NEWS

UK news Competition watchdog sees sharp rise in inquiries from GP commissioners, p 2
World news Vitamin D supplementation to prevent osteoporosis is not warranted, p 4
References and full versions of news stories are on bmj.com

bmj.com
UK watchdog advises patients to fight for their rights

Competition rules over merger has cost NHS £1.8m

Gareth Iacobucci BMJ

The lengthy battle over the proposed merger of two hospital foundation trusts in England has cost the NHS almost £2m in legal and consultancy fees, a *BMJ* investigation has shown.

Plans to merge the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, first proposed in 2011, were provisionally blocked by the Competition Commission in July, with a final ruling due by 21 October.

The trusts said that the plans were essential to ensure the sustainability of services in the area, but the commission provisionally ruled that the move would reduce patients' choice. The plan has been opposed by BMI Healthcare,[1] which runs a private hospital in Poole.

In response to a request from the *BMJ* made under freedom of information legislation, the two NHS trusts disclosed that they had spent a combined sum of £1.8m on legal and consultancy fees related to the merger, as at August 2013.

The finding came after Stephen Thornton, deputy chairman of the health sector regulator Monitor, recently warned that the government's new competition arrangements for the NHS in England were a "bonanza for lawyers and consultants" and could lead to scandals if money was being diverted from the care of patients.[2]

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust said that costs associated with the planned merger had been met by NHS South of England, the former strategic health authority dissolved on 31 March 2013, and insisted that funding allocated to patient care had not been used to fund legal and consultancy support.

PETER D NOYCE/ALAMY

The merger was opposed by a private company

But the disclosure provides evidence of the huge costs associated with the case, which is the first involving two hospital foundation trusts that have tried to merge—and is widely viewed as a test for future cases.

Royal Bournemouth and Christchurch said, "While the cost of merger has been funded through public money, funding allocated for patient care at the Royal Bournemouth, Poole, or Christchurch Hospitals has not been used.

"The legal and consultancy costs for the proposed merger as at August 2013 were £1 880 000."

Paul Flynn, chairman of the BMA's Central Consultants and Specialists Committee, said that he was concerned about money being diverted from patient care by the new competition rules. "If competition means that money is spent on legal fees and consultancy fees, then it's hard to see that that is going to lead to benefits for patients."

David Lock, a barrister and expert on NHS contract issues, said that the costs were a "direct and predictable" byproduct of the government's NHS changes.

The news came in the same week that Monitor announced it was to investigate a complaint by the private provider Spire Healthcare against two clinical commissioning groups in the north west of England. It accused Blackpool CCG and Fylde and Wyre CCG of directing patients away from a Spire hospital to an NHS hospital.[3] Amanda Doyle, chief clinical officer for Blackpool CCG, was angry at the complaint. She said, "Although we are happy to work with Monitor to assist their investigation, there is not a shred of evidence to substantiate Spire's supposition that we have told GPs to direct patients to any particular provider."

Cite this as: *BMJ* 2013;347:f6246

Australasian college of physicians sacks its ethics committee

David Brill SYDNEY

The Royal Australasian College of Physicians has sacked its own ethics committee just days after the committee produced strict new guidelines on doctors' ties to industry.

The college has also provoked an outcry by refusing to release its guidelines for public consultation, opting for an internal process instead.

The draft *Guidelines for Ethical Relationships Between Health Professionals and Industry* had strengthened the already tough, pro-transparency stance of previous editions. These labelled doctors' use of drug samples and starter packs as "inappropriate," the guidance said, given that these were "primarily a marketing exercise."

The draft guidance also explicitly called on the college to establish processes for publicly declaring its relations with the drug industry and the competing interests of members and office holders—something the college does not currently do.

Three years in the making, the 105 page document briefly appeared on the college's website in early September before being quickly taken down.

Paul Komesaroff, who chaired the guideline working party and also the now defunct ethics expert advisory group, warned that valid public consultation was "critical" to ensuring the legitimacy and integrity of the final document.

In an open letter to the college's president, Leslie Bolitho, which was also signed by 12 working party members, Komesaroff said that the draft reflected "the large volume of data now available concerning the nature and impact of relationships between health professionals and components of industry."

