



PAUL BOSTON

● EDITORIAL, p 7
 ● RESEARCH, p 12
 ● ANALYSIS, p 23

NEWS

- 1 Pressure mounts for firms to hand over data on antidiabetes drugs
New King's Fund group will look at integrating health and social care
- 2 Obesity contributes to doubling in incidence of oesophageal cancer
Study finds low referral rates for gastroscopy put patients at risk of worse outcomes
- 3 Reconfiguration of children's heart surgery is suspended by Jeremy Hunt
HPV testing could cut cervical cancers by a third
- 4 E-cigarettes are to be regulated as medicines
Independent researchers should publish trial results if original teams don't
First reviews based on the "totality of the evidence" are published
- 5 UK regulators deny that their access to oseltamivir trial data was insufficient to assess its efficacy
- 6 Report into death of pregnant woman who was denied an abortion identifies clinical shortcomings
Doctors accused of being "horrible" over cancer awareness campaign



E-cigarettes to be regulated as medicines from 2016, p 4

RESEARCH

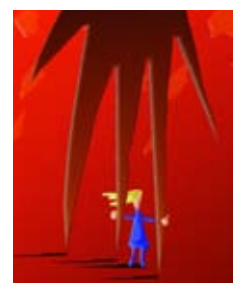
RESEARCH NEWS

- 11 All you need to read in the other general journals
- 12 Searching for unpublished data for Cochrane reviews: cross sectional study
Jeppe Bennekou Schroll et al
● EDITORIAL, p 7; ANALYSIS, p 23
- 13 Telemonitoring based service redesign for the management of uncontrolled hypertension: multicentre randomised controlled trial
Brian McKinstry et al
- 14 Implementation of self management support for long term conditions in routine primary care settings: cluster randomised controlled trial
Salford NIHR GI programme Grant Research Group
● EDITORIAL, p 10
- 15 Shared care obesity management in 3-10 year old children: 12 month outcomes of HopSCOTCH randomised trial
Melissa Wake et al

COMMENT

EDITORIALS

- 7 Restoring the integrity of the clinical trial evidence base Elizabeth Loder et al
● RESEARCH, p 12; ANALYSIS, p 23
- 8 Posterior circulation stroke: still a Cinderella disease
Hedley C A Emsley
- 9 Intimate partner and sexual violence against women
Alex Hardip Sohal and Davina James-Hanman
- 10 Interventions to enhance self management support
Xin Sun and Gordon H Guyatt
● RESEARCH, p 14



Big public health issue, p 9

HEAD TO HEAD

- 16 Should electronic cigarettes be as freely available as tobacco?
The Medicines and Healthcare Products Regulatory Agency has decided to license electronic cigarettes as medicines from 2016. Jean-François Etter thinks they should be as freely available as tobacco to reduce harm to smokers, but Simon Chapman sees them as another way for big tobacco to try to make nicotine addiction socially acceptable again

FEATURES

- 18 Are accident and emergency attendances increasing?
John Appleby unpicks the claims made for the causes of rising waiting times in emergency departments
- 20 Why we can't trust clinical guidelines
Despite repeated calls to prohibit or limit conflicts of interests among authors and sponsors of clinical guidelines, the problem persists. Jeanne Lenzer investigates



Dealing with conflicts of interests of guideline creators, p 20

ANALYSIS

- 23 Restoring invisible and abandoned trials: a call for people to publish the findings
Unpublished and misreported studies make it difficult to determine the true value of a treatment. Peter Doshi and colleagues call for sponsors and investigators of abandoned studies to publish (or republish) and propose a system for independent publishing if sponsors fail to respond
EDITORIAL, p 7; RESEARCH, p 12

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Doctors not tied to hygiene, p 31

COMMENT

LETTERS

- 27 Profits from pregnancy, Recurrent UTI in non-pregnant women
- 28 GMC's 2013 guidance to doctors, NICE on reproduction

OBSERVATIONS

REALITY CHECK

- 29 Sunlight of disclosure may shine brighter down under

Ray Moynihan

ETHICS MAN

- 30 Patients we don't like

Daniel K Sokol

PERSONAL VIEW

- 31 Put your ties back on: scruffy doctors damage our reputation and indicate a decline in hygiene

Stephanie Dancer

OBITUARIES

- 32 James Edmond Wraith
Paediatrician whose research crucially contributed to treatments for lysosomal storage diseases
- 33 François Jacob
Molecular biology pioneer and Nobel prize winner

LAST WORDS

- 43 End the scandal of free medical education
Des Spence
- Ether frolics Wendy Moore

EDUCATION

CLINICAL REVIEW

- 34 Diagnosis and management of first trimester miscarriage

Davor Jurkovic et al

PRACTICE

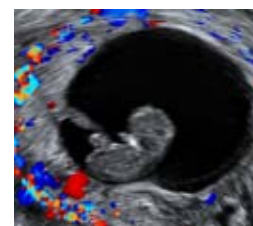
THERAPEUTICS

- 38 Opioids for chronic non-cancer pain

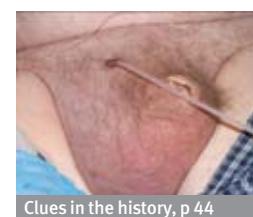
Rainer Freynhagen et al

ENDGAMES

- 42 Quiz page for doctors in training



Early fetal demise, p 34



Clues in the history, p 44

MINERVA

Breathlessness, and other stories

Returning from a break?

