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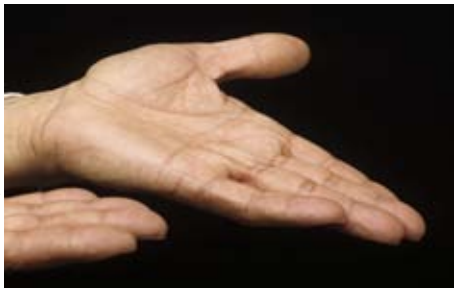
LETTERS

PALLIATIVE CARE

Importance of keeping both hands open



BERND EBERLE/GETTY IMAGES

Gott and colleagues explore clinicians' views about transitions to palliative care in acute hospitals.[1] Genuine uncertainty in recognising the point of transition emerges, alongside the inherent problem of "either-or" linear thinking about life, death, medicine, and the experience of being human.

The use of so called life prolonging treatments in acute settings does not preclude the use of palliative care with its focus on compassionate, patient centred care. The guiding principles of kindness and asking what matters most for this person undergoing this illness at this time (rather than what might be technically possible) could apply to all medical practice.[2]

However, the transition towards dying is a process, not a point. Different doctors may recognise different points. One GP noted that the "surprise question" probably applied to everyone over 65 in his practice. Patients facing dying also experience non-linear processes; ambivalence; liminality; and oscillation between acceptance and the desire for life prolonging interventions.[3] What was heard, and what the patient understands, evolves over time.[4]

The Amber care bundle from Guy's and St Thomas' Hospitals allows active treatment, alongside attention to symptom control and patient priorities for hospital patients whose outlook is uncertain over the next months.[5]

Doctors and patients travel together, holding in one hand the possibility of active treatment and more time, and in the other the importance of optimising comfort and planning for "just in case." The two are not mutually exclusive. Keeping both hands open in the face of uncertainty may help in the human journey of facing death and dying more skilfully. It can also be humbling: I cannot be the only palliative care specialist whose patients have sometimes, despite their doctor's honest predictions, got better.

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Competing interests: None declared.

1 Gott M, Ingleton C, Bennett MI, Gardiner C. Transitions to palliative care in acute hospitals in England: qualitative study. *BMJ* 2011;342:d1773. (29 March.)
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Cite this as: *BMJ* 2011;342:d2887

Palliative care is not same as end of life care

Gott and colleagues' paper resonates with our research findings from focus groups with ward staff caring for dying patients.[1 2]

We wonder if terminology is a barrier that was not discussed. The provision of palliative care should depend on need not prognosis.[3] However, focus group participants considered palliative care as synonymous with end of life care; this seems not to have been challenged or considered a core theme. In our practice this incorrect association contributes to the "either-or" "active-palliative" dichotomy described.

The authors highlight the focus on cure within acute hospitals, which reinforces the current "community good, hospital bad" paradigm for end of life care we perceive increasingly from the standards that palliative care teams and trusts are measured by. Perhaps the inclusion of more hospital participants might have shown the conflicting pressures that secondary care professionals are under. Culture change in hospitals is necessary but will take time when views are deeply held and reinforced by systems of working that default to active management for patients' safety. Perhaps primary care teams requesting admission could be asked to communicate realistic goals of care to patients, their families, and acute hospital staff to make actively dying patients more likely to receive appropriate care.

This paper highlights that end of life care is complex and involves whole system approaches. We hope it signals to primary care trusts and commissioners how dangerously simplistic some of the targets that trusts are asked to commit to are. We doubt we are alone in this hope.

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Competing interests: None declared.

1 Gott M, Ingleton C, Bennett MI, Gardiner C. Transitions to palliative care in acute hospitals in England: qualitative study. *BMJ* 2011;342:d1773. (29 March.)
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Cite this as: *BMJ* 2011;342:d2735

CHEMOTHERAPY IN TERMINAL CANCER

Treatment decisions in end stage cancer

Buiting and colleagues' study suggests that medical oncologists' treatment decisions in end stage cancer are based mostly on rational considerations regarding (side) effects.[1] This contrasts with the findings of our qualitative interview study with medical oncologists that explored the factors contributing to such decisions.[2]

All 17 doctors interviewed reported numerous "non-medical" factors that they deemed relevant for treatment decisions in end stage cancer. They cited personal (for example, own clinical experience), situational (for example, time pressure), and other contextual (for example, available resources) factors. Moreover, several doctors acknowledged that such decisions are not necessarily determined by patients' preferences but often reflect their own perceptions and values.

