

EDITORIALS

- 289 Anticoagulation in people with atrial fibrillation**
Risk prediction tools help, but treatment must be tailored individually, says Margaret C Fang
[» Research, p 320](#)
- 290 Chest compression or conventional CPR after out of hospital cardiac arrest?**
Definitive evidence is lacking, but either is better than no CPR, says Ian G Jacobs
[» Research, p 321](#)
- 291 Primary prevention of cardiovascular disease**
The current model in the UK is not necessarily the right one or the only one, says John P D Reckless
[» Analysis, pp 313, 316](#) [» Research, p 322](#)
- 292 Adverse outcomes from IVF**
Should be systematically reported so that lessons can be learnt and appropriate action taken, say Susan Bewley and colleagues
- 293 Prevention and control of chronic diseases**
September's UN General Assembly meeting is a unique opportunity to put them on the world's agenda, say Peter Piot and Shah Ebrahim
[» Filler, p 329](#)

LETTERS

- 295 Open letter to the BMA; Interim cancer drugs fund**
- 296 Paracetamol; Infective endocarditis**
- 297 Flu questions and answers; Research approval; Reduced access to database**
- 298 Access to clinical trial data; Out of hospital cardiac arrest; NHS drug budget**

NEWS

- 299 MPs support NHS changes as health bill passes first hurdle**
Florida judge says health reform act is unconstitutional
- 300 New appointment of evangelical Christian to drug advisory body sparks controversy**
Experts say drinks industry is not interested in health
- 301 BMA calls special meeting on NHS reforms**
US manufacturer of lethal injection stops drug production
- 302 US health department recovers \$4bn through antifraud action**
Older Americans are paying the price of high smoking rates in the 1950s and 1960s
- 303 MEPs criticise WHO for alarm created by H1N1 pandemic advice**
Spain's tough line on smoking in public spreads to other countries
- 304 Gates and Cameron pledge to eradicate polio**
Germany pushes for more organ donation
US firms may have to prove safety of ECT machines
- 305 Widening the market for drugs affects safety**

SHORT CUTS

- 306 What's new in the other general journals**

FEATURES

- 308 Well enough to work?**
Increasing numbers of people previously deemed medically unfit to work are being taken off state benefits after assessments. Margaret McCartney investigates the ethics and fairness of the system
- 310 Does poor health justify NHS reform?**
Andrew Lansley claims radical NHS reform is necessary to drive up the UK's poor health outcomes compared with Europe. But is our record really so bad, questions John Appleby?

OBSERVATIONS

ETHICS

- 312 "Make the care of your patient your first concern"**
Daniel K Sokol

ANALYSIS

- 313 How should we balance individual and population benefits of statins for preventing cardiovascular disease?**
US and UK groups revising recommendations on primary prevention of cardiovascular disease will have to decide whether to concentrate on high risk individuals or the whole population. Aroon Hingorani and Harry Hemingway argue that the evidence favours a population approach
[» Editorial, p 291](#) [» Research, p 322](#)
- 316 Unanswered questions over NHS health checks**
England plans to target vascular disease by offering all adults aged 40-74 a regular health check, but Kamlesh Khunti and colleagues point out that success is far from guaranteed
[» Editorial, p 291](#) [» Research, p 322](#)

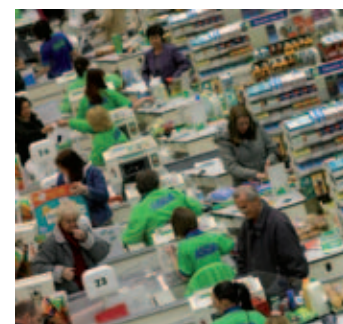
RESEARCH

- 319 Research highlights:**
the pick of *BMJ* research papers this week
- 320 Validation of risk stratification schemes for predicting stroke and thromboembolism in patients with atrial fibrillation: nationwide cohort study**
Jonas Bjerring Olesen, Gregory Y H Lip, Morten Lock Hansen, Peter Riis Hansen, Janne Schurmann Tolstrup, Jesper Lindhardsen, Christian Selmer, Ole Ahlehoff, Anne-Marie Schjerning Olsen, Gunnar Hilmar Gislason, Christian Torp-Pedersen
[» Editorial, p 289](#)
- 321 Outcomes of chest compression only CPR versus conventional CPR conducted by lay people in patients with out of hospital cardiopulmonary arrest witnessed by bystanders: nationwide population based observational study**
Toshio Ogawa, Manabu Akahane, Soichi Koike, Seizan Tanabe, Tatsuhiro Mizoguchi, Tomoaki Imamura
[» Editorial, p 290](#)



MALCOLM WILLET

Editorial, p 291; Analysis, pp 313, 316; Research, p 322



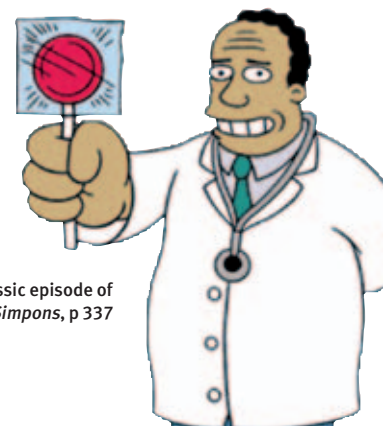
Health and the alcohol industry, p 300



The business of "fit notes," p 308



Who needs anticoagulants? p 289



A classic episode of *The Simpsons*, p 337

- 322 Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom: interrupted time series study**

Brian Serumaga, Dennis Ross-Degnan, Anthony J Avery, Rachel A Elliott, Sumit R Majumdar, Fang Zhang, Stephen B Soumera

