THIS WEEK

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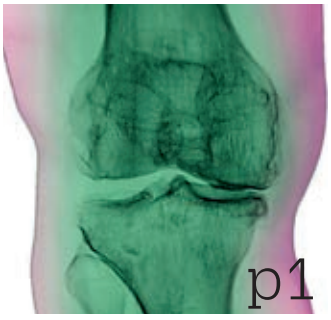

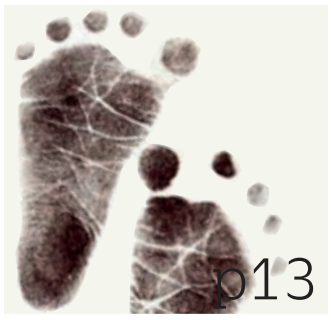

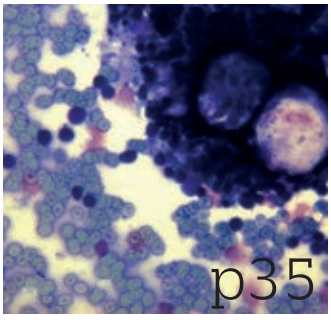

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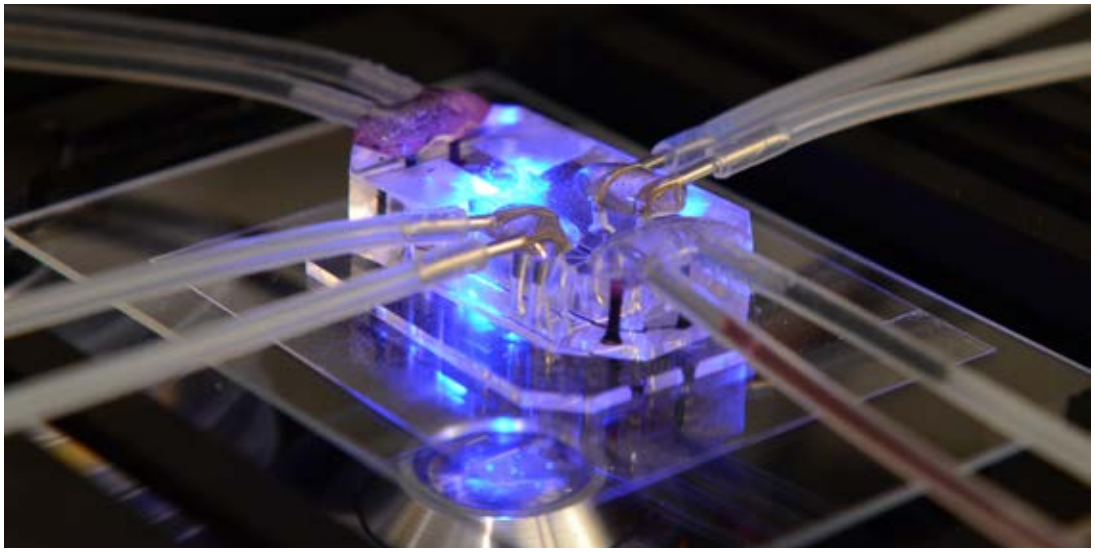


PICTURE OF THE WEEK

A microchip lined with human cells that mimics the complex tissue structures, functions, and mechanical motions of whole organs has won the Design Museum Design of the Year Award for 2015. Designers Donald Ingber and Dan Dongeun Huh at Harvard University's Wyss Institute hope that their microdevices, named Human Organs-on-Chips, can help advance personalised medicine, accelerate drug discovery, and decrease development costs. This is the first time that a design from the field of medicine has won the top prize in the Design of the Year competition, now in its eighth year.

THEBMJ.COM POLLS

Last week's polls asked:

Should knee surgery for middle aged and older patients be stopped?

YES 26% NO 74%

Total votes cast: 508

BMJ 2015;350:h2747

Should migrants be charged for access to health services?

YES 49% NO 51%

Total votes cast: 129

BMJ 2015;350:h3056

SARAH ALCALAY/DOCTORS OF THE WORLD

This week's polls:

Is informed consent impossible at the end of life?

bit.ly/1NguxRu

Should doctors in Australia boycott working in its immigration centres?

BMJ 2015;350:h3269

VOTE NOW ON THEBMJ.COM

Online highlights from thebmj.com

THIS WEEK IN 1915

Within a few months of the start of the first world war, rumours that camps and soldiers had "attracted most undesirable attention not only from professional prostitutes but also from a large number of young and giddy girls" who "hung persistently about the camps and were the cause of much annoyance both to the men themselves and to the military police" had started to circulate. Some members of the public, however, regarded the "unfortunate girls as heroines" who "had but little to give their country, and had given it all." A committee was formed to investigate. It found that reports of a large number of illegitimate "war babies" (it was alleged that one town of 18 000 was expecting 2000 war babies) were without foundation.

Cite this as *BMJ* 1915;1:1089

POPULAR ONLINE

Time to consider the risks of caesarean delivery for long term child health
BMJ 2015;350:h2410

Comparison of content of FDA letters not approving applications for new drugs and associated public announcements from sponsors
BMJ 2015;350:h2758

Arthroscopic surgery for degenerative knee
BMJ 2015;350:h2747

TWEETS

These tweets were sent in response to the latest article in the series What Your Patient is Thinking: "Excuse me, doctor: I can still hear you."

@DebHazeldine: "I have experienced the same; curtains are not sound proof. Thankfully another member of staff reassured. #scared"

@betabetic: "Hardest of all is hearing a patient being berated or a healthcare professional about to make a mistake—step in or butt out?"

