this week

SWINE FLU VACCINE page 255 • **FOOTBALL HEAD INJURIES** page 256

£9.5bn needed to deliver plans for NHS

The sustainability and transformation plans (STPs), set up to improve the quality of care and save £15bn of the £22bn needed across England by 2020, will cost £9.5bn to deliver, the BMA has said in a new analysis.

The costs relate to the infrastructure that is needed to make the savings—such as building projects and investment in community facilities—responses to freedom of information requests submitted by 37 of the 44 footprint areas charged with making the plans have shown.

More than half of the STP footprint areas have told NHS England that they would need more than £100m up front to make changes to how they deliver care, and a handful have said that they need more than £500m, including Manchester, Cambridgeshire and Peterborough, and West Yorkshire.

The plans from all 44 areas were submitted to NHS England before the end of 2016 and officials are now reviewing them to see how they should be carried forward.

Mark Porter, BMA chair of council, said that the findings showed that the desired "transformation" from the plans is impossible to achieve without further investment. The only way to make the plans work will be to cut services "on a drastic scale."

In the spending review in 2015 the Department of Health was given an annual capital allocation of £4.8bn from 2016-17 to 2020-21. Figures suggest that hospitals need more than £2bn to pay for outstanding "significant" or "high risk" maintenance needs. In addition, Chris Hopson, chief executive of NHS Providers, has said that this pot of money is being raided to cover deficits in trusts' income, and David Williams, finance director at the Department of Health, has admitted that raids on the capital budget were likely to continue.

The BMA has said that these losses mean that the capital stands closer to £1.6bn for the next financial year.

Porter said: "The NHS is at breaking point and the STP process could have offered a chance to deal with some of the problems it is facing, like unnecessary competition, expensive fragmentation, and buildings and equipment often unfit for purpose, but there is clearly nowhere near the funding required to carry out these plans."

A spokesperson for NHS England said: "Yes there are pressures and constraints facing the NHS, but for patients' sake we should all try and make the best of the situation, rather than just stand to one side and say 'well I wouldn't start from here'."

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2017;356:j799

The BMA said that without extra investment service cuts on a "drastic" scale would be the only way to make STPs work

LATEST ONLINE

- New QOF indicators target acute kidney injury
- US cardiologist is sentenced to prison for plot to kill rival doctor
- Roche asks WHO to remove Avastin from essential medicines list

SEVEN DAYS IN

NHS England chairman, Malcolm Grant, said that the new guidance would bring a "consistent approach to conflicts of interest"

TONY BUCKINGHAM/REX/SHUTTERSTOCK

Doctors win right to keep private income private

NHS England has dropped plans to make doctors reveal how much they earn from private work.

The proposal was made in a consultation issued last September but met strong opposition from some medical groups.

Clinical staff will have to declare what private practice they do, how long they spend doing it and where, but not their earnings, new guidance for NHS staff and organisations on managing conflicts of interest says.

NHS work was expected to "take precedence" over private practice, where there would otherwise be a conflict or potential conflict of interest, it said.

NHS England had originally proposed that clinical staff should declare their earnings from private practice and whether they earned less than £50 000; £50 000 to £100 000; or more than £100 000. This information would then be included on their employers' register of interests.

But the Hospital Consultants and Specialists Association said that such a move, not extended to other senior NHS staff, would be "unfair."

The BMA warned NHS England that the bandings would give the false impression that large numbers of doctors were earning £50 000 from private work, even though many earned very small amounts from public speaking and other engagements.

Matthew Limb, London Cite this as: *BMJ* 2017;356:j744

Patient safety

Warning over another Mid Staffs-type scandal

Robert Francis QC, who led the public inquiry into Mid Staffordshire Hospital after more than 400 excess deaths occurred from 2005 to 2008, warned that another such hospital scandal is "inevitable." Francis told the *Health Service Journal*, "Let's make no bones about it, the NHS is facing an existential crisis . . . The service is running faster and faster to try and keep up and is failing, manifestly failing. There will come a point where public confidence in the service dissipates."

Brexit

MPs vote against NHS amendment

MPs voted down an amendment to the government's Article 50 Bill on leaving the EU that would have required the government to publish a report on the effect of EU withdrawal on national finances, particularly health spending. Proposed by a Labour MP, Chuka Umunna, the amendment followed claims by Leave campaigners that withdrawal from the EU would allow an extra £350m a week to be spent on the NHS.

New cancer drugs could be delayed by two years

UK patients are likely to wait longer for new cancer drugs after the UK leaves the EU because drug companies will prioritise winning approval for access to the larger European market, a former chair of the Medicines and Healthcare Products Regulatory Agency, Alasdair Breckenridge, warned on BBC Radio 4's *Today* programme. David Jeffreys, vice president of the Japanese drug company Eisai, said, "UK patients may be getting medicines 12, 18, 24 months later than they would if we remained in the European system."

Organ transplants

Chinese official should not have attended summit

Doctors and medical ethicists criticised the Vatican for inviting a Chinese health official to a summit on organ trafficking despite claims that China still

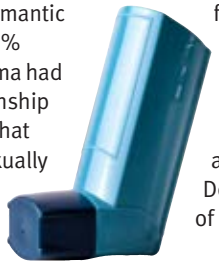
sanctions the removal of organs from executed prisoners and minority ethnic groups. Huang Jiefu, a former health minister and chair of China's national organ donation and transplant body, dismissed suggestions that the practice was ongoing. "I am the person who arranged to stop using prisoners' organs from January 2015," Huang told *The BMJ*. (doi:10.1136/bmj.j729)

EDITORIAL, p 262

Asthma

Asthma affects sex life

A survey by Asthma UK found that 68% of 544 people with asthma thought that their condition affected their sex life, and 73% had been embarrassed about using an inhaler on a romantic night out. Just under 15% thought that their asthma had contributed to a relationship ending, and 46% said that they would be more sexually confident if they did not have asthma.



NHS performance

More patients wait longer for treatment

By the end of 2016 some 367 877 patients were waiting longer than 18 weeks for treatment, NHS England figures showed—100 000 more than in 2015. The government's target for 92% of patients to be treated within 18 weeks has not been met since February 2016. Neurosurgery is the worst performing specialty, as 83.2% of treatments were yet to start within 18 weeks in December 2016, down from 87.4% in 2015.