In a statement a spokesman for the college said that disbanding the ethics committee was part of streamlining the organisation's outdated and "overly bureaucratic structure." The move was not linked to the release of the guidelines, which had been circulated to almost 100 parties for feedback, consistent with standard college practice.

Cite this as: *BMJ* 2013;347:f6242

IN BRIEF

Canadian court upholds ban on physician assisted suicide: British Columbia's Court of Appeal has upheld Canada's ban on physician assisted suicide. Last June the province's Supreme Court ruled that the ban on physician assisted dying in Canada's criminal code was unconstitutional,[1] but the federal government appealed the ruling and won. The British Colombia Civil Liberties Association, which backed the plaintiffs in the original case, said that it would now take its fight to the Supreme Court of Canada.

Children must have MMR vaccine, judge rules: A High Court judge has ruled that two sisters, aged 15 and 11 years, must have the MMR vaccine against the wishes of their mother. The children's father had originally agreed with their mother not to vaccinate the girls, but he changed his mind about the safety of the vaccine amid the recent measles outbreak. He took the case to the courts after his divorce.

More hospitals could be investigated in Savile case: England's health secretary, Jeremy Hunt, has asked the Metropolitan Police to look into expanding its investigation into alleged sexual abuse by the television presenter Jimmy Savile after it uncovered new evidence that may relate to health and care settings. Thirteen hospital trusts are currently being investigated. The final reports are expected in June 2014 or possibly sooner.

Surgeons operate more quickly when paid incentives: Surgeons in a Portuguese public hospital took 43 minutes less on average to carry out operations outside their normal working hours when they were paid incentives to reduce waiting lists (83 minutes) than when they were operating during normal working hours (126 minutes), a study presented at the National Health Economics Conference in Braga, Portugal, has found.[2]

Quebec college says no to "degrading" virginity tests: The Quebec College of Physicians has advised its 21 000 members that they must not issue "certificates of virginity" or conduct gynaecological examinations to establish virginity if asked to do so. University of Montreal researchers have recently reported cases of families seeking tests.

Cite this as: *BMJ* 2013;347:f6208

Checking GP patients' citizenship would be "bureaucratic nightmare," says GP leader

Clare Dyer BMJ

Attempts to curb "health tourism" by charging people living in the United Kingdom who don't have permanent rights of residence to access healthcare form part of a wide ranging immigration bill unveiled on 10 October.

GPs have protested that the plans could create a "bureaucratic nightmare," and charities providing healthcare to migrants said that the move would lead to a class of ill people unable to access healthcare.

Under the current rules illegal migrants and short term visitors from outside the European Economic Area (EEA) (those with less than six months' permission to live in the UK) have free access to primary care. They are supposed to be charged for secondary care, but in practice limited checks are made.

The bill would make both groups pay for primary as well as secondary care, and there would be new checks on eligibility for secondary care.

Temporary migrants from outside the EEA—those with at least six months' permission to stay—currently get both primary care and hospital care for free but in future they would have to pay a health surcharge as a condition of entry to qualify for free care at the point of use. A figure of £200 has been mentioned. Short term visitors and illegal migrants would not have the option of paying the surcharge to access care. But the Home Office said that certain categories, including asylum seekers and those seeking humanitarian protection, would be exempt from the surcharge.

The immigration minister, Mark Harper, said, "The Immigration Bill will stop migrants using public services to which they are not entitled, [and] reduce the pull factors which encourage people to come to the UK."

But Richard Vautrey, deputy chairman of the BMA's General Practitioners Committee, told BBC Radio 5 Live that although the system for charging by hospitals could be improved, introducing a system for general practice "could be a bureaucratic nightmare." David Lloyd, a GP in Harrow,

Competition watchdog sees sharp rise in inquiries from GP commissioners

Gareth Iacobucci BMJ

The regulator in charge of overseeing competition in the NHS in England has been deluged by inquiries from the new clinical commissioning groups confused at whether they need to tender services on the open market, said one of the regulator's senior executives.

Catherine Davies, executive director of cooperation and competition at Monitor, said that the number of inquiries rose by 55% in the period May to July 2013 over the monthly average last year. This rise coincided with new laws on tendering for contracts that came into force in April,[1] and Davies said that most requests were from commissioning groups unsure of how the new rules applied to them.

