EDITORIALS

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The BMJ, the definite article

A new name, logo, website design, and homepage address (thebmj.com)

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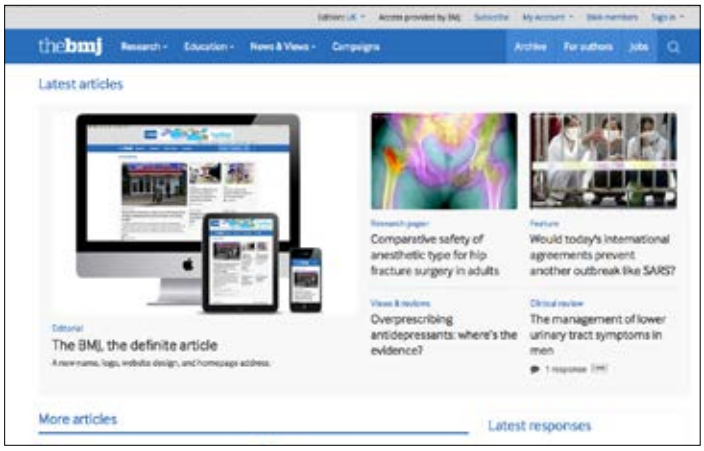
The journal will be 175 years old next year. During that time it has had four names: the *Provincial Medical and Surgical Journal* (1840-52), the *Association Medical Journal* (1853-56), the *British Medical Journal* (1857-1988), and *BMJ* (1988-2014). Now it gets a fifth, with the inclusion in its name of the definite article. The journal formerly known as *BMJ* will now be formally known as *The BMJ*.

This subtle change has several aims and consequences. Firstly, it allows us to embrace and champion the growing number of products and services within our publishing company, which last year adopted the name BMJ. Many people remain unaware that we (the journal and the publishing company) do more than publish journals. Our sister journals and our learning and evidence products are flourishing around the world and have also been rebranded to emphasise their connectedness with the journal and each other.

To highlight the range of tools we now provide for clinicians, researchers, and others involved in healthcare, BMJ the company will take on the journal's url, www.bmj.com, with a new website to be launched later this year, and the journal's homepage address changes to www.thebmj.com. Most of the journal's internal urls will remain unchanged, so if your website links directly to an article in *The BMJ* it will still work.

The journal's website has been completely redesigned. The new site is fully responsive, which means that its pages automatically fit the different screen sizes of desktop and laptop computers, tablet devices, and smartphones. Four years ago, before the launch of the iPad and other tablet computers, less than 2% of our online traffic was through mobile devices. That figure has risen to almost 25%. The responsive design removes the need to pinch or expand text and provides a better reading experience on all screens, whatever their size.

The new design is also less cluttered, which should make navigation easier and pages load faster. Links to our sister products such as Best Practice, BMJ Learning, BMJ Masterclasses, BMJ specialty journals, and our online clinical community doc2doc have moved to the dark blue footer panel at the bottom of every page, and we have simplified the main navigation bar by merging "news" and "comment" into a single "news and views" channel and removing the "specialties" and "multimedia" tabs. Specialty and series collections can now be accessed from the "archive" tab and as links from the footer, rather than the main navigation bar. They will also continue to appear as colour coded links on relevant articles.



The new site is fully responsive, which means that its pages automatically fit the different screen sizes of desktop and laptop computers, tablet devices, and smartphones

We have also improved the way the main navigation bar works. It now remains visible as you scroll down a page, which means you won't need to return to the top of the page to navigate the site after reaching the end of an article. We hope this feature will encourage you to browse the journal and click across its different sections.

Audio and video files (multimedia) mostly relate to articles, and you will find the files embedded in the relevant pages. The archive section now has links to *The BMJ*'s YouTube and Soundcloud channels. You can access all audio and video that has been produced to date (since 2008) from the archive channel.

We have added a new "for authors" tab to the main navigation bar to make it easier to submit manuscripts for publication and to explain more about the types of research, education, and comment that we publish.

There is a new "campaigns" channel, which includes our patient partnership initiative and our campaigns on access to clinical trial data and overdiagnosis. You will also find information about some collections of articles on public health challenges, including climate change and alcohol pricing, and a list of investigative features ranging from metal-on-metal hips to sports drinks. We have badged the website as beta to encourage feedback, which you can provide by clicking the feedback button and selecting "*The BMJ* website feedback" from the category drop-down in the online form.

New logo: warm, informal, friendly, forceful

Finally, the journal's new name means a new logo, one that includes the definite article. The logo has been designed for us by award winning magazine designer, Simon Esterson. The font is Duplicate Slab, which was created by Christian Schwartz based on an earlier font by French typographer Roger Excoffon (1910-83). It is described as having a warm and informal texture, a friendly but forceful feel, and an antique but not old fashioned tone, which seems a good fit for the journal. The font's serif version in lower case is set within a distinctive blue "lozenge" so that it works across all digital resources at any size.

