PAUL BOSTON

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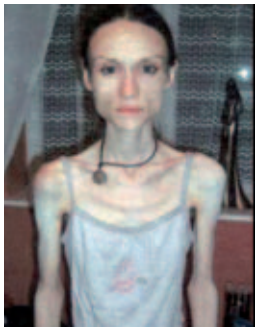
NEWS



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Articles appearing in this print journal have already been published on bmj.com, and the version in print may have been shortened. bmj.com also contains material that is supplementary to articles: this will be indicated in the text (references are given as w1, w2, etc) and be labelled as extra on bmj.com.

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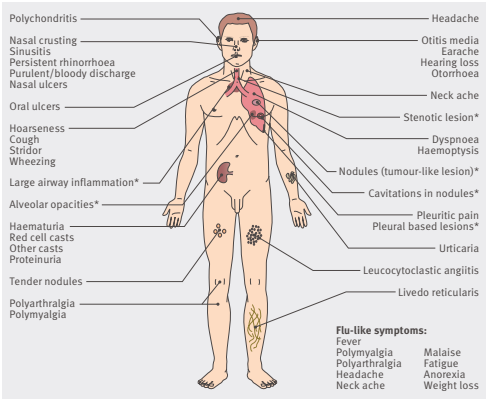

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YUI MOK/PA/AP

PICTURE OF THE WEEK

Protesters outside The Harley Medical Group offices call for private clinics to replace PIP breast implants free. The government has said the NHS would remove and replace the implants without charge if patients that the NHS had operated on remained concerned. The Harley Medical Group fitted more of the implants than any other UK firm but said it will not replace them free of charge because the cost would put the firm out of business. Read Marge Berer's blog "The breast implant fiasco: a scandal of private medicine" on bmj.com at http://bit.ly/xzQPCQ

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MOST READ ON BMJ.COM

Timing of onset of cognitive decline: results from Whitehall II prospective cohort study

Orthopaedic surgeons: as strong as an ox and almost twice as clever? Multicentre prospective comparative study

Influence of experience on performance of individual surgeons in thyroid surgery: prospective cross sectional multicentre study

Effects of glucagon-like peptide-1 receptor agonists on weight loss: systematic review and meta-analyses of randomised controlled trials

CORRECTION

In the Week in Numbers in the print issue of 17 December 2011 we reported that 1 in 3333 people in the United Kingdom had experienced anaphylaxis. We should have said 1 in 1333, as given in the Practice article in the same print issue (*BMJ* 2011;343:d7595).

BMJ.COM POLL

Last week we asked, "Should doctors be able to self prescribe?"

65% voted yes (total 1614 votes cast)

This week's poll asks, "Should public funds pay when private healthcare goes wrong?"

bmj.com
BMJ 2012;344:e306

RESPONSE OF THE WEEK

"The simplifying assumptions about the efficacy of peer review and professional ethics and responsibility fail miserably when the emperor is discovered marching around buck naked"

John H Noble Jr, emeritus professor, Georgetown, Texas, USA, in response to "Research misconduct is widespread and harms patients"

(*BMJ* 2012;344:e14)

EDITOR'S CHOICE

Saving carbon and money

Some saving will come from simply turning off lights and machines that are not being used. But there are other big ticket items

There's a certain irony in healthcare's substantial contribution to greenhouse gas emissions, given that climate change has been called the greatest threat to public health of the 21st century. The UK is among the world's lowest carbon emitters relative to gross domestic product, says John Appleby (p 24), and is also the only country committed to a legally binding reduction in emissions of 80% by 2050. So that's something to feel good about. Except that getting there is going to be a huge challenge, and healthcare is going to have to play its part.

Ray Moynihan describes how patients and professionals are taking the initiative, trying to save both carbon and money (p 21). An NHS Sustainability Day is planned for March 28, bringing together a raft of activities across the UK. If you want to find out more or to volunteer to help, join the discussion on doc2doc (http://bit.ly/ygLy2t).

Some saving will come from simply turning off lights and machines that are not being used. But there are other big ticket items. Pharmaceuticals account for about 22% of NHS emissions, according to the NHS Sustainable Development Unit. Its director, David Pencheon, says this is because the drugs are highly refined in big factories and then moved around the world. And because we waste a lot of them.

This high carbon contribution is yet another reason to make sure we make rational decisions on which drugs to use. This week sees the return to the knotty matter of oseltamivir (Tamiflu), the drug on which governments around the world have spent billions of dollars—and tonnes of carbon—because of claims that it reduces transmission, symptoms, and complications of influenza. Two years ago in these pages the drug's manufacturer, Roche, promised to make the trial data available, after Cochrane reviewers declined to judge oseltamivir's effectiveness on the basis of unpublished Roche-funded trials (*BMJ* 2009;339:b5405). But the Cochrane reviewers believe that what Roche has delivered is inadequate to answer their research question (doi:10.1136/bmj.d7898). Because of a host of inconsistencies in what they have unearthed, they base their latest Cochrane update on only those trials for which they could read the full clinical study report. Twenty-two thousand pages later, they conclude that the drug shortens duration of symptoms, but there's insufficient trial evidence that it reduces complications (*Cochrane Database Syst Rev* 2012;1:CD008965).

In a linked investigation, Deborah Cohen shows how different regulators took different approaches to the data (doi:10.1136/bmj.e458). The European Medicines Agency did not obtain the full study reports on oseltamivir and, along with the US Centers for Disease Control, continues to say the drug reduces complications when given to healthy adults. The US Food and Drugs Administration analysed more of the data and says this is not the case. The EMA has told the *BMJ* that it plans to start publishing reports for all drugs submitted for approval in the next few years. This will be a huge advance, putting the EMA ahead of its US counterpart perhaps for the first time.

Still, we're a long way from where we need to be. Disagreements between regulators highlight an absurd situation. In a globalised world, and given the scale of the challenge of data review, regulators need to cooperate and pool their limited resources. Otherwise we will continue to waste money and risk people's health on drugs that don't work.

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