new drugs. On page 958, Light and Lexchin challenge this foreign rip-off theory and present and discuss the evidence that disputes it. They say that the “free riding”

argument is an economic artefact and suggest that the US cuts the prices of drugs rather than trying to force other rich countries to raise them.

bmjupdates+

Oestrogen does not improve quality of life for postmenopausal women after hysterectomy

Research question Does hormone replacement therapy (HRT) with oestrogen have any impact on quality of life for postmenopausal women who have had a hysterectomy?

Answer No, although it can reduce vasomotor symptoms such as hot flushes.

Why did the authors do the study? The landmark women's health initiative trial reported last year that HRT with oestrogen does not provide any overall health benefits to women who have had a hysterectomy, but does increase their risk of stroke. Since oestrogens are still being prescribed for these women, the authors wanted to find out if HRT improved their quality of life. It's likely that hope of a better quality of life plays a part in any woman's decision to take oestrogen after a hysterectomy.

What did they do? They analysed data on quality of life collected during the women's health initiative trial, which included 10 739 women who took conjugated equine oestrogen or a placebo for more than six years. The women were all postmenopausal after a hysterectomy. Most were asymptomatic, but 17.3% had vasomotor symptoms such as hot flushes or night sweats at the start of the trial.

What did they find? Oestrogen had no clinically meaningful effect on any measure of quality of life after one year, or after three years of treatment in a subgroup of women. Specifically, it had no effect on mood, general health, physical functioning, pain, energy and fatigue, cognitive function, sexual satisfaction, or a global measure that simply asked women to rate their quality of life as poor, moderate, good, or excellent. After one year, 40% of both groups rated their quality of life as excellent, and 3% of both groups rated it poor. Among the women with vasomotor symptoms, those who took oestrogen were more likely to be symptom free one year later than women who took placebo (73.4% of 913 v 55.6% of 917), but the difference did not translate to a better quality of life.

The authors conclude that for this cohort of mainly healthy postmenopausal women, hormone replacement with oestrogen makes little if any difference to quality of life, even if treatment is extended to three years.

What does it mean? These findings are consistent with those of other randomised trials, including a large sister trial evaluating combined HRT (oestrogen and progestin) in menopausal women with a uterus. It now seems fairly clear that healthy postmenopausal women without a uterus should not expect equine oestrogen to make them feel better overall, although oestrogen should reduce any vasomotor symptoms they have.

Brunner RL et al. Effects of conjugated equine estrogen on health-related quality of life in postmenopausal women with hysterectomy. *Archives of Internal Medicine* 2005;165:1976-86.

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Editor's choice

Better decisions

The world seems to have shrunk this year. The South Asian earthquake and the possibility of a bird flu pandemic—coming hard on the heels of the Asian tsunami, the sub-Saharan famine, and hurricane Katrina—continue to bump national politics and celebrity gossip off our front pages and screens. Not so long ago, natural disasters and diseases affecting the world's poorest and most disadvantaged people would grab headlines for only a few days. Is the richer world genuinely more interested now? It should be, and not only for humanitarian reasons: these events and the responses to them can inform and improve policy decisions in our own countries (p 916, p 921, and p926).

National politics never goes away completely, though, and the debate on the future of the NHS rages on. Ian Kunkler, an oncologist from Scotland, calls for an independent regulator to see that commercial interests and unfair pricing don't disadvantage the public and cause long term damage to health care (p 965). How political should a medical journal be? Allyson Pollock (p 964) and Julian Tudor Hart (p 964) chastise the *BMJ* for staying neutral over NHS reforms, while John R Cherry and Andrew J Ashworth say that we went too far in publishing last week's personal view on Tory Kenneth Clarke's interests in the tobacco industry (<http://bmj.com/cgi/eletters/331/7521/912>).

The ethical standards we expect from clinical research may inadvertently manipulate and bias important results, as two papers show this week. Recruiting people to an observational study, Junghans and colleagues (p 940) randomised patients to opt in or out of giving consent and found that those opting in were less ill than the rest. Al-Shahi and colleagues (p 942), who found similar, though less predictable biases in their study, say it may be more ethical to do away with consent for health services research and epidemiological studies, thereby delivering the greater good.

Some of you say we overdo the *BMJ*'s coverage of global health, politics, and ethics and should stick to clinical topics. This week you'll find, among other things, up to date evidence on preventing myocardial infarction in elderly surgical patients (p 932, p 935) and preventing cervical cancer (p 915). And on this page we're launching a new weekly column—bmjupdates+—to pick up important evidence you may have missed. The column will summarise recent citations selected for scientific quality and relevance from more than 110 premier clinical journals. To get free email alerts from bmjupdates+, tailored to your interests, sign up at <http://bmjupdates.mcmaster.ca/index.asp>. These alerts could help you to make better clinical decisions, although you might also want to take Rollnick and colleagues' advice, in their article on health promotion, to “nudge, listen, summarise” when sharing decisions with patients (p 961).

Trish Groves senior assistant editor (tgroves@bmj.com)

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