We hope you like the new look journal and that you find it easier to browse whatever device you are using. Welcome to *The BMJ*.

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thebmj.com/archive

Research: Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study (*BMJ* 2011;343:d7400)

NICE's draft guideline on intrapartum care

Where is the evidence?

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In March 2014 the National Institute for Health and Care Excellence (NICE) released for consultation a draft of its updated guideline on intrapartum care.[1] Publication of the final version is scheduled for October this year.

Although this update has involved a broad group of professionals and lay people (appointed through a transparent process of competitive interview), the "collective clinical experience" of obstetric practice came from just three obstetricians and two midwives. The guideline includes over 300 recommendations, and the evidence published with the full guideline will provide clinicians with a comprehensive, quality assessed resource of clinical trials and expert discussion. NICE has followed the suggested presentation of recommendations by the GRADE Working Group.

However, we are concerned that using the terminology "strongly recommend," "consider," or "offer" for each point rather than the previous grading system (A to D) could make it more difficult to judge the level of evidence underpinning each recommendation without reading the full guideline. Most clinicians will not have the time to do this given that the complete guideline has increased from 305 to 805 pages, and this could lead them to misinterpret the strength of recommendations. Furthermore, the summary is 127 pages long, reducing its usefulness at the point of care.

Additionally, the length of both the full and the summary guideline may limit detailed review of the guidance by many clinicians and stakeholders. This is a vital step in the peer review process ensuring the validity of the work presented. We suggest that in future NICE should consider dividing its guidelines on intrapartum care into the first, second, and third stages of labour.

The new normal

We consider that the guideline's greatest effect will be to support the normalisation of birth and in turn reduce unnecessary intervention. Drawing on the results of the Birthplace study,[2] it recommends that all multiparous women with low risk pregnancies should deliver at home or in a midwifery led unit and all primiparous women with an uncomplicated pregnancy in a midwifery led unit. The risk table will help clinicians inform women and encourage shared decision making on the place of birth by providing data on safety and intervention rates.

The guideline comprehensively covers intrapartum fetal monitoring (both electronic fetal heart monitoring and intermittent auscultation). The continued emphasis on the safety of intermittent auscultation will help promote vaginal delivery. The interpretation of electronic fetal heart monitoring was substantially reclassified in 2007,[3] and this has again been changed, with the overall classification now categorised into five rather than three headings, without robust justification. This is likely to cause confusion, and there is no evidence that it will improve safety.

Recommendations regarding additional methods of assessing the fetus in labour are inconsistent. The evidence supporting fetal scalp stimulation and fetal electrocardiography[4] is at least as good as, if not stronger than, that for fetal blood sampling.[5] Despite this, the guideline development group recommends the use of fetal blood sampling based on collective clinical experience. This may reflect the difficulties of objectively assessing evidence in the light of accepted clinical practice. It is disappointing that the opportunity to critically assess and influence the use of fetal blood sampling in the UK has been missed.

S AND R GREENHILL/ALAMY

Risking the Cochrane "wooden spoon"

The guideline's greatest effect will be to support the normalisation of birth and in turn reduce unnecessary intervention

When the 2007 guideline on intrapartum care was published, there was concern about the recommendation to accept an active second stage of up to 4 hours as normal. This recommendation remains. Despite many gynaecologists' concerns that this would increase damage to the pelvic floor, little research has been published in the past five years on whether the guideline has affected the length of second stage, reduced operative delivery, or had adverse effects on the pelvic floor. The limited evaluation of guideline implementation is a concern.

The guideline development group has focused on the management of the third stage of labour and delayed cord clamping, a subject of long-standing controversy in both resource rich and resource poor countries. Data show that delayed cord clamping is safe, but the increased risk of jaundice requiring phototherapy should be balanced against the benefit of improved iron stores with potential positive benefit on neurological development. The "strong recommendation" to delay cord clamping for between 1 and 5 minutes after delivery is helpful as it clarifies the UK position, although from an international perspective it would seem that the jury is still out.[6 7]

Although NICE no longer insists that recommendations should be based on published clinical trials (grade 1+ evidence), care needs to be exercised over some of the recommendations in this draft guideline that are based on clinical experience (such as the use of fetal blood sampling). The paucity of data around intrapartum care needs attention from the specialty. Otherwise we are in danger of being awarded the Cochrane "wooden spoon" again.[8]

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thebmj.com/archive
Research: Explaining trends in Scottish coronary heart disease mortality between 2000 and 2010 using IMPACTSEC model (*BMJ* 2014;348:g1088)
Observations: Too much angioplasty (*BMJ* 2013;347:f5741)

Revascularisation for patients with stable coronary artery disease

CABG and contemporary PCI can both reduce mortality

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There is strong evidence that percutaneous coronary interventions (PCI) reduce the risk of myocardial infarction and death among patients with acute coronary syndromes. However, these benefits have not been established for patients with stable coronary artery disease. For such patients, PCI relieves angina and improves quality of life, but studies have found no evidence that the procedure reduces mortality or risk of myocardial infarction compared with the best medical treatment.[1] Emphasis on the limited role of PCI for patients with stable disease may have contributed to a decrease in its use in recent years.