In a discussion at the Commissioning in Healthcare conference held in London on 8 October, Davies said that Monitor had also received inquiries from healthcare providers that believed they had unfairly lost a tender and others from commissioners unclear how the new rules applied to efforts to integrate services.

Davies said that Monitor would shortly be publishing new guidance containing a series of hypothetical scenarios to help commissioners avoid "difficult situations where you find yourselves in breach of the rules."

"Of all the questions that we're asked, the one we're asked most commonly is how we can avoid running a tender," said Davies.

"There, we say to people, 'What work have you done to understand who can provide the services in your particular area?' If there is only person, and you know there is only one, and you've done some market testing, then in that situation there is no point in running a competitive tender. We don't see them as a set of regulations which force commissioners to competitively tender services. Rather, they provide a framework for a series of questions for commissioners to work through. We're working with commissioners to help them all understand how the rules apply."

Davies, who was legal director at the NHS Cooperation and Competition Panel before the organisation was subsumed by Monitor, said that the number of inquiries had risen since new laws governing competition in the NHS came into force in April.

"From 2009 [up to April 2013] the cooperation and competition panel received 1000 queries for informal advice. Since April this year we have been receiving around 55% more requests for informal advice," she said. "What we're trying to do is avoid people getting into difficult situations."

Cite this as: *BMJ* 2013;347:f6137

SALLY AND RICHARD GREENHILL/ALAMY

GPs would have to "act like Border Agency staff"

north London, told Sky News that the changes would mean GPs acting like Border Agency staff.

Paquita de Zulueta, a GP who volunteers at a clinic run by the humanitarian organisation Doctors of the World in Bethnal Green, east London, said, "Many people are afraid to come forward as it is. In the long run it will end up costing more money if vulnerable migrants are forced to go to the already overstretched accident and emergency services."

Cite this as: *BMJ* 2013;347:f6181

Fit for work service led by GPs helped seven in 10 patients avoid long term sickness absence

Zosia Kmietowicz BMJ

Just under seven out of 10 patients in Leicestershire who were potentially heading for long term sickness absence have been helped to stay in work after being referred by their general practitioner to the county's fit for work service.

Rob Hampton, a portfolio GP who runs the service, told the *BMJ* that 94% of general practices in Leicestershire had referred patients who had been off work for four weeks to the service, with 63% referring five patients or more.

The service was one of six pilots funded by the Department for Work and Pensions.

Hampton told the *BMJ*, "The idea was to try and intervene early for people who were heading for long term absence. If you leave it longer than six weeks, then you have missed the opportunity. The government has picked up that to intervene early was worthwhile economically."

GPs still have to write the first fit note for patients they refer to the service, but then that becomes the responsibility of the fit for work team. "Using fit notes as the currency for ability to work is such a powerful thing to do for patients and employers. You can stimulate change just by the wording you use," Hampton said.

The pilots ran for three years from April 2010. During this time the Leicestershire service received 1655 referrals and kept 67% of patients in work.

"The most active intervention was mediation in the workplace and negotiating with employers to help people stay at work," said Hampton.

The Department for Work and Pensions is currently developing proposals for how the national service will work, including who will take responsibility for issuing fit notes, when it is rolled out after April 2014. It says that the service will save employers up to £160m a year in statutory sick pay and increase economic output by up to £900m a year.

Cite this as: *BMJ* 2013;347:f6191

Advice that might have prevented the death of a woman after miscarriage "has been widely ignored"

Muiris Houston GALWAY

A report from Ireland's patient safety watchdog has found that the Health Service Executive failed to act on a series of recommendations made by previous investigations into maternity care, some of which may have helped prevent the death of 31 year old dentist Savita Halappanavar at University Hospital Galway last October.

The Health Information and Quality Authority's investigation into her death from sepsis when 17 weeks pregnant listed 13 "missed opportunities" which, had they been identified and acted upon, might have potentially changed the outcome of her care.[1] These included a failure to comprehensively record four hourly vital signs after the patient's membranes had ruptured; and the failure of staff to respond appropriately, over time, to clinical measurements indicating marked hypotension and tachycardia. It concluded that University Hospital Galway failed to provide Halappanavar with "the most basic elements of patient care."