Rise in delayed discharges

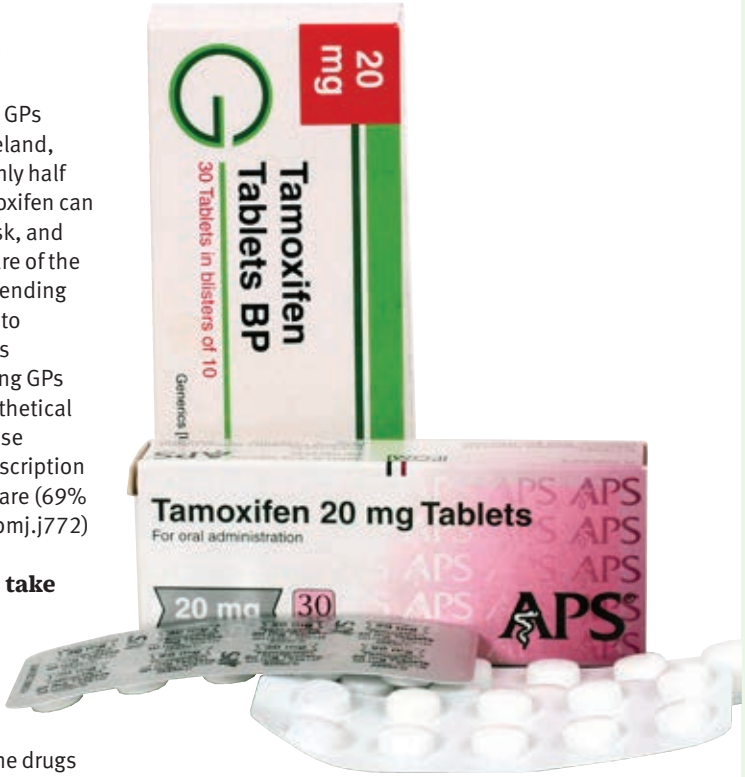
Delayed discharges totalled 195 300 days in December 2016, up 27% from 154 000 in December 2015. The proportion of delays attributable to social care increased over the past year to 36% in December 2016, up from 32%. The main reason for social care delays was patients awaiting care packages in their own home, which accounted for 37% of all social care delays in December 2016, a rise of 53%.

MEDICINE

Cancer drugs

GPs are unaware of tamoxifen benefits

An online survey of 928 GPs in England, Northern Ireland, and Wales found that only half (51.7%) knew that tamoxifen can reduce breast cancer risk, and only a quarter were aware of the NICE guideline recommending its use. The willingness to prescribe tamoxifen was significantly lower among GPs asked to initiate a hypothetical prescription than in those asked to continue a prescription initiated in secondary care (69% *v* 85%). (doi:10.1136/bmj.j772)



Universities should take drugs to market

To make new drugs more affordable universities and academics should take greater control of the drugs they discover, researchers said—for example, by partnering private enterprises to trial and market drug discoveries to create competition. Paul Workman, chief executive of the Institute of Cancer Research in London, said, "If we're to end this era of $100 000 [£80 000] cancer drugs, we're going to have to make some radical changes. We need academic organisations to become braver at moving new treatments into clinical trials and onto the market."

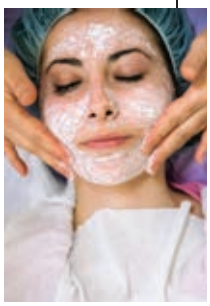
Surgery

Bed shortage leaves surgeons under-occupied

Surgeons have been left "kicking their heels" because thousands of operations have been cancelled as a result of a bed shortage this winter, said Clare Marx, president of the Royal College of Surgeons, and Chris Hopson, chief executive of NHS Providers, in a letter to the *Times*. "This is frustrating for staff, who just want to care for patients—rising numbers of whom suffer the anxiety of having their planned operations cancelled on the day," they wrote, demanding that NHS England review what can be done to reduce the pressure on beds seen this winter.

Demand for cosmetic surgery fell in 2016

In 2016 only 30 750 people had cosmetic surgery in the UK, compared with 51 140 in 2015—a 40% drop—figures from the British Association of Aesthetic Plastic Surgeons showed. It said that more people had chosen cheaper, non-surgical procedures, such as chemical peels. The biggest fall was in the number of brow lifts (down 71%), while breast augmentation remained the most popular surgery despite falling by 20%.



Cite this as: *BMJ* 2017;356:j802

SURGEON MORALE

Low morale was cited by 51% of surgeons and 65% of trainee surgeons as their main problem at work, a survey of 3500 surgeons by the Royal College of Surgeons found

SIXTY SECONDS ON . . . SWINE FLU VACCINE

SWINE FLU'S NOT BACK, IS IT?

Fortunately not, but it's in the news because of a High Court ruling that could mean the government having to make big payouts to children who developed narcolepsy after vaccination against swine flu.

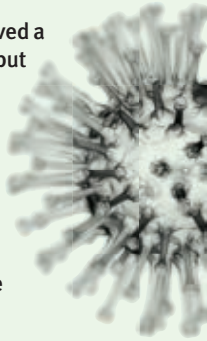
TELL ME MORE

A boy called "John," now 14 years old, received the Pandremix vaccine in December 2009, when the A/H1N1 swine flu pandemic was in full swing: he was one of around 668 000 UK children who received the vaccine. In April 2010 John developed narcolepsy and cataplexy. He became disruptive at school, cannot take part in many social activities, meaning he has few friends, and cannot swim or take a bus on his own.

HAS A LINK BETWEEN THE VACCINE AND NARCOLEPSY BEEN PROVED?

A link was disputed at first, but a *BMJ* paper in 2013 showed that one in 55 000 children given the vaccine developed narcolepsy.

SO THE GOVERNMENT HAS BEEN QUICK TO PAY OUT, THEN?



Not exactly. In 2015 John received a one-off payment of £120 000, but the family has always argued that this would not cover a lifetime of disability. The new judgment means that the government has to consider the effect of the disability on a person's entire life, not just the effect at the time of the vaccination.

HOW MANY PEOPLE ARE AFFECTED?

It is thought that around 100 people in the UK developed narcolepsy after receiving the vaccine. John's solicitors are acting for 88 claimants, mostly children. In August 2016 an inquest into the suicide of 23 year old Katie Clack concluded that it was "most likely" that the nursery nurse developed the condition after receiving the vaccination.

BUT APART FROM THESE CASES, THE RESPONSE TO SWINE FLU WAS A SUCCESS?

Not really. A report by the Council of Europe said the World Health Organization whipped up an "unjustified scare" over the disease, and a *BMJ* investigation found links between WHO scientific advisers and vaccine manufacturers.

Anne Gulland, London

Cite this as: *BMJ* 2017;356:j749

FIVE MINUTES WITH . . .

Stephen Westaby

The pioneering heart surgeon and inventor explains why over-regulation is stifling innovation among doctors

"I was 68 when I recently stopped working for the NHS, having done 11 000 to 12 000 heart operations during my 40 years in cardiac surgery. I had already decided to stop operating because years of having instruments slapped into my right hand meant I had a contracture and surgery would need time to recover from.

"But my decision was influenced when I got back to my office at 6 am after operating all night . I turned on my computer to find a message from the medical director saying he would not sign off my revalidation because my personal development plan was not up to scratch.

"What was wanted was ticking boxes, which bears no relation to medical or surgical competence. Like a lot of my senior colleagues who have decided to stop work earlier than planned, I am weary of the regulation system. It means we focus on ourselves when we should be focusing on patients.

"I've pioneered use of the artificial heart and am working on implantation of stem cells to reverse heart failure and the development of a new wellness service supported by the Welsh government to bring care out of acute hospitals.

"I've written 15 textbooks and more than 350 peer reviewed articles, and I'm educating people constantly. I don't have a lot of time to spend going through websites and accruing CPD points.

"The whole revalidation issue was a response to the Bristol scandal and then Shipman. But it has now put every medical practitioner on the back foot.

"And publishing death rates for individual surgeons compounds this. Most deaths are related to team dynamics and hospital infrastructure rather than surgical error.

"REVALIDATION HAS PUT MEDICAL PRACTITIONERS ON THE BACK FOOT"

"Publishing surgeon specific mortality shifts emphasis from patient care to self preservation. Surgeons struggle to maintain low death rates in outdated facilities with inconsistent teams and without circulatory support devices available elsewhere.

