NEWS

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bmj.com
NHS should ban the use of starch based intravenous fluids, say researchers

Most NHS services must go out to tender, rules say

Gareth Iacobucci BMJ

The UK government has come under fire after publishing legislation this month that compels the new clinical commissioning groups in England to place the bulk of NHS services on the open market.

The new rules, due to come into effect from 1 April 2013, will require commissioners to allow all qualified providers of services—whether they are NHS, private, or voluntary providers—to bid for NHS contracts under competitive tender, except in certain limited circumstances.

But the UK Labour Party and the new National Health Action Party said that the legislation contradicted previous assurances by Conservative ministers that commissioners would not be forced to open NHS services to the market, and they urged MPs to force a parliamentary debate to try to halt the process.

Proposals to expand competition in the health service have proved among the most controversial elements of the coalition government's changes to the NHS. After pressure from professional bodies, opposition parties, and the Liberal Democrats, the then health secretary for England, Andrew Lansley, announced concessions to his original plans in the Health and Social Care Act 2012, which included redefining the role of the healthcare regulator Monitor to promote integration as well as competition.

In March 2012 the health minister Lord Howe told the House of Lords that commissioners would "be under no legal obligation to create new markets" and would "be free to commission services in the way they consider best,"[2] while Lansley wrote to leaders of clinical commissioning groups to reassure them that Monitor "would not have the power to force you to put services out to competition."[3]

PA

Lord Howe said last year that GPs would "be free to commission services in the way they consider best"

But critics said that secondary legislation published this month,[4] which relates to section 75 of the act, shows that the Conservatives have misled their coalition partners, as it states that commissioners "may not refuse to include a provider on a list where that provider meets the criteria established by the relevant body for the purposes of that decision."

The legislation, published after a consultation carried out in August 2012,[5] said that commissioners "must not include any restrictions on competition that are not necessary for the attainment of intended outcomes which are beneficial for people who use such services."

Commissioning bodies would not be able to exclude providers from qualifying to provide local services except in cases where "to do so would exceed the limit the commissioner has set on the number of providers (eg to ensure best value in the provision of services)."

Labour MPs challenged the current health secretary, Jeremy Hunt, in the House of Commons this week to fully debate the legislation in both parliamentary houses, but he insisted that the regulations were "consistent" with procurement guidelines issued by the previous Labour government.

Cite this as: *BMJ* 2013;346:f1322

Tougher action is needed on alcohol pricing, labelling, and adverts, say experts

Zosia Kmietowicz BMJ

More than 70 health organisations have backed a call for tougher action to tackle the problems caused by excessive drinking in the United Kingdom, including targets to reduce the amount of alcohol that adults drink and to reduce the number of deaths from liver disease.

The strategy for action by the Alcohol Health Alliance says that the government needs to go beyond messages about "responsible" drinking and instead prioritise policies that would reduce alcohol sales, alcohol consumption, and alcohol related harm.[1] Among its 30 recommendations are a 50p minimum price per unit of alcohol sold, graphic warning labels on bottles, and a ban on alcohol sponsorship and advertising.

Scotland introduced legislation in May 2012 for a 50p minimum price per unit of alcohol,[2] although this is being challenged in the courts by the drinks industry.[3] England and Wales launched a public consultation on a minimum price of 45p in November last year, which closed in February.[4]

But the strategy says that more ambitious action was needed. It recommends that UK governments should set targets to reduce sales of pure alcohol from 10.2 L to 8 L per adult each year and that the rate of deaths from liver disease should be cut from 11.4 per 100 000 population to four per 100 000 by 2020.

To achieve these targets it says that the sale of alcohol in shops should be restricted to specific times and areas and that the legal limit on blood alcohol for drivers be reduced from 80 mg/100 mL to 50 mg/100 mL.

Andrew Langford, chief executive of the British Liver Trust, said, "We must all do something to reverse a trend that sees well over 10 000 people a year dying prematurely because of alcohol related harm."

Cite this as: *BMJ* 2013;346:f1292

Two drugs for type 2 diabetes seem to raise risk of acute pancreatitis

Deborah Cohen BMJ

People with type 2 diabetes who take exenatide and sitagliptin have double the risk of hospitalisation for acute pancreatitis as people who use other antidiabetes drugs, a study published in *JAMA Internal Medicine* concludes, though the absolute risk is still low.[1]

Both drugs are glucagon-like peptide-1 (GLP1) based treatments and have previously been shown to cause acute pancreatitis in rodents.

Lead author, Sonal Singh, assistant professor at Johns Hopkins University School of Medicine, and colleagues, analysed data from seven BlueCross BlueShield health insurance plans in the United States between 1 February 2005 and 31 December 2008. They identified 1269 people with type 2 diabetes who filled at least one prescription for any drug to treat the disease between 2005 and 2008 and matched them with 1269 people with type 2 diabetes who had not used one of the GLP-1 drugs.

After controlling for confounding variables such as gallstones the researchers found that people who took one of the GLP-1 drugs were twice as likely to be hospitalised with acute pancreatitis within 60 days of first taking the drugs as those who had taken different drugs (adjusted odds ratio 2.02 (95% confidence interval 1.31 to 3.01; P=0.01)). Singh said that the baseline risk of pancreatitis in people with type 2 diabetes was 0.3%. "But we found that the GLP-1 based drugs double the risk to 0.6%."

The study was funded by Johns Hopkins University and the US National Institutes of Health.

However, in the US both drugs—and others in the class—already carry warnings on their label about pancreatitis. In the UK several drugs in the class, including exenatide and linagliptin, currently carry a black triangle warning. Others, such as sitagliptin, saxagliptin, and liraglutide, have had their warnings recently removed.

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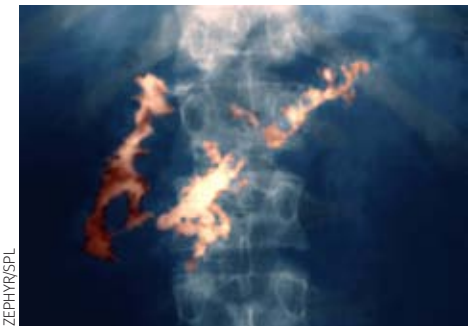

ZEPHYR/SPL

Two drugs increased the risk of acute pancreatitis from 0.3% to 0.6% in type 2 diabetes patients

Nine out of 10 palliative care experts would choose Liverpool care pathway

Krishna Chinthapalli BMJ

The Liverpool care pathway represents best practice for the care of dying patients, according to 89% of UK palliative medicine consultants in an online survey by the *BMJ* and Channel 4's *Dispatches* programme.[1]

The same proportion of consultants said they would choose it for themselves if they were dying from a terminal illness, and over 97% of consultants thought that the pathway allows patients to die with dignity when used correctly.

The anonymous online survey was emailed to 3021 hospital doctors in early February. The results are based on responses from 563 doctors who had used the pathway. These respondents comprised 185 palliative medicine consultants (about 40% of UK consultants in the specialty), 210 doctors in other specialties, and 168 in other grades in palliative medicine.

Almost three quarters (74%) of the palliative medicine consultants also thought that recent negative press coverage had led to less use of the Liverpool care pathway. And 60% said patients and relatives had asked them not to use it, while 80% said staff were apprehensive about relatives' complaints.

One specialist said the negative coverage "has caused additional distress for relatives at an already distressing time when their loved one is dying." Another said that end of life care had been put back 20 years.

The Liverpool care pathway is the most widely used integrated care pathway for end of life care, but it has recently been criticised after accounts in the media of

GMC is to get legal power to check English skills of European doctors

Helen Jaques BMJ CAREERS

The General Medical Council will be given legal power to check the English language skills of doctors from other European countries who seek to practise in the United Kingdom, the government has said.

A public consultation will be held in summer 2013 on amendments to the 1983 Medical Act that would strengthen the GMC's power to check doctors' language skills.[1] A consultation on the role of responsible officers is likely to give employers more powers.