The apparent differences in oncologists' awareness of factors underlying such treatment decisions deserve further exploration, not least because of practical implications. A multi-professional approach to improving end of life decision making, as suggested by Buiting and colleagues, is realistic only if healthcare professionals are aware of the clinical and ethical premises of their practice.

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Competing interests: None declared.

1 Buiting HM, Rurup ML, Wijsbek H, van Zuylen L, den Hartogh G. Understanding the provision of chemotherapy to patients with end stage cancer: qualitative interview study. *BMJ* 2011;342:d1933. (8 April.)

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Cite this as: *BMJ* 2011;342:d2720

TACKLING KNIFE VIOLENCE

Young men view things differently

While appreciating Shepherd and Brennan's[1] call for an integrated approach to tackling knife crime, findings from our interview study undertaken with a sample of young white British males attending a youth centre in a large British city suggest further factors that require attention in terms of injury prevention.

Our analysis found that the young men in our sample interpreted knife carrying as a legitimate response both to potential threats and to the lack of protection provided by authorities. Further, our sample viewed young men who do not carry knives as irresponsible and thus deserving of any violence they experience.

We suggest that creating simple associations between knife carrying and immaturity or deviance might prevent the success of campaigns aimed at reducing this behaviour. We argue that preventing knife injuries must involve promoting recognition of the low controllability and unpredictability of knives, demonstrating to young men that knives actually increase, rather than decrease, personal risk.

In contrast to Shepherd and Brennan's suggestion that the threat of being caught is perhaps more important than the actual consequences of being caught, our sample reported that the consequences of being convicted for knife related violence (that is, minimal time in prison) were perceived as relatively insignificant in comparison with the crime. This would suggest that carrying through on commensurate levels of incarceration for knife related convictions is equally as important as increased policing of knife carrying.

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Competing interests: None declared.

1 Shepherd J, Brennan I. Tackling knife violence. *BMJ* 2008;337:a849.

Cite this as: *BMJ* 2011;342:d2903

IMPROVING CHILD HEALTH SERVICES

Future rests with GPs

Concerns about the competency of GPs in managing health problems in children are not new,[1] but with the onset of GP commissioning the requirement to address them is urgent. The first step is for general practice as a profession to recognise its important role in the health and welfare of children. Then two things need to happen.

Firstly, the children's champion of the Royal College of General Practitioners needs full support from the college and the profession to develop and promote a child health strategy that will define what is expected of rank and file GPs working with children in the 21st century. Without clear leadership it will be impossible to galvanise a coherent and cohesive response from general practice.

Secondly, GP commissioners must appreciate the extent of the failure of current services to meet the health needs of children, and recognise the need to develop the sort of integrated services that will deliver the improved outcomes seen in other countries. As primary care trusts seem to be disappearing, the power of acute foundation trusts rises, raising the spectre not of greater cooperation and cohesion but of greater competition and fragmentation. It falls to fledgling GP consortiums to support and develop existing partnerships to ensure that any progress towards better integration of services, favoured by many clinicians and professional bodies, is not lost. Equally, GP consortiums need to appreciate the complex but often necessary partnership working required with other agencies in the children's workforce. The danger is that, whereas improvement takes time, deterioration may happen rapidly without a broad strategic perspective on commissioning.

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Competing interests: None declared.

1 Wolfe I, Cass H, Thompson MJ, Craft A, Peile E, Wiegersma PA, et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. *BMJ* 2011;342:d1277. (8 March.)

Cite this as: *BMJ* 2011;342:d2890

View from the frontline

Some parts of the NHS seem to want to take paediatrics out of general practice. Wolfe and colleagues' analysis supports this process but lacks evidence for its proposals and at times contradicts itself.[1]

They imply that poor outcomes are due to poor primary care but poor patient behaviour may be the problem and they provide no evidence to show that it isn't. The assertion that only 3% of patients have asthma management plans is a typical example. I wonder how many plans are used in practice as opposed to being left in the cupboard with the Volumatic still in its box.

They believe that new paediatric teams are the solution to the poor outcomes, but where is the evidence? They have already referred to the multiplicity of services and access points as being an issue but then propose a new paediatric service.