"We've got the perfect storm of trainees being deterred by working conditions and Department of Health policies; falling numbers going into a lot of specialties; and seniors being frustrated by time consuming revalidation procedures and by individual surgeons' death rates. This leads to risk averse, defensive behaviour, with a stressed profession not happy to innovate.

"We need to be able to try new approaches or patients will miss out. Ditch the 'name and shame' culture and give us the tools to do the job."

Stephen Westaby's book tracing his career in cardiac surgery, *Fragile Lives*, was published this week (Harper Collins, ISBN 9780008196769).

Susan Mayor, London **Cite this as: *BMJ* 2017;356:j769**

Professional football may be linked to brain injuries seen in boxing

Playing football at a high level may lead to the same kind of brain injuries as boxing, postmortem studies at the Institute of Neurology in London have found.

The brains of six dead male footballers, all of whom had dementia, were examined, and four showed signs of chronic traumatic encephalopathy (CTE), a characteristic pattern of damage that is nearly universal in the brains of boxers but uncommon in the general population.

Although the numbers were small the results suggested that repeated heading of the ball, together with other head impacts from collisions and falls, can cause damage leading to dementia. But the analysis was complicated because the six brains also all showed changes characteristic of Alzheimer's disease.

"CTE has been found in 100% of the brains of boxers, but only 6% of the general population," Helen Ling, lead author of the study, told a briefing at the Science Media Centre in London. "In addition, we know of three other case histories of footballers found to show CTE post-mortem."

While Alzheimer's and CTE are both linked to depositions of tau protein in the brain, the way tau is distributed in the brain is different in CTE, said Ling. The researchers concluded in *Acta Neuropathologica* that, while the study does not provide "a firm causal relationship" between CTE and the repetitive head impacts of playing football, it does indicate a pressing need for

Healthcare regulation will change, government says

Major changes to the way doctors and other healthcare professionals are regulated are to be proposed by the UK government within months.

The plans could see doctors and nurses policed by a single regulator or even the creation of a super-regulator to replace the nine that currently cover doctors, dentists, nurses, pharmacists, and other healthcare professionals.

Ministers believe that the current regulatory regime—with separate rules and procedures for the different professions, which have been altered piecemeal over the years—is bureaucratic, outdated, and insufficiently focused on protecting the public.

The proposal could meet resistance. Mark Porter, chair of the BMA's ruling council, said, "Given the diversity of training structures, career paths, and healthcare responsibilities among the different professions, we believe that the public interest is best served by continued regulation of doctors through a separate medical regulator."

Ian Eardley, vice president of the Royal College of Surgeons, said, "Anything that makes it simpler for the public to understand who to contact if they have concerns is a good thing. However, regulators have built up specific expertise and there is a danger of this being lost in a single merged super-regulator covering around a million staff."

New legislation could also provide the streamlined procedures for which the doctors' regulator, the General Medical Council, has long been pressing.

The GMC said that it would not comment before the government issued its consultation document.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;356:j742

MATTHEW VINCENT/PA

larger studies that may lead to ways of mitigating damage.

Suspicion has been growing that playing football at a high level may not be benign, although evidence shows that professional footballers live longer and have much lower risks of cardiovascular disease, said Huw Morris, a coauthor.

The six players whose brains were examined had been part of a cohort of 14 retired footballers who had developed dementia. They were followed until their deaths, and clinical histories, such as concussion data, were collected. When they died their next of kin gave approval for detailed brain examination in only six of the cases: five professional players and one keen amateur, who had played the game for an average of 26 years.

While the study was small it suggested that repeatedly heading the ball "may result in long term brain damage," said Rob Howard, professor of old age psychiatry

The men experienced cognitive impairment from their mid-60s and died on average 10 years later. Concussion was rare, leading to the conclusion that a multitude of minor impacts had caused the damage rather than a few major ones. Although they had all played in the era of leather balls, which became much heavier in wet conditions, the researchers warned that modern footballs may do as much damage.

Rob Howard, professor of old age psychiatry at University College London, who was not a member of the study team, said, "With the limitation that this is a small and potentially unrepresentative sample, the demonstration of CTE in the brains of soccer players is important. We've known that the concussive impacts of American football players can lead to this pathology, but this paper suggests that aspects of 'real' football—perhaps repeatedly heading the ball—might also result in long term brain damage."

He warned against drawing sweeping conclusions. "It may only be individuals who suffer the most repeated minor head trauma who go on to develop these problems," said Howard. "It is premature to be too alarmed about the dangers of routine amounts of heading."

Nigel Hawkes, London

Cite this as: *BMJ* 2017;356:j811

Surgeon is investigated over alleged unnecessary operations

Police are investigating allegations that a consultant orthopaedic surgeon profited from carrying out unnecessary operations on NHS and private patients at a private hospital.

BMI Healthcare's Fawkham Manor Hospital in Kent withdrew practising privileges from Mohammed Suhaib Sait (right) last July after it was contacted by Kent Police. BMI Healthcare, which has suspended Sait's admitting privileges at all of its hospitals, has commissioned its own independent investigation.

"Kent Police is investigating an allegation of fraud relating to payments made for surgeries carried out at Fawkham Manor Hospital in Manor Lane, Longfield," the force said. "No arrests have been made and inquiries are ongoing."

Many of the operations were carried out on NHS patients, raising questions about the oversight of contracts between the NHS and private hospitals to treat NHS patients, paid for from the public purse. Almost 42% of BMI Healthcare's activity is for the NHS.

Many of the procedures involved arthroscopy, keyhole surgery on the knee or other joints. The central allegation is believed to be that the procedures were unnecessary or inappropriate for the patient's condition.

Sait continues to work as an NHS consultant for Dartford and Gravesham NHS Trust at Darent Valley Hospital. The trust said that it was aware of the Fawkham Manor investigation, was in close liaison with the team there, and awaited the outcome of the formal investigation there. "We will at all times act appropriately, taking into account any evidence that is presented to the trust," it said.

Reports prepared by other orthopaedic surgeons after Sait was suspended from Fawkham Manor were leaked to the Bureau for Investigative Journalism. According to the bureau, one surgeon who reviewed 33 cases estimated that half the procedures had been unnecessary or needed further review. Another, who reviewed 15 cases, questioned treatment in 14.

"One surgeon who reviewed 33 cases estimated that half the procedures had been unnecessary or needed further review"

The police were alerted to concerns about Sait's private practice by insurer AXA PPP, which told *The BMJ* that Sait was suspended immediately and investigations were ongoing.

Sait declined to comment on the investigation.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;356:j714

NHS staff are key to meeting productivity challenges, says former health secretary

Productivity in the NHS will not improve unless staff are given support to change the way they work, former health secretary Stephen Dorrell has said.

Speaking at a Westminster health conference in London on 9 February, Dorrell said that people were key to improving productivity in the NHS because "health and care services are a people business."

Dorrell, who is now the chairman of the NHS Confederation, said that productivity could be delivered in other sectors through the use of technology, but that this wasn't possible in the same way in the NHS.

"It is about how we enable people to use their skills differently, organise work patterns differently," he said. "Productivity in health and care services is about how the user experience of these services is delivered by people working differently."

He added, "There is no point talking about workforce issues on one day and productivity challenges on the next day; they are one and the same thing. That is something that is key for us to understand. Productivity challenges are challenges about how the committed workforce of the health and care systems deliver those services."