However, the authority's investigating team had a wider remit to examine the safety of maternity care nationally. It found that only five of the country's 19 maternity units and hospitals were able to provide a status report on the implementation of recommendations from an investigation with many similarities to the Halappanavar case.

The other investigation was into the death of Tania McCabe in 2007 at Our Lady of Lourdes Hospital in Drogheda after delivering twins. The pathologist in that case concluded that the cause of death was as a result of multiorgan failure and postpartum haemorrhage that was due to sepsis.

The report concluded, "The lack of a nationally co-ordinated approach to the implementation of the recommendations of the HSE inquiry into the death of Tania McCabe… raises a fundamental and worrying deficit in our health system."

Cite this as: *BMJ* 2013;347:f6210

BRENDAN DONNELLY/DEMOTIX/PA

Women in Dublin protest that Savita Halappanavar was denied a lifesaving abortion

Vitamin D supplementation to prevent osteoporosis is not warranted, new research concludes

Jacqui Wise LONDON

Taking vitamin D supplements to prevent osteoporosis is not justified in healthy adults, a systematic review and meta-analysis has concluded.

The research, funded by the Health Research Council of New Zealand, included 23 randomised controlled trials of 4000 participants with an average age of 59.[1]

The study, published in the *Lancet*, found very little evidence of an overall benefit in terms of bone density of vitamin D supplementation. Supplementation for two years resulted in no change in spine, total hip, radial, or total body bone mineral density. The only significant increase was found at the femoral neck (0.8% increase (95% confidence interval 0.2% to 1.4%)).

The authors, from the University of Auckland, New Zealand, concluded, "This systematic review provides very little evidence of an overall benefit of vitamin D supplementation on bone density . . . Continuing widespread use of vitamin D for osteoporosis prevention in community-dwelling adults without specific risk factors for vitamin D deficiency seems to be inappropriate."

Writing in a linked comment, Clifford J Rosen, of the Maine Medical Center Research Institute, pointed out that bone mineral density, although widely used as a surrogate measure of fracture risk, is only a modestly good predictor of subsequent fractures in this age group. Nevertheless he said, "Supplementation to prevent osteoporosis in healthy adults is not warranted. However, maintenance of vitamin D stores in the elderly combined with sufficient dietary calcium intake (800-1200 mg per day) remains an effective approach for prevention of hip fractures."

The current recommendation in the UK is that certain groups of people who may not get enough vitamin D as a result of their diet or lifestyle should take a supplement of 10 micrograms a day. These include people who are housebound or keep covered up in sunlight.

Cite this as: *BMJ* 2013;347:f6156

Hydroxyethyl starch solutions should not be used in critically ill, sepsis, or burns patients, confirms EMA

Susan Mayor LONDON

Hydroxethyl starch solutions (HES) should not be used for fluid replacement in critically ill patients or those with sepsis or burn injuries, ruled the European Medicines Agency (EMA) on 11 October after reviewing evidence showing increased risk of death or kidney injury.[1]

But the agency says these commonly used plasma substitutes can be used to treat patients with low blood volume caused by acute blood loss where treatment with a crystalloid infusion solution alone is not sufficient. Potential risks should be minimised by using HES solutions for no more than 24 hours and monitoring the kidney function of patients for at least 90 days.

The agency's pharmacovigilance assessment committee (EMA-PRAC) assessed information on the commonly used plasma substitutes, including meta-analyses showing increased mortality and kidney injury in patients with sepsis and increased risk of kidney injury in critically ill patients after treatment with HES solutions.[2-4]

The meta-analyses excluded trials from Joachim Boldt, a German anaesthetist, some of whose research in the field has been retracted because of scientific misconduct.[5 6]

The committee initially recommended in June 2013 that use of HES solutions should be suspended in all patients. Since then it has considered new evidence, proposals for measures to minimise the risk, and suggestions for further studies.

It concluded that there is clear evidence for increased risk of kidney injury and mortality in critically ill and sepsis patients resulting in the recommendation to avoid HES solutions in these patients. But the committee considered that HES solutions could continue to be used in patients with hypovolaemia caused by acute blood loss as long as clinicians take the recommended steps to reduce risk.

The EMA committee has requested that further studies are carried out on the use of HES solutions in elective surgery and trauma patients.

"Many physicians have, quite correctly, stopped using HES solutions to treat critically ill patients, but the EMA-PRAC recommendation for further study of these drugs in surgery and trauma patients is valid and welcome," said Rupert Pearse, professor and consultant in intensive care medicine, Queen Mary University of London, UK.

Writing in the *BMJ* earlier this year, together with John Prowle, consultant in intensive care and renal medicine at Barts Health NHS Trust, London, Pearse noted that "maintaining effective plasma volume is, perhaps, the most persistent challenge faced by clinicians who treat critically ill patients." They suggested that important lessons have been learnt from the crystalloid-colloid debate, "in particular, our failure to recognise the limitations provided by small clinical trials has slowed progress in patient care."[7]

Cite this as: *BMJ* 2013;347:f6197

Alliance Boots accused of avoiding £1bn in UK tax

Ingrid Torjesen LONDON

Alliance Boots, the parent company of Britain's biggest high street pharmacy chain, Boots, has avoided paying at least £1.12bn in UK tax since it became a privately held company six years ago, by offsetting debt repayments against its UK profits, it has emerged.

The £1.12bn figure is given in a report published on 15 October by the trade union Unite, the antipoverty charity War on Want, and the Change to Win federation of US trade unions.[1]

Alliance Boots has issued a statement claiming that the report contains several inaccuracies and emphasising that it "conducts its business and organises its tax affairs strictly in compliance with all applicable law (including legislation in the UK) and observes the highest standard of good ethics." The statement adds that the company found it "extraordinary and disappointing" that the report's authors had

SCOTT CAMAZINE/SPL

Osteoporosis: people without vitamin D deficiency do not benefit from supplementation

not contacted it during the preparation of the report or subsequently, and it pointed out that no dividends had been paid to shareholders since the privatisation.

In 2007 the multinational company left the FTSE 100, the share index of the 100 companies listed on the London Stock Exchange with the highest market capitalisation, and became a privately held firm in Europe's largest ever leveraged buyout. The transaction was led by the US private equity firm Kohlberg Kravis Roberts & Co and the executive chairman of Alliance Boots, the Italian Stefano Pessina, who lives in tax free Monaco.

The new report says that Alliance Boots took on a £9bn debt to fund the buyout. Although the company operates in 25 countries, largely through its wholesaling business, its more profitable retail business is based mostly in the United Kingdom. By locating almost all of the leveraged buyout debt in the UK, Alliance Boots has been able to offset its finance costs from taxable income in its most profitable market.

The report estimates that during the six years since the buyout Alliance Boots has reduced its UK taxable income by an estimated £4.2bn, saving it £1.28bn in tax.

In 2008 Alliance Boots also relocated to the low tax canton of Zug, Switzerland, even though the company generates no revenue there.[2] The holding company that owns Alliance Boots, AB Acquisitions Holdings, is located in Gibraltar.

Alliance Boots said that, although its registered office was in Switzerland, "we pay the same amount of tax in the UK as we would have paid if we were in the UK."

Cite this as: *BMJ* 2013;347:f6236

Unpublished studies hold twice as much data on drugs as those in the public domain

Zosia Kmietowicz BMJ

Unpublished records of clinical studies provide more than twice as much information about a drug's benefits and harms as those of published reports, a study has found.

The researchers, from Germany's Institute for Quality and Efficiency in Health Care (IQWiG), said that access to clinical study reports (CSRs) was essential for doctors to be able to make fully informed choices about how to treat their patients. They have called for CSRs from past and future trials to be made publicly available.

CSRs hold vast amounts of information on the conduct, adverse events, and outcomes of a trial. They are held by drug companies and form the basis of submissions to drug regulators when a new drug is being assessed for licensing. CSRs have previously been kept secret, but researchers are now realising that they hold valuable information and have been asking to see them.

