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The Editor, *BMJ*
 BMA House, Tavistock Square,
 London WC1H 9JR
 Email: editor@bmj.com
 Tel: +44 (0)20 7387 4410
 Fax: +44 (0)20 7383 6418
BMA MEMBERS' ENQUIRIES
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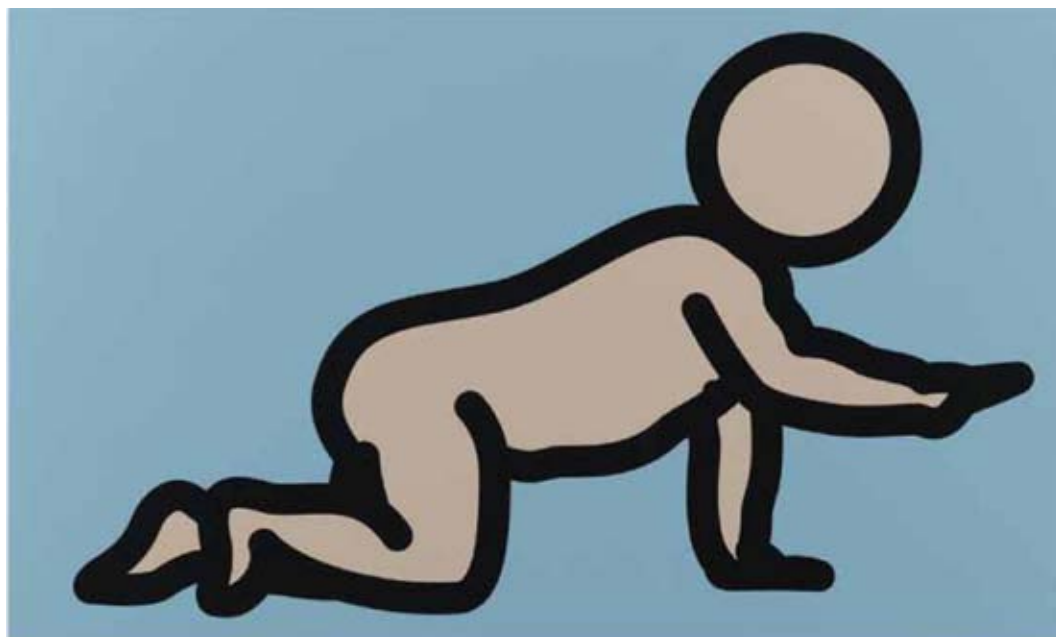
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PICTURE OF THE WEEK

Dino Crawling, 4 by Julian Opie is one of 26 works by some of Britain's top artists donated for auction to help raise £550 000 for research into the causes of premature birth. The other artists include Anthony Gormley, Anish Kapoor, and Grayson Perry. The auction will take place at Christie's in London on Wednesday 26 June. More details are at borne.org.uk.

RESPONSE OF THE WEEK

Kinesh Patel argues that clinical examination is redundant in an age of readily available investigations. Surely a more helpful approach is to evaluate and use components of clinical examination in the same way as we would other diagnostic tests? What is the sensitivity and specificity, positive and negative predictive value of examination manoeuvres in different clinical scenarios?

Such an approach keeps the useful parts of examination, saves time by allowing unhelpful components to be jettisoned, and allows rational selection of further investigation. Unthinking, undirected investigation already imposes huge costs in terms of time, resources, and iatrogenic harm; abandoning clinical examination entirely will only make these problems worse.

Miles D Witham, clinical senior lecturer in ageing and health, University of Dundee, Dundee, UK, in response to "Is clinical examination dead?" (*BMJ* 2013;346:f3442)

MOST SHARED

Statins and the risk of developing diabetes
 Am I missing something in the essay on the science of obesity?
 Restricting dietary carbohydrate versus increasing physical activity in tackling obesity
 Implementation of self management support for long term conditions in routine primary care settings: cluster randomised controlled trial
 P values or confidence intervals?