Dorrell's comments echoed those made by Anita Charlesworth, director of economics and research at the Health Foundation, earlier in the day. She said that the bulk of the £22bn efficiency savings the NHS has been challenged to make by 2020 would come from the secondary care sector.

"There is no point talking about workforce issues on one day and productivity challenges on the next day; they are one and the same thing"

"Over two thirds of the costs of secondary care providers is their pay bill for staff," she said. "So actually this is often referred to as back office savings which is an utter misnomer. The vast bulk of the savings here don't come from changing procurement, important as that is, they come from teams working differently to unlock productivity improvements."

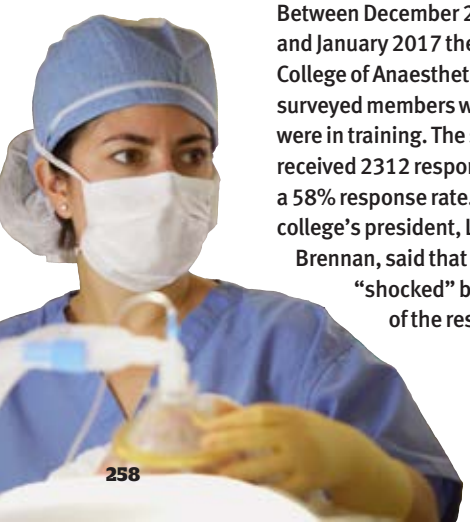
Also speaking at the conference, Grant Fitzner, economics director at NHS Improvement, said that a greater focus was needed on enabling existing staff to work differently. "To my mind the biggest gap is around the lack of focus on the existing workforce," he said. "Yes we can train new doctors and nurses and advanced nurse practitioners and physician associates, but actually most people who will be delivering new care models are the existing workforce."

Fitzner also argued that there was a lack of clarity around who was ultimately responsible for NHS workforce issues. He said, "I've worked in this area for five years and it's always felt somewhat disconnected and that different bits are doing their own thing and sometimes they work in alignment." He hoped that the Department of Health's workforce strategy, which is due to be published later this year, would bring some clarity to this area.

Abi Rimmer, BMJ Careers

Cite this as: *BMJ* 2017;356:j787

FIVE FACTS ABOUT CONDITIONS IN ANAESTHETICS TRAINING



Between December 2016 and January 2017 the Royal College of Anaesthetists surveyed members who were in training. The survey received 2312 responses, a 58% response rate. The college's president, Liam Brennan, said that he was "shocked" by some of the results

1 Workload

Almost all of the trainees (95%) said that in the previous month they had stayed on at work after their shift. Two thirds (65%) had stayed 1-2 hours longer, and 26% had stayed more than two hours. Nearly two thirds (62%) said that in the previous month they had gone through a shift without a meal.

2 Health

Sixty four per cent of the anaesthetics trainees thought that their job had affected their physical health, and 61% thought it had affected their mental health. The college said that the negative effects on physical and mental wellbeing seemed to be worst after core training and before trainees became fellows.

3 Morale

Trainees were asked what sapped their morale. The top five factors reported to affect morale negatively were work-life balance, the burden of assessment, career uncertainty, frequent rotations, and terms and conditions of service.

Productivity in the NHS grows for fifth year running, data show

Productivity in the NHS has grown for the fifth year running, Office for National Statistics (ONS) data show.

To calculate the figures, the ONS adjusted measures of the output of the health service for improvements in quality, and then compared total healthcare outputs in the UK from 1997 to 2014 with total healthcare inputs over the same period. It found that outputs had grown by 5.2% in 2014, while inputs had grown by 2.8%, implying a net growth in productivity of 2.3%.

From 1997 to 2014, inputs to the health service grew by an average of 3.8% a year, though after 2009 the growth in inputs slowed to 1.7% a year. Measured inputs encompassed labour costs, goods, services, and the depreciation of NHS assets. Outputs were defined as the number of individual healthcare activities performed, adjusted for quality.

For hospital and community health services, quality adjustment was based on short term survival rates, health gains, and waiting times. For primary care, quality was the percentage of patients meeting particular physiological targets. Further adjustments were made on the basis of the National Patient Survey, and these factored in patients' experiences of the NHS. The overall quality adjustment tended to be positive over the study period, adding approximately 0.5% annually to the output growth rates.

The ONS report showed stronger growth than previously published figures for the same period

The ONS report showed stronger growth than previously published figures for the same period from the Health Foundation and the Centre for Health Economics. But the scope of the ONS's report differed, in that the ONS surveyed the whole of the UK, rather than just England, it looked at both primary and acute care, and it adjusted for quality.

Matt Wilkes, *The BMJ*

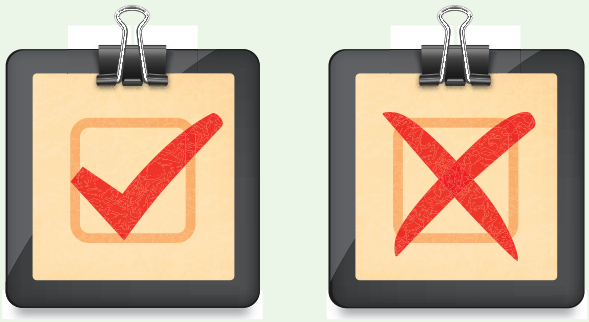
Cite this as: *BMJ* 2017;356:j786

4 Patient safety

The survey asked trainees what they thought worsened patient safety. The three most commonly cited factors were lack of available hospital beds, staff morale, and rota gaps in the medical and allied health professions. The college said that trainees were being asked to fill a gap in rotas on average six times a month.

5 Burnout risk

A total of 1801 respondents answered optional questions to screen for the risk of burnout. The survey found that 85% of respondents had a high risk of burnout. This risk was common across grades but was higher among acute care common stem (ACCS) trainees in the junior training grades and among the pre-fellowship senior training grades.



Trainees dissatisfied with "tick box" annual review

Trainees are dissatisfied with the "tick box" nature of the annual review of competence progression (ARCP), researchers have found.

Researchers from UCL Medical School surveyed 96 trainees and 41 trainers about their perceptions of the validity of the ARCP. They found that there was "general dissatisfaction with ARCPs, especially among UK graduates," and although trainers tended to view the process more positively they did voice negative views.

The paper, published in the *Journal of the Royal Society of Medicine*, said, "ARCPs were described as a 'tickbox exercise' in 27 of the 65 interviews and focus groups; this was generally a criticism of populating the e-portfolio. ARCPs were felt to test clerical ability rather than clinical ability which some believed were inversely correlated."

One of the authors of the paper, Rowena Viney, said that trainees found ARCPs most useful when they had a good relationship with their trainer, and when their trainer showed interest in their progress and completed paperwork on time.

She said, "There is some confusion about the summative versus formative nature of the assessment, which needs to be considered, especially as trainees valued the feedback that they received from the more formative elements of the assessment and believed that the emphasis on minimal competency could discourage excellence."

Wendy Reid, director of education and quality at Health Education England, recently told *The BMJ* that her organisation would be reviewing the ARCP process this year.

"There's a sense that doctors in training in the UK are heavily regulated, and quite rightly," Reid said. "However, the ARCP process is delivered in multiple ways across England. Even in the same specialty there are variations across different parts of the country."

Viney said that some of the trainees who took part in the research said that they had experienced differences in how the ARCP process was conducted in different specialties and in different deaneries and local education and training boards.

