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EDITOR'S CHOICE

The danger in the next big thing

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What is the next big thing? How do we know it when we see it? Is it the burger flipping robot that creates 360 different varieties of burger? What would such burgers taste like? It might be the 3D printing technology that is heralded as part of a new industrial revolution (doi:10.1136/bmj.g2963). Our picture of the week, inevitably rendered in glorious two dimensions, is a plastic skull created with 3D printing and used in an operation in a Dutch hospital. However, this plastic skull is not to be confused with helmets that don't seem to work in the treatment of infant skull deformities (doi:10.1136/bmj.g2741, doi:10.1136/bmj.g2906).

With drugs, we're usually informed about the next best thing by a company marketing campaign, a grand announcement at a major conference, or a study published in a medical journal. In fact, usually all three. The positive noise about a new drug emerges quickly. Cautionary messages take longer to be heard, by which time the latest wonder drug may have achieved blockbuster sales—and probably raised concerns about harm.

The incretin based drugs were one such product, the "new darlings of diabetes treatment," and the biggest breakthrough, apparently, since the discovery of insulin nearly 100 years before. Reviews of the safety profiles of these drugs by the US Food and Drug Administration and the European Medicines Agency prompted an investigation by *The BMJ*, which last year identified the risk of pancreatic damage (*BMJ* 2013;346:f3680). Two studies in this week's issue, a systematic review and meta-analysis of mostly industry funded trials and a cohort study drawn from the UK Clinical Practice Research Datalink practice database, indicate that any risk of acute pancreatitis is likely to be small. Given the available evidence, it is hard to be conclusive, and the potential for pancreatitis should be discussed with patients (doi:10.1136/bmj.g2779, doi:10.1136/bmj.g2366, doi:10.1136/bmj.g2780).

The next best thing in the world of torture tends to keep a lower profile. Waterboarding was exposed as a frequently used interrogation method in Abu Ghraib, Guantanamo, and the US Central Intelligence Agency's secret prisons. But what role did doctors play in the abuse of detainees in the "war on terror"? A new report by the Institute of Medicines as a Profession and the Open Society Foundations finds that doctors were "monitoring oxygen saturations during waterboarding, watching for edema in detainees forced to stand in stress positions, and helping increase psychological distress by sharing prisoners' individual health information with interrogators" (doi:10.1136/bmj.g2947). The report calls for the medical profession to unflinchingly reject involvement in abusive interrogations and suggests legislation to discourage unethical conduct by health professionals towards prisoners.

In an argument to revive a previously best thing, Helena Watson explains why feminism isn't a dirty word and in medicine needs a revival (doi:10.1136/bmj.g2623). Readers may struggle with the word feminism, says Watson, as it has been tarnished by the caricature of a man hating fundamentalist. An example of women's broader struggle is an unethical new policy introduced by the International Olympic Committee requiring women with hyperandrogenism to lower testosterone concentrations to compete. The policy effectively outlaws natural physiological variation and condones unnecessary medical intervention (doi:10.1136/bmj.g2926). Perhaps this latest industrial revolution is missing its own age of enlightenment?

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