THIS WEEK

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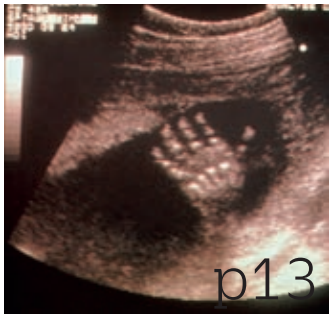

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NEIL WEBB

Sudden cardiac death in athletes
CLINICAL REVIEW, p 27

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The Editor, *The BMJ*
BMA House, Tavistock Square,
London WC1H 9JR
Email: editor@bmj.com
Tel: +44 (0)20 7387 4410
Fax: +44 (0)20 7383 6418

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GONZALO FUENTES/REUTERS

PICTURE OF THE WEEK

Doctors and medical students from all over France took to the streets of Paris last weekend in the French medical profession's biggest protest march in over two decades. With the support of professions allied to medicine, they were protesting against a new public healthcare bill, which they claim will increase their administrative workload. Currently, patients in France pay upfront for a medical consultation and later claim reimbursement from a public fund. But the new bill proposes that patients pay nothing upfront and that it becomes the doctor's responsibility to claim back their fee from the fund. The French government says the present arrangement deters poorer patients from seeing their doctors.

THEBMJ.COM POLL

Last week's poll asked:

Is it the role of GPs to identify people at risk of cold homes?

YES 14%
NO 86%
Total votes cast: 211

This week's poll:

Is it feasible to tell patients all the risks associated with a procedure or treatment?

BMJ 2015;350:h1481

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Online highlights from thebmj.com

THIS WEEK IN 1915

In August 1914 a boy aged 7 watched as a grown-up friend used a knife to open a golf ball. Suddenly it exploded and threw fluid (possibly a mixture of barium sulphate, soap, and a free alkali) into his eye. R H Elliot and W S Inman note in their case report that injuries to the eye from contact with the contents of the so called "water core " golf balls are becoming so frequent as to constitute "a serious menace." The authors cite a recent bill by the legislature of Massachusetts to prohibit the sale of the dangerous forms of golf ball, and the United States Golf Association has warned against opening them. The authors conclude: "If more cases are reported—and we believe that not a few have really occurred—of serious damage to eyesight from this cause, it will be a question whether more vigorous action should not be taken by the profession.

BMJ 1915;1:501

RESPONSE OF THE WEEK

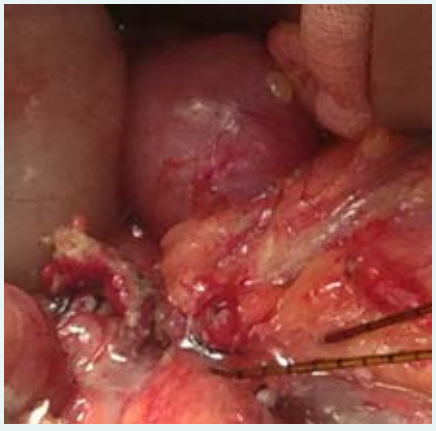
The deepest effect [of QOF] has been on the doctor-patient relationship. We now move from patient centred consultations, where one looks at the person, to QOF centred consultations, where one looks at the computer. Vocation has moved to automation to feed the beast of QOF. This profoundly demoralises doctors, who are retiring early or refuse to join this "painting by numbers," fragmented approach to care—we were trained to be holistic masterpiece artists.

I have spoken to GPs leaving practice who report they would carry on if they could just look after patients. QOF and related impositions damage our professional motivation. While we have been distracted, hospital admissions have risen so we would do well to recall the wise words, "It is not the healthy who need a doctor, but the sick."

Jonathan M Orrell, GP, Weymouth, UK, in response to, "Does paying for performance in primary care save lives?"

BMJ 2015;350:h1051

STATE OF THE ART CLINICAL REVIEW: PANCREATIC CANCER



This week our State of the Art review focuses on stage III pancreatic cancer and the role of irreversible electroporation. About a third of patients with pancreatic cancer present with locally advanced disease that cannot be surgically resected. Conventional ablative therapies (thermal ablation and cryoablation) could be beneficial, but their use is limited in the pancreas.

These limitations could be overcome by irreversible electroporation (IRE)—a new, non-thermal ablative method that is gaining popularity for the treatment of many soft tissue tumours, including those of the pancreas. IRE uses high energy electrical pulses that cause apoptosis of cells while preserving of integrity of nearby vessels and structures.