"In light of this it would be useful for more research to be conducted on how much variability there is, why, and what effect it has, as this would be particularly useful to feed into the current review of the ARCP," Viney said.

Abi Rimmer, BMJ Careers

Cite this as: *BMJ* 2017;356:j788

THE BIG PICTURE

Keep the door open for child refugees

Simon Wessely, president of the Royal College of Psychiatrists, drew on his family's story of the Kindertransport children, arguing that the United Kingdom should not close the door to unaccompanied child refugees.

Pictured right are child refugees arriving from Vienna at London's Liverpool Street station in 1939. Between 1938 and 1940 over 9000 children, most of them Jewish, were brought from Germany, Austria, Czechoslovakia, and Poland to the UK.

On our relaunched BMJ Opinion site (see Editorial, p 264), Wessely explains how his father, Rudi, similarly came to Britain at the age of 13 on a train from Prague (http://bit.ly/simonwessely). On the same train were boys named Alf Dubs and Petr Schiller, who Wessely met recently.

Wessely wrote, "What happened to Alf? He went into politics, became the Labour member for Battersea, and on his retirement joined the House of Lords. As the Syrian refugee crisis deepened, Alf decided to do something, drawing on the legacy of the Kindertransport. Last year he introduced an amendment to the Immigration Bill that would mandate the government to arrange to bring to the UK refugee children who were trapped in Europe. Initially, he proposed 3500 children for the scheme, but later withdrew an exact figure. Instead, the government agreed to let in 400. But the government got into hot water when it seemed that it was stopping the scheme before it had reached even that modest target.

"[Given] the scale of the Syrian refugee crisis, even if the government… returned to the original figure of 3500 isolated children, the Dubs amendment would barely dent the scale of the problem.

"But that misses the point," says Wessely. "Sitting in some squalid camp somewhere in Europe are children just like Rudi, Petr, and Alf. And if they came to this country, they too would be as grateful to our country as Rudi, Petr, and Alf were. And 50 years later we would see another generation of former refugees giving back to society something of what they had received, by their own charitable and humanitarian activities."

Tom Moberly, *The BMJ*

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Simon Wessely's father Rudi (below right); Rudi's visa for UK entry (top left); Rudi, with grandsons Ben and Alex, and Simon (bottom left)

GEORGE W HALES/FOX PHOTOS/GETTY IMAGES

EDITORIAL

Engaging with China on organ transplantation

Stop all professional engagement pending transparency about procurement and accountability for past abuses

AFP/GETTY IMAGES

In 2005, one of China's most prominent liver transplant surgeons travelled to the far western province of Xinjiang. There he performed a highly complex autologous liver transplantation. The patient's liver was explanted, the cancer excised, and the liver retransplanted.

As a backup to this innovative, risky procedure, the surgeon ordered two extra livers by phoning hospitals in Chongqing and Guangzhou. These were delivered the next morning.[1-4] Such events are unimaginable in systems where organs are freely donated, scarce, and allocated according to need. In China in 2005, most organs for transplants came from executed prisoners.[5]

This incident was widely reported in the Chinese media, identifying the surgeon as Huang Jiefu, familiar to many in the West as the official spokesperson for China's organ transplantation system. In February, Huang represented China at the Pontifical Academy of Sciences (PAS) summit on organ trafficking and transplant tourism at the Vatican. There he will, according to the official Communist Party newspaper, *People's Daily*, "share with the world China's solution to organ donation and transplantation: 'The Chinese Path.'"[6]

We wholeheartedly support the PAS's commitment to exposing and combating human exploitation, commodification, trafficking, and other human rights abuses associated with the sale of organs. But in tackling these issues, the global community must consider the question of when and how to engage with an organ procurement system as deeply compromised as China's.

Researchers believe that the majority of organs come from prisoners of conscience, who are executed without due process

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Current professional interactions with Chinese transplant doctors are guided by the international Transplantation Society's 2006 principles, which endorse a "cooperation" philosophy: "Interaction with Chinese officials is the only true route to effect long term change."[7] In issuing these principles, the society acknowledged that the situation in China was unique, relying as it did on the organs of executed prisoners. However, the term "executed prisoners" obscures the distinction between people sentenced to death by the Chinese criminal justice system (who, by law, must be executed within seven days) and prisoners of conscience killed extrajudicially. Researchers believe that the majority of organs come from prisoners of conscience, who are executed without due process.[8]

Slow progress

Since January 2015, China has vowed to halt the use of organs from executed prisoners.[9] After a pilot in 2010-14, a procurement programme using donated organs from people who meet circulatory death criteria was rolled out nationally. There are now national transplantation registries and organ procurement organisations. Yet there is no new law or regulation in China banning the use of organs from executed prisoners. Nor have existing regulations permitting the use of prisoners' organs been rescinded. Prisoners remain a legal source of organs if they are deemed to have consented before execution, thus permitting ongoing retrieval of organs from prisoners executed with or without due process.[10]

The transplant registries are not open to public scrutiny or independent verification. Inexplicably high volumes of transplantation continue to take place in China,[8] and wealthy foreigners can still obtain liver and heart transplants, booked in advance.[11] The Transplantation Society's former president Francis Delmonico acknowledged under oath at a recent US Congressional hearing that he cannot verify claims about reform in China.[11]

Given the nature and magnitude of the allegations against China, we suggest that the international medical community demand accountability and transparency regarding organ procurement in China and withhold further international recognition until this is delivered. All professional engagement with Chinese transplant surgeons should be suspended.

States can introduce legislation to limit and punish transplantation tourism[15 16] and can refuse to issue international visas for people who have been involved in organ harvesting. We need independent scrutiny of Chinese practice by an appropriate international body with the power to perform unscheduled visits and interview donor families, as well as publicly accessible transplant registries. Evidence of Chinese legal reform should include rescinding the 1984 regulations permitting the use of prisoner organs, with criminal punishments for those who breach the new legal framework. Finally, those who have committed crimes or been complicit in forced organ harvesting must be brought to account.

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EDITORIAL

Making "health tourists" pay for care

A pointless and damaging distraction from bigger problems in NHS

The recent announcement by the secretary of state for health that all hospitals will need to charge patients not eligible for free NHS treatment before they receive non-urgent care seeks to address this in England.[3] Similar discussions are occurring elsewhere, including in South Africa[1] and Thailand.[2] The question is, will it work?

The first barrier to success is the lack of a unique identifier of eligibility to NHS care. Passports or utility bills are not reliable indicators. Research funded by the Department of Health showed that British expatriates, holding British passports but no longer eligible for NHS care, incur the highest average cost of all visitor types.[4] Given the chequered history of information technology in the NHS, implementing a reliable system of identification that will cost less to run than the amount to be recovered is likely to prove challenging.

Upfront charges will have an unknown effect on front line clinical care and public health

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Barriers to success

Moreover, the Public Accounts Committee found that the NHS charged only 16% of the total possible amount for visitors from the European Economic Area (EEA), compared with 65% for those from other countries. EEA visitors thus seem to be the prime target for any identification system.[5] Yet, with just two years to go until Brexit, any system designed to improve cost recovery under European Union rules would not seem the best use of stretched resources.