Twitter @bmj_latest

RESPONSE OF THE WEEK

Perhaps making the cost of resources more widely known would help us all to play our part in saving money in the NHS. At medical school we receive very little teaching on the cost of resources, and when we start work we often have no idea of the prices of the tests we are requesting or the equipment we are using. Of course patients' needs must always be considered before cost, and price should not be a barrier to patients receiving the best care possible. However, if prices were displayed on hospital IT systems used to order investigations or on boxes of equipment in utility rooms, it might prompt us to think more carefully about how we use resources. My FY1 colleagues and I used to request an international normalised ratio (INR) as part of the set of routine bloods that were carried out for our surgical patients every few days, until our registrar informed us that each INR cost the trust £40 to measure. Once we knew this we ensured that we only included an INR in the request if the patient truly needed it. There must be many similar situations happening on the wards every day which would be helped by increasing awareness among healthcare staff.

Naomi D Adelson, FY1 doctor, writes in response to White C. Wide variation in price paid for basic supplies means NHS wastes millions, 350:doi 10.1136/bmj.h3104

BMJ 2015;350:h3104

LATEST BLOGS

"Diagnose, treat, and cure" is largely dead

The model of "diagnose, treat, and cure" has lost its usefulness, says Richard Smith. He explains how the shift in epidemiology from patients with single acute problems to those with multiple long term conditions has sounded the death knell for this medical paradigm.

http://bit.ly/diagnose_dead

Clot buster coverage in the mainstream media

Doubts have been raised by the medical community about the use of alteplase in ischaemic stroke. Helen Macdonald reviews the concerns about the underpinning evidence and discusses a recent episode of *File on 4* on the radio, where doctors and patients explain how the arrival of alteplase gave them "something" to use in patients presenting with ischaemic stroke rather than watching and waiting.

http://bit.ly/Alteplase

To doctor is to diagnose

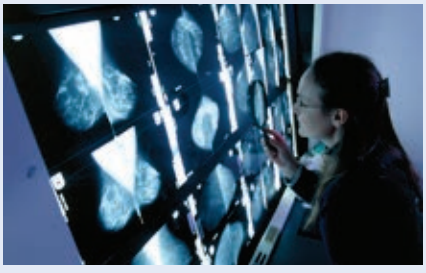
William Cayley unpicks the idea in Richard Smith's blog (above) that "diagnosis is no longer important because most patients have long term conditions." He believes that for patients experiencing the confusing symptoms of (potentially) multiple long term conditions, having a doctor who will work with you to find out what is going on is more important than ever.

http://bit.ly/to_doctor_to_diagnose

Why do five recent reports on breast screening reach conflicting conclusions?

Since 2012, five collaborative efforts to quantify the benefits and harms of breast screening have been published. The estimates and recommendations of each report have varied. Karsten Juhl Jørgensen looks at why there are conflicting results.

http://bit.ly/Jørgensen



EDITOR'S CHOICE

Getting our house in order

What is of interest now is who obstructs, who facilitates

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Anyone with even a fleeting acquaintance with *The BMJ* will have noticed the words "oseltamivir" (Tamiflu) and "statins" appearing a lot recently. With two online collections devoted to the drugs (thebmj.com/tamiflu and thebmj.com/statins), it may seem we've developed an unhealthy obsession. What we're obsessed with is getting sight of the evidence for oseltamivir's efficacy and statins' adverse effects. It could have been any drug; it's just that these showed up on our radar first.

Alteplase would make an equally worthy candidate for closer scrutiny of both risks and benefits, as our News story shows (*BMJ* 2015;350:h3301). Roger Shinton and three other senior clinicians have called on the health secretary for England to get unpublished trial data on alteplase released into the public domain. Until that happens, they say, the routine use of alteplase for ischaemic stroke should be suspended.

Such fighting talk can lose friends as well as influence people. Last week England's chief medical officer, Sally Davies, wrote to the Academy of Medical Sciences decrying recent controversies that "had damaged the public's faith in the way research was carried out and presented" (*BMJ* 2015;350:h3300). Oseltamivir and statins both received special mentions. "Reluctantly," Davies concluded, "we do need an authoritative independent report looking at how society should judge the safety and efficacy of drugs as an intervention."

Into the breach has stepped the academy, an intriguing development given that it's one of the few similar outfits not to have come out in favour of the AllTrials campaign (alltrials.net), which calls for all clinical trials to report their results. The academy has promised to report back by the end of the year on its "Evaluating evidence" project. Meanwhile, we at *The BMJ* are unrepentant: we want all data that underpin decision making about medical interventions to be publicly available, along with the competing interests of the decision makers. We can't see any alternative. Failure risks endangering the public's trust in science, without which doctors may as well pack up and go home. So the ultimate destination cannot be in doubt, even if the timescale is a bit hazy. What is of interest now is who obstructs, who facilitates.

We asked Ben Goldacre and Carl Heneghan, founders of AllTrials, for their thoughts on the Academy of Medical Sciences' impending review. They worry that the academy may accept shortcomings in the evidence as inevitable (p 7). As an alternative, they describe six "simple practical improvements" that the academy could endorse and that would alleviate legitimate concerns. "The public is increasingly aware of the shortcomings we collectively tolerate in the evidence base for clinical practice," they warn. The time has come to "get our house in order."

Evidence that balancing drugs' risks and benefits is not just a UK preoccupation comes from *Prescrire*, the French cousin of our *Drug and Therapeutics Bulletin*. Each year its editors assess new drugs entering the French market. Its dismal tally for 2014 was that three "offered a real advance," five "offered an advantage," 15 were "possibly helpful," 35 brought "nothing new," and 19 were "not acceptable" (p 22).

Many houses, much disorder.

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