This review summarises the status of IRE in the treatment of stage III locally advanced pancreatic cancer. Evidence about its use is mainly based on non-randomised prospective series, which show that irreversible electroporation may improve overall survival and pain control in locally advanced pancreatic cancer. Randomised controlled trials are needed to document its efficacy and safety more precisely.

BMJ 2015;350:h369

LATEST BLOGS

Sabre-toothed tigers and the lottery

A low threshold for attending accident and emergency departments is straining the NHS, says Samir Dawlatly. Patients need to take the blame for turning up at A&E or calling an ambulance inappropriately, he writes. Is it because we are hard wired to worry, he asks—and how can patients be educated to assess risk better?

http://bmj.co/nhsstrain

Manchester—the birth and death of the NHS

Is the devolution of the NHS budget in Greater Manchester the end of the NHS? Yes, argues David Wrigley. And it is a hugely worrying and risky deal, he says.

http://bmj.co/manchester

How to be an academic social media star

How can academics publicise their research? By using social media, says Melissa Terras. David Payne found out how she became the most downloaded academic in her faculty at UCL.

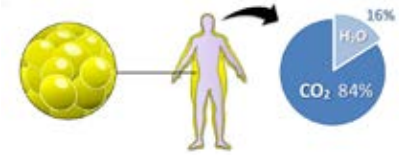
http://bmj.co/socialmedia

Upside down, down under

Imagine being strapped into a helicopter, turned upside down, plunged into water, and told to escape—all this is part of the helicopter underwater escape training for retrieval registrars in Australia.

http://bmj.co/HUET

MOST READ ARTICLES ONLINE



When somebody loses weight, where does the fat go?

BMJ 2014;349:g7257

Assessment and management of behavioural and psychological symptoms of dementia

BMJ 2015;350:h3694

Diagnosis and management of asthma in children

BMJ 2015;350:h996

The Darwin Awards: sex differences in idiotic behaviour

BMJ 2014;349:g7094

EDITOR'S CHOICE

New rules of consent: the patient decides

The law now obliges "even those doctors who have less skill or inclination for communication, or who are more hurried, to pause and engage in the discussion"

How much information should patients be given about the risks of treatment? And who decides what a patient needs to know? Until now, in the United Kingdom, doctors have been allowed to decide this, and the 30 year old Bolam test specified that their conduct would be considered acceptable if it would be supported by a responsible body of medical opinion.

But this has all just changed. Last week the UK's Supreme Court judged that it was for patients to decide whether the risks of treatment and alternative options have been adequately communicated. Nadine Montgomery, who has diabetes, was not told of the risks of shoulder dystocia to her baby boy, who subsequently developed cerebral palsy (p 1). Her obstetrician justified holding back this information on the grounds that it might have discouraged her from having a vaginal delivery.

This will no longer do. As Daniel Sokol explains (p 22), the Montgomery ruling means that doctors will have to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments." Sokol advises doctors to make extra sure that the discussion is fully documented.

What counts as a material risk? Here the Supreme Court has landed a clear and crucial blow to medical paternalism. Instead of a responsible body of medical opinion, the judgment now rests with "a reasonable person in the patient's position."

Sokol outlines the questions doctors should now ask themselves when seeking consent from patients. The result will surely be a better conversation. Some doctors will say they don't have time, but if ethics and professionalism are not enough to bring about the necessary change in attitudes and behaviour, the court is uncompromising: the law now obliges "even those doctors who have less skill or inclination for communication, or who are more hurried, to pause and engage in the discussion."

The days should be long gone when obtaining consent was left to the most junior trainee, tasked with getting the patient's signature on a standard form, like a salesperson on commission. But how well things are done will vary from person to person and place to place. These days, in the best centres, patients who are considering undergoing a major procedure or course of treatment are invited to a specialist clinic, where experts in communicating risk spend time going through the options, including the option of doing nothing.

But this is a skill that all doctors need to learn, perhaps, dare I say it, especially surgeons. So it's good to hear from Clare Marx, recently appointed president of the Royal College of Surgeons, that, along with improving the quality of surgical training, shared decision making is high on her agenda. The college's recent report *Good Surgical Practice* emphasises the importance of collaboration and shared decision making. In *The BMJ*'s interview published this week (p 16) Luisa Dillner, herself a former surgical trainee, asks, "Are these traditional surgical attributes?" Marx's reply: "They will be."

Fiona Godlee, editor in chief, *The BMJ*
fgodlee@bmj.com

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