Secondly, upfront charges will have an unknown (but likely adverse) effect on front line clinical care and public health. At what point, and by whom, will patients be identified and told that they cannot have a clinically necessary procedure until they pay for it? Whenever clinicians discuss eligibility based on criteria other than clinical need, this changes the doctor-patient relationship from advocacy to adversary.[6] Misinformation about eligibility could easily dissuade hard-to-reach populations from accessing healthcare when they need it, hampering the control of communicable diseases and increasing the burden on emergency care as treatable conditions are ignored for fear of payment.[7]

But even if these difficulties are dealt with, how much does the NHS actually stand to gain? The Department of Health's target of £500m to be recouped annually is based on modelling that made a large number of assumptions: the number of irregular migrants comes from out-of-date population estimates, while estimates for health tourism "are a structured judgment."[4] The health department has acknowledged to the Public Accounts Committee that this figure should not be regarded as "overly scientific" and should be viewed as a "stretch target," admitting that only £346m would be charged.[5] This more realistic amount is around 0.3% of the total NHS England budget of around £116bn.

No reliable data

Reliable figures on health tourists are hard to come by. Analysis of the International Passenger Survey showed around 52 000 foreign patients coming into the UK for treatment annually.[8] However, this figure includes people visiting the UK with the intention to pay for their care. These people are particularly lucrative when compared with domestic private patients.[8] For example,18 hospitals in London receive 25% of their private income from foreign patients, who account for just 7% of their private patients.[8] This income provides important extra revenue to the NHS at a time of stretched public resources.

But there are also 63 000 UK patients, eligible for NHS care, who go overseas for treatment, thus providing a saving for the NHS. Generating a picture of the net effect of patient mobility is thus notoriously difficult and unlikely to be robust enough to base a major policy initiative on.

Given that unrecovered charges from people not eligible for NHS care represent a tiny proportion of the NHS budget, are likely to be dwarfed by the administrative costs, and could have detrimental public health outcomes, it seems an odd policy priority. Rather, their pursuit seems more of a response to the xenophobic overtones of the Brexit movement and a smokescreen to divert attention from the more fundamental issues within the NHS, such as chronic funding crises and staff burnout.

The current debate about overseas visitors and their access to the English NHS highlights not just funding problems within UK politics. More fundamentally, it is about our urgent need to manage international patient mobility at a global level rather than one country going it alone.[1]

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Welcome to BMJ Opinion

A new space for informed debate about facts

In this age of rampant populism, one person's fact is another person's opinion. Facts were once sacred. Now they are faked, twisted, and ignored. If we don't like your fact it becomes an opinion. If we like your opinion it becomes a fact. While we hope that our love of facts is established at *The BMJ*, we have sometimes taken a sceptical view of opinion.

But the world has changed. Opinion is no longer the domain of the ranting egotist with snake oil to sell. Opinion is now respectable, valuable, and essential. When we're struggling to make sense of these maddening times, an opinion piece can separate fact from fake fact. It can inform, inflame, and console. Importantly, it can help us organise our thinking and motivate us to take action. It can do these things quickly. Opinion can save the world, or in the wrong hands destroy it. Against this backdrop we are relaunching our popular blogs site as BMJ Opinion (http://blogs.bmj.com/bmj/).

Opinion is no longer the domain of the ranting egotist with snake oil to sell

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From slow beginnings…

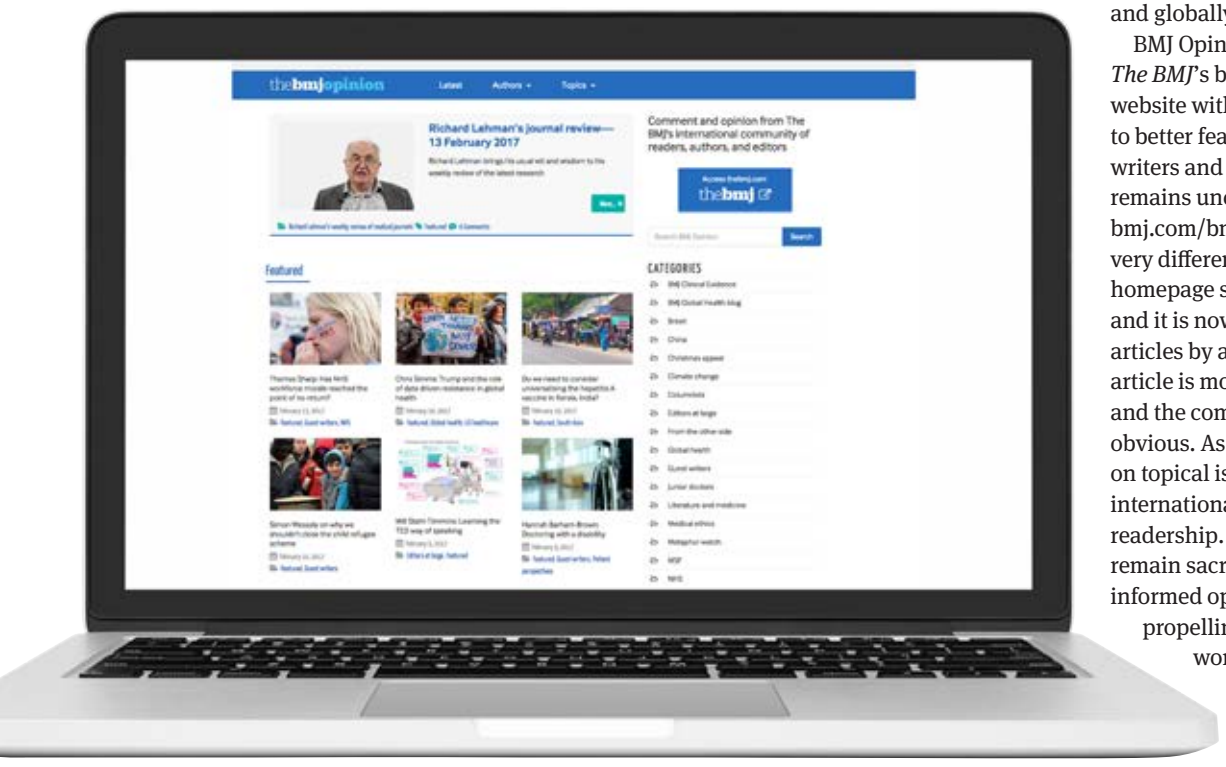
The BMJ took to blogs slowly. Writing in 2004, former editor Richard Smith described a trip to the World Economic Forum in Davos, commenting on everything from a talk on information overload to a speech by Dick Cheney, then vice president of the US, taking in the food and his travel. This was our first blog, and the next was published two months later. It was a further two years before Richard Lehman started a weekly review of the general medical journals. Blogging was then the currency of opinion online. It allowed people beyond the mainstream media to join local, national, and global conversations, and the world was richer for these newfound freedoms.

…to a vibrant forum

Although *The BMJ* was late to the delights of blogging we now publish around two or three posts a day, from a wide range of international writers across many different specialties. Recently, we've published blogs about female genital mutilation in India, China's two child policy, the difficulties and rewards of general practice in a Brazilian favela, the UK's health service crisis, and, inevitably, the deeds and misdeeds of Donald Trump. We also feature regular contributions from patients. *The BMJ*'s blogs are popular, achieving more than 50 000 page views a month.

But we can't justify calling these articles blogs anymore. Most are commissioned, and all of them are professionally edited and curated. We don't turn our online space over to a blogger and say, do what you will. Instead, these articles are best described as online opinion pieces that we can publish quickly. The speed with which we are able to publish means that we can react immediately to developing events, both in the UK and internationally, as we did with last year's UK junior doctors' strikes and Brexit vote, and are now able to do in response to Trump's divisive agenda in the US and globally.