Doctors from outside the European Union must pass language and clinical skills tests before being granted a licence to practise in the UK. EU legislation prevents the GMC from testing the language skills of doctors from the European Economic Area (EEA) and Switzerland, although a European parliament review of the relevant legislation could give the GMC these powers.[2]

The health minister Dan Poulter said, "These new checks will ensure that all doctors who want to work in the NHS can speak proficient English and prevent those who can't from treating patients."

The planned changes to the Medical Act would allow the GMC to seek evidence of a doctor's ability to speak English if "serious and concrete" concerns about a doctor's language skills arose during the registration process.

A doctor turning up to their ID check with a translator, a poorly written application or supporting documentation, admission of language difficulty during the application process, or poor language skills during phone conversations with the GMC contact centre would all be "red flags" for language concerns.

In such cases the GMC would seek evidence of the doctor's language skills before a licence to practise was issued.

The government has also suggested that the GMC should be allowed to investigate concerns about a doctor's language skills that arise after registration. The regulator would then be able to put conditions on the doctor's licence to practise or could suspend the licence.

The GMC welcomed the opportunity to "close this gap in our regulatory defences." Niall Dickson, its chief executive, said, "Our position is clear: patients must be confident that the doctor who treats them has the right communications skills to do the job. If doctors cannot speak English to a safe standard then the GMC must be able to protect patients by preventing them from practising in the UK."

As well as new checks nationally at GMC level, it is likely that employers will soon have the power to ensure that the doctors they hire have adequate English language skills. A consultation on the regulations concerning responsible officers suggests that these officers in hospitals and at the NHS Commissioning Board should have a specific duty to ensure that hospital doctors and GPs can speak English well enough to communicate with patients, colleagues, and the public.[3 4]

The consultation closed in January, and responses are currently being analysed.

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patients having food and fluids withdrawn and hospitals being offered financial incentives for using the pathway.[2] As a result, the Department of Health and the NHS national end of life care programme are currently reviewing the pathway.[3]

Despite the media reports, almost all doctors (98%) did not think that pressure on beds or other resources had influenced decisions to use the pathway. However, only 13% of all doctors agreed that hospitals should be offered financial incentives for using the pathway, with over half (58%) disagreeing.

The survey also raised concerns over training: 78% of palliative medicine consultants thought doctors and nurses were able to judge when a patient was dying, but doctors in other specialties thought only 69% of relevant healthcare professionals were trained in the use of the pathway at their workplace.

Many commented on damaging misconceptions of the pathway that were perpetuated by the media, and one pointed out that "there is no barrier to eating, drinking, [taking] antibiotics and fluids while on the pathway, if deemed appropriate for symptom management." Another said that "regular review does happen" and the pathway should not be seen as a one way process.

Fiona Godlee, *BMJ* editor in chief, said: "This survey gives overwhelming support for the Liverpool care pathway from doctors who have experience in using the pathway when caring for patients in the last few days of life.

"The fact that most of these doctors said they would choose the pathway for themselves is doubly reassuring. The recent adverse media coverage of the Liverpool care pathway has been misleading and has damaged patient care. I hope this survey goes some way to restoring public confidence in the pathway as a reasonable and compassionate choice for patients and their families when making decisions about end of life care."

The results are also due to be aired on Channel 4's *Dispatches* on Monday 4 March 2013.

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Cite this as: *BMJ* 2013;346:f1303

POSED BY MODEL

Negative press reports had reduced the use of the Liverpool care pathway, said 74% of palliative medicine consultants

BSIP/UIG/GETTY IMAGES

The challenges of a birth were often planned for while those of death were not, said Scott Murray

Classes may ensure life ends as well as it starts, conference hears

Bryan Christie EDINBURGH

Families and services should give as much priority to preparing for a death as they do to preparing for a new baby, a conference in Edinburgh has been told.

Community based classes similar to antenatal sessions offered to new mothers could be one initiative to help remove the stigma concerning the end of life and encourage its discussion, the conference heard.

