**EDITORIALS**

1319 Safety of tiotropium
Indirect evidence suggests the Respimat inhaler is riskier than the Handihaler, says Christopher J Cates
> Editor, p 1319

1320 Treatments for common and plantar warts
Salicylic acid or liquid nitrogen is probably no more effective than a wait and see policy, says Jan Nico Bouwes Bavinck and colleagues
> Research, p 1349

1321 Should pregnant women sleep on their left?
The suggestion that this may help to prevent late stillbirth requires further study, say Lucy C Chappell and Gordon C Smith
> Research, p 1350

1322 H1N1 influenza in pregnant women
Vaccination is the key to mitigating the higher incidence of adverse outcomes, say K S Joseph and Robert M Liston
> Research, p 1350

1323 The Future Forum proposes major changes to the government’s plans for NHS reform
Integrated care should be given priority, with less emphasis on competition says Chris Ham

**LETTERS**

1325 Prostate cancer screening

1327 Incidental eosinophilia; Infective endocarditis; New management of gonorrhoea

1328 NHS reforms; Patient participation groups; Perniosis or chilblains?

**NEWS**

1329 UK government spells out new plan for NHS in England
London vaccination summit is a “milestone in global health”

1330 GP groups must learn from US experience
Hospital will continue to offer HIV tests to A&E patients
UK sues Servier over alleged blocking of generic substitute

1331 Doctors will be asked to help identify people at risk of becoming terrorists

1332 Germany legislatates to boost organ transplant numbers
Loss of trials from UK must end, NHS body says

1333 Pfizer launches virtual clinical trial that uses “apps”
Research into treatments for mental illness is under threat

1334 Peer review must stay as guarantee of quality of scientific research, academics tell MPs
More than half of child labourers work in hazardous conditions

1335 Firm sues doctor after he reports slimming product to regulator
Bahraini doctors deny anti-state activities at military trial

**SHORT CUTS**

1336 What’s new in the other general journals

**FEATURES**

1338 Clinical trials: can technology solve the problem of low recruitment?
Getting people to take part in clinical trials is often difficult. Toby Reynolds looks at new strategies to increase participation

**HEAD TO HEAD**

1340 Are traditional birth attendants good for improving maternal and perinatal health?
Joseph Ana argues that the shortage of skilled health workers means traditional birth attendants have a valuable place, but Kelsey A Harrison believes they do more harm than good

**OBSErvations**

ETHICS MAN

1342 Crouching tiger, hidden surgeon Daniel K Sokol

MEDICINE AND THE MEDIA

1343 An early warning for Alzheimer’s disease? Margaret McCartney

LOBBY WATCH

1344 The College of Medicine Jane Cassidy

**ANALYSIS**

1345 How foreign policy can influence health
Ilona Kickbusch argues that public health experts need to work with diplomats in order to achieve global health goals

**Research**

1347 Research highlights: the pick of BMJ research papers this week

1348 Mortality associated with tiotropium mist inhaler in patients with chronic obstructive pulmonary disease: systematic review and meta-analysis of randomised controlled trials
Sonal Singh, Yoon K Loke, Paul L Enright, Curt D Furberg
> Editorial, p 1319

1349 Cryotherapy versus salicylic acid for the treatment of plantar warts (verrucae): a randomised controlled trial
Sarah Cockayne, Catherine Hewitt, Kate Hicks, Shalimini Jayakody, Arthur Ricky Kang’ombe, Eugena Stamuli, Gwen Turner, Kim Thomas, Mike Curran, Gary Denby, Farina Hashmi, Caroline McIntosh, Nichola MclLarnon, David Torgerson, Ian Watt, on behalf of the EverT Team
> Editorial, p 1320

1350 Association between maternal sleep practices and risk of late stillbirth: a case-control study
> Editorial, p 1321

**Research**

1349 Cryotherapy versus salicylic acid for the treatment of plantar warts (verrucae): a randomised controlled trial
Sarah Cockayne, Catherine Hewitt, Kate Hicks, Shalimini Jayakody, Arthur Ricky Kang’ombe, Eugena Stamuli, Gwen Turner, Kim Thomas, Mike Curran, Gary Denby, Farina Hashmi, Caroline McIntosh, Nichola MclLarnon, David Torgerson, Ian Watt, on behalf of the EverT Team
> Editorial, p 1320

