eight specific substantial doubts.[13] It did this partly because Chandra's university was unable to investigate further when Chandra failed to provide raw data and then resigned.[12] But doubts now remain about Chandra's other studies, and the fact that these have not been resolved has already caused problems to meta-analysts.[14] These papers exist in scientific limbo.

The stories of Singh and Chandra are sorry tales, with no clear resolution. What more can journals do when their attempts to get someone else to investigate fail? Some researchers and editors argue that journals should keep collective confidential "black lists" of suspected papers and authors. But the sheer number of journals makes this unreliable; more seriously, it would imply someone was guilty until proven innocent—with a worrying lack of due process. Others suggest that journals should ask authors to deposit a copy of their dataset in a secure archive so that data could be audited if questions arise. But that too demands an infrastructure that doesn't exist. Perhaps rather than waiting for definitive proof, journals should in future be more ready to share their concerns about published papers, using the mechanism we use today—the publication of an expression of concern—where they have reasonable grounds to believe that serious questions exist about a paper. The expression of concern does not resolve the suspicions but it alerts researchers, and in particular systematic reviewers, to doubts about the studies. And it may in turn prompt an organisation with the capacity and standing to take the action necessary to do the necessary investigations.

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Tackling the political determinants of global health

Is essential if we want to abolish poverty

This month sees the launch of an "alternative world health report," a document that will from now on appear every two years.[1] For the first time the institutions charged with improving global health are held accountable by the collective view of a coalition of civil society organisations reporting a clear message: the crisis in global health is not a crisis of disease, it is a crisis of governance.[2]

In tune with other citizens' movements for global social justice, this report argues that we have reached a stage in the history of public health where we can no longer accept profound inequities in access to health and treatment around the world. The report concludes that poverty and the lack of resources for the health of the poor are the key factors that hinder progress in global health, but it does not restrict itself to call for more charity. Instead the world needs a new policy model based on entitlement, in which good health is an integral part of social, economic, and cultural rights and citizenship and is ensured as a global public good. Achieving this will depend on an accountable mechanism for global governance and a strengthened public sector at all levels.

The alternative world health report scrutinises the conduct of global organisations—such as the World Health Organization, the United Nations Children's Fund (UNICEF), and the World Bank, global trade regimes, transnational corporations, and the rich nations—and their approaches to aid and debt relief. It underlines that the global regimes that support the international system of finance and trade need to be balanced by a global social contract that benefits people. It analyses how international organisations and donors have contributed to the current crisis and that many national governments have not prioritised population health. Critical processes are the redirection of global health functions from interstate mechanisms to a fragmented group of actors; the discussion of major health issues in forums (trade, agriculture, intellectual property, security) to which the public health community has little access; a commercialisation and privatisation of global health, which introduces a biomedical and technological bias and often stands in the way of building sustainable health systems.

The alternative world health report proposes that the current crisis of governance is provoked by the rich nations wanting to shape the international world order to their image—such a view lets some developing nations, particularly those that have become global players in their own right, get away too lightly. Also the report presupposes too easily that a more "equal" distribution of power in the international system would lead to a greater adherence to human rights and a greater commitment to equity—the ideological divergence in the current global system is too large and too

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fluid to be sure of such an outcome.[3] These are issues that must be dealt with in future reports—as must the accountability of other players, such as foundations and non-governmental organisations.

The global health governance system needs a strong core that develops and monitors norms and standards including international health treaties, tackles key health issues of the poor, and ensures global health security through international regulations, surveillance, and rapid outbreak response. With this in mind, the chapter analysing WHO and the leadership and governance problems it faces is one of the most worrying in this report. The report makes specific proposals for a stronger WHO, for better funding and organisation of global health, and for cooperation between civil society movements committed to global public goods such as water, education, and health. It also proposes a global campaign for a tax to finance global public goods. How difficult such a shift will be could be seen at the recent G8 summit.[4] Even so, when public health experts suggested a tax on airline tickets for global public health several years ago,[5 6] they were considered dreamers; now this issue is part of the deliberation of heads of state, and airlines would do well in spearheading a movement for global health security on which their business depends.

I would hesitate to put most of the reason for failure down to the all encompassing concepts of neoliberalism and globalisation, as the alternative world health report is prone to doing, but health is deeply political. We need to tackle the political determinants of health. National public health associations and medical associations should be at the forefront of explaining and exploring the interface of national and global public health, maybe through the mechanism of national global health summits.[7] They should commit to this unique historical opportunity, which is like the 19th century golden age of public health. Then as now: if we want "to make poverty history," we need to tackle health.

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Evidence based prescribing

Is the goal, but prescribers still need education, experience, and common sense

Papers p 263 and *Letters* p 292

Evidence based medicine has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[1] Few areas of medical practice have felt the effects of this movement more clearly than prescribing. Until recently doctors could prescribe medicines without worrying that their choices might be judged against evidence accumulated in the world's literature. Now, prescribers are increasingly expected to back up their decisions with evidence.[2] Enthusiasm for evidence based prescribing is welcome and should lead to safer and more effective use of medicines. But it also poses some real problems for prescribers.

Reliable information to underpin everyday prescribing decisions at the point of prescription is hard to find. One solution is to provide modern information technology systems in the consulting room or at the bedside.[3] But even these may deliver too much unfiltered information including some original research, some guidance derived from research, and some unsubstantiated opinion. The modern prescriber has to decide which data are the most reliable, accurate, and representative of true evidence rather than conjecture.

What should the prescriber do, however, if he or she finds several apparently reliable sources giving differing advice about the same clinical problem? In this issue of the *BMJ* Vidal et al (p 263) compare the advice given in four respected prescribers' guides on adjusting in renal impairment the dosages of 100 commonly used drugs.[4] They find that the four texts differ in their recommendations on dose and dosing interval, and even in their definition of renal impairment. They conclude that this variation is "remarkable," as is the lack of detail about how the advice was reached, and describe the sources as "ill suited for clinical use." These conclusions seem harsh and deserve further analysis.

Should we be surprised that respected texts vary? Probably not. Even when there is very good evidence—for example for managing hypertension—different experts may synthesise it to produce a variety of conclusions about optimal prescribing.[5 6] Vidal et al focus on recommended adjustments in dose for a relatively small proportion of patients with a problem that is much rarer than hypertension. In more than half the instances of discrepant advice, the authors acknowledge that they could find no firm evidence despite prolonged searching of Medline.[4] Clinicians often have no relevant scientific evidence on which to base a decision.[7] Rapid accumulation of research findings and international efforts to sort and rationalise them systematically are closing some of these gaps in

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