Surveys have shown that around two thirds of people are uncomfortable talking about death. Richard Smith, former editor of the *BMJ*, said that society was "in denial" about death, which resulted in needless pain and suffering for many people. The reluctance to talk about death meant that people nearing the end of life faced fear and isolation, unnecessary distress, and dying without a will and without having the opportunity of saying goodbye to loved ones.

The conference, organised by the University of Edinburgh and the Royal College of General Practitioners in Scotland, focused specifically on multimorbidity in the last year of life. It considered how families, clinicians, and carers could best meet the challenge of improving their support and care of people who are dying.

Scotland's chief medical officer, Harry Burns, said that increasing evidence showed that resilience among individuals and communities in the face of changing circumstances was an important determinant of health. He said that this was more important than smoking or poor diet in explaining premature death rates in the west of Scotland, which are among the highest in the developed world.

Too often, systems do things to people, not with them, he said, and the key lay in unlocking people's own assets to cope better with what life throws at them. "That is what we have to do in end of life care. We have to help people to manage a whole set of new and unanticipated challenges."

Scott Murray, professor of primary palliative care at the University of Edinburgh, agreed to such an approach. He said that care at the end of life should be made as good as antenatal care, but at the moment less than 40% of patients even in the richest countries benefited from it.

He called for the provision of early, integrated palliative care that had the same type of planning that went into preparing for a new birth. Support should be given to communities and individuals to make the most of their resources, and he called for a much wider public debate and discussion of issues concerning death and dying.

Alex Jadad, professor of e-health innovation at the University of Toronto, said that health should no longer be seen simply as the absence of disease. It should be seen as the capacity of an individual or a community to adapt and manage physical, mental, or social challenges.

Cite this as: *BMJ* 2013;346:f1242

IN BRIEF

Review will consider training of healthcare assistants in England: An independent review will look at how the training and support of healthcare and other care assistants can be strengthened so they give better care to patients, England's health secretary, Jeremy Hunt, has announced. The review will be led by the *Times* journalist Camilla Cavendish, who will report back to government at the end of May.

Side effect scare reduces sales of later generation pills: Sales of third and fourth generation contraceptive pills fell in France by 25% from early December to late January, in comparison with the same period a year before, amid a scare over risks of venous thromboembolism associated with the drugs.[1] Sales of second generation pills rose by 16% over the same period.

SPL

Plan aims to control untreatable gonorrhoea: The Health Protection Agency has launched the first gonorrhoea resistance action plan for England and Wales to extend the life of current treatments and to try to stop the spread of drug resistant strains of the bacterium (http://bit.ly/YUBduL). The plan gives guidance on data collection, rapid detection of treatment failures, and encouraging safer sexual behaviour.

MP calls for Nicholson to answer questions about gagging clauses: The Conservative MP Steve Barclay, a member of the UK parliament's Public Accounts Committee, said that £14.7m of public money was spent on 598 NHS compromise agreements between 2008 and 2011. Of these, 90% included gagging clauses. Barclay said that the NHS chief executive, David Nicholson, should answer questions about whether officials knew whistleblowers were being silenced.

Children's access to antiretrovirals gets a boost: A key paediatric antiretroviral, abacavir, can be supplied in the 118 countries where most (98.7%) children with HIV live, under a patent licence agreed between the Medicines Patent Pool, the initiative to fund HIV treatments through a levy on airline tickets,[2] and ViiV Healthcare, a venture between GlaxoSmithKline, Pfizer, and Shionogi. Only 562 000 out of 3.4 million children worldwide with HIV, have access to antiretrovirals, WHO has said.

Cite this as: *BMJ* 2013;346:f1295

Campaigners demand mandatory standards for hospital food

Matthew Limb LONDON

Campaigners have accused successive UK governments of "wasting" more than £54m (€62m; $82m) on "failed" voluntary schemes to improve hospital food over the past 21 years when what are needed are mandatory nutritional standards.

Sustain, an alliance of organisations that campaigns on food and farming matters, listed 21 ineffective government initiatives between 1992 and 2013 in a report published last week on behalf of 89 members of the Campaign for Better Hospital Food.[1]

The report said that, although all these initiatives had been based on thorough research of the problems, none had succeeded because recommendations were not made compulsory.

