NEWS

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thebmj.com
Norwegian doctor who has worked in Gaza is refused entry to Israel

NHS chief spells out England's four possible models of care delivery

Gareth Iacobucci THE BMJ

NHS England will not dictate which "evolutionary path" local areas should follow in implementing new models of healthcare delivery but will expect most to fall into one of four broad types, its chief executive, Simon Stevens, has told *The BMJ*.

In an exclusive interview (p 14),[1] Stevens said that the new care models proposed in the *Five Year Forward View* for the NHS had "already begun to stimulate thinking and debate" since the vision was launched last month.[2 3]

He told *The BMJ* that NHS England would shortly be setting out in more detail the options that local areas could pursue over the next five years, "recognising that there aren't 211 versions of it [the number of clinical commissioning groups], but nor is there one." The options suggested for a sustainable and integrated NHS include hospitals taking control of general practice services or GPs heading up multispecialty provider groups that include consultants.

Stevens said that a few areas fell into the category of being well on the way to implementing a form of integrated care. He cited Yeovil in Somerset, where the district general hospital is looking to merge with primary and community care, and parts of Birmingham, where general practices have clustered together, as areas that were "already on the cusp" of achieving integration.

By contrast, other areas where existing services were struggling under huge financial pressures would fall into a second category where "it's pretty obvious to people that the status quo is not viable," he said.

The third category, said Stevens, "would be the bulk of the country that is in neither of those two extremes, where people have some degree of freedom." Some places may choose to continue with the existing model while others will want to do things differently.

He said that the final group would be the small number of new towns or developments in brownfield sites where "we have an opportunity to almost design from scratch what a 21st century health service would look like, rather than just having to tweak legacy models of care.

FEATURE, p 14

Cite this as: *BMJ* 2014;349:g6905

ANTONIA REEVE/SPL

Only three surgeons out of 5 000 have been identified as outliers from the new surgical data

Keogh hails release of mortality data as "a major step forward"

Matthew Limb LONDON

Bruce Keogh, medical director of NHS England, this week defended the publication of new mortality data for surgeons in 13 specialties against claims that it would deter surgeons from taking on high risk patients.

Keogh described the process as a "major step forward in NHS transparency" that would drive up standards of care. He said, "This is about demonstrating that surgery in this country is as good as anywhere in the western world and that, in some specialties, we know it is better."

However, a surgeons' leader has attacked the "crude" way in which the new data were being published. John MacFie, president of the Federation of Surgical Specialty Associations, said that publication of data on individual surgeons was already deterring some doctors from taking on high risk cases. He told *The BMJ*, "There is no doubt that anecdotally it is affecting surgeons' performance, and I'm worried that patients might suffer because of it. It is particularly the case with younger surgeons—they are now worried and feel threatened by publication of data like this."

An official in charge of the programme said that presentation of data was improving and patients would feel "reassured," confirming that only three of some 5000 surgeons had been identified as "outliers," whose mortality rates fell outside the expected range.

The second round of consultant outcomes data in England was due to be published on Wednesday 19 November on the NHS Choices and My NHS websites, after *The BMJ* went to press. The new data add three new specialties—lung cancer, neurosurgery, and urogynaecology, to the 10 specialties that were published in the first wave of data in 2013, which listed around 4000 surgeons.

The results are based on national clinical audit data and show whether clinical outcomes for each consultant are within expected limits. Officials said the figures would show that mortality rates for almost all surgeons were within the expected range.

Ben Bridgewater, a consultant cardiac surgeon at the University Hospital of South Manchester, who led the reporting programme as director of outcomes publication for the Healthcare Quality Improvement Partnership, said that this finding would reassure patients. He told *The BMJ*, "The variation is low. There are some mortality outliers, but those numbers are small. But I think it's important to recognise there's a whole bunch of different reasons why mortality rates for an individual surgeon may be high."