The AllTrials initiative (alltrials.net), which was set up in January, is calling for full disclosure of CSRs.[1] Similarly, the *BMJ* has been campaigning for researchers at the Cochrane Collaboration to have access to anonymised patient level data on Roche's drug oseltamivir (marketed as Tamiflu), held on CSRs, which the researchers have been trying to access since 2009 (see bmj.com/tamiflu).[2]

For their study the researchers from IQWiG, the German equivalent of the UK National Institute for Health and Care Excellence, compared information from 101 clinical trials in publicly available sources, such as journal articles or reports published on a register, with information in CSRs requested from drug companies.[3]

The trials included 1080 outcomes relevant to patients, including symptom relief, side effects, and mortality data. But although the CSRs provided complete information on 86% of outcomes, the combined publicly available sources provided this on just 39% of outcomes. CSRs also provided considerably more information on harms.

Missing information uncovered by the study included how antidepressants affected symptoms and the adverse events they caused, such as suicidal behaviour and sexual dysfunction; exacerbation of asthma in trials of asthma drugs; and strokes and myocardial infarction rates in trials of diabetes drugs.

The European Medicines Agency (EMA) is finalising plans to make clinical trial data it holds on drugs publicly available from January 2014.[4] In addition, the European Union and the European Commission are considering legal measures to improve the transparency of clinical trial data.

But the researchers pointed out that both these initiatives would probably apply only to drugs that are approved after January 2014 and not to drugs already in use.

They concluded, "CSRs should be made publicly available as they may substantially influence conclusions concerning the actual position of an individual drug in a therapeutic area. Our findings underline the importance of CSRs—both for past and future trials—for unbiased trial evaluation, thus supporting informed decision-making in health care."

However, there are signs that the drug industry will resist attempts to get it to disclose CSRs. In an email to the journal *Nature* Richard Bergström, director general of the European Federation of Pharmaceutical Industries and Associations, said that in their current state CSRs were not suitable for publication.[5] He said that the federation had concerns about how the EMA proposed to protect commercially sensitive and personal details contained in many of these documents. Personal data would need to be properly redacted if these documents were to be made public, said Bergström.

"My members are very concerned about this," he said. "If the EMA accepts our redactions, we have no problem." But he warned that if the agency disregarded the federation's concerns a series of lawsuits against the EMA might follow.

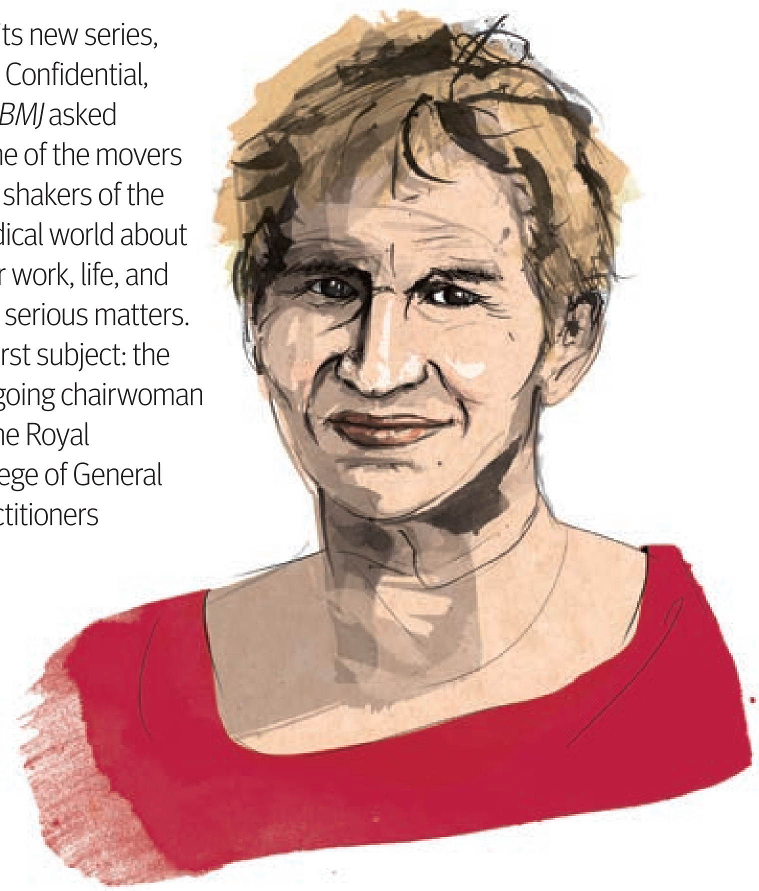
Cite this as: *BMJ* 2013;347:f6179

Richard Bergström, representing European drug companies, said his members had concerns about how personal data would be redacted

Clare Gerada

Best move: “getting into drugs”

For its new series, BMJ Confidential, the *BMJ* asked some of the movers and shakers of the medical world about their work, life, and less serious matters. Its first subject: the outgoing chairwoman of the Royal College of General Practitioners



PETER LOCKE

What was your earliest ambition?
To be a doctor—just like my father.

