

Editor's choice

The drugs don't work:

Allen Rogers, worldwide vice president of genetics at Glaxo SmithKline

Younger readers of the *BMJ*, of whom there are many, will be familiar with the Verve's song "The drugs don't work." It's unclear whether this song, which is sung in a distinctly druggy manner, is referring to legal or illegal drugs or even the drug of love. But a spoof piece on the web claims that: "The world's major pharmaceutical companies are to sue the Verve for loss of earnings and defamation following the release of their single." Now business has outdone parody, and Allen Rogers, worldwide vice president of genetics at Glaxo SmithKline, is reported on the front page of the *Independent* (8 December, p 1) as saying: "Our drugs don't work on most patients." ([p 1366](#))

This is of course no news to doctors. Anybody familiar with the notion of "number needed to treat" (NNT) knows that it's usually necessary to treat many patients in order for one to benefit. NNTs under 5 are unusual, whereas NNTs over 20 are common. Rogers's quote has, however, hit the media like a bombshell. Why is the NHS paying over £7bn (\$12bn; €10bn) a year for drugs that don't work? Rogers has been compared with Gerald Ratner, the head of a jewellery firm, who famously said that most of the company's products were "total crap."

There is, of course, method in Rogers's madness. He is an enthusiast for pharmacogenomics and hopes that greater understanding of genetics will mean that we will be able to identify with a "simple genetic test" people who will respond to drugs and design drugs for individuals rather than populations. We have, however, been hearing this tune for a long time, and it's hard to see the business model for individually tailored drugs.

Hywell Williams, a dermatologist, tells the sad story of a drug that doesn't seem to work for anybody ([p 1358](#)). It has taken some 20 years to show as conclusively as is possible that evening primrose oil is of no use in atopic dermatitis. A systematic review published in 2000 found that the largest and best studies did not show benefit, but the possibility remained that very high doses might work. A trial we publish today shows that is not the case ([p 1385](#)), and the UK's Medicines Control Agency has anyway withdrawn the drug's product licence.

"How," asks Williams, "was this drug licensed in the first place and why have so few data been available in the public domain for open scientific debate?" The *BMJ* is on difficult ground here for the champion of this drug was David Horrobin, and our critical obituary of him earlier this year caused a storm of protest (19 April, [p 885](#)). Yet Williams tells a sorry tale of failures to publish company sponsored trials supposedly showing benefit, unjustified accusations against authors of a study that found no benefit, editorial suppression of criticisms, threats of legal action, and governmental suppression of important data. This can't be a good way to make decisions on drugs. Let the sun shine in.

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