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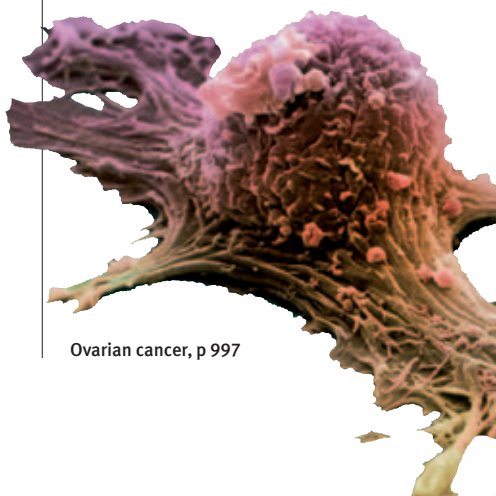

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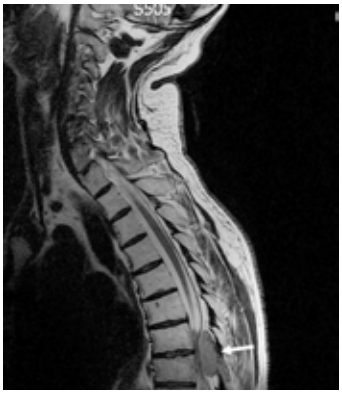

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PICTURE OF THE WEEK

"We plan to drink the drugs together and die together." The British couple Don and Iris Flounders, who took their own lives last week by drinking pentobarbital at their adopted home in Australia, made a video shortly before their deaths to appeal for a change in the law on assisted dying (http://bit.ly/IDHR5M). Mr Flounders, aged 81, who was terminally ill with mesothelioma and said he had no quality of life, and his wife, aged 88, who was not terminally ill but did not want to remain alive without Don, had obtained the pentobarbital from Mexico. In the video, Don said he resented having had to "travel half way round the world" to get the drug and that it should have been available at his local pharmacy. See Head to Head, p 1002

THE WEEK IN NUMBERS

£1440 Incremental cost effectiveness ratio per additional quality adjusted life year for hysterectomy compared with a levonorgestrel releasing intrauterine system in heavy menstrual bleeding **(Research, p 1012)**

10% Proportion of people who need retreatment as a result of initial undertreatment, overtreatment, or regression after laser refractive eye surgery **(Clinical Review, p 1014)**

35 000 Number of people who die from lung cancer every year in the United Kingdom **(Practice, p 1019)**

5-10% Proportion of patients with cancer who also have metastatic cord compression **(Practice, p 1023)**

QUOTE OF THE WEEK

"Health professionals assigned to the DoD [Department of Defense] to provide medical and mental health care to GTMO [Guantánamo Bay] detainees neglected and/or concealed evidence of intentional harm"

Doctors working for Physicians for Human Rights in a report on doctors' involvement in torture at Guantánamo Bay **(News, p 998)**

QUESTION OF THE WEEK

Last week we asked, "Should the law on assisted dying be changed?

31% said yes (total 665 votes cast)

This week's poll asks, "Does the UN have a duty to intervene to halt violations of medical neutrality in countries such as Bahrain" **(Editorials, p 988)**

bmj.com Read the latest news about the situation in Bahrain and cast your vote

EDITOR'S CHOICE

Cost is an ethical issue

We need to understand effectiveness and cost effectiveness in real clinical settings

Money is tight, so getting value for money has to be a top priority for all of us in healthcare. As Jim Easton, the man in charge of improvement and efficiency for the NHS, says whenever he speaks, cost is an ethical issue. Why, then, do we have so little information on cost effectiveness?

Teppo Järvinen and colleagues find this especially worrying in the case of drug treatments for prevention (p 1006). They say that for major preventive drugs, such as statins, antihypertensives, and bisphosphonates, there are "no valid data" on effectiveness or cost effectiveness. This may come as a surprise to some of you. It did to me. They explain that claims for the cost effectiveness of these and other drugs are based on efficacy data from randomised trials in idealised populations. In the real world of clinical care, true cost effectiveness may be much lower. Malcolm Willett's accompanying cartoon shows a man standing on the bottom "efficacy" rung of a ladder: "This is fine," he says. "I can see all the evidence I need from here."

What Järvinen and colleagues urge us to recognise is that we can't. To really see whether these drugs represent value for money, we need to take two steps up. We need to understand effectiveness and cost effectiveness in real clinical settings. As an example of how to do this, they refer to a 2001 study by Clare Robertson and colleagues (*BMJ* 2001;322:701, doi:10.1136/bmj.322.7288.701). But they point out that this assessed a non-drug intervention—exercise for preventing falls in older adults. "We wonder at the virtual absence of empirical cost effectiveness data on preventive drugs when drug companies stand to make millions of profit a week if their drugs are shown to reduce important clinical outcomes in the community setting."

The *BMJ* has a longstanding policy of publishing cost effectiveness studies alongside or after randomised trials and systematic reviews. This week we apply the policy to the challenge of how best to treat heavy menstrual bleeding. A systematic review and individual patient data meta-analysis published last year found that hysterectomy scores higher (least dissatisfaction among patients) than endometrial ablation or the Mirena coil (*BMJ* 2010;341:c3929, doi:10.1136/bmj.c3929). Now the same group has done a full cost effectiveness analysis (p 1012) and concludes that hysterectomy is likely to be the most cost effective strategy. NICE guidelines currently favour Mirena.

At least we do have NICE. With all its inevitable imperfections, it's still a national treasure. Spare a thought for those charged with creating something similar in the United States, where the C word can't be mentioned. Instead of "cost," the focus is firmly on comparative effectiveness in the form of head to head comparisons. And even then, as Doug Kamerow reports (p 1004), the *Wall Street Journal* snipes "Comparative effectiveness isn't about informing choices, it's about taking away options." But there's no alternative to comparing one treatment with another if we are to make rational decisions; and whatever your health system, cost is an ethical issue.

Fiona Godlee, editor, *BMJ*

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Career Focus, jobs, and courses appear after p 1032

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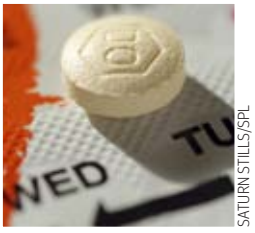

SATURN STILLS/SPL

Risk of non-fatal venous thromboembolism in women using oral contraceptives containing drospirenone compared with women using oral contraceptives containing levonorgestrel

Calcium supplements with or without vitamin D and risk of cardiovascular events

Risk of venous thromboembolism in users of oral contraceptives containing drospirenone or levonorgestrel

Levothyroxine dose and risk of fractures in older adults

Muslim customs surrounding death, bereavement, postmortem examinations, and organ transplants

Do calcium plus vitamin D supplements increase cardiovascular risk?