The risks of separating paediatrics from general practice are fragmenting the service, confusing patients, and deskilling GPs. It is disappointing that these recommendations come from nine authors but only one seems to be working in general practice (part time).

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Competing interests: None declared.

1 Wolfe I, Cass H, Thompson MJ, Craft A, Peile E, Wiegersma PA, et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. *BMJ* 2011;342:d1277. (8 March.)

Cite this as: *BMJ* 2011;342:d2891

UNINTENTIONAL WEIGHT LOSS

When should "blind" investigations be considered?

McMinn and colleagues suggest history, examination, chest radiography, and faecal occult blood testing for initial investigation of unintentional weight loss in elderly patients.[1] Given that 13% of this population will have gastrointestinal cancer,[1] the sensitivity of anaemia, C reactive protein, and erythrocyte sedimentation rate in this population would be helpful.

We performed 116 oesophagogastroduodenoscopies for indications including weight loss, 58 for isolated weight loss. Five cancers were found; all these patients had other symptoms (pain or dysphagia) and only one had abnormal blood test results (anaemia). Sixteen had other gastrointestinal disease requiring further action (four presented with isolated weight loss, three were anaemic).

Weight loss is not a recordable indicator for colonoscopy at our centre. In the past year 13 of the 131 patients assessed for colorectal cancer had weight loss among their presenting symptoms; seven of these patients had no distal metastases. Five of the patients with weight loss had normal full blood counts, and three of these had no distal metastases. That colorectal cancer presented with other indications beside weight loss is reassuring but may be related to sampling bias if colonoscopy is not recognised as an indicated investigation.

Our superficial analysis supports McMinn and colleagues' suggested approach of selecting patients for oesophagogastroduodenoscopy. However, the finding that a large proportion of patients with weight loss attributable to colorectal cancer had normal blood test results and curable disease is worrying, given the low sensitivity of faecal occult blood testing (20% in asymptomatic people).[2]

McMinn and colleagues ask when "blind" investigations are indicated.[1] One study showed that when weight loss was confirmed 15 out of 41 patients had a gastrointestinal malignancy (five upper gastrointestinal tract, four colonic, and six pancreatic).[3] Computed tomography colonography might be expected to pick up colonic and pancreatic disease. The potential early stage of some of these tumours should focus decision making on the time interval before blind investigation is considered.

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Competing interests: None declared.

1 McMinn J, Steel C, Bowman A. Investigation and management of unintentional weight loss in older adults. *BMJ* 2011;342:d1732. (29 March.)
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Cite this as: *BMJ* 2011;342:d2737

Think of giant cell arteritis

McMinn and colleagues comprehensively reviewed unintentional weight loss in elderly people.[1] Many older people referred with unexplained weight loss to our department are subsequently found to have giant cell arteritis (temporal arteritis).

Patients with giant cell arteritis may have minimal symptoms and not have headache,[2] but they are at risk of visual loss and permanent blindness. Systemic inflammatory disorders may affect only 4% of patients with unexplained weight loss, but these disorders are easily treated with corticosteroids, and morbidity and mortality are high if they are missed. Connective tissue diseases such as giant cell arteritis may also have an insidious onset, so they should be considered as part of the work-up in patients with weight loss. Inflammatory markers such as erythrocyte sedimentation rate and C reactive protein may not always be detected.

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Competing interests: None declared.

1 McMinn J, Steel C, Bowman A. Investigation and management of unintentional weight loss in older adults. *BMJ* 2011;342:d1732. (29 March.)
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Cite this as: *BMJ* 2010;342:d2889

JOURNAL'S WITHDRAWAL OF ARTICLE

Not because of drug company's complaints

Contrary to the impression created by the recent news article,[1] the online article by Elashoff and colleagues in *Gastroenterology* was not retracted or withdrawn because of complaints from drug manufacturers. Rather, the online version was withdrawn to allow the authors to complete their final revision of the article before publication of the print version scheduled for July 2011.

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Competing interests: None declared.

1 Hawkes N. Journal withdraws article after complaints from drug manufacturers. *BMJ* 2011;342:d2335. (11 April.)

Cite this as: *BMJ* 2011;342:d2721

Concerns about methods used

I would like to share some information regarding the *BMJ* news article about a draft "article in press" recently withdrawn from the *Gastroenterology* website.[1]

Merck/MSD encourages and supports scientific discussion and debate that contributes to the ongoing care of patients with type 2 diabetes and fully supports the peer review process. The company submitted a letter to the editor of *Gastroenterology* to express concerns about the scientific methodology used in the exploratory analysis presented in the draft article. The letter was submitted for consideration only and contained no statement on whether the journal should publish the article.