» Editorial, p 291

- 323 Impact of a statewide intensive care unit quality improvement initiative on hospital mortality and length of stay: retrospective comparative analysis**

Allison Lipitz-Snyderman, Donald Steinwachs, Dale M Needham, Elizabeth Colantuoni, Laura L Morlock, Peter J Pronovost

- 324 Portrayal of caesarean section in Brazilian women's magazines: 20 year review**

Maria Regina Torloni, Silvia Daher, Ana Pilar Betrán, Mariana Widmer, Pilar Montilla, Joao Paulo Souza, Mario Merialdx

CLINICAL REVIEW

- 325 The assessment and management of rectal prolapse, rectal intussusception, rectocele, and enterocele in adults**

Oliver M Jones, Christopher Cunningham, Ian Lindsey

PRACTICE

RATIONAL TESTING

- 330 Testing for secondary causes of osteoporosis**

Melissa O Premaor, Juliet E Compston

SAFETY ALERTS

- 332 Safer loading doses of medicines: summary of a safety report from the National Patient Safety Agency**

Tara Lamont, David Cousins, Anna Bischler, David Gerrett

OBITUARIES

- 334 Leslie James Clark-Wilson; John Mark Gibson; Catherine Margaret Hall; Anthony Howard James; Samarthji Lal; Ian Hayes Fyfe Murray**

VIEWS AND REVIEWS

PERSONAL VIEW

- 335 Give judges evidence on which to base sentencing**
Sheila M Bird and colleagues

REVIEW OF THE WEEK

- 336 Ars Intrinsic**
An exhibition at the Röntgen Museum
Arpan K Banerjee

BETWEEN THE LINES

- 337 Tuberculosis and genius**
Theodore Dalrymple

MEDICAL CLASSICS

- 337 One Fish, Two Fish, Blowfish, Blue Fish**
An episode of *The Simpsons* Desmond O'Neill

COLUMNISTS

- 338 Bad medicine: cardiology** Des Spence
Definitely not acceptable Ike Iheanacho

ENDGAMES

- 339 Quiz page for doctors in training**

MINERVA

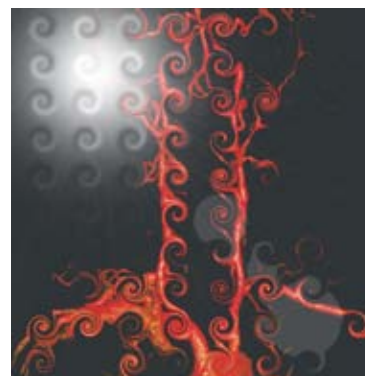
- 340 Albrecht Dürer's *Praying Hands*, and other stories**

FILLERS

- 329 Analysis of temporal trends in the *BMJ* archive**
» Editorial, p 293



Rectal prolapse, p 325



Radiography meets art, p 336



Did tuberculosis make Voltaire a genius? p 337

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EDITOR'S CHOICE

Chronic disease must top the agenda

Unhelpful myths include that these are diseases of affluence, that they are not a cause of premature death, and that there are no cost effective interventions

The *BMJ* archive has been put to various good uses since it was digitised and made available on bmj.com two years ago (*BMJ* 2010;341:c6898, c6738, c5168). This week, Mangesh Thorat and colleagues present a brief summary of their findings after searching the archive from 1840 for mentions of four communicable and four non-communicable diseases (p 329). The temporal trends are not surprising and nicely illustrate a story of our time—the past 50 years have been the era of chronic disease.

If the *BMJ* does its job properly over the next 50 years, the trajectory of coverage of chronic disease is likely to climb even more steeply. In their editorial Peter Piot and Shah Ebrahim report that already nearly two thirds of global deaths are attributable to chronic diseases and that the number of deaths from chronic diseases is projected to rise dramatically between now and 2030 (p 293).

Given the size of the challenge, why is chronic disease not at the top of the world's health and political agendas? Piot and Ebrahim blame unhelpful myths. These include that chronic diseases are due to affluence, that they are not a cause of premature death, and that there are no cost effective interventions. But neglect is also due to lack of leadership, they say, and the absence of powerful community activists.

Successful lobbying for change tends to be modelled on the individual disease approach exemplified by the HIV/AIDS movement. But the major chronic diseases—cardiovascular diseases, cancers, respiratory diseases, and diabetes—are a heterogeneous group. They share underlying lifestyle and societal causes that require

political, fiscal, and legal mechanisms more than intervention at the level of the individual. Even so, Piot and Ebrahim still feel that civil society, patients, and survivors of cancer can be powerful agents for change.

What can we do between now and September's UN General Assembly meeting on chronic diseases? Piot and Ebrahim make an urgent call for us to develop a concrete "ask"—a call to action for UN member states. Their own ask includes full implementation of the Framework Convention on Tobacco Control; reduction of salt, fat, and sugar in processed foods; and specific goals and funding for reducing the burden of chronic disease. What else do you think should be on the list if we are to push chronic disease to the top of the world's agenda?

As for the UK, it turns out that our outcomes for heart disease and cancer are not as bad as some politicians would have us believe (p 310). But there is clearly more that we can and must do. Exactly where to target our efforts for primary prevention of heart disease is a continuing debate, if the articles in this week's journal are anything to go by. Aroon Hingorani and Harry Hemingway argue for a population approach (p 313), but Kamlesh Khunti and colleagues are dubious about the proposed NHS health checks (p 316). In his editorial, John Reckless suggests that the NHS health checks should not preclude other efforts to target people at high risk (p 291). Watch this space.

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Cite this as: *BMJ* 2011;342:d716

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Career Focus, jobs, and courses appear after p 338

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