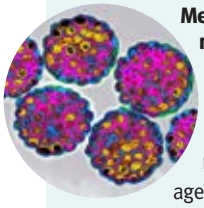
Bridgewater said that in cardiac surgery, where the overall mortality rate was 2.5%, surgeons who were mortality outliers had been "named" for some time and that the process of transparency was improving the quality of information, which doctors would welcome.

Cite this as: *BMJ* 2014;349:g6981

IN BRIEF

Emergency departments get extra £300m to relieve pressure: The UK government has released an extra £300m to help fund hospital emergency departments in England on top of the £400m it announced in the summer. The money will be used to boost staff numbers, especially at the weekends. Emergency departments are supposed to see 95% of patients within four hours, but performance dipped below 94% in recent weeks.

Cancer Drugs Fund to be reviewed: England's Cancer Drugs Fund is to reassess 42 drugs on its list and remove those that are deemed too expensive or ineffective. The fund, which was set up in 2010, has been used to provide cancer drugs that are not routinely available on the NHS in England. Some 55 000 people have used the fund so far. Its original £200m budget is being increased to £280m after overspending.



Men who have sex with men should get HPV vaccine: The UK Joint Committee on Vaccination and Immunisation has recommended that men aged 16 to 40 who have sex with men should be vaccinated against human papillomavirus, provided that the programme is cost effective.

Patients' charity criticises England's health ombudsman service: The parliamentary and health service ombudsman needs to be made accountable and more effective in dealing with concerns raised by patients and their families and carers, the Patients Association has said. In a report the association highlights how families have turned to the ombudsman only as a last resort and believes that its investigations are inadequate, untimely, secretive, flawed, and outdated.[1]

WHO calls for action to prevent drowning: A total of 372 000 people drown each year, with those aged under 5 years at greatest risk, says a WHO report.[2] Males are twice as likely to drown as females, and rates are highest in Africa, South East Asia, and the western Pacific. The report recommends several community and national interventions, including barriers to control access to water, teaching children basic swimming skills, training bystanders in safe rescue and resuscitation, better boating, shipping, and ferry regulations, and better flood risk management.

Cite this as: *BMJ* 2014;349:g6902

BMA criticises CQC for banding GP practices before inspectors arrive

Staff at the Irlam Medical Practice 2, Salford, were awarded an outstanding rating by the CQC

Jacqui Wise LONDON

The Care Quality Commission's decision to publish information on every general practice in England has been criticised by the British Medical Association as confusing and potentially misleading to patients and for undermining GPs' morale.

The CQC's "intelligent monitoring" of general practices includes 38 indicators relating to patients' experience, care, and treatment (http://bit.ly/11o2HzX). It has said that it will use the data to categorise general practices into one of six priority bands that are based on the proportion of indicators that have been identified as at "risk." These bands will be used to prioritise the CQC's inspections under its new inspection regime (with band 1 representing the practices at highest priority for inspection).

GP PRACTICE BANDING
78% in the 4 lowest bands
3797 in the highest band 6

The new analysis shows that 78% (6076 practices) are in the four lowest bands, with 3797 in band 6 (the lowest perceived concern). The 1200 practices in bands 1 and 2 will be considered for inspection from next year.

Patients will be able to search for their general practice by postcode and see information that comes from sources such as the Quality and Outcomes Framework, the GP patient survey, hospital episode statistics, and electronic prescribing analysis and cost data.

Within two years every general practice will have been inspected and rated as either "outstanding," "good," "requires improvement," or "inadequate." The CQC this week announced the first practices to be awarded ratings of outstanding, both in Salford: Salford Health Matters and Irlam Medical Practice.

Richard Vautrey, deputy chair of the BMA's General Practitioners Committee, said, "The publication of 38 more targets that practices will be judged by will add to the growing burden and bureaucracy on practices and could further undermine hardworking GPs' morale."

He added, "Publishing data with no context about a GP practice before inspectors have even arrived will at best confuse patients and at worst mislead them. It will not give an accurate picture of how GP services are operating. The information does not take into account the differing circumstances GP practices operate in, including levels of deprivation in the community they deliver care to or the state of their facilities."

