CLINICAL REVIEW, p 28

Last week's front cover illustration was by the 18th century cartoonist George Cruikshank

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Energy drinks and alcohol: downplaying the harms
Mixing alcohol with so called energy drinks has become popular, but with what risk? Peter Miller worries that research does not consider real world levels of consumption and that researchers' conflicts of interest need to be declared in full

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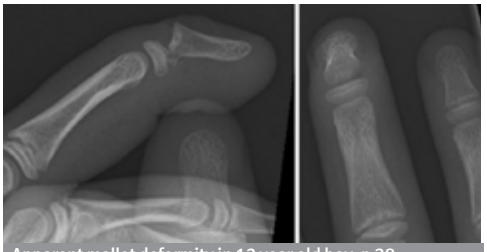

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FILLER

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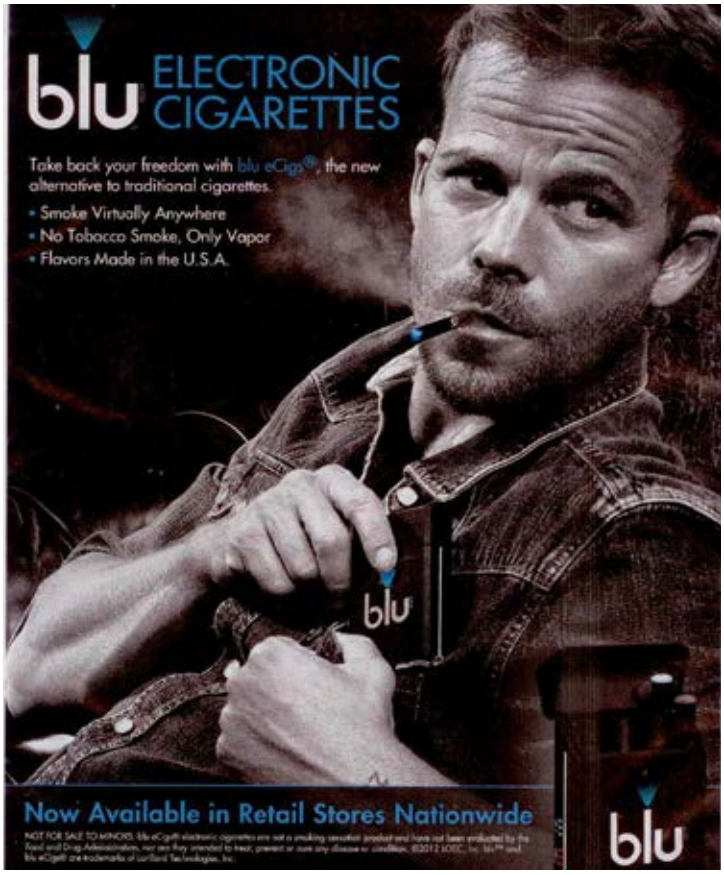

CREDIT

PICTURE OF THE WEEK

Advertisements for e-cigarettes have come under criticism for portraying the product as "masculine, sexy, or glamorous," just like cigarette advertisements of old.

NEWS, p 3

RESPONSE OF THE WEEK

No patient should die or be at serious risk of dying without healthcare providers taking efforts to create a genuine and empathic relationship.

I recently polled medical students:

Who makes a specific effort to establish rapport with their patients and learn about their lives and interests? None confessed to doing so.

Nor did they routinely 'FIFE' seriously ill patients. (How do you Feel about what is happening to you? What are your Ideas and understanding of what is happening? What can't you do that is problematic now? (Function) What are your Expectations for treatment?)

Carrying out these simple tasks creates a basis for a genuine and much more 'friendly' relationship.

Stephen R Workman, internist, Dalhousie University, Halifax, NS, Canada, in response to "Communication in difficult situations: what would a friend say?"
(*BMJ* 2013;347:f5037)

MOST READ

BMJ.COM POLL

Last week's poll asked: "Do risks outweigh benefits in thrombolysis for stroke?"

54% voted yes
(total 612 votes cast)
BMJ 2013;347:f5215

This week's poll asks:

"Would older people benefit from having a named general practitioner?"

BMJ 2013;347:fXXXX

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EDITOR'S CHOICE

Why a hospital?

The constantly changing needs of patients, and the treatments available to them, mean that the rationale for hospitals is forever on the move

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Ronald Coase, the most important economist you've (probably) never heard of, died this month aged 102. One of the two articles that won him the Nobel prize for economics, based on a lecture he gave when he was just 21, was the first rigorous explanation of why companies exist. His answer was that they exist when bringing things under one roof cuts the cost of doing business.

Under the auspices of the Royal College of Physicians, a conclave of the great and the good of British medicine has been pondering a similarly fundamental question: why do hospitals exist? Whereas Coase's answer may turn out to be true for all places and all times, the constantly changing needs of patients, and the treatments available to them, mean that the rationale for hospitals is forever on the move.

"Conventional models of health service design in which a hospital site is the sole focus for the delivery of emergency, acute and elective services are dated," says the Future Health Commission's report, and they need to be brought up to date. Nigel Hawkes's news story (p 1) and feature (p 18) and Mark Newbold's editorial (p 7) discuss the commission's extensive to do list. There's a discernible "physicianly" bias, perhaps not surprising given the report's provenance.

What have treatments for child sex offenders and the use of catheter ablation for atrial fibrillation got in common? They both have lousy evidence bases. Niklas Långström and colleagues found that research is inconclusive concerning the effectiveness of psychological and medical interventions for adults who have sexually abused children (p 12). No studies that met minimal quality thresholds were available for drug treatment—yet such treatments "are widely implemented in correctional and forensic mental health settings." What is going on? In her editorial, Jackie Craissati says that the field has been plagued with a belief in interventions with little basis in research (p 8). Thankfully, the future direction of treatment for sexual offenders against children has "exciting possibilities." Recent revelations in the UK suggest that there won't be a shortage of subjects for rigorously conducted randomised controlled trials.

For atrial fibrillation, the exciting possibility of destroying small areas of the atrium is already here, and the numbers of ablations performed worldwide are increasing sharply. But does it work? Already I can count several friends who have spent frustrating, and terrifying, hours in the cath lab, failing to have their arrhythmias reversed. Hans Van Brabandt and colleagues don't think that evidence from clinical trials justifies the current enthusiasm for the procedure (p 15). No large randomised controlled trial has yet compared ablation with rate controlling drugs in atrial fibrillation. And direct evidence on outcomes that matter to patients—such as stroke, mortality, and quality of life—is lacking.

Light relief comes from Anton Joseph's Filler, where he tracks down the first usage of the word "revalidation" in the sense that Britain's doctors now use it (p 37). Donald Irvine initiated this use in a letter, which he wrote when GMC president. "As to the roots of the word, it is entirely down to my sloppy thinking," he confessed recently. "Recertification or Re-licensure had been much in my mind, and this word seemed to embrace the meaning of both." As it does, now.

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