are increasingly entering the legitimate medicines supply chain. Such incidents appear to be part of very deliberate criminal strategies.[3] Between 2001 and 2005 the EU experienced at least 27 incidents involving counterfeit drugs and in 2005 counterfeit versions of Pfizer's Lipitor® were found on the market in the UK. When the Medicines and Healthcare products Regulatory Agency (MHRA) ordered the recall of drugs involved in the incidents, over 50% of the returned product was found to be counterfeit. Overall, the European Commission has reported a dramatic increase in illicit drugs trying to access the EU market. During 2005, half a million counterfeit medicines were seized at community borders and these are thought to be only the tip of the iceberg. This ever-growing problem is particularly acute in the UK. There is clear evidence that counterfeiters will exploit any weakness or inconsistencies in EU member states' supply arrangements for medicines.

In the UK, there are a number of factors, such as a complicated supply chain, that encourages grey market activity making the market attractive to the counterfeiting of medicines, including a huge number of prescriptions. The UK has become a common transit position for counterfeit. Counterfeit medicines often pass through the UK en route to other countries. The scale of the problem in the UK is demonstrated by the fact that there have been 14 known incidents of counterfeit medicines penetrating the UK supply chain since August 2004, ranging from antipsychotic medicines to antiplatelet agents and drugs for chemotherapy. As yet no fatalities have been attributed to counterfeit medicines in the UK but it must be remembered that it is extremely difficult to prove that a defective medicine was responsible for death in such circumstances. Moreover, health professionals have a relatively low index of suspicion when confronted with patients who may show signs of lack of efficacy or safety-related drug adverse events. It is possible that a degree of under-reporting may be occurring in the UK.

The MHRA now sees counterfeit medicines as a major public health issue especially given the vulnerabilities in the UK supply chain. These vulnerabilities begin at the point of importation and stretch through to the point of distribution. The MHRA published its new strategy for the next three years to tackle the supply and distribution of counterfeit medicines.[4] Activities include monitoring websites and medicines on sale in pharmacies in conjunction with industry and law enforcement agencies. These strategic activities will focus on resources and production most at risk. The MHRA will encourage thorough reporting and investigation of all referrals of suspected counterfeiting and broadening the targeted market surveillance scheme together with increasing the risk of prosecution for those involved. The MHRA is also collaborating closely with WHO international medical counterfeiting task force, International Medical Products Anti-Counterfeiting Taskforce (IMPACT), which has a permanent focus on international pharmaceutical crime. The worldwide regulation countries, the industry and law enforcement agencies now recognise and are active in concert to mitigate the potential catastrophic public health and safety issues. Where do the health professionals and especially the medical profession fit into this scheme? The key issue is awareness and a raised index of suspicion when making differential diagnoses where drug activity in terms of safety and/or efficacy may cause one to suspect counterfeit medicines.

References

1 Scrip 3255; 5 April 2007, www.scripnews.com
2 www.who.int/mediacentre/factsheets/fs275/en/print.html
3 Scrip 13 November 2006, www.scripnews.com
4 www.mhra.gov.uk

Most significant developments as a journal editor

John R Ashton CBE
Director of Public Health and County Medical Officer, Ginny Hall, Dent, Cumbria

Email: john.ashton@cumbria.pct.nhs.uk

I cannot profess to having had a lifetime ambition to edit a health journal but some of life's most pleasant experiences come on you unexpectedly. I have, however, always enjoyed writing and publishing the findings of my own research as well as various texts in support of the new public health has always been one of the joys of my career. Consequently, when Carlos Alvarez Dardet of Alicante approached me in 1996 with the suggestion that we co-edit the *Journal of Epidemiology and Community Health* (*JECH*), the BMJ's specialist public health journal, it took but a moment's thought to agree.

The *JECH* that we inherited was the well-established house journal of the Society of Social Medicine. It was the sort of origin which it shared with many of the specialist BMJ journals – the product of a group of enthusiasts wishing to communicate advances in their specialty between its members. In the case of the *JECH* and the Society of Social Medicine, the beginnings had been the fruits of collaboration between social medicine at the London School of Hygiene and Tropical Medicine and social science at Bedford College and elsewhere. It was a respected journal with a strong slant towards academic epidemiology and a desire to translate its insights in socially useful ways. Members of the society were accustomed to the abstracts of the papers that they had presented at their annual conference being automatically published in the journal. As a journal its focus was almost entirely UK and English speaking.