BMJ Opinion, our new name for *The BMJ*'s blogs, offers an improved website with mobile optimisation to better feature the quality of writers and writing. For now, the url remains unchanged (http://blogs.bmj.com/bmj/), but the pages look very different. A new BMJ Opinion homepage showcases more content, and it is now easier to find articles by author and topic. Each article is more clearly presented, and the comment function more obvious. As ever, we welcome debate on topical issues of relevance to our international medical and healthcare readership. Although facts must remain sacred, our belief is that informed opinion has its place too in propelling us towards a healthier world.



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BRIEFING

GPs and private work

Recent reports of an NHS general practice in Dorset offering private consultations on its premises have sparked debate about what is acceptable, as **Gareth Iacobucci** explains

What private work can GPs do while working for the NHS?

General practitioners working in the NHS under General Medical Services (GMS) or Personal Medical Services (PMS) contracts are restricted in terms of the private practice they can offer to their NHS registered patients. However, they are permitted to charge NHS patients for a limited list of services such as travel vaccinations, injury or sickness certificates for insurance purposes, and holiday insurance certificates.[1]

Neither GMS nor PMS contracts preclude practices from accepting private patients for care, but patients cannot simultaneously be registered as NHS and private patients with the same practice.

There is a 10% limit on private earnings within the practice premises. If a GP earns more than 10% private earnings from his or her practice's premises then their cost or notional rent reimbursement they receive from the NHS will be reduced accordingly (eg, a practice earning 20% of its income from private earnings will have a 20% cut in notional rent).[2 3]

How many GPs are doing private work?

It is difficult to track the number of GPs carrying out private work because data are not collected centrally. Healthcare analysts LaingBuisson estimated in 2011 that private general practice amounted to around seven million consultations a year, or around 3% of GP consultations.[4] The paucity of data makes it equally difficult to know whether this proportion has risen since then. But various things indicate that the number of GPs doing private work could be rising. Uber-style services like Doctaly and Babylon, which exploit patients' demand for quicker appointments, are booming.[5] And in Oxfordshire GP leaders are pursuing a plan that would enable NHS GPs to charge fees for carrying out non-contractual work by developing third party companies.[6]

How much do GPs earn from private work?

GPs are not required to differentiate between NHS and private earnings on self assessment tax returns so it is not possible to separate the two. The average income for NHS GPs—including partners and salaried GPs—was £90 600 in 2014-15.[7] This translates on average as £101 500 for partners and £53 600 for salaried GPs. These figures include part time and full time doctors; data are not separated to show an average full time salary.

Full time salaried GP jobs in the private sector can offer up to £90 000 a year.

Are the lines between private and NHS care becoming increasingly blurred?

It would seem so. Dorset Private GP[8]—a service run from an NHS practice that charges £40 for a 10 minute phone consultation, £80 for a 20 minute face-to-face appointment, or £145 for a 40 minute appointment—is not the first example. But Jonathan Ashworth, the shadow health secretary called it, "the thin end of the wedge" and the latest sign that the NHS is headed towards a two tier system. Although the practice is operating within the rules because it is open only to people not registered with the practice, NHS England's head, Simon Stevens, has said the arrangements seem "questionable."[9]

BMA ethics guidance states clearly that doctors should not put pressure on patients to seek private treatment or initiate discussion about private practice with patients on their NHS list.[10] But if more areas follow Oxfordshire and Dorset's lead, the line between NHS and private work will become increasingly faint.

How much is this contributing to the shortage of GPs?

The lack of data on GPs' private work makes it hard to determine how it is affecting the NHS workforce. But the BMA says that the number of GPs doing both NHS and private work remains small and that most GPs still work full time for the NHS. But if more GPs consider options such as those described above, it stands to reason that they will have less time to spend seeing NHS patients and that this may exacerbate the overall shortfall.

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DRUG DEPENDENCY

A plan for addiction in America

Doctors can reduce the misuse epidemic, the US surgeon general recently told **Richard Hurley**

"If we're really going to address not just the opiate crisis but addiction in America we need the medical profession to be a key part of the solution," implores Vivek Murthy, the US surgeon general, when I interview him for *The BMJ*.

Describing the country's epidemic of drug addiction as a "crisis" and a "moral test for America," he calls for "a cultural shift in how we think about addiction."

Clinicians have an important role, he says, not just in their prescribing practice but also because "they have the ability to reframe how our country thinks about addiction.

"For far too long addiction has been looked at as a character flaw or a moral failing," he says. "It's been looked at differently from other illnesses like diabetes and heart disease—with more judgment. Many people with addiction have not felt comfortable coming forward and asking for help."

"This is a public health problem that requires a public health solution. We now have evidence based treatment strategies that work," he says. "The challenge is ensuring that we get these to the people who need them."

"We are losing thousands and thousands of people each year to prescription opioid and heroin overdoses"—Vivek Murthy

He wants more clinicians to have training to screen for, recognise, and treat substance use disorders because, he says, "Only one in 10 people actually gets treatment. That's a massive gap that we have to close."

To this end, in November he published the first surgeon general's report on alcohol and drugs, *Facing Addiction in America*. The surgeon general reports, which reflect key current public health concerns, are highly regarded and have prompted major public health initiatives. The latest report offers evidence based strategies to help healthcare professionals and policy makers and is accessible to the general public.

As an internal medicine physician in Boston, Murthy saw the damage that opioid dependency inflicts on the lives of patients and their families. And as surgeon general he has seen people affected by substance use disorders in "every community he has been to, all around America."

Inadvertent overprescribing of opioid painkillers such as oxycodone has fuelled the epidemic, Murthy confirms. "We urged doctors and nurse practitioners to be more aggressive about treating pain without giving them the tools or the training to do so safely and effectively," he explains. "And the result is that we had an increase in inappropriate prescribing.

"We've seen the prescription opioid epidemic feed into what has become an even larger heroin epidemic. We've seen it contribute to the spread of HIV and hepatitis C through the sharing of needles." Now, he says, "we are losing thousands and thousands of people each year to prescription opioid and heroin overdoses."

Pledges for prescribing

In 2016 Murthy wrote to 2.3 million healthcare professionals, including doctors, dentists, and nurse practitioners asking them to pledge to lead efforts to turn the epidemic around and highlighting guidelines for the rational prescribing of opioids (http://turnthetiderx.org).

PATIENT VIEW

Kelly Young

It's harder now to get the pills I need

In 2011 my US doctor was no longer allowed to order my prescription electronically; instead I had to carry it to the pharmacist. Soon after, my regular drive through pharmacy insisted that I come inside the store with identification. These were minor inconveniences.

In 2014, Florida began a severe crackdown on painkillers. People have humiliated me in their attempt to comply with the law. One practice I had never visited before demanded I urinate in a cup on arrival. Once I told an intrusive pharmacy technician, "You have no idea why I need that medicine. It's not your role to approve or disapprove."

People could no longer get their prescriptions from their doctors but were forced to visit specific pain clinics, an added expense for people with chronic diseases who already pay high costs. Prescriptions were limited to 30 days, requiring additional visits for refills.

People like me with complex chronic medical conditions have legitimate need for long term prescriptions for controlled medications. Patients need not be harmed by reasonable measures to prevent medication misuse. Patients are not harmed when illegitimate "pill mills" are shut down, such as in Florida's crackdown. However, creating an atmosphere of fear among pharmacists and medical professionals can harm patients without having any effect on the conduct of irresponsible prescribers.