But Steve Field, the CQC's chief inspector of general practice, said, "It is important to remember that the [banding] is not a judgment, as it is only when we inspect that we can determine if a practice provides safe, high quality, and compassionate care. The data are a further tool that will help us to decide where to inspect and when."

Cite this as: *BMJ* 2014;349:g6950

Chief accuses Monitor of undermining leaders

Mark Newbold (left) has been supported by colleagues after being pressured to resign by Monitor, headed by David Bennett

Richard Vize LONDON

The consultant physician Mark Newbold has resigned as chief executive of Heart of England NHS Foundation Trust, Birmingham, saying that the regulator Monitor had set too short a timescale for improvements to be made at the trust.

Last month the regulator put a condition on the trust's licence that raised the prospect of forcing a change

"Unprecedented demand" on A&E caused major incident at Essex hospital

Zosia Kmietowicz THE BMJ

A major incident was declared at Colchester General Hospital on 13 November after "unprecedented demand" from emergency department admissions and concerns about the way some patients were being treated.

The emergency assessment unit at the hospital in northeast Essex has been closed to new patients and an emergency control centre set up. Patients have been urged to use the hospital's emergency department only if they have a serious or life threatening condition.

Inspectors from the Care and Quality Commission (CQC) made an unannounced inspection of its emergency department and assessment unit on 12 November. The report of the inspection has not yet been published, but senior managers at the hospital admitted that inspectors had raised concerns over safeguarding issues as well as the problems in the emergency service. The *Guardian* newspaper reported that patients were being inappropriately restrained, sedated without consent, and resuscitated when they had asked not to be.[1]

Lucy Moore, chief executive of Colchester Hospital University NHS Foundation Trust, which runs the hospital, told staff that "the trust declared an internal major incident because of the extreme pressures we are experiencing and the lack of capacity. A high number of escalation beds are in use and we are, unfortunately, having to postpone some elective operations."

Peter Wilson, the trust's acting chairman, told the *Guardian*, "We are facing unprecedented demand at the front end and have declared today a major incident, which means a whole-hospital review of demand, capacity, staffing levels, and discharge processes."

Cite this as: *BMJ* 2014;349:g6891

OPERATION ON GINA BEDDOE
TOOK: 2 hours
INVOLVED: 22 surgical staff
COMPLETED AT: 24+2 weeks

Ross Welch with Gina Beddoe, Dan Lavis, and Frankie in Plymouth at the end of October

NHS funds first prenatal repair of open spina bifida

Zosia Kmietowicz THE BMJ

The first operation to repair open spina bifida in utero funded by the NHS took place in June this year, with the baby born at the end of August in Plymouth.

Fetal medicine specialists from England, Belgium, and Switzerland performed the operation on Gina Beddoe, 35, from Plymouth, at Leuven teaching hospital in Belgium after spina bifida in the fetus was diagnosed in Derriford Hospital in Plymouth at 19 weeks of pregnancy.

The operation, which took two hours and involved 22 surgical staff, was completed at 24 weeks and two days, and Beddoe was discharged back to Plymouth one week later on nifedipine prophylaxis. It was the ninth such operation carried out at the Belgian centre, one of only two units in Europe that offer prenatal open surgery for spina bifida.

Approval for the operation, which cost €10 455 (£8270), was given by NHS England within 30 minutes of the request being made.

Ross Welch, the consultant in fetomaternal medicine at Derriford Hospital who coordinated Beddoe's care, believes that more UK patients might benefit from the procedure if they knew about it and that eventually a centre might be established in England to provide the procedure.

Meanwhile, however, he told *The BMJ* that he believed that it would be most cost effective for patients to use either the centre in Belgium or the Zurich Centre for Fetal Diagnosis in Switzerland, which collaborate closely.

"At the moment I think we should feed Belgium and Zurich with cases from the UK until their capacity is met, not least because it is going to be significantly cheaper than setting up a new centre here," said Welch. "We might find that there are only 20 women in the UK a year who would want this operation, which means we would have one unit doing a procedure every two to three weeks."