Carlos and I, however, came from a somewhat different place. For myself, my career has represented a clear effort to bridge the worlds of analysis and reflection, policy and practice perhaps best caricatured by an antipathy towards academic activity which demonstrates excellence in the irrelevant towards that which is good enough to make a difference on the ground.

Carlos is an enthusiastic epidemiologist, one of the Spanish leaders of the discipline who is deeply rooted in political action for health having grown up in the dying years of Franco. We had met in the late 1980s when Carlos and his colleagues were reinventing public health in Spain after Franco's death. As with Hitler and Germany, non-eugenic public health had been anathema and, while in Germany many of its (Jewish) practitioners had been murdered, the term 'social medicine' in Spain had become a term of abuse linked to 'socialism'. Planning regulations were virtually non-existent and it was commonplace to find people living in the shadow of massive industrial pollution akin to that of the Industrial Revolution in the UK. I worked closely with Alicante and Valencia to re-establish public health teaching and a master's programme. The vehicle for public health practice became rapidly the World Health Organization's (WHO's) Healthy Cities project, of which I was the coordinator, and within a short time almost the entire population of the Valencia region was living in a municipality dedicated to becoming a 'healthy city' – the merging of academia and practice on the ground was exhilarating and contrasted with that in many British centres where academic epidemiology was content to nest in the ivory towers.

Editing the journal gave us a platform for the new public health with its emphasis on the WHO philosophy of re-orientating healthcare towards a public health system grounded in prevention, primary care, active citizenship and collaborative multidisciplinary working. Our pitch to the BMJ was based on this and a desire to globalise the publication as a leading international public health journal as likely to be read in China, the USA or Latin America as in the UK. We were helped in our task by the enthusiastic support of the BMJ staff and our own network of public health academics and practitioners from around the world, many of whom were corralled into being part of an active editorial board – itself something not as common as those who submit papers to journals might imagine. The challenge of editing a journal from two countries was met by having resourceful support in Liverpool and Alicante but also by the advent of the internet which meant that within a short time of our taking up the reins, we were producing the journal electronically with paper submission, peer review and editing all done at the push of a button. However, it is arguable whether we could have produced the energy and the creative dynamic which followed if our project had not been based on strong bonds of friendship and familiarity, good food and wine and the annual meeting of the editorial board generously supported by the BMJ in Spain or the North West of England.

So what were the challenges and what did we achieve in a very rapidly changing publishing environment? Early on that sear of medical editorship Richard Smith shared with the editors of the BMJ journals his strategic vision of where this world was headed – globalisation, electronic publishing with a shift towards early publishing, particularly of the backup data on the internet, while the journals themselves became much more chatty and interpretive (like *New Scientist* or *New Society* had been), conglomeration and outsourcing. Much of what Richard envisaged has come to pass – some of it not without teething problems, such as quality control of copy-editing from the Far East and keeping to a schedule. But as for the achievements we have:

- gone fully global with a much increased proportion of papers submitted from non-English speaking countries but also now appealing to English speaking countries such as the USA where previously authors would not have looked beyond their own domestic journals
- gone from bi-monthly to monthly with in excess of 1,500 papers submitted every year
- an impact factor which has gone from 1.4 to 3 between 1998 and 2006. En route we have twice changed the cover (but not the title)
- introduced new sections on policy and practice, public health past and present, speakers' corner, continuing professional education and research reports
- asked authors to specify the policy and practice implications of their findings. The response to this began slowly and seemed to support the belief that academics were not interested in the practical consequences of their work. More recently there has been a significant shift in the emphasis of submissions towards the practical and the boxes in the text for policy and practice implications are now usually completed. This contrasts sharply with the previously common conclusion from academics that 'more research is needed'.

As with so many other journals, subscriptions for paper copies have slumped as individuals and librarians opt for the internet over paper on shelves but the *JECH* has seen a large uptake of electronic subscriptions and internet hits.

So what are the final thoughts after 10 years of editing something which has become part of the family? Having a clear strategic vision of what we wanted to achieve was important. We have done most of it. What would we have done differently? Well, editing a journal like this is a joy – but doing it in free time and at weekends means that you can never quite explore the outer reaches. It would have been good to develop the gallery more with photographs and other cultural and arts angles on public health. We did manage to have Liverpool poet Levi Tafari accessible online with readings of his poems on sustainability, and public health consultant Gabriel Scally singing his public health call, invoking pioneers of the past, but it would have been nice to have done more. The baton now passes to Professor Mauricio Barreto in Brazil and we look forward to a rich new perspective as the child we have nurtured continues to grow and develop.