EDITORIALS

665 Reducing unwarranted variations in healthcare in the English NHS
Information in the NHS atlas is illuminating but changing practice is what matters, says Nicholas Mays
» Analysis, p 687

666 What have we learnt from the rosiglitazone saga?
That regulators, prescribers, and patients all have a role in promoting patient safety, say Victor M Montori and Nilay D Shah
» Research, p 692

667 Prevention of pain from propofol injection
Adequately studied, but inadequately managed, say Duminda N Wijeysundera and Brian P Kavanagh
» Research, p 694

668 Pituitary apoplexy
New guidelines refine best practice, but some areas remain uncertain, say Janice M Kerr and Margaret E Wierman
» Practice, p 704

669 New proposals for reorganisation of healthcare staff in England
Extensive, rapid, and risky, says Jennifer Dixon

LETTERS

671 Gynaecological examinations; Old drugs, new tricks

672 Hospital reconfiguration; GPs and child protection; Network meta-analysis

NEWS

673 Inquiry calls for radical change to improve quality of GP care
Attacks on doctors in the Middle East need to be investigated

674 Report reveals low rate of cancer surgery in middle aged
Surgeons call for more use of outcome data to improve care
Value based drug pricing could increase NHS drugs bill

675 Draft bill tells courts how to weed out poor expert witnesses

676 Exodus of medical staff leaves Libya's health service in chaos
Death toll climbs and healthcare needs escalate in Japanese crisis

677 Human rights group claims US psychiatrists are failing to protect military prisoners from torture
New government is to introduce universal primary care for Ireland

678 Community groups take on India's public health challenges
France plans overhaul of drug regulation

679 Poor nutrition is increasing obesity in developing world
HIV patients are happy with virtual care

SHORT CUTS

680 What's new in the other general journals

FEATURES

682 The highs and lows of primary care
A new report into the quality of primary care finds standards are generally good but highlights the need for more cooperation both between practices and with secondary care, Nigel Hawkes reports

684 Excellence in healthcare education: Top education picks for 2011
Christiane Rehwagen and Christine Ward introduce the shortlist

685 Long term conditions: what next?
Patients with chronic conditions dominate Western health services. Luisa Dillner talks to the clinician in charge of overhauling NHS services and listens to the evidence of what might work in practice

OBSERVATIONS

MEDICINE AND THE MEDIA

686 Nuclear panic overshadows Japan's real plight
Margaret McCartney

ANALYSIS

687 Time to tackle unwarranted variations in practice
Much of the variation in use of healthcare is accounted for by the willingness and ability of doctors to offer treatment rather than differences in illness or patient preference. Identifying and reducing such variation should be a priority for health providers, says John Wennberg

Commentary: The Dutch approach to unwarranted medical practice variation
Gert P Westert and Marjan Faber
» Editorial, p 665

RESEARCH

691 Research highlights: the pick of BMJ research papers this week

692 Comparative cardiovascular effects of thiazolidinediones: systematic review and meta-analysis of observational studies
Yoon Kong Loke, Chun Shing Kwok, Sonal Singh
» Editorial, p 666

693 Effect of statins on atrial fibrillation: collaborative meta-analysis of published and unpublished evidence from randomised controlled trials
Kazem Rahimi, Jonathan Emberson, Paul McGale, William Majoni, Amal Merhi, Folkert W Asselbergs, Vera Krane, Peter W Macfarlane, PWM is acting on behalf of the PROSPER Executive
694 Prevention of pain on injection of propofol: systematic review and meta-analysis
Leena Jalota, Vicki Kalira, Elizabeth George, Yung-Ying Shi, Cyril Hornuss, Oliver Radke, Nathan L Pace, Christian C Apfel, on behalf of the Perioperative Clinical Research Core
>> Editorial, p 667

695 Randomised trial of glutamine, selenium, or both, to supplement parenteral nutrition for critically ill patients

CLINICAL REVIEW

696 Managing adult patients who need home parenteral nutrition
Geert Wanten, Philip C Calder, Alastair Forbes

PRACTICE
GUIDELINES
702 Inpatient management of diabetic foot problems: summary of NICE guidance
T Tan, E J Shaw, F Siddiqui, P Kandaswamy, P W Barry, M Baker, on behalf of the Guideline Development Group

LESSON OF THE WEEK
704 Pituitary infarction: a potentially fatal cause of postoperative hyponatraemia and ocular palsy
Helen Prescott, Elna Ellis, Steven Soule
>> Editorial, p 668

10-MINUTE CONSULTATION
706 Malaria prevention
Deen M Mirza, Muhammad Jawad Hashim, Aziz Sheikh

OBITUARIES
708 Sean Spence
Advanced the study of deception and free will

709 Solomon Adler; David Prydderch Davies; John Fyfe; Ronald Parfitt; Albert Rinsler; Hosie Byram Tavadia; Reginald Lavis Walker