He added, "When the numbers of NHS patients likely to request this procedure are better known, a much better financial and governance argument may be made for a UK centre, and the specialists from Belgium and Switzerland could then mentor a UK centre."

The new option of fetal repair of open spina bifida became more accepted after the Management of Myelomeningocele Study, published in the *New England Journal of Medicine* in 2011, which was stopped early because of the benefits seen in infants.[1] By 30 months infants who had prenatal surgery were also more likely to be able to walk without assistance than those who had surgery after birth (42% versus 21%; relative risk 2.01 (95% confidence interval 1.16 to 3.48)).

Cite this as: *BMJ* 2014;349:g6875

of leadership.[1] It acted after the trust failed to reduce waiting times in the emergency department, for routine operations, and for treatment for cancer, alongside concerns over death rates. Last year Monitor said that the trust was suspected of breaching its licence over waiting times in the emergency department.

Before entering management, Newbold spent 20 years as a consultant specialising in gastrointestinal disease and histopathology at Warwick Hospital and at University Hospitals Coventry and Warwickshire NHS Trust.

Newbold, known for using social media to reach patients and staff, published his resignation letter on his blog.[2] He told the trust board's chair, Les Lawrence, that the trust's strategy "will bring improvement in time, but…the timescale…will be longer than the regulators wish to see." He regretted failing to solve the problem of overcrowding, which he saw as the cause of poor mortality figures and poor staff morale.

Commenting in his blog post on his decision to quit after four years, Newbold accused Monitor of using language in its announcement of enforcement action that was "undermining to leaders, and I wondered if this was the intention."

Newbold has been supported by other health managers and professionals in social media. Robert Royce, project lead for urgent care at Ipswich Hospital NHS Trust, tweeted that Newbold showed "knowledge, sincerity & honesty." Chris Ash, integrated services director at Southern Health, described him as "an example of leadership with real integrity."

Kieran Walshe, professor of health policy and management at Manchester Business School, said, "How can anyone (even Monitor) think it will improve things for patients at HEFT [Heart of England NHS Foundation Trust] to dismiss Mark Newbold? And who will want that CEO job now?"

Cite this as: *BMJ* 2014;349:g6883

MATT ALEXANDER/PA

Capsules maketh the antibiotics man

Zosia Kmietowicz THE BMJ

This image of Alexander Fleming by the portrait artist Nathan Wyburn was created from 25 800 empty drug capsules, the average number of amoxicillin 500 mg pills dispensed in England every 100 minutes. The portrait marks the opening for entries for the Longitude prize (www.longitudeprize.org) on 18 November.

Earlier this year the UK public voted for antibiotics to be the focus of the £10m prize.[1] The race is now on to develop a revolutionary test to detect and identify infections to help ensure that the right antibiotics are used at the right time. The test must be affordable, provide results in 30 minutes, and be easy to use anywhere in the world.

Competitors have up to five years to find a solution to the challenge.

Cite this as: *BMJ* 2014;349:g6848

Cost of drugs prescribed on the NHS in England rose by £1bn last year

Nigel Hawkes LONDON

The total cost to the NHS in England of prescribed drugs rose by more than £1bn to £14.4bn in 2013-14, new data from the Health and Social Care Information Centre show.[1]

By far the sharpest rise was in hospital prescribing, where the total spend rose by 15.1% to almost £5.8bn. The total spend in primary care was greater, at almost £8.5bn, but the increase over 2012-13 was smaller, at 3.2%.

The faster rise in hospital spending was attributed to the introduction of innovative drugs, which are more likely to be dispensed in hospitals and which are in general more expensive. Seven prescribed drugs cost more than £100m a year, all of them predominantly prescribed in hospital. All but one were biologicals.

Three of the seven most expensive drugs are licensed for rheumatoid arthritis, three for cancer, and one for wet age related macular degeneration. Lenalidomide, which is derived from thalidomide, notorious in the 1950s and 1960s for causing birth defects, is the only non-biological drug in the top seven, licensed for treating myeloma.

