THIS WEEK

Articles appearing in this print journal have already been published on thebmj.com, and the print version may have been shortened

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2 Cameron reiterates promise of seven day access to GPs by 2020
GMC will develop single exam for all medical graduates wishing to practise in UK
3 Privately run NHS hospital is warned over standards
Guidelines are often based on evidence not relevant to primary care, study finds
4 Mass shootings in US more than double in six years, says FBI report
Everyone is happier in UK except for long term sick, figures show
Company withholds lifesaving drug in row
5 China tells UN climate talks it should still be treated as developing nation

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“Fighter against injustice”

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The BMJ website is fully responsive, which means that its pages automatically fit the different screen sizes of desktop and laptop computers, tablet devices, and smartphones. The new design is also less cluttered, which should mean that browsing is easier and pages load faster, with more prominent links to The BMJ’s campaigns, investigations, and advice for authors.
PICTURE OF THE WEEK

The Chinese government has announced a $7.6bn (£4.7bn; €6bn) plan to combat pollution, with over 100 environmental protection measures aimed at reducing vehicle emissions and factory and domestic pollution. This photograph illustrates the scale of the problem: a large screen showing blue skies beams out of Beijing's smog.

RESPONSE OF THE WEEK

This week’s The BMJ has many responses on “reducing admissions,” and our CCG like many is planning on this nebulous ideal as the only way it will meet its budget.

May I suggest we stop this patently unachievable game? Yes we need care in the community, more GPs, more A&E doctors, more scanners, more cancer specialists, more district nurses—for which there is no politically supplied funding. However, as the population gets older and demands better quicker care, hospital trips will increase even though they may be shorter and more intense. We should plan and budget for this.

Other industries welcome increased demand and activity. The funding structure distorts things in healthcare, and the political lack of will to state the obvious, that healthcare is rationed and has always been and will continue to be. We all know this but for some reason continue with these illusionary policies of salvation.

Nicholas Sharvill, GP, Deal, UK, in response to, “Preventing hospital admission: we need evidence based policy rather than “policy based evidence” (BMJ 2014;349:g5538)
Two years ago the UK government said it would introduce a minimum price on a unit of alcohol. Instead it chose to ban below-cost selling. Alan Brennan and colleagues have now modelled the two approaches and found a big difference in their likely impact (p 13). A minimum unit price of 43p would affect nearly a quarter of all units sold, compared with just 0.7% affected by the ban. Our editorialist Tim Stockwell (p 9) thinks we can trust this analysis and wonders why the UK alcohol industry is so against a minimum unit price, while the policy has been embraced in Canada. Could it be the fear that the policy would prove beneficial to health and open the door to restrictions of other health harming commodities such as tobacco and fast food?

This battle for the public’s health accompanies a host of clinical content in this week’s journal. Perthes’ disease is easily missed. As Peter Kannu and Andrew Howard explain, just under half of cases are diagnosed at an advanced stage (p 32). The problem for doctors is that musculoskeletal complaints are common in children and are usually benign.

Meanwhile, Kristin Jensen and Peter Bulova review the management of adults with Down’s syndrome (p 27). Often now living well into middle age, people with the syndrome have several factors in their favour, including a lower risk of hypertension, coronary heart disease, and solid tumours. But their doctors need to be on the lookout for other conditions: hypothyroidism, sleep apnoea, osteoporosis, Alzheimer’s dementia, and respiratory infection, which is the leading cause of death.

Mike Crawford and colleagues ask whether mood stabilisers are helpful in treating borderline personality disorder (p 34). UK and US guidelines give conflicting advice, and our authors decide against. While acknowledging the challenges of supporting these patients, they point to a lack of good evidence of benefit, adverse events, and potential toxicity.

What of the controversy over whether doctors should be allowed to prescribe the unlicensed drug bevacizumab (Avastin) for wet age related macular degeneration instead of the much more expensive and licensed ranibizumab (Lucentis)? Already shown to be equally effective, bevacizumab has now been found by a Cochrane review to be safe. In Last Words (p 37) David Lock says it’s time for healthcare commissioners to act rationally and show courage. “Why should an NHS under vast financial pressure give clinicians the choice to use a less cost effective drug?” he asks. It should be bevacizumab or nothing.

So there’s no shortage of clinical reading. But if you have time for only one article this week let it be “The science of anthropogenic climate change: what every doctor should know” (p 17). As I explain in a linked editorial (p 10), this Analysis article is pure climate science, intended to give you information you will need to become informed advocates for action against climate change. Time is short, geophysically and politically. We have just over a year until the next round of climate talks in Paris in December 2015. If you haven’t already done so please visit the Global Climate and Health Alliance website (www.climateandhealthalliance.org) and see what you can do to make your voice heard.

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