VIEWS AND REVIEWS
PERSONAL VIEW
710 We need a simple test for prosopagnosia
David R Fine

REVIEW
711 Tracking Medicine: A Researcher’s Quest to Understand Health Care by John E Wennberg
Chris Ham

712 Junior Doctors: Your Life in Their Hands
Yusuf Mirza

BETWEEN THE LINES
713 Shakespeare on alcohol
Theodore Dalrymple

MEDICAL CLASSICS
713 Dartmouth Atlas of Health Care
by John E Wennberg and Megan McAndrew Cooper
Richard Smith

COLUMNISTS
714 Alternatives to audit
Des Spence

A tax on the English
Ike Iheanacho

ENDGAMES
715 Quiz page for doctors in training

MINERVA
716 Gender and smoking, and other stories

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Excess deaths for every 100,000 patients who receive rosiglitazone rather than pioglitazone

Proportion of patients who experience pain on injection of propofol alone

Year that intravenous nutrition in the home was introduced for patients with long term intestinal failure

Proportion of people with diabetes who will have a foot ulcer at some point in their lives

PICTURE OF THE WEEK

Chinese residents queue at a wholesale market to buy salt. Supermarkets in Taiyuan, Shanxi province, have sold out of salt after rumours that its iodide content can protect against radioactive emissions from the nuclear power station in Fukushima, Japan.

See NEWS, p 676, OBSERVATIONS, p 686


THE WEEK IN NUMBERS

431 Excess deaths for every 100,000 patients who receive rosiglitazone rather than pioglitazone (Research, p 692)

60% Proportion of patients who experience pain on injection of propofol alone (Research, p 694)

1967 Year that intravenous nutrition in the home was introduced for patients with long term intestinal failure (Clinical Review, p 696)

15% Proportion of people with diabetes who will have a foot ulcer at some point in their lives (Practice, p 702)

QUOTE OF THE WEEK

“The arbitrary and iniquitous application of the tax doesn’t help either. Its defenders sometimes highlight that roughly 90% of prescriptions don’t attract the payment, which must be a great consolation to those payers who have long term medical conditions that are not on the list of exemptions”

Ike Iheanacho, editor of the Drug and Therapeutics Bulletin on England being the only country to retain (and increase) charges for drug prescriptions (Views and Reviews, p 714)
EDITOR’S CHOICE

Tackling practice variation

Our enthusiasm for tackling the topic of practice variation has led us to commission five articles and a podcast. There’s an Analysis from “Jack” Wennberg, the undisputed father of practice variation, in which he deftly summarises the evidence of underuse, overuse, and misuse of health care in the US and the UK (p 687). There’s a commentary from Gert Westert and Marjan Faber from the Netherlands showing that variations are less extreme in what was, until recently, a centrally planned health system (p 688). We have a review by Chris Ham of Wennberg’s latest book (p 711), and a review of one of his earliest, the Dartmouth Atlas of Health Care, now a medical classic (p 713). Richard Smith compares it with Darwin’s On the Origin of Species because of its rigorous accumulation of data and for fundamentally changing our view of the world. Finally, an editorial from Nick Mays discusses the atlas’s first direct offspring, the NHS Atlas of Variation in Healthcare (p 665). Published late last year by the Department of Health, this shows how primary care trusts vary in their care of patients, their costs, and their outcomes.

Is this coverage overkill—or, in the language of practice variation, supply sensitive overuse? Given the importance of the topic to health systems and patients around the world, I don’t think so. The evidence that more care does not mean better care is overwhelming, and the scope for savings from more rational pathways of care is huge, especially with chronic conditions. All five articles are worth reading because they present the story, and the concepts behind it, in different ways. And by the time you’ve read them all and listened to the podcast (http://podcasts.bmj.com/bmj/2010/12/10/a-tale-of-two-cycles/), you will easily be able to answer the following questions:

Who was the first person to document variations in clinical practice and what did he find?

How did he explain his findings?

How did Jack Wennberg tackle the same problem in Vermont 40 years later? What are Wennberg’s three categories of care in relation to practice variation? Which ones are “OK” and which are not? What is Roemer’s law? How much would the US save if the whole country followed practice patterns of organised systems such as Mayo Clinic? What is Jack Wennberg’s main solution to unwarranted practice variation? (Clue: the Salzburg declaration is just published on bmj.com (doi:10.1136/bmj.d1745)).

The first reader to get all the answers right will get a pat on the back. The first health system to get to grips properly with unwarranted practice variation will get a high quality, low cost health system, which must be everyone’s goal. Sadly, if Nick Mays is right, the NHS is heading in the wrong direction. General practitioner consortiums may do better than primary care trusts, he says, because of stronger incentives to be efficient and to reinvest savings in services. But other changes—the scrapping of the Audit Commission, the emphasis on localism, and the blurring of geographically defined populations—may bring more not less variation. And they won’t help the collection of data or the integration of care for chronic conditions.

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