The data came from two sources. The hospital data came from IMS Health, which audits use by hospital trusts, and the primary care data came from prescriptions dispensed in the community.

Cite this as: *BMJ* 2014;349:g6867

THE 7 MOST EXPENSIVE DRUGS

- Adalimumab (marketed as Humira, whose total cost was £311m)
- Ranibizumab (Lucentis, £244m)
- Etanercept (Enbrel, £233m)
- Infliximab (Remicade, £142m)
- Rituximab (MabThera, £135m)
- Trastuzumab (Herceptin, £123m)
- Lenalidomide (Revlimid, £104m)

Ombudsman questions EU drugs agency over AbbVie redactions

Rory Watson BRUSSELS

The European ombudsman, Emily O'Reilly, has written to the European Medicines Agency asking it to explain by 31 January 2015 the redactions it made in the clinical trial data provided by AbbVie for its best selling drug adalimumab (Humira), for rheumatoid arthritis.

Emily O'Reilly has "doubts and concerns" about certain redactions

The redactions were made as part of the settlement between the agency and the company after AbbVie had gone to court to try to prevent publication of certain clinical trial data.

In her letter O'Reilly acknowledged that "certain redactions may be justified to protect the personal data of patients." She also accepted that "certain other redactions, which mention the names of companies that provided services to AbbVie, or the names of software used by AbbVie, are not, in my view, problematic, as they may be considered to relate to the confidential business relationships of AbbVie."

But after examining the original and the redacted versions of the clinical trial data, internal agency communications, and correspondence between the agency and the company, she expressed "doubts and concerns as regards other redactions." O'Reilly, who opened an investigation into the case in April, identified 16 instances where she wanted the agency to explain why the redactions were necessary to protect AbbVie's legitimate commercial interests.

She asked, for instance, why redaction of information on the rationale for dosage selections or the considerations used in determining sample sizes was justified. She noted "that the determination of sample size would appear to be a vital element" to a clinical study report.

In another case, she pointed out that a sentence had been redacted even though the internal communications of the agency staff who reviewed AbbVie's suggested redactions did not identify the information as commercially confidential. "Rather, the internal communications of the EMA staff suggest that the redacted information reflects standard practice in clinical trials," she suggested.

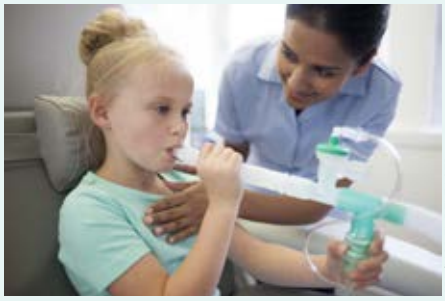
O'Reilly told the agency that she found "no obvious reason why the release of the redacted text relating to protocol changes . . . would undermine a legitimate commercial interest of AbbVie."

At stake is the extent to which the European Medicines Agency may have established a precedent in its settlement with AbbVie just months before its new policy on the release of trial data comes into effect on 1 January 2015.

In its response to the ombudsman's letter the agency confirmed that "a detailed reply to the . . . queries shall follow in due course."

Cite this as: *BMJ* 2014;349:g6904

Cystic fibrosis patients now live 20 years longer



SPL/MODEL RELEASED

Survival improved because of rigorous infection control, new drugs, and more transplants

Clinical trials of Ebola therapies to begin this year in Guinea

Anne Gulland LONDON

The first clinical trials of therapies for Ebola virus disease will begin next month in the treatment centres run by Médecins Sans Frontières in Guinea.

At a press conference in Geneva the principal investigators of the trials announced that three therapies would be tested at three separate sites. They said that the trials would begin in December, and 100-200 patients at each treatment centre would undergo testing.

A team led by the French National Institute of Health and Medical Research will test the antiviral drug favipiravir in Gueckedou, the antiviral brincidofovir will be tested by a consortium led by the University of Oxford at a site yet to be announced, and convalescent whole blood and plasma therapy will be tested by the Antwerp Institute of Tropical Medicine in Conakry.