The *BMJ* article describes concerns raised by scientists at two drug companies regarding the methodology used to develop the exploratory analysis in the *Gastroenterology* draft article. Readers might like to know that the European Association for the Study of Diabetes independently posted a statement on their website on 16 March that raised scientific concerns about the *Gastroenterology* draft article.[2]

The *BMJ* article also referenced information posted online on 4 March by the German Diabetes Society in reference to the draft article on the *Gastroenterology* website. The German Diabetes Society updated their statement on 7 March, with additional guidance for physicians and patients.[3]

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Competing interests: BJG is an employee of Merck Research Laboratories.

1 Hawkes N. Journal withdraws article after complaints from drug manufacturers. *BMJ* 2011;342:d2335. (11 April.)
2 European Association for the Study of Diabetes. EASD commentary on the publication by Elashoff et al, published online in Gastroenterology, February 2011. Increased incidence of pancreatitis and cancer among patients given glucagon like peptide-1-based therapy. 2011. www.easd.org/easdwebfiles/statements/Elashoff_Commentary.pdf.
3 German Diabetes Society. Update der Stellungnahme zur Publikation von Elashoff zur Sicherheit von GLP-1 basierten Therapien bei Patienten mit Typ 2 Diabetes. 2011. www.deutsche-diabetes-gesellschaft.de/redaktion/news/stellungnahmeElashoff070320111800final.pdf.

Cite this as: *BMJ* 2011;342:d2722

Paper OK, title wrong

The paper at the centre of the recent news article used disproportionality analysis to compare reports of pancreatitis and pancreatic or thyroid cancer to the US Food and Drug Administration associated with sitagliptine or exenatide versus four other drugs used in diabetes—rosiglitazone, nateglinide, repaglinide, and glipizide.[1 2]

They found increased relative reporting of pancreatitis, pancreatic cancer, and thyroid cancer with exenatide and sitagliptine, compared with five control events. The study was carefully thought out and in an extensive discussion the authors point out that this finding may have biological plausibility and clinical consequences considering the increased risk of cancer in type 2 diabetes.

They remain cautious on the real meaning of results from spontaneous reporting and disproportionality analysis, which are subject to many biases.[3 4] Epidemiological studies seem more reassuring.[5] The authors rightly ask for more studies, considering the consequences of a possible increased risk of pancreatitis and cancer, or alternatively a false alarm that would limit recourse to effective treatments for type 2 diabetes.

The title of the paper is misleading, however—it does not show increased incidence but increased reporting of cancer or pancreatitis. Whether this is related to the drugs themselves, the patients' characteristics, or reporting biases remains to be verified. This might be an alert, but it is not an alarm yet, and the authors need to change the paper's title.

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Competing interests: NM discussed an earlier version of this paper with a friend working with Lilly, manufacturers of exenatide.

1 Elashoff M, Matveyenko AV, Gier B, Elashoff R, Butler PC. Increased incidence of pancreatitis and cancer among patients given glucagon like peptide-1 based therapy. *Gastroenterology* 2011; online 17 February.
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Cite this as: *BMJ* 2011;342:d2732

TEACHING JUNIOR DOCTORS

A little learning

I doubt that there has been deterioration in the fundamental personal attributes of medical school applicants and trainees entering higher professional training. However, the capabilities of those in training grades are lower than required before training was "reformed." Not only is this a disservice to those entering training but it has added significantly to consultant workload. The author may not be aware of what his or her seniors are occupied with when out of view.[1] Much of it is work that would have been done by a trainee: I think appropriately, although medical educators would disagree.

Furthermore, the need to document assessment has detracted from direct teaching time. Much of this assessment is bland and lacks the power to distinguish trainees' competencies and needs. Too much reliance is placed on formal teaching in the lecture theatre and, worse, the clinical skills laboratory. Each has its place, but not at the expense of genuine clinical exposure. The mantra that there is no benefit in the repetition of practical procedures is at variance with the experience of elite performers in other disciplines and certainly with mine each time I have to insert a cannula when others cannot.