"Inexcusably, successive health ministers have persisted with this failed approach, and have continued where their predecessors left off, simply repackaging and relaunching weak, voluntary guidance," the report says.

Despite some successful attempts to improve meals in a "handful" of hospitals, it adds, "the majority of hospital food remains as bad as ever."

Sustain said legally binding food standards in hospitals were needed, supporting a call made days earlier by the Academy of Medical Royal Colleges.[2] It said ministers had ignored "at least" 14 warnings from government advisers, MPs, commercial caterers, and health, environmental, and animal welfare organisations that voluntary initiatives to improve hospital food were inadequate.

Several "celebrity" advisers backed the call for compulsory nutritional standards to be introduced in hospitals in England, as they had been in schools.

ANDY SOTIRIOU/THE IMAGE BANK/GETTY IMAGES

More than 20 government initiatives failed because their guidance was not mandatory, the report says

Broadcaster Lloyd Grossman, who led the government's Better Hospital Food initiative between 2001 and 2006, said in the foreword to the Sustain report that despite some successes efforts had been "hampered by a lack of political will." He went on: "There has not yet been a noticeable change in the way hospital food is produced, prepared, cooked and served. I welcome the publication of this report and hope that it prompts government to take a new and effective approach to improving hospital food, including by requiring it to meet mandatory standards."

Chef Albert Roux, whose opinion on how to improve hospital food was sought by the Department of Health in 1995, said in the foreword: "If we have learned anything from the last twenty years it is that meetings, speeches and gimmicks do not work—what we need now is change to the whole hospital food system."

Helen Davidson, honorary chairwoman of the British Dietetic Association, said: "Good food and appropriate nutrition must, at all times, be an absolute priority."

Health minister Dan Poulter said schemes that relied on celebrity chefs had not worked in the past and that patients were best placed "to decide what is good and what is not. That is why an army of thousands of patient assessors will join a tough new inspection programme starting in April 2013 to drive up standards," he said.

Cite this as: *BMJ* 2013;346:f1251

NICE joins campaign for data disclosure

Matthew Limb LONDON

The UK National Institute for Health and Clinical Excellence (NICE) is supporting a campaign backed by the *BMJ* to promote openness in reporting of clinical trials.

NICE signed the AllTrials campaign's petition (alltrials.net) on 19 February, joining a host of leading medical bodies and charities, as the number of signatories rose above 30 000.

NICE's chairman, Michael Rawlins, said, "We strongly believe that all clinical trial data should be made available so that that those with responsibility for developing clinical guidance and making treatment decisions have all the necessary information to hand to help them do so safely and efficiently."

The AllTrials campaign was launched in January by the *BMJ*, *Bad Science* author Ben Goldacre, the charity Sense About Science, the James Lind Alliance, and Oxford University's Centre for Evidence-based Medicine.[1] It calls on responsible bodies to ensure that all trials are registered and that the full methods and results are published.

Supporters of the campaign say that despite years of commitments to openness on clini-

Research council failed to communicate its open access policy, say peers

Susan Mayor LONDON

The House of Lords Science and Technology Committee has criticised Research Councils UK (RCUK) for failures in communicating its policy on open access. In a report published on 22 February the peers recommended that RCUK clarify its guidance, communicate it more clearly, and monitor implementation.[1]

RCUK's policy on open access is to make peer reviewed journal articles resulting from work funded by its councils available online at no cost to readers.[2]

The House of Lords inquiry heard from academics who said that RCUK's open access policy took a "one size fits all" approach that was not appropriate in some disciplines.

Publishers were worried about specific requirements of the policy as they changed to open access business models, including RCUK's requirement for embargo periods of only six months for science publications, during which readers have to pay to access research papers.

John Krebs, chairman of the Science and Technology Committee, said, "RCUK did not consult or communicate effectively with key stakeholders in the publishing and academic communities when implementing its open access policy."