The treatments were chosen from a list drawn up by the World Health Organization and were selected for their safety, efficacy, and—importantly—availability. Both favipiravir and brincidofovir have been tested in humans with influenza virus. Other experimental drugs such as ZMapp, which was given to UK nurse Will Pooley when he became infected with the virus, were not available in large enough quantities to test.

Annick Antierens, coordinator of the trials for Médecins Sans Frontières, said, "One of the major issues has been availability. Some promising drugs were not considered because there is not availability." She added that the number of trial sites may be expanded as more drugs became available.

Peter Horby, who is leading the Oxford University trial, said that there was both a humanitarian and scientific need to carry out the trials now. "We have these products which may or may not work. The only way to test them is during an epidemic. If we're going to find a treatment we have to do it now. We're going fast by clinical trials standards but maybe not fast enough for the people on the ground," he said.

He said that everyone involved in the trial had left their "comfort zone," including the institutions that were fast tracking the trials, Médecins Sans Frontières (which had not previously been involved in a clinical trial during a disease outbreak), pharmaceutical companies, and the authorities in Guinea.

The studies will be conducted on a single arm basis, and they have a broad target of 14 day survival. The therapies will be tested on both adults and children, although pregnant women will be excluded from the trials of the antiviral drugs. If mortality drops below 40% the trials will be terminated, and if survival exceeds 80% the trial will be stopped and the drugs will be made available to other patients.

The researchers said that they expected the first results in February and March next year, but Horby said that it would depend on the number of patients who were seen at the trial sites and consented to the treatment. "The other unknown is the effect of the drug. If there's a big effect we will get the answer quicker," he said.

The Dutch researchers will test whole blood products first, while the logistics of plasma production are put in place. Johan van Griensven, principal investigator on the trial, said that the most important aspect of the trial was engaging with the community. "We're conducting an in-depth anthropological evaluation to understand whether such an intervention—blood donation used for treatment—is acceptable to the community in Guinea and to Ebola survivors," he said.

The latest figures on the disease from WHO showed 14 098 cases, including 5160 deaths.

Cite this as: *BMJ* 2014;349:g6827

KRISTIN PALITZA/DPA/ALAMY

A baby being cared for in Gueckedou, Guinea, the site where favipiravir will be tested

Susan Mayor LONDON

People with cystic fibrosis are living for 20 years longer than they did in the 1990s, figures from a Canadian study have shown.

Researchers analysed data from the Canadian Cystic Fibrosis Registry,[1] a population based cohort that collects yearly clinical information on patients who receive care at the 43 accredited cystic fibrosis centres in Canada. The registry included 5787 people from 1990 to 2012.

The results showed that the median survival increased from 31.9 years (95% confidence interval 28.3 to 35.2) in 1990 to 49.7 years (46.1 to 52.2) in 2012. And an updated figure, released after the study was published, showed that the median survival had increased again in 2013, to 50.9 years.

"By analysing national data we can confirm what we are seeing clinically—specifically, that our cystic fibrosis patients are living longer, well into adulthood and middle age," said Anne Stephenson, a respiratory physician at St Michael's Hospital in Toronto and the lead author of the study.

CYSTIC FIBROSIS: MEDIAN SURVIVAL
1990: 31.9 YEARS
2012: 49.7 YEARS
2013: 50.9 YEARS

Improvements in survival among people with cystic fibrosis resulted from increased multidisciplinary care, rigorous infection control practices, the availability of new medicines such as inhaled antibiotics and mucolytics, and increased lung transplantation, said Stephenson, adding that improved nutrition from birth had also had a major effect on their health.

The data showed improved survival in all groups of cystic fibrosis patients, including those with the mutations associated with the most severe forms of the disease. However, patients who were malnourished, those who had multiple exacerbations, and women with cystic fibrosis related diabetes had a higher risk of death than the other patients.

Although fewer patients are now malnourished—only 19% in 2012 had a body mass index lower than 19 kg/m^2—Stephenson said that they could benefit from aggressive nutritional support to improve survival.