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WHO IS THE SURGEON GENERAL?

Vice Admiral Vivek H Murthy was confirmed as the 19th surgeon general in 2014.

As "America's doctor," his mission is to communicate scientific information to advance personal and public health. Murthy holds a bachelor's degree from Harvard and MD and MBA degrees from Yale. He completed residency training in internal medicine at Brigham and Women's Hospital and Harvard Medical School in Boston before joining the faculty.

The surgeon general's reports are landmark scientific publications that highlight urgent public health concerns. The first, in 1964, on smoking, is revered as having prompted a new era of tobacco control. The latest is on addiction.

"Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly—almost enough for every adult in America to have a bottle of pills," he wrote.

Murthy also thinks healthcare professionals should be advocating for and speaking up for patients and calling for more investment in treatment and prevention programmes.

"More often than not clinicians are reluctant to step up and make their views known," he says. "They're reluctant to meet with policy makers." This is not going to get the result Murthy wants: "If we only operate in the clinics, and if we don't have a larger voice in the public sphere to call for changes to our healthcare system, then we're not going to be able to help our patients as much as they need."

Crime and punishment

But how can stigma surrounding drug dependency be removed while possession of even small amounts of some substances is a crime and punishable? Murthy's report makes little mention of growing calls, including from *The BMJ*, to consider decriminalisation of small scale drug possession. Evidence from Portugal, for example, has indicated that such a move can help reduce harms associated with drug use.

Murthy points to existing US programmes that circumvent the criminal justice response. "We have more than 3400 drug courts in operation across the United States which serve more than 55 000 people annually," he explains. But this is a drop in the ocean, Murthy acknowledges: "One million offenders with substance use disorders pass through the United States criminal justice system each year. So we have more to do."

Murthy thinks President Trump's new government will continue support for his approach. "It's been an issue that Democrats and Republicans very much care about.

"[Drug dependency] affects people of all racial and ethnic groups and certainly people of all political persuasions."

But repeal of the Affordable Care Act puts 20 million people's coverage at risk, including treatment for substance use disorders.

"We have to make sure that we don't lose ground when it comes to coverage," says Murthy, but he admits that he is "encouraged" by the bipartisan support he's received for tackling America's addiction.

Of doctors, he tells me, "Our role is not just to care for the individual patient but also to care for the entire community. And the more we're able to embrace that role, the more we're able to advocate for system changes that will serve them and their families."

The report's foreword seeks comparisons with the first surgeon general's report published in 1964 on smoking, which preceded half a century of tobacco control efforts helping US smoking rates plummet from 42% to 16%.

"I'll leave it up to history to determine whether our current report has as much impact," quips Murthy.

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AMERICA'S MISUSE EPIDEMIC

- 48 million Americans misused an illicit or prescription drug in 2015
- More than 20 million US residents have a substance use disorder
- Healthcare, lost productivity, and criminal justice drain more than $400bn a year
- 47 055 people died from drug overdose in 2014, with 28 647 deaths associated with opioids, including prescription painkillers and heroin—the most ever recorded

COMMENTARY

Michael H Basler

Could we see similar in the UK?

A recent UK report from the charity Drugwise has highlighted misuse of prescribed substances. The report says prescriptions for opioids increased 400% in the past decade and those for antidepressants by 500% since 1992. But the degree of our misuse problem is unclear because we lack adequate data, particularly about diagnoses.

Prescription rates cannot differentiate patients with musculoskeletal pain who rely on a mid-range analgesic to function at work from the "Hartlepool housewives" who the report says are using codeine just to "get through the day." When looking at antidepressant prescribing, how can you tell a functioning person from the addict who adds this to a cocktail of illicit substances?

Our integrated NHS has probably spared the UK from the excesses of the United States' public health disaster. But we should not be complacent. Current figures for Glasgow indicate that tramadol and benzodiazepine use has decreased, but use of stronger opioids and gabapentinoids may be increasing.

For non-cancer pain the prescription of strong opioids in the community needs to be monitored and linked to diagnosis as well as psychological morbidity. This would allow regional comparisons. To prevent another period of opiophobia clinicians need to realise that inappropriate drug use is not inert and can produce harm. Doctors should give patients realistic expectations of what is achievable, particularly with pain. Initiation of medication should be subject to review, and pain relief is not an adequate outcome measure on its own. Polypharmacy of psychoactive substances (including gabapentinoids) in high risk groups should be discouraged unless there are clear benefits.

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ILLUSTRATION: DUNCAN SMITH

Peter Aitken is a consultant psychiatrist at Devon Partnership NHS Trust and chair of the faculty of liaison psychiatry at the Royal College of Psychiatrists, which awarded him this year's psychiatrist of the year award. Liaison psychiatry—providing mental healthcare to those with physical illness—was a latecomer to the UK and is still, he admits, patchily established, but the faculty now boasts more than 4000 members. He tweets as DrP8ken, including mentions of the national lifeboat service (he is medical adviser to the Exmouth crew) and glimpses of working life.

BMJ CONFIDENTIAL

Peter Aitken
Psychiatrist of the year

What was your earliest ambition?
To be a doctor. All my grandfather's fault. He was a surgeon who served in the second world war and told me great medical stories before I could walk.

Who has been your biggest inspiration?
The faculty in the professorial departments of mental health sciences and addictive behaviours at St George's Hospital medical school in the 1990s. They all taught me, and I worked for most of them. Looking back it was a golden era.

What was the worst mistake in your career?
There have been a few. Most memorable was taking pride to straighten a man's toes while an orthopaedic senior house officer, only to find that by lengthening them I'd denied him access to his prized Church's shoe collection. The toes were revised.

What was your best career move?
Liaison psychiatry—all of a sudden medicine made sense.

Who is the person you would most like to thank and why?
The late Matt Holmes for accepting a skinny 17 year old into the University of Glasgow medical school, and Leslie Young, my head teacher, for telling me to go and knock on the admissions office door and ask.

To whom would you most like to apologise?
To my family, for always being on my iPhone.

If you were given £1m what would you spend it on?
Invest, or I'd give small grants to support well planned, good ideas. I'm amazed that it is so difficult to raise small amounts to support and sustain great community projects like our local Neighbourhood Health Watch.

What single unheralded change has made the most difference in your field?
Antipsychotics, without which many would still be in institutional care.

Do you support doctor assisted suicide?
No. I've devoted much of my career to suicide prevention and know that over 80% of high lethality survivors regret the attempt.

What book should every doctor read?
The Nation's Health, from the *Times* in September 1937. It's a fascinating 195 pages, with many great ideas including a Public Health Service and a National Health Service from a time without either.

What poem, song, or passage of prose would you like at your funeral?
Joan Baez's version of "A Hard Rain's A-Gonna Fall." I grew up beside the UK nuclear arsenal, and the fact it's being played means that it hasn't happened.

What is your most treasured possession?
My grandfather's copy of *The Principles and Practice of Medicine* by Osler and McCrae. It reminds me that today's evidence base is only today's evidence base.

What personal ambition do you still have?
To see psychiatry become the discipline that attracts the most talented medical undergraduates and young scientists.

What is your pet hate?
Endless debate about what to call psychiatry and mental illness. As if softer words will ease the centuries of fear.

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