BMJ.COM POLL

Last week's poll asked:
 "Should we sequence everyone's genome?"

70% voted no
 (total 1112 votes cast)

Head to Head:

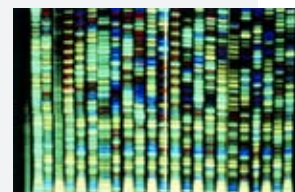
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This week's poll asks:

"Is clinical examination dead?"

► *BMJ* 2013;346:f3442

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EDITOR'S CHOICE

Balancing benefits and harms

When it comes to statins, the balancing act must now include the risk of diabetes. But is this a class effect or is the risk higher with some statins than with others?

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It is a basic principle of pharmacotherapy that all drugs have beneficial and harmful effects. And as Risto Huupponen and Jorma Viikari say in their editorial this week, it is the doctor's job to find a justified balance between them (p 8). When it comes to statins, the balancing act must now include the risk of diabetes. But is this a class effect or is the risk higher with some statins than with others?

A meta-analysis in the *Lancet* three years ago identified an increased risk of diabetes in people taking statins. Now, Aleesa A Carter and colleagues have analysed data from nearly 500 000 new users of statins. They found a greater risk of diabetes with the more potent statins and with higher doses (p 14). Huupponen and Viikari conclude that the overall benefits of statins still outweigh the risks but recommend maintaining the lowest possible potency and dose.

Unfortunately in the balance between benefits and risks, it is an uncomfortable truth that most drugs do not work in most patients. On the positive side, Andrew Moore and colleagues say that if we can embrace the fact that most treatments fail, we will deliver better and safer care. But this needs a radical shift in the way we evaluate and use drugs (p 19).

Using data from systematic reviews in pain medication, the authors found that fewer than half of patients achieved at least a 50% reduction in pain intensity, with failure rates highest over the longer term in patients with chronic pain. But, importantly, hidden within this sobering picture are a minority of patients who respond well to treatment.

The authors recommend a different approach to the

data—responder analysis—which reports the proportion of patients achieving outcomes that patients consider worthwhile. Clinical trials that don't take this approach will underestimate the effectiveness of treatments, they say. They call for a change in the way regulators decide on which drugs to license. "Regulators need to recognise that failure is the norm," they say.

As for clinicians, if you expect failure in individual patients and act swiftly when it occurs, your patients are more likely to get the best and safest treatment. If a drug fails it should be stopped, avoiding its adverse effects and opening the door to other treatment options. "Only effective drugs should continue to be prescribed," they say.

This may sound obvious, but the key here is to move away from "a slavish reliance on the average." And because success rates are low, a wide range of drugs is needed to do the best for most patients, especially in complex chronic conditions. Practice guidelines therefore need to reflect the realities of drug failure. Instead of restricting treatment options to one or two drugs, less restrictive guidance centred on the interaction between patient and clinician may do better. The authors hold up as a good example of such guidance the guidelines on osteoarthritis from the National Institute for Health and Care Excellence.

The challenge for doctors is to find what works for whom in what circumstances. As well as evidence, the authors prescribe "a large dose of clinical wisdom."

Fiona Godlee, editor, *BMJ*
fgodlee@bmj.com

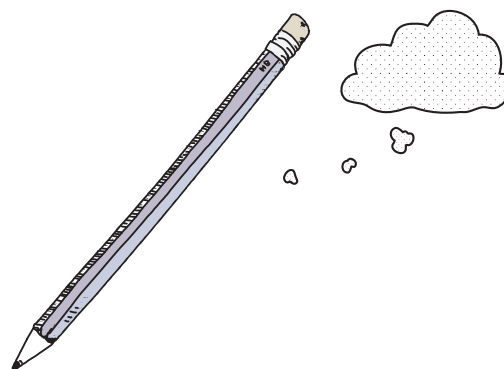
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