**Cochrane censorship and editorial misconduct: intravenous alpha-1 antitrypsin and other issues**

By Peter C Gøtzsche

In 2008, intravenous alpha-1 antitrypsin was used in some countries for patients with lung disease caused by inherited alpha-1 antitrypsin deficiency. But it was extraordinarily expensive, cost up to €116,000 annually per patient, and its benefit was uncertain.

Nonetheless, Danish lung specialists had successfully lobbied a political majority in Parliament to agree to reimburse the drug. As the deterioration in lung function is slow, and very slow if the patients don’t smoke, the drug was to be used for many years in each patient.

The Committee on Health in Parliament asked me to review the trials before any decision would be taken. It took me only four weeks to write a report documenting that there was no convincing evidence that the drug worked.

When I presented my results for the Committee, a Social Democrat argued that the drug should be funded because it was funded in countries Denmark usually compared itself with. I asked him which countries he alluded to. When he said Germany, I replied that Germans were also fond of homoeopathy and that we were not that foolish in Denmark. It amused the Committee members who were not used so such a pointed remark from a scientist, and they decided not to reimburse alpha-1 antitrypsin.

In the media, the Board of Health took credit for having saved a huge amount of money for Danish taxpayers. My name was not mentioned even though I had saved at least €30 million every year.

I decided to do a Cochrane review about the drug with my wife, Helle Krogh Johansen, who is an expert in another chronic lung disease, cystic fibrosis.

However, dealing with the Cochrane Cystic Fibrosis and Genetic Disorders Group was extremely difficult and frustrating.

The editors refused to send our research for peer review before we had found a third author who needed to be a content area expert. We explained we had plenty of access to experts, but that they didn’t need to be co-authors. In fact, it would be impossible to add an author because we had already done the work. Such an extra person would have become a so-called guest author, a practice uniformly condemned by medical journal editors.

We noted that there had been a content area expert on our protocol, Asger Dirksen, who was first author on the only two trial reports that existed. He withdrew his authorship when he saw our negative results!

The Cochrane editors provided us with comments from an expert with numerous conflicts of interest in relation to the obscenely expensive drug we had studied. They even wrote to us that he would be willing to become co-author, which was outrageous. One of Cochrane’s ten key principles is to avoid conflicts of interest.

As I couldn’t persuade the group’s editor, Alan Smyth, to move ahead, I described the case anonymously on the discussion list of the World Association of Medical Editors. There was no sympathy whatsoever with Cochrane’s attitude. I complained to the Cochrane publication arbiters and to Cochrane’s Editor-in-Chief, David Tovey, and the deadlock only ended when Tovey told the group to send our work out for peer review without demanding a third author.

The editors in the Cochrane Cystic Fibrosis and Genetic Disorders Group were so unprofessional and incompetent, also in relation to elementary statistical issues, that I asked Tovey to transfer our review to another Cochrane group, which published it.1 I could not convince them, for example, that P = 0.06 spoke about as much against the null hypothesis of no difference as P = 0.03 (we had both P-values in our review, and the former indicated harm, the latter benefit of the intervention).

In 2024, the Danish Medical Council recommended using the drug because “there is a reasonable relationship between the value of the medicine and the costs of the treatment.”2 How is this possible for a drug that doesn’t work and is highly expensive? Since we published the Cochrane review, only one new trial has been published, and it is of inhaled drug.3 There were more exacerbations, more adverse events, and more dropouts on drug than on placebo. I often wonder why healthcare is so irrational.

One of my friends, John Ioannidis from Stanford University, is the world’s most cited medical researcher, and he had also had negative experiences of having content area experts in a review team. We published a paper in the *BMJ* two years later where we warned against this, as experts may have personal prejudices and idiosyncrasies.4 We noted that the stronger the expertise, the stronger the prior opinion, the lower the quality of the reviews, and the less time is spent on them.5

We also mentioned that when convincing randomised trials or systematic reviews find results that invalidate expert based practice, there is always a flurry of reviews, editorials, and letters from content area experts that try to refute, or even denigrate, the evidence. We gave examples of this wholesale editorial assault, one of which was my experience with alpha-1 antitrypsin. Moreover, experts tend to ignore the rigour of primary research and to praise papers of lesser quality that provide the results that confirm their beliefs.

When basic knowledge of an area being reviewed is needed, it can usually be acquired by consulting textbooks and reading review articles. And content area experts are happy to assist if review authors need help.

John and I noted that the Cochrane Collaboration stated in its handbook that review teams must include expertise in the topic area being reviewed and include, or have access to, expertise in systematic review methodology. We suggested turning this recommendation around: Review teams should include expertise in systematic review methodology and have access to expertise in the topic area. We also told our *BMJ* readers that we regard the theory of evolution as the most important discovery of all times and that Charles Darwin had no qualifications in biology. He studied medicine, law, and theology.

When I did a review of soft laser therapy for unwanted hair growth with a dermatologist, the Cochrane Skin Group told me they required a consumer as co-author. It is not clear to me why a woman with a hairy upper lip would become a good author of a scientific paper. We found one, but as she didn’t contribute meaningfully, we dropped her as an author.6

The Cochrane Anaesthesia Group required that all author teams must have access to a BSc, MSc, or PhD qualified statistician. I argued that I knew an excellent statistician who had no formal education in statistics and that I had authored 12 Cochrane reviews without needing support from statisticians, as I have studied statistics extensively. They accepted my arguments.

The freedom Cochrane groups and editors have in setting their own standards sometimes lead to absurd demands that do not exist in other scientific journals. This is still a major problem.

When my co-author and I in 2023 tried to update our Cochrane review of mammography screening,7 which we had updated before, we faced a road-block. The Cochrane editors had numerous absurd demands. It was as if we had never published the review before. They did not even understand the basics of cancer screening. They requested, for example, with reference to the Cochrane Handbook,8 that our statement "did not show a benefit in terms of a reduction in breast cancer mortality" should be "may show little or no difference in terms of a reduction in breast cancer mortality." We objected, as there was no statistically significant reduction in breast cancer mortality. We also noted it is subjective whether a difference is small or not.

We were ignored, and our update, with more deaths, was rejected in February 2025 for no good reason. I had anticipated this because I had been exposed to Cochrane censorship and editorial misconduct many times earlier, e.g. in relation to our assessment of the quality of 53 new Cochrane reviews,9 mammography screening,10 house dust mites,11 alpha-1 antitrypsin, and antidepressants.12 I had therefore published our updated results in 2023, on my website.13

Cochrane has fallen so deep now that it seems to be beyond repair.

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