Who has been your biggest inspiration?
My father. He was a singlehanded GP who started off with a practice in the front room of our house. He inspired me and taught me that to be a good GP you had to be part of your local community and to listen to patients.

What was the worst mistake in your career?
When working at the Department of Health I took away a large file, as part of a major inquiry, to work on at home. I lost the file. I thought it had fallen off my bike and searched and re-searched the whole route but couldn’t find it. I thought my career was over.

It was under the bed.

Who is the person you would most like to thank and why?
My GP partners and past partners, David, Frances, Mark, Cynthia, Arvind, and Murray, for giving me the time and space and support to forge a career within general practice.

What was your best career move?
Getting into drugs. Actually spending time specialising in substance misuse during my psychiatric training, then taking this interest with me into general practice and becoming a big fish in a small sea.

Clare Gerada is a GP in south London and chairwoman of the council of the Royal College of General Practitioners. A vocal defender of the NHS, she sprang to prominence as a leading voice in the opposition to the coalition government’s reorganisation of the NHS in England. She was named in February 2013 by BBC Radio 4’s *Woman’s Hour* programme as one of the most powerful 100 women in the UK.

She is a Twitter addict. Sample tweet: “Psychiatrists should undertake at last six months’ training in primary care—or marry a GP.” She is married to Simon Wessely, a prominent psychiatrist.

Bevan or Lansley? Who’s been the best and the worst health secretary in your lifetime?
The worst was Ken Clarke. He was arrogant, didn’t understand GPs, and brought in the beginning of the purchaser-provider split and a marketised health service. The best was Stephen Dorrell. He was intelligent, in command of his brief, always polite, committed, and listened.

If you were given £1m, what would you spend it on?
Some to my partners to spend on a good night out for putting up with me over the past 20 years. Most to my college, the RCGP, to help develop the next generation of general practitioners.

Where are or were you happiest?
The day I went to see my name on the MBBS finals list outside the canteen at University College Hospital. I rang my father and said, “Hello Dad, this is Dr Gerada.”

What single unheralded change has made the most difference in your field in your lifetime?
The computer. As with all general practices we have been fully computerised and paperless for nearly two decades. I couldn’t imagine going back to paper records.

What book should every doctor read?
Intelligent Kindness by John Ballatt and Penelope Campling.

What is your guiltiest pleasure?
Watching *Come Dine With Me* with a glass of white wine and spaghetti omelette (cooked spaghetti drained and rinsed in cold water, mixed with two beaten eggs, salt, pepper, and parmesan cheese, and fried in olive oil for three minutes on each side).

Your most treasured possession?
Need you ask? My Jack Russell, Lucy.

What personal ambition do you still have?
To lead the NHS.

Summarise your personality in three words
Energetic, passionate, @Clarercgp.

Where does alcohol fit into your life?
As with many of my generation, as a constant pleasure that needs to be watched to avoid overconsumption.

What is your pet hate?
So called “experts” (consultants, think tanks, advisers) who purport to know best, on the basis of theories that were never based on or tested in reality. Once described to me as seagulls: they fly overhead, crap on those below, and fly off.

What would be on the menu for your last supper?
Pork scratchings (if I still had teeth), Bird’s instant custard with bananas and hundreds and thousands on top, and Thai green curry. In that order.

Do you have any regrets about becoming a doctor or politician?
No, none. My only regret is that the majority of my career is now behind me.

If you weren’t a doctor what would you be doing instead?
I am training in group analysis and would love to take that forward into the future as part of the service I offer to sick doctors (www.php.nhs.uk).

Cite this as: *BMJ* 2013;347:f6192