Consultants have consistently fought against the changes imposed on training but there has been no will to hear that dissent. It remains to be seen whether the Royal College of Surgeons will be successful in its challenge to the European Working Time Directive. Moreover, until training carries an equivalent tariff to direct clinical care, service providers are unlikely to sanction their consultants rebalancing job plans in favour of training.

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Competing interests: None declared.

1 Anonymous. Junior doctors don't get enough teaching. *BMJ* 2011;342:d2246. (13 April.)

Cite this as: *BMJ* 2011;342:d2893

Not for the want of trying

The depressing picture painted by the anonymous junior doctor certainly reflects the current situation on my wards.[1] However, we can't turn the clock back—no matter how much the Royal College of Surgeons would like to—and the amount of structured teaching that foundation doctors undergo is far greater than when I was a junior trainee 15 years ago.

Two things have changed for the worse.

Firstly, the fragmentation of rotas means that I never have the same foundation doctor on a ward round twice in a row. I therefore cannot teach with any continuity—and teaching isn't easy when your trainee colleagues don't know anything about the patients. The solution may be to corral acute receiving and acute nights into separate jobs—treat them like emergency medicine jobs—because acute receiving and ward work do not mix in contemporary medicine.

Secondly, we as consultants have less time than ever before. A consultant delivered service without a large enough expansion in consultant numbers means less time for teaching: I cannot spend the time teaching (which I love) when I have three hours in which to see 30 older, frail patients with complex disease.

Far from ducking the issue as consultants, we exhaust ourselves struggling to be heard by a management culture indifferent to our opinions. This too takes time—time in meetings that eats into our teaching. We want to teach; we like to teach, but there are not enough hours in the day to do so, and those whom we wish to teach are often not there.

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Competing interests: None declared.

1 Anonymous. Junior doctors don't get enough teaching. *BMJ* 2011;342:d2246. (13 April.)

Cite this as: *BMJ* 2011;342:d2894

Time for a medical Reformation?

The anonymous author is right that junior doctors don't get enough teaching,[1] but what are we to do?

Rather than pontificate in prose, I'll put down a series of key phrases that most of us will recognise as going some way to redress the balance: consultant teaching rounds, on call rotas (as opposed to elaborately constructed shifts), resurrect the firm structure, team camaraderie, supervision, steep learning curve, rapid acquisition of clinical skills, apprenticeship, renounce European Working Time Directive, bedside teaching.

To move towards such a world would require, as happened in the late Middle Ages in Europe (then in a religious context), nothing less than a Reformation. It would require that the royal colleges regain their primacy in determining standards and directing postgraduate education; it would require that doctors renounce their corporate allegiances as de facto civil servants. And it would require the General Medical Council to tear itself away from its comfortable position as a Department of Health quasi-quango.

Are doctors willing to stand up and be counted, as the president of the Royal College of Surgeons and some other brave souls have recently done, or, to push the analogy even further, as Martin Luther did in Wittenberg in 1517? The prize would be an independent profession—and the beneficiaries would be patients.

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Competing interests: None declared.

1 Anonymous. Junior doctors don't get enough teaching. *BMJ* 2011;342:d2246. (13 April.)

Cite this as: *BMJ* 2011;342:d2895

CLIMATE CHANGE

Overpopulation is main driver

Why did Jarvis and colleagues miss an opportunity to discuss the one, easy, cheap thing that the medical profession can do to influence climate change, ill health, and conflict yet continually refuses to discuss?[1]

We must break the taboo on discussing responsible reproduction. There are one million more humans on the planet every five days, but only a few people dare to suggest that having more than two children per couple, provided that the couple has access to education and contraception, is increasingly irresponsible and unfair.

Watch Sir David Attenborough's lecture to the RSA.[2]

We do not hesitate to promote other aspects of healthy living, yet it is obvious that a lack of resources and the resultant conflicts are about to have massive impacts on health for all of us. General practitioners, obstetricians, midwives, and health visitors have a duty to discuss family size at every relevant opportunity.

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Competing interests: PH is a trustee of Population Matters.

1 Jarvis L, Hugh Montgomery H, Morisetti N, Gilmore I. Climate change, ill health, and conflict. *BMJ* 2011;342:d1819. (5 April.)
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Cite this as: *BMJ* 2011;342:d2886