/7 urgency.

What is your guiltiest pleasure?
The schadenfreude when "I told you so" comes true.

If you could be invisible for a day what would you do?
See what my elderly mother is actually eating.

Clarkson or Clark? Would you rather watch *Top Gear* or *Civilisation*?
Civilisation, if *Borgen* was not available.

What is your most treasured possession?
An Arsenal season ticket.

What personal ambition do you still have?
To write a novel (along with everyone else).

Summarise your personality in three words.
Calm; optimistic; exacting.

Where does alcohol fit into your life?
Wine most (all) evenings.

What is your pet hate?
People engrossed in mobile gizmos, walking down the street ignoring everyone.

What would be on the menu for your last supper?
Thai red lentil soup; grilled halloumi (with lime vinaigrette), garlic roast potatoes, and rocket; and summer pudding with Greek yoghurt.

Do you have any regrets about becoming a doctor?
None—what's not to like about helping people and being well paid and respected?

If you weren't a doctor what would you be doing instead?
An architect restoring old buildings (assuming Arsenal didn't want me as manager).

References are in the version on bmj.com.

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