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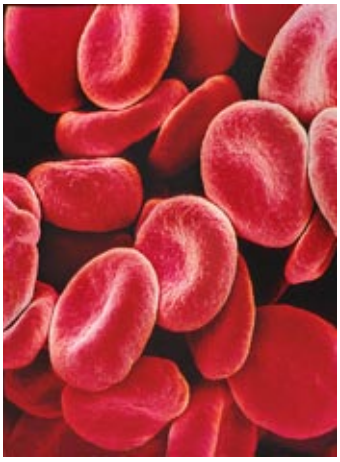
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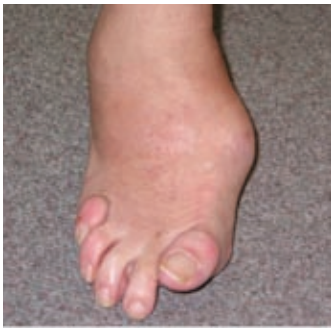

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MARIANA BAZO/REUTERS

PICTURE OF THE WEEK

Prostitutes in Lima, Peru, queue at a brothel to be tested for HIV as part of an awareness campaign promoted by the government. See News, p 1281.

THE WEEK IN NUMBERS

72.3bn Maximum predicted cost of an influenza pandemic with high fatality **(Research, p 1298)**

6.5% Haemoglobin A_{1c} value at which type 2 diabetes should be diagnosed **(Analysis, p 1288)**

5% Proportion of patients with diabetes who get foot problems each year, causing considerable morbidity and mortality **(Clinical Review, p 1304)**

$103m Damages paid by Pfizer to two women who developed cancer after using HRT **(News, p 1275)**

75% Proportion of published clinical trials sponsored by industry that have positive results **(Head to Head, p 1286)**

THE WEEK IN QUOTES

"These new risk prediction algorithms for osteoporotic fracture and hip fracture can be used in primary care or for individual self assessment" (Research, p 1291)

"You have to have unexplained variation to drive improvement" (Feature, p 1284)

"Primary hyperparathyroidism is the commonest cause of hypercalcaemia in the community" (Practice, p 1308)

"Anyone know what a doula is?" (Personal View, p 1316)

"The vast majority of people who take cannabis remain happy and healthy" (News, p 1279)

EDITOR'S CHOICE

We need to put the evidence to work

ARNO MASSEE/SPL

The hand of a premature baby lit by ultrared light

Editorial, p 1265
Research, p 1297

Could the current economic crisis be the making of evidence based medicine? Important though the past two decades have been for evolving EBM's concepts, tools, and methods, I wonder if we have been only playing at putting evidence into practice. Perhaps it's only now, in this harshest of financial climates, that we'll really have to put the evidence to work

Speaking at the King's Fund's annual conference last week, John Appleby, the fund's chief economist, left no doubt about the harshness of the financial climate or how cold it's going to get. The King's Fund and the Institute of Fiscal Studies' three scenarios for future NHS funding start at "arctic" and warm up only to "tepid." The middle scenario, "cold," shows zero growth, something the NHS has never yet experienced. This scenario would still inflict a 3% cut on other government departments and leave a £19-20bn gap compared with what the 2007 Wanless report said we should be spending on health care (*BMJ* 2009;339:b5124).

Where will the money come from to even partly fill this gap? Appleby concluded with only two real options: increased taxation and "getting more bang for our NHS buck." Mark Jennings, director of healthcare improvement at the King's Fund, took us on from there, calling for a new healthcare paradigm in which quality care (effective, safe, and delivering a good patient experience) must also be efficient. This means eliminating "clinical waste"—not the stuff in the yellow bins but the unwarranted variations in what we do and how we do it. It's in widely varying lengths of hospital stay and rates of prescribing generics that we have most scope to increase quality and reduce cost (*BMJ* 2009;339:b5075).