In a linked paper Windecker and colleagues[2] report the results of a meta-analysis to compare the outcomes of patients with stable disease who were assigned to initial medical treatment or to medical treatment plus coronary artery revascularisation.

The authors' findings corroborate consistent observations from individual trials of coronary artery bypass grafting (CABG); surgical revascularisation significantly reduced mortality compared with medical treatment (20% relative reduction), with a narrow credibility interval. In contrast and despite generally including a larger number of patients, trials, and patient years of follow-up, revascularisation with balloon angioplasty, bare metal stents, and first generation drug eluting stents did not. These earlier devices averaged an impact on mortality (non-significant 10% relative reduction) about half that provided by CABG.

Lastly, the newest PCI devices, so called second generation drug eluting stents, reduced mortality by a significant 25-35% compared with best medical treatment. Their effect on mortality seems comparable to that of CABG, although with wider credibility intervals. These results suggest that the latest evolution of PCI has crossed that elusive threshold—compared with medical treatment alone, all cause mortality was significantly reduced among patients with stable coronary artery disease undergoing PCI with second generation drug eluting stents.

Better than medical treatment?

Important milestone

This is an important milestone for interventional cardiology and represents the culmination of decades of iterative scientific advances refining techniques, devices, and drug treatments. Bare metal stents practically eliminated abrupt vessel closure. Advanced intracoronary imaging helped refine stenting techniques, and the use of oral dual antiplatelet therapy reduced the risk of stent thrombosis to under 1%.[3] First generation drug eluting stents reduced the risk of restenosis and need for repeat revascularisation by more than 50% compared with bare metal stents.[4 5] Most recently, innovations in stent design, polymer properties, and drug elution kinetics led to a second generation of drug eluting stents with enhanced efficacy, and these further reduced the risk of repeat revascularisation, subsequent myocardial infarction,[6] and stent thrombosis.[7]

How might revascularisation help prevent myocardial infarction or even death in patients with stable but severe atherosclerotic heart disease? Unquestionably, severe myocardial ischaemia can reduce the threshold for fatal ventricular arrhythmias and in the long term impair left ventricular function. For patients with stable ischaemic heart disease these risks are low but cumulative over time and proportional to the extent of vulnerable myocardium. Revascularisation decreases or eliminates myocardial ischaemia, yet it is intuitive that for a revascularisation strategy to reduce mortality in a stable cohort it must be extremely effective, durable, and have a low complication rate.

For years, CABG has been known to reduce mortality if the ischaemic burden was large. Early PCI procedures were effective in reducing ischaemia, but the revascularisation provided by CABG was more extensive (for example, bypassing total vessel occlusions) and more durable (associated with lower rates of subsequent PCI or CABG).

With serial advances in percutaneous devices and concomitant drug treatments, the durability of percutaneous revascularisation has sequentially improved. Bare metal stents have proved better than balloon angioplasty, first generation drug eluting stents have proved better than bare metal stents, and, most recently, second generation drug eluting stents have proved better than the first generation ones.

Studies included in this network meta-analysis spanned several decades, when advances in optimal medical treatment also improved outcomes for patients with coronary artery disease. Survival was improved by treatment with statins, as well as with β blockers and angiotensin converting enzyme inhibitors for those with ventricular dysfunction. Revascularisation was not and should not be considered an alternative to these evidence based medical treatments but rather used as an additional strategy to minimise myocardial ischaemia. Indeed, the many advances in medical treatment should be credited for helping the focal treatment approach of drug eluting stents to approximate the results of CABG.

Windecker and colleagues' findings should reassure both doctors and patients that, when indicated, referring patients with stable coronary artery disease for PCI or CABG is reasonable and beneficial. However, the lack of patient level data does not help doctors identify subgroups of patients who are likely to benefit most from a drug eluting stent, CABG, or medical treatment alone.