1350 Association between maternal sleep practices and risk of late stillbirth: a case-control study
> Editorial, p 1321
1351 Perinatal outcomes after maternal 2009/H1N1 infection: national cohort study
Matthias Pierce, Jennifer J Kurinczuk, Patsy Spark, Peter Brocklehurst, Marian Knight on behalf of UKOSS
≫ Editorial, p 1322

1352 Evidence against the proposition that “UK cancer survival statistics are misleading”: simulation study with National Cancer Registry data
Laura M Woods, Michel P Coleman, Gill Lawrence, Jem Rashbass, Franco Berrino, Bernard Rachet

1353 Diagnosis and management of ectopic pregnancy
Davor Jurkovic, Helen Wilkinson

1358 Congenital cataract
Heather C Russell, Valerie McDougall, Gordon N Dutton

1360 Living with obstetric fistula
Fatima Aliyu, G Esegbona

1363 John MacVicar
Pioneer of medical ultrasound

1364 John Anthony Robert Anson; Margaret Aureol Austin; Leslie Russell Davis; Christopher John Goodwill; George Kenneth Mackenzie; John Guymer Roberts; Peter Thompson

1365 For-profit companies will strip NHS assets under reforms Lucy Reynolds

1366 Terry Pratchett: Choosing to Die
Desmond O’Neill

1367 Troubled hearts
Theodore Dalrymple

1368 Undoing diagnoses
Des Spence

1369 Quiz page for doctors in training

1370 Jumping athletes, and other stories
163 days Median days to clearance of plantar warts with self-applied 50% salicylic acid for a maximum of eight weeks (Research, p 1349)

12,000 Ectopic pregnancies diagnosed each year in the United Kingdom (Clinical Review, p 1353)

200-300 Children born with congenital cataract each year in the United Kingdom (Practice, p 1358)

3.93/1000 Absolute risk of late stillbirth associated with maternal non-left sided sleep position (Research, p 1350)
EDITOR’S CHOICE

Better obstetric outcomes

Obstetric fistula is a disease of poverty and is almost entirely preventable

Fatima Aliyu was 25 years old when she went into labour with her first child. Six days later, the baby was dead—stillborn by caesarean section—and Fatima had lost control of her bladder and bowels. “I cried in the dark because I was left behind, my dignity was gone,” she writes (p 1360). Ten years on, still struggling with the effects of her prolonged obstructed labour, with two obstetric fistulas, sphincter damage, and foot drop, Fatima is nonetheless one of the lucky ones. Despite the social stigma and huge practical challenges of her incontinence and her inability to have other children, her family has stood by her. She has also had specialist surgery. Of the estimated two million women who live with the effects of obstetric fistula, most are ostracised and fall into extreme poverty. And according to Gloria Esegbona’s accompanying commentary, at best only 10-20% will get the surgical care they need.

Obstetric fistula is a disease of poverty and is almost entirely preventable. What Fatima lacked, in common with most of the estimated 350 000 women who die each year in pregnancy and childbirth (http://bit.ly/mBKsis), was timely access to skilled obstetric care. Esegbona acknowledges the crucial importance of tackling the wider social and cultural issues—poverty, lack of education for girls, early marriage, and pregnancy. But she is clear that even if these were addressed, without improvements in obstetric care women will still suffer the effects of ignorance and neglect during labour that lead to serious pelvic damage.

Achieving the necessary improvements in obstetric care in developing countries is far from simple. In this week’s Head to Head (p 1340), Joseph Ana and Kelsey Harrison argue out the pros and cons of one approach—the training of traditional birth attendants. WHO suggests that, until sufficient numbers of skilled midwives are ready to live in villages where their services are most needed, the best policy is to identify, train, and support traditional birth attendants. Ana agrees, citing a randomised controlled trial published a few weeks ago in the BMJ, which found that training traditional birth attendants in Zambia significantly reduced neonatal mortality (BMJ 2011;342:d346). But Harrison argues that traditional birth attendants have little or no place in the better future that women in developing countries are now demanding. He says it’s hard to justify investing in traditional birth attendants. “Their use is a distraction in that it seeks to manage extreme poverty instead of working to eliminate it.”

Of course skilled obstetric care, however achieved, is only one essential factor in reducing maternal mortality and morbidity. Also crucial is the provisions of safe and effective contraception. WHO says that this is still not available to around 215 million women who would prefer to delay or avoid pregnancy, and it estimates that satisfying this unmet need could cut the number of maternal deaths by almost a third. As the clock ticks towards 2015, how much more progress can the world make towards the fifth millennium development goal: reduction in maternal mortality by three quarters and universal access to reproductive health?

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