Cite this as: *BMJ* 2014;349:g6844

John Oldham
Hates the "jobsworth" mindset

PETER LOCKE

JOHN OLDHAM has for more than 20 years been the go-to man for large scale change and new approaches to improving primary care. For 30 years a GP in Glossop, Derbyshire, he also headed the National Primary Care Development Team from 2000 to 2006 and in 2013 was asked by the Labour Party to carry out an independent review of how best to integrate care, called One Person One Team One System. He enjoys the blues—music, not mood—and is an unlikely fan of David Bowie, tweeting enthusiastically about his recent comeback record.

If you were given £1m what would you spend it on?
"I would sponsor a research project on managing people with multiple problems. Out of £1bn of public money that is spent on clinical research next to nothing, zilch, is spent on the biggest issue facing health and social care"

What was your earliest ambition?
To become a steam engine driver—an ambition that I realised earlier this year on an excellent course at the Ecclesbourne Valley Railway.

Who has been your biggest inspiration?
My father, who saw the best in people, tried to bring the best out of them, and was always optimistic about overcoming problems. Also, Teddy Chester of Manchester Business School, who gave me early opportunities as a trainee to broaden my horizons by learning from outside healthcare.

What was the worst mistake in your career?
I'll let you know that when my career is finished. Some of the worst mistakes I have seen, though, are made by people, including politicians, not acting for fear of making a mistake.

What was your best career move?
Becoming a GP in a town on the edge of the Peak District.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
Alan Milburn was the best for vision and for the inclusive process that he led and inspired to help deliver it. John Moore did nothing, but he might have been better than those who acted without listening.

Who is the person you would most like to thank and why?
My wife; together we are better at so many things. And I'm grateful to her for tolerating my "projects."

To whom would you most like to apologise?
The many for whom I didn't get it right the first time.

If you were given £1m what would you spend it on?
I would sponsor a research project on managing people with multiple problems. Out of £1bn of public money that is spent on clinical research next to nothing, zilch, is spent on the biggest issue facing health and social care.

Where are or were you happiest?
Then: on family holidays as a child, especially in Devon. Now: walking the hills or going to a blues or jazz club.

What single unheralded change has made the most difference in your field in your lifetime?
The electronic medical record, although we don't yet exploit it fully. It is time the digital revolution transformed healthcare delivery. Patients having legal ownership of records is part of that, even though the records themselves might reside elsewhere.

Do you support doctor assisted suicide?
Yes, having listened to patients.

What book should every doctor read?
Understanding Organisations by Charles Handy, which shows how human attributes can shape motivation, roles, leadership, teams, and the culture of organisations. I also recommend anything by W Edwards Deming on quality improvement, and, if I may, our recent report, *One Person One Team One System*.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Bring Me Sunshine, of Morecambe and Wise fame, would send people out with a smile. Alternatively, *Heroes* by David Bowie.

What is your guiltiest pleasure?
Bread and butter pudding, glazed with Seville orange marmalade.

If you could be invisible for a day what would you do?
If I could time travel, I'd watch Leonardo da Vinci. But today I'd find out where ISIS hostages are being kept.

What is your most treasured possession?
Old family photos and my grandfather's recipe book from his bakery. Some of those recipes have been passed down through many generations.

What, if anything, are you doing to reduce your carbon footprint?
I once took a ride in a friend's Toyota Prius, and I travel by train a lot, but I haven't yet overcome my lifelong love of sports cars.

Summarise your personality in three words
Persistent, humanitarian, and I think humorous—though it's not always appreciated!

Where does alcohol fit into your life?
Most places in an evening, reds especially.

What is your pet hate?
"Computer says no": namely, the "jobsworth" mindset that is more precious to some people than trying to deliver a service and helping to make things work.

What would be on the menu for your last supper?
Scallops with chorizo on rocket, beef in beer with pommes dauphinoise, and lime tart; but I'd want to cook all of it.

If you weren't in your present position what would you be doing instead?
I'd be a steam engine driver.

Cite this as: *BMJ* 2014;349:g6956