But are variations in practice always a bad thing? According to a surprising consensus reached at the end of last week's BMJ/King's Fund debate, the answer is no (p 1284). Variations are only bad where there is strong evidence for a specific course of action. Delegates agreed that in such cases we should strive to eliminate unwarranted variation. But where there's no strong evidence, eliminating such variation would drive out essential innovation, argued Robert Lechler. Since more interventions in health care lack an evidence base than have one, there's huge scope for experimentation. But it has to be tied to proper evaluation and reliable comparative local data on what's actually happening, which are badly lacking at the moment (p 1275)

Good data can change things, especially when combined with good clinical leadership, as several speakers demonstrated. This is also the message of a report from Rwanda in the *BMJ* this week (p 1311) The BMJ Group is working on both fronts, developing evidence based performance metrics and about to launch a modular online leadership programme in partnership with the Open University (http://group.bmj.com/products/learning/clinical-leadership).

It's easy to ignore data that make us look bad, as individuals or as organisations. Mark Jennings presented some common reactions. (1) The data are wrong. (2) The data are right, but it's not a real problem. (3) The data are right, and it's a real problem, but it's not my problem. (4) The data are right, it's a real problem, and it's my problem—but I don't need to do anything about it. What's changed? It's the economy, stupid.

Fiona Godlee, editor, *BMJ* fgodlee@bmj.com

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See *Clinical Evidence* for the latest updates to these and other reviews
clinicalevidence.bmj.com

PLUS Career Focus, jobs, and courses appear after p 1318

WHAT'S NEW ON BMJ.COM

LATEST RESEARCH

Are people with negative diabetes screening tests falsely reassured?
A negative test result at diabetes screening does not seem to promote false reassurance, whether this is expressed as lower perceived risk, lower intentions for health related behavioural change, or higher self rated health, according to this cohort study embedded in a randomised controlled trial. The findings imply that the process of attending a primary care based stepwise diabetes screening programme would be unlikely to lead to an adverse shift in the population distribution of plasma glucose and cardiovascular risk as a result of an increase in unhealthy behaviours.
Read this and more research at http://www.bmj.com/channels/research.dtl

NEW PROGRAMME FOR LEADERSHIP IN MEDICAL EDUCATION

Applications are being accepted for an exciting and innovative programme in Leadership in Medical Education, developed as a partnership between Sweden's Karolinska Institute and the *BMJ*. "Leading for Change in Health Education" aims to create a network of international leaders who will transform health professional education. The programme will be held in Stockholm from 17 to 21 May 2010.
For more information and to apply online, please visit bmj.com/leadforchange.

LATEST BLOGS

Junior doctor Louise Kenny in Guatemala literally wakes up and smells the coffee. Her team visited a coffee plantation of approximately 250 people, many of whom had jaundice, skin diseases, and gastrointestinal symptoms owing to deficient water sanitation. Providing medical care in this environment would be a challenge for any medical team, but Louise is struck by something else: "Unlike the rest of us who think we can't live without coffee . . . Here workers earn £0.025 per lb, which is sold on at an average of £2.20 per lb and hits our streets at around £7.50 per lb. It's big business and despite many a mocho-choca-frappe-cappuccino, I had never thought about the hand that picks the bean."
Read this and other blogs at http://blogs.bmj.com/bmj/

MOST COMMENTED ON

Tennis elbow
Salt intake, stroke, and cardiovascular disease
The power of stories
Poor service provision is blamed for overuse of antipsychotics in dementia patients
Slow walking speed and cardiovascular death in well functioning older adults

LATEST PODCAST

The King's Fund 2009 annual conference was entitled "Transforming quality, creating value: developing health care for a new economic era." What can health care do to continue its work of improving quality and safety and save money? We ask Cleve Killingsworth, the CEO of Blue Cross Blue Shield of Massachusetts, about how the American insurance giant is tackling the issue.

Last week's poll asked:

"Should the NHS strive to eradicate all unexplained variation in practice?"
You voted:
No: 181 (65%) Yes: 96 (35%)

This week's poll asks:

"Is the conflict of interest unacceptable when drug companies conduct trials on their own drugs?"

Go to bmj.com to vote

doc2doc

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Universal standard of medical doctors!
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