EDITORIAL, p 7
RESEARCH, p 14
LAST WORDS, p 39

NEWS

Charity raises £60 000 after UK doctor is killed in Syria, p 3

RESEARCH

RESEARCH NEWS

RESEARCH PAPERS

COMMENT

EDITORIALS

Doubling Tamiflu dosage, p 10

FEATURES

Fears of further privatisation from EU-US treaty, p 16

ANALYSIS

Articles appearing in this print journal have already been published on bmj.com, and the version in print may have been shortened. bmj.com also contains material that is supplementary to articles: this will be indicated in the text (references are given as w1, w2, etc) and be labelled as extra on bmj.com.

Please cite all articles by year, volume, and elocator (rather than page number), eg *BMJ* 2013; 346:f286.

A note on how to cite each article appears at the end of each article, and this is the form the reference will take in PubMed and other indexes.

100% recycled

The *BMJ* is printed on 100% recycled paper (except the cover)


Expert in human gait, p 26

COMMENT

LETTERS

OBSERVATIONS

BODY POLITIC

PERSONAL VIEW

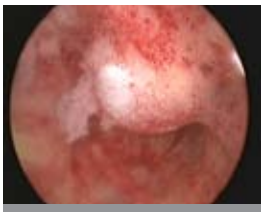

The challenges to families of a choice to die at home, p 26

OBITUARIES

LