DTB at 60

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The Drug and Therapeutics Bulletin (DTB) was obligatory reading; as a final year medical student, it was a four-page freebie in simple black font that arrived in the post and brought clarity to what was a confusing panoply of therapeutic choices. As a junior doctor, I remember it as the first usable example of evidence-based medicine and a way of understanding options.

The bulletin was the brainchild of Andrew Herxheimer (Editor 1962-1992) and Joe Collier (Editor 1992-2004) and I became aware of it, thanks to Joe, who taught me as a medical student at St George's Hospital Medical School and who I later worked with as his junior lecturer. It was a time (the 1980s) when treatment options were many and the notion of restricting choices based on evidence was in its infancy. The DTB was a front runner, it was clear and straightforward and avoided just leaving it up to the reader to 'consider' various options. It came off the fence.

Later, when I joined DTB's editorial board and advisory council (1992-2004), I saw how all this worked. Joe and the brilliant in-house team—who were then all based within the Consumers' Association (the 'Which' organisation)—would commission from an expert a first draft of an article on treatment of a specific medical problem, or across a range of drug options. The team would push for the author to be bold and simple in their recommendations. The inevitably challenging piece would then be circulated widely for comment, to industry, practitioners, the Department of Health, academics and others. And comment they did! The final crafting was down to Joe and he would hone the arguments, test the evidence and ensure clarity. Sometimes, the initial author would write an affronted letter bemoaning the alterations in their articles, but more often than not they saw that the finished thing did a specific job and did it well.

In many ways, the DTB was a forerunner of what the National Institute for Health and Care Excellence ended up doing, although in a very different way and for different purposes. It did something rather important, it helped generalists and others to feel confident about their prescribing options and what the alternatives were. It helped us all have the confidence to move to new drugs where appropriate and to avoid moving to ones that did not offer an advantage or had no sensible comparison with existing treatments. It did not do what so many articles and guidelines do, which is to leave the least expert person (very often us the reader) to have to make a choice which the experts had not been able to decide on. It tried to lay out what was known and what was unknown, and where the gaps in comparisons were and it turned all this into a concise recommendation. We now have lots of groups doing this across the world, but when the DTB started we did not.

Of course, the DTB changed over time, and both Andrew and Joe changed as well. Joe became an early advocate of something he termed 'optimal pathways of treatment', and Andrew started the database of individual patient experiences. The latter, a recognition of how to crowd source information and recognise the difference between the aggregate and the individual response to a medicine.

As it reaches 60, I hope that the DTB will continue to challenge, evolve, inform and educate.

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His personal research was in the area of diseases of blood vessels and endothelial biology.

From 1992 until 2004, he was a member of DTB's Editorial Board and Advisory Council.

Competing interests None declared.

Provenance and peer review Commissioned; internally peer reviewed.

DOI: 10.1136/dtb.2022.000016