Nuclear factory workers are at increased risk of cancer

Even low doses of ionising radiation that nuclear industry workers typically receive are associated with an increased risk of cancer. In a retrospective cohort study, Cardis and colleagues (p 77) monitored 407 391 nuclear industry workers in 15 countries for external radiation, with a total follow-up of 3.2 million person years. From these results they estimated that 1-2% of deaths from cancer among workers in this cohort are attributable to radiation. These estimates are higher than the risk estimates used for current radiation protection standards.

Psychosocial intervention doesn’t improve lumbago

A Dutch study found that a minimal intervention aimed at assessment and modification of psychosocial factors was no more effective than usual care for (sub)acute low back pain. In a cluster randomised controlled trial that included 60 general practitioners and 314 patients, Jellema and colleagues (p 84) measured functional disability, perceived recovery, and sickness leave at baseline and after 6, 13, 26, and 52 weeks. None of the outcomes showed improvement in the intervention group, but the authors say that not enough studies have been done on the effectiveness of such interventions.

Routine funduscopy isn’t justified in patients with hypertension

There is no evidence that routine funduscopy adds value in the management of patients with hypertension. In a systematic review, van den Born and colleagues (p 73) searched for studies examining the association between hypertensive retinopathy and blood pressure, hypertensive organ damage, and cardiovascular risk. Large interobserver variations in the assessment of retinal microvascular changes, low predictive values for the association between retinopathy and blood pressure, and inconsistent associations between retinal changes and cardiovascular risk all hamper finding evidence to support routine funduscopy in patients with high blood pressure.

Patients don’t mind students in general practice consultations

Medical students’ participation in general practice consultations doesn’t seem to bother patients. Benson and colleagues (p 89) used validated instruments to survey 240 patients who had students present at consultations and 409 whose consultations were not for teaching (response rates 82% and 72%, respectively). The scores did not differ significantly between the two groups. Qualitative data obtained from 10 focus groups showed that patients generally supported the teaching of students in their practice, but would like to know how many students, and of which sex, would be present, and to have a choice about participation.

Living with locked-in syndrome

Nick Chisholm has been living with locked-in syndrome, also known as coma vigilante, since being injured on a rugby field in year 2000. Dissection of the vertebral arteries left him
quadriplegic and without the ability to speak, but completely conscious. He shares his story on p 94. Interspersed with Nick’s narrative, Grant Gillett provides information on this rare medical condition and discusses clinical and ethical issues that arise in locked-in syndrome.

**Academic medicine, where are you headed?**

Will academic medicine in 2025 be the pillar of medical advancement, a long forgotten historical scribble, or something in between? Who knows; as Clark says on p 101, it is impossible to predict the future. ICRAM, the international campaign to revitalise academic medicine, created a team to develop a vision for the future of academic medicine. The five resulting scenarios aim to enable richer conversations by stretching thinking on what the future might bring.

---

**POEM**

**Don’t use hip spica in kids with femoral fracture**

**Question** Is external fixation more effective than hip spica casting in preventing malunion in children with femoral fractures?

**Synopsis** Children aged 4-10 years who were admitted to one of four paediatric hospitals with diaphyseal femoral fractures were randomly assigned (concealed allocation) to early application of hip spica (n = 60) or to external fixation (n = 48). Physicians unaware of the patient’s treatment regimen and previous assessments. The researchers evaluated the children three months, nine months, 15 months, and 24 months after the fracture; the patients wore tights to the evaluation to mask the fracture; the patients wore tights to the evaluation to mask the fracture. Fracture malunion occurred in 45% of the patients in the hip spica group and in 16% in the external fixator group (number needed to treat = 4; 95% CI, 2.2 to 8.3). The average time the child was immobilised with a hip spica or used the external fixator was 77 and 58 days, respectively (P = 0.001). Nearly half (45%) of the children treated with the external fixator developed pin tract infections requiring oral antibiotics (number needed to treat to harm = 3), but none required hospitalisation. There were no differences in the secondary outcomes.

**Bottom line** External fixation of paediatric diaphyseal femoral fractures significantly prevents malunion two years after fracture compared with early hip spica application. Because of the very high malunion rate, primary care physicians should stop placing these patients in hip spica casts while patients are waiting to see an orthopaedic surgeon. Instead, they should arrange for rapid orthopaedic consultation.

**Level of evidence** 1b (see www.infopoeams.com/levels.html). Individual randomised controlled trials (with narrow confidence interval)


* Patient-Oriented Evidence that Matters. See editorial (BMJ 2002;325:983)

---

**Editor’s choice**

**Where are the leaders?**

Got the wrist band, got the “Make Poverty History” T-shirt, and glad to have been in Edinburgh among what Colin Douglas calls “the marching innocents” (p 117). At the time of writing it’s not clear what, if anything, will come out of the G8 summit, so naive optimism is still, it seems to me, a legitimate option. The same won’t do for academic medicine. Long taken for granted as medicine’s indispensable research and teaching arm, academic medicine is now the focus of international concern, a sick patient with an uncertain prognosis. The diagnosis is becoming clear, thanks to the work of a global campaign to revitalise academic medicine launched by the *BMJ* and partners in 2003, which reports back this week (p 101). Academic medicine lacks vision and leadership. It is failing to engage with the real issues of health care and failing to attract the best young recruits. It’s hard to think about academic medicine in the abstract. Who are these academics and what do they do? A simple definition is that they are people who do at least two of three things related to medicine: research, teaching, and clinical practice. Over the years, as Jocelyn Clark explains, they have helped us to think, discover, evaluate, learn, and improve. Without them, we would not have recognised the link between smoking and lung cancer or the need for early treatment after myocardial infarction. Without them, we are unlikely to find cures for cancer or vaccines for HIV and malaria. A future without strong global academic medicine is hard to imagine.

But that is what’s in store, according to the campaign, unless something radical is done. The question is, what and by whom? To help find an answer, the campaign working group has developed a series of scenarios that illustrate alternative futures. They provide an opportunity to steer a new course towards greater engagement with the public, greater global equity, incentives for innovation, mentoring and support for young academics, flexible career paths, robust institutions with secure long term funding, leadership, and vision for academic medicine around the world.

The five scenarios are not mutually exclusive. Nor are they entirely futuristic. As Sally Davies points out in her commentary (p 105), elements from the scenarios are already discernable. Zulma Ortiz (p 106) thinks we already have the worst possible combination from each scenario but acknowledges that the seeds of change are also here. Karen Sliwa-Hahnle gives a formidable account of how to succeed in today’s climate (careerfocus.bmjjournals.com). Tiago Villanueva calls for practical hands-on education for medical students (p 105), something that Benson and colleagues report is acceptable to patients in general practice (p 89). Amye Leong (p 107) speaks for patients and all of us in saying, “When academic medicine thrives, we all win.”

These entertaining scenarios are at root deeply serious, reflecting a crisis at the heart of academic medicine. The debate presents a clear challenge to the people currently in leadership positions in academic medicine. Step up to the plate and engage with the issues. Or step down.

Fiona Godlee editor (fgodlee@bmj.com)