For answers to these questions we must turn to dedicated randomised trials evaluating the options in specific clinical settings and patient subgroups.[8 9] Therapeutic choices must also take full account of individual patient characteristics that can influence outcome after the various treatment options.[10]

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thebmj.com
- Observations: Assisted dying is not the same as euthanasia (*BMJ* 2014;348:g3532)
- Letter: All RCGP members should be balloted on assisted dying (*BMJ* 2014;348:g3274)
- Feature: The end of life (*BMJ* 2014;348:g2261)

***The BMJ* Blog**
Denying people assistance in dying is simply cruel

Why the Assisted Dying Bill should become law in England and Wales

It's the right thing to do, and most people want it

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Lord Falconer's Assisted Dying Bill is expected to receive its second reading in the House of Lords this month. *The BMJ* hopes that this bill will eventually become law.

The bill would allow adults who are expected to live six months or less to be provided with assistance to end their lives.[1] Two doctors must be satisfied that the person is terminally ill, has the capacity to make the decision to end his or her life, and has a clear and settled intention to do so. This decision must have been reached voluntarily, on an informed basis, and without coercion or duress. Both doctors must be satisfied that the person has been fully informed of the palliative, hospice, and other available care options.

Once both doctors have countersigned the declaration that the person wants to end his or her life, the attending doctor can prescribe the life ending medication, which would be dispensed only after a "cooling off" period of 14 days (or six days if prognosis is less than a month). The person would administer the medication themselves. This is what differentiates "assisted dying" from "voluntary euthanasia," where the doctor administers the lethal drug(s).

What are the arguments for such a law? People should be able to exercise choice over their lives, which should include how and when they die, when death is imminent. In recent decades, respect for autonomy has emerged as the cardinal principle in medical ethics and underpins developments in informed consent, patient confidentiality, and advance directives.[2] Recognition of an individual's right to determine his or her best interests lies at the heart of efforts to advance patient partnership.[3 4] It would be perverse to suspend this partnership at the moment a person's days were numbered.

As shown by harrowing personal accounts, some terminally ill people want the option to call "time."[5-7] And the majority of the British public want the option too. The 2010 British Social Attitudes survey shows that 82% of people are in favour of a change in the law on assisted dying.[8]

What are the arguments against such a law? People opposed to the bill cite the difficulties of establishing that someone has less than six months to live. Yet most studies suggest that doctors consistently overestimate rather than underestimate prognosis.[9]

Another argument is that individual choice should be limited when it has a profound effect on others. But we already accept people's decision to reject life saving treatments, if they have mental capacity, regardless of any effects their subsequent deaths may have on those they leave behind. The Falconer Bill allows for the secretary of state to issue codes of practice on the assessment of mental capacity, "recognising and taking account of the effects of depression or other psychological disorders that may impair a person's decision making."

Those who oppose a change in the law often shift their arguments to hypothetical victims, some of them glimpsed at the bottom of a slippery slope. It's therefore important to say who will and will not be affected by the new law. The Assisted Dying Bill does not cover people with disabilities who are not terminally ill, other people with non-terminal illness, people who are not mentally competent, or children. That much mentioned victim—the elderly lady who believes she has become a burden to others and offers herself up for assisted dying—will not qualify.

Passing the law would not represent a leap in the dark: the US state of Oregon, on which the bill in England and Wales is closely modelled, has allowed assisted dying since 1997. Last year, 122 dying Oregonians were given life ending prescriptions; 71 took the life ending medication and died. Altogether, "assisted deaths" accounted for 2.2 per 1000 total deaths in the state.[10]

Extrapolating Oregon's figures to England and Wales, each year about one patient per general practice of 9300 patients would discuss the issue of assisted dying; each general practice would issue one prescription for life ending medication every five or six years, and every eight to nine years one patient per general practice would take life ending medication.

No adverse effects on palliative care

Oregon's experience confounds claims that assisted dying legislation impedes the development of palliative care. Oregon is now regarded as a national leader in palliative care.[11] Tellingly, the Oregon Hospice Association, initially opposed to assisted dying, found "no evidence that assisted dying has undermined Oregon's end of life care or harmed the interests of vulnerable people."[12] In 2011 the European Association for Palliative Care concluded that palliative care in European countries with legalised assistance to die is as well developed as it is elsewhere.[13]

Some doctors are unhappy about the part they would be asked to play. However, the bill makes allowance for conscientious objection—a provision that has worked well for the almost 50 years of the Abortion Act. Discovering what "the average doctor" thinks about assisted dying, however, has been difficult, with professional bodies going through extraordinary contortions to avoid asking individual members for their opinions.

Ultimately, however, this is a matter for parliament, not doctors, to decide. Last month the UK Supreme Court upped the ante. Its president said that unless parliament satisfactorily addresses the Suicide Act 1961, which prevents doctors helping patients to end their lives, the court could force change upon them by declaring the act incompatible with the European convention on human rights.[14] Let us hope that our timid lawmakers will rise to the challenge.

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ANNABEL WRIGHT/HEART