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EDITOR'S CHOICE

Hard cases

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One of the more controversial papers we've published recently was a meta-analysis of the cardiovascular effects of calcium supplements by Mark Bolland and others (*BMJ* 2010;341:c3691). It reported that calcium supplements without co-administered vitamin D were associated with an increased incidence of myocardial infarction. The researchers called for a reassessment of the role of calcium supplements in the management of osteoporosis. Many respondents were unhappy about the paper, and those with commercial interests in the supplement industry were the unhappiest of all.

Less than a year later, Bolland's team is back, having re-analysed a large randomised controlled trial of calcium and vitamin D supplementation and updated its earlier meta-analysis on the topic (doi:10.1136/bmj.d2040). The general findings—and the researchers' message—are the same. Editorialists Bo Abrahamsen and Opinder Sahota, however, aren't convinced and want more research.

The "truth," if and when it emerges, will be thanks to the positivist philosophy that underpins quantitative research. John Paley and Richard Lilford provide a nuanced discussion of this philosophical position en route to savaging its alternative: constructivism (doi:10.1136/bmj.d424). The debate is not purely academic: for some, the qualitative research published by this journal depends on constructivist philosophy for its credentials.

In an account that might have been titled *The Poverty of Constructivism* (had not others got there first) the authors warn against allowing constructivism to gain a foothold in medicine, as it has done recently in disciplines such as nursing. (For the record, the *BMJ* publishes more qualitative research than other general medical journals—and it's cited less than quantitative research.)

Positivism or constructivism, quantitative or qualitative research? Which has the greater chance of throwing light on the apparently intractable problem of unhappy officers belonging to London's Metropolitan Police Service? Derek Summerfield reflects on his years as a consultant occupational psychiatrist to the service, which grants pensions only on completion of 30 years' service or on grounds of ill health (doi:10.1136/bmj.d2127).

"To qualify for retirement on psychiatric grounds an officer must be deemed 'permanently disabled' from resuming the full duties of a police officer, a test that in my clinical judgment only a few could pass," wrote Summerfield of the 300 assessments he made concerning retirement for ill health. "The number one predictive factor regarding return to work and career was whether the officer wanted to, which no psychiatric formulation captures." He approves of the recent switch in sickness certification that focuses on what people can do rather than what they can't. Clearly, with "work stress" now the commonest cause of sickness absence in the UK, his comments are relevant far beyond the Metropolitan Police Service.

Tough love is all around us. So what will happen to the smack of strong leadership, something of a recent cult in the NHS, in these straitened times? Michael Jenkins ponders the options (doi:10.1136/bmj.d2552). The NHS loves strong leadership, he notes, "so much that Andrew Lansley recently wrote a letter to GPs urging those interested to develop their leadership skills through the National Leadership Council … made up of 28 core members, supported by six nationally renowned patrons, who in turn 'draw upon' fellows, and so on."

My recollection of the consultation period for Mr Lansley's Health and Social Care Bill saw every medical outfit in the country submitting a considered response—thereby providing exemplary displays of leadership. That the health secretary chose to ignore all but one or two responses now looks like a fatal, unforced error (see this week's Letters, doi:10.1136/bmj.d2584 , doi:10.1136/bmj.d2587 , doi:10.1136/bmj.d2591, doi:10.1136/bmj.d2597). Just for the moment, could we hear less from Mr Lansley and his department on the delights of strong leadership?

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