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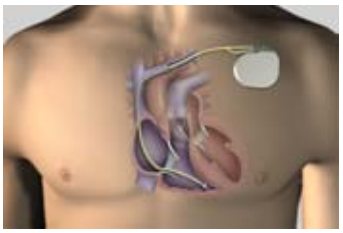
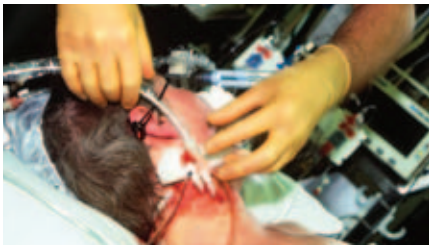
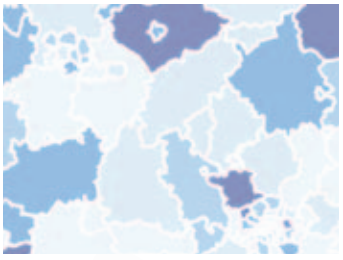
Analysis, p 1198, Editorial, p 1171, Feature, p 1190



When to implant defibrillators, p 1174

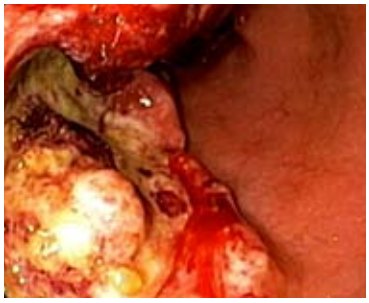


Reporting scheme cuts infections, p 1183



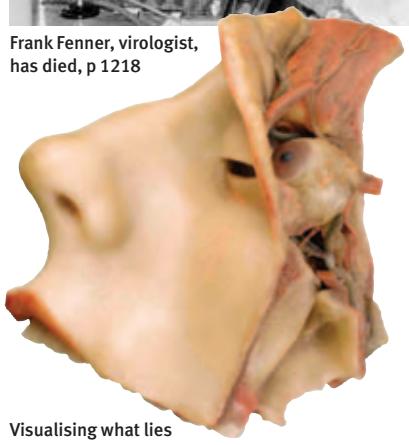
How UK care varies, pp 1184, 1206

Why rush to clamp the cord? p 1220



Oesophageal adenocarcinoma, p 1207

Frank Fenner, virologist, has died, p 1218



Visualising what lies beneath, p 1222

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KIERAN DODDS/PANOS

PICTURE OF THE WEEK

On 1 December the Scottish parliament voted on the End of Life Assistance Bill, a proposal that would give terminally ill people the right to choose when to die. Rudi Vogels, above, campaigned in favour of the bill.

THE WEEK IN NUMBERS

19 ml/year Adjusted decline in forced expiratory volume in one second with a community based intervention for chronic obstructive pulmonary disease **(Research, p 1203)**

65–70 years Average age of onset of oesophagal cancer **(Clinical Review, p 1207)**

7 times Increase in long term sickness absence for back pain between the 1950s and 1990s in Great Britain **(Practice, p 1213)**

6-12 hours Period of time in which rapid development of severe pain, swelling, tenderness, and overlying erythema usually peaks in cases of gout **(Practice, p 1216)**

QUOTE OF THE WEEK

"The UK has one of the best systems of specialty training for general practice in the world . . . yet this does not translate into specialty status at the European level, apparently because of a lack of political will on the part of successive UK governments"

Iona Heath, general practitioner, London , on what we can learn from the Ubani case **(Observations, p 1194)**

QUESTION OF THE WEEK

Last week's poll asked, "Is the coalition government turning the clock back on advances in public health?"

78% said yes (total 270 votes cast)

This week's poll asks, "Should health systems stop supporting low volume units?"

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EDITOR'S CHOICE

Lessons from around the world

Brazil's Family Health Programme is probably the most impressive example worldwide of a rapidly scaled up primary care system

It's hard to resist the pull of American healthcare. Despite its poor outcomes and high costs, we tend automatically to look to the United States for new ways of delivering care. Flawed though it is, US healthcare fascinates with its flashes of excellence. I doubt this will change soon, but we shouldn't be blinded—there is much we can learn from elsewhere. The *BMJ*'s occasional series "Looking to Europe" has so far covered France (*BMJ* 2008;336:254), Germany (*BMJ* 2008;337:a1997), Spain (*BMJ* 2009;338:b1170), the Netherlands (*BMJ* 2009;339:b3397), and Sweden (*BMJ* 2009;339:b4566), and a forthcoming article will look at Turkey's successful healthcare reforms. Now it's time to look further afield.

Andy Haines has long championed Brazil's public health successes (*BMJ* 1993;306:503-6). This week, with Matthew Harris (p 1171), he itemises them again—remarkable reductions in infant mortality and hospital admissions for diabetes and stroke, and great leaps in antenatal care and vaccination coverage, exceeding even the ambitions of the Millennium Development Goals. All of this since its Unified Health System was set up in response to the constitution of 1988. The Family Health Programme followed in the 1990s; staffed by doctors, nurses, and community health workers, it is "probably the most impressive example worldwide of a rapidly scaled up, cost effective, comprehensive primary care system." On Brazil's behalf they complain that its successes have not had the recognition they deserve.

Haines and Matthews don't underestimate the challenges ahead. Nor, while celebrating Brazil's undoubted achievements, do Tom Hennigan (p 1190) or Frederico Guanais (p 1198). Although health outcomes have improved, large disparities persist, while support for the public system is falling among the emerging middle class. Here too are lessons for the rest of us.

Meanwhile colleagues around the world face difficulties that doctors working in industrialised countries can scarcely imagine. What can we learn from them? Our clinical review this week—on oesophageal cancer—comes from Sweden (p 1207). But it is accompanied by a commentary on managing this condition in a resource poor setting, Malawi (p 1212). Alexander Thumbs and Eric Borstein describe the suffering of patients who present late and must travel long distances for rudimentary investigation and without hope of a cure. But some are benefiting from self expanding metal stents provided through a charity funded trial. If readers find this sort of commentary interesting and useful, we will commission more of them.

Finally, a reminder that we may also need to unlearn things. Early clamping of the umbilical cord has become established practice. And despite research and editorials saying that it is better to delay clamping, the practice continues. Recently James Neilson made a renewed call for it to stop (*BMJ* 2010;340:c1720). This week David Hutchon writes that clamping the functioning umbilical cord before natural vasospasm has done its work is an unproved intervention that may harm the baby (p 1220). Unhelpfully, NICE guidelines still advise early cord clamping as part of the active management of the third stage of labour. It would be good to hear why.

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Career Focus, jobs, and courses appear after p 1224

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BMJ.COM: MOST READ

Patterns of alcohol consumption and ischaemic heart disease in culturally divergent countries

Evidence based medicine: what it is and what it isn't

Long term risk for hypertension, renal impairment, and cardiovascular disease after gastroenteritis from drinking water contaminated with *Escherichia coli* O157:H7

Open letter to prime minister David Cameron and health secretary Andrew Lansley

Is early retirement good for your health?