While investigating the issue, the committee found that RCUK planned to phase in its open access policy over an initial implementation stage of five years, during which it was willing to be flexible over embargo periods. But the committee said that RCUK should have made this clearer much sooner and has asked it to clarify its policy guidance to reflect this incremental approach to compliance. The committee has also asked RCUK to monitor the effects of open access.

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cal trial results, governments, regulators, and research bodies have failed to take decisive action that would benefit patients, researchers, pharmacists, doctors, and regulators everywhere.

Signatories of the petition now include the Royal Society of Medicine, Rethink Mental Illness, Cystic Fibrosis Unite, Muscular Dystrophy Campaign, the Migraine Trust, Parkinson's UK, the British Pharmacological Society, and the drug company GlaxoSmithKline.[2]

Campaigners believe that under-reporting is a type of research misconduct that leads to overestimation of the benefits of drugs and underestimation of their harmful effects.

Cite this as: *BMJ* 2013;346:f1269

Four emergency departments in London to be downgraded

Adrian O'Dowd LONDON

Local NHS commissioners have taken the controversial decision to downgrade four emergency departments in London despite strong resistance from local doctors, the community, and a local authority.

Following public consultation, a business case was made for the *Shaping a Healthier Future* programme, which concerned the provision of healthcare in northwest London.[1] NHS North West London's joint committee of primary care trusts (JCPCT) has agreed with all recommendations made in the business case report, confirming its decision on 19 February.

The decision means that emergency departments at Charing Cross, Central Middlesex, Hammersmith, and Ealing hospitals will be downgraded to urgent care centres, while an additional £190m will be invested in care out of hospitals to improve community facilities and the care provided by general practitioners.

Following the changes, more serious cases will be referred to emergency departments at Hillingdon, Northwick Park, West Middlesex, Chelsea and Westminster, or St Mary's hospitals.

The joint committee said the purpose of the *Shaping a Healthier Future* programme was to deal with the challenges of an ageing population, more people with chronic conditions, and unacceptable variations in the quality of care.

Jeff Zitron, chair of the joint committee, said: "We have not taken this decision lightly, and have been very careful to consider the many thousands of responses we received during our extensive consultation last summer."

Mark Spencer, medical director for *Shaping a Healthier Future* and a GP in Ealing, said: "I am pleased that the JCPCT agreed that this was the best decision for a clinically safe, high quality, and financially secure future for all the hospitals and NHS trusts in northwest London."

The announcement has prompted condemnation from some corners—including Andy Slaughter, Labour MP for Hammersmith, who said: "Two million west London residents are affected and 100 000 have already signed petitions opposing the closures. Those people have been ignored."

Consultants from Ealing Hospital NHS Trust published a letter in August 2012 detailing their opposition to the proposals.[2]

Ealing Council also opposes the changes, and says that its health overview and scrutiny committee would be reviewing the decision. Julian Bell, council leader, stated: "We are worried about the ability of the remaining hospitals to cope with the extra demand, the scale and speed of these plans, and if they are safe. We are looking at all the options open to us to fight these plans, including referring it to the secretary of state and challenging it through a judicial review."

Cite this as: *BMJ* 2013;346:f1200

DAVID NASH/DEMOTIX/PA

A choir leads a protest on 16 February against the planned closure of A&E departments at (below, left to right) Central Middlesex, Charing Cross, Ealing, and Hammersmith hospitals in London

Tramadol needs stronger controls to reduce deaths from misuse, say experts

Susan Mayor LONDON

The UK government should make the analgesic tramadol a controlled class C substance that carries a potential fine and prison sentence for anyone found using it without a prescription or dealing in the drug, an expert group has said.

The Advisory Council on the Misuse of Drugs made its recommendation after conducting a review in response to the rise in deaths from misuse of the drug.[1]

Tramadol is a synthetic opioid that is not currently classified under the Misuse of Drugs Act 1971, which controls access to drugs considered to be have potential for harm and misuse.

If the government adopts the recommended change, anyone convicted of possessing tramadol without a prescription for it could receive up to two years in prison or an unlimited fine, or both. Anyone found guilty of dealing in a class C drug can receive a prison sentence of up to 14 years in prison, an unlimited fine, or both.