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GONZALO FUENTES/REUTERS

PICTURE OF THE WEEK

A manikin representing the state of the French health service is paraded by healthcare professionals in a demonstration in Paris last Saturday. Around 8000 doctors and other medical staff were protesting against the effect on healthcare of the government's austerity measures. See bmj.com for more articles on the effect of austerity measures in Europe (to be published in a forthcoming print issue):

- Editorial: Austerity policies in Europe—bad for health (*BMJ* 2013;346:f3716)
- Analysis: Will austerity cuts dismantle the Spanish healthcare system? (*BMJ* 2013;346:f2362)
- Review: Warning: austerity can seriously damage your health (*BMJ* 2013;346:f3659)
- Feature: Has austerity brought Europe to the brink of a health disaster? (*BMJ* 2013;346:f3773)

RESPONSE OF THE WEEK

The continuing scandal of unaffordable PFI hospitals is alarming. Peterborough/Stamford is not the first trust to go bust and neither will it be the last. It seems unbelievable that no one in NHS Central understands the meaning of unaffordable debt, and just as amazing that PFI debt is not being renegotiated country-wide. It is possible. Local authorities can secure large loans at low interest rates.

Currently the “preferred” options for financially challenged trusts are merger, takeover, or closure (or a combination of these) dressed up as rationalisation for clinical gain. Staff know that the result is longer waits in fewer A&E departments and intolerable pressure on acute beds. Patients know that mergers mean greater travel distances. Take PFI debt away and a large number of these schemes would be unnecessary.

Andrew N Bamji, consultant rheumatologist, Orpington, UK, in response to “PFI scheme is blamed for financial collapse of Peterborough and Stamford trust” (*BMJ* 2013;346:f3735)

MOST SHARED

Bicycle helmets and the law
Statins and the risk of developing diabetes
Am I missing something in the essay on the science of obesity?
Restricting dietary carbohydrate versus increasing physical activity in tackling obesity
P values or confidence intervals?

BMJ.COM POLL

Last week's poll asked: “Will access to individual surgeons' performance data improve patient care?”

51% voted no (total 642 votes cast)

► *BMJ* 2013;346:f3795

This week's poll asks:

“Should electronic cigarettes be as freely available as tobacco cigarettes?”

Head to Head:

Yes ► *BMJ* 2013;346:f3845

No ► *BMJ* 2013;346:f3840

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EDITOR'S CHOICE

In praise of informed scepticism

Although the rules on conflict of interest may be tightening, the current standards of care across much of medicine originate with similarly biased guideline panels

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Earlier this year, guidelines from three respected US professional societies advised doctors to give alteplase to patients with acute stroke. The recommendation was based on what the guidelines' authors considered grade A evidence. Yet as Jeanne Lenzer reports (p 20), surveys show that many if not most emergency physicians are sceptical of the benefits and concerned about the harms of alteplase. The published evidence shows reductions in disability but not in mortality, with only two of the 12 randomised trials showing benefit and five having been terminated early because of lack of benefit, higher mortality, and significant increases in brain haemorrhage.

So how did this grade A recommendation occur? Lenzer has found that, as with other clinical practice guidelines before them, these were written by authors almost all of whom had direct or indirect ties with the drug's manufacturer. It is hard not to feel a certain fatigue as I relay this information. Hasn't this been identified before as a major problem with the credibility of guidelines, not least in a thorough and well publicised report by the US Institute of Medicine in 2011? The institute recommended that no authors of guidelines should have financial conflicts of interest, or where this was unavoidable, authors with conflicts should be in the minority.

Lenzer has found that for one of the guidelines recommending alteplase, seven of eight panel members had ties with industry: three had direct relationships with companies that market alteplase, while four had links with an educational foundation wholly funded by industry, whose president and founder was an outspoken advocate for alteplase on acute stroke. The

remaining author had resigned from the panel six years earlier.

Meanwhile, emergency physicians find themselves in a difficult position. The guidelines represent the standard of care against which they will be judged in any claims of malpractice. And although the rules on conflict of interest may be tightening, the current standards of care across much of medicine originate with similarly biased guideline panels. Doctors will have to wait for new guidance that they and their patients can trust. Earlier this year, longstanding guidance recommending high dose steroids in acute spinal injury was reversed because of lack of evidence of benefit and clear evidence of harm. In that case too, as Lenzer reports, the initial guidance was tainted with financial conflicts of interest, and physicians were sceptical based on their own clinical experience with the treatment.

So let us put our faith in informed scepticism. And with that in mind, take a look at the unusual proposal launched in this week's *BMJ*, to restore invisible and abandoned trials (RIAT) (p 24). Peter Doshi and colleagues have compiled a dossier of trials that have never been published or have been misreported but for which the data are in the public domain through legal proceedings or freedom of information requests. The list of these trials, on bmj.com, makes fascinating reading. The RIAT authors are calling for volunteer authors to reanalyse the data, and as we say in the linked editorial (p 7), the *BMJ* and *PLoS Medicine* are the first of what we hope will be a long list of journals keen to publish the results.

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

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