The council, which advises the government on issues related to drugs, reviewed the harms associated with the non-medical use of tramadol after NHS reports showed increasing misuse. Deaths in which tramadol was mentioned on death certificates rose from 83 in 2008 to 154 in 2011. Most of these deaths were of people who had obtained tramadol without a prescription for it.

The rise in deaths linked with tramadol has occurred against a background of increased prescribing of the drug. The number of daily defined doses (which is based on the average daily maintenance dose when used by adults for its main indication) in England nearly doubled in seven years from around 5.9 million in September 2005 to 11.1 million in September 2012.

In the report the council warns, "Tramadol's unique dual action increases the risk of adverse effects, particularly in overdose." The drug has weak agonist activity at opiate receptors in the brain, which may cause euphoria and respiratory depression. It also enhances serotoninergic and noradrenergic systems in the brain by inhibiting their reuptake mechanisms. The fact that only the opioid effects of tramadol are reversible with naloxone makes it more likely to cause harm than other opioids, particularly when combined with other monoamine active drugs.

In a letter to the home secretary and the health secretary, Les Iversen, chairman of the council, said, "The [council's] review of the evidence has caused it concern, particularly the increase in tramadol related deaths."

Cite this as: *BMJ* 2013;346:f1264

Doctor groups identify five of their own inappropriate practices

RIA NOVOSTI/SPL

Imaging of the carotid arteries should not be carried out for simple syncope without other neurological symptoms, neurologists said

Miriam E Tucker BETHESDA

Physicians from 17 specialty medical organisations in the US have each produced lists of five common practices that are of questionable value, as part of a project to promote dialogue with patients about appropriate use of tests, procedures, and medications.

The Choosing Wisely initiative (www.choosingwisely.org), set up by the American Board of Internal Medicine Foundation, has launched 17 new lists.

Each specialty society's list is made up of common practices that are not supported by evidence, are not necessary, or may cause harm. The "five things physicians and patients should question" are written in simple language, including explanations for why the practice is not advised.

Antibiotic use is a major target, with advice against its routine use for acute sinusitis (from the American Academy of Family Physicians), adenoviral conjunctivitis (the American Academy of Ophthalmology), and acute external otitis (the American Academy of Otolaryngology).

Unnecessary imaging is another frequent theme. The American Academy of Neurology says, "Don't perform imaging of the carotid arteries for simple syncope without other neurologic symptoms." And the Society for Vascular Medicine tells physicians: "Don't re-image deep vein thrombosis in the absence of a clinical change."

Both the American Geriatrics Society and the American Academy of Hospice and Palliative Medicine cite practices that, although generally beneficial, are not appropriate in situations of limited life expectancy. Among these are "Don't leave an implantable cardioverter-defibrillator activated when it is inconsistent with the patient/family goals of care," and "Avoid using medications to achieve hemoglobin A_{1c} less than 7.5% in most adults age 65 and older."

This new set of lists is the second go-round for the *Choosing Wisely* initiative, which was first launched in April 2012, with nine specialty organisations issuing "Don'ts."[1] Since then, those organisations have developed materials based on their lists for their members and for patients. The widely read magazine *Consumer Reports*, AARP (formerly the American Association for Retired Persons), and Wikipedia have also joined in the effort to target the messages at the general public.

The ongoing initiative is expected to influence healthcare policy as well as practice.

Christine Cassel, president and chief executive officer of the American Board of Internal Medicine Foundation, said at a press briefing, "We've begun to stimulate a conversation about quality, safety, and patient centered care, along with reducing unnecessary tests and procedures."

She said that Choosing Wisely "is about the right care at the right time for the right patient and changing the notion that more is always better."

David Longworth, chair of the Cleveland Clinic's Medicine Institute, said that his organisation had already embedded the original "Don't" lists into its clinical practice guidelines. "The drive to value for healthcare delivery in this country is a profoundly fundamental issue for our time, and we think this initiative supports that," he said.

● EDITORIAL, p 10

Cite this as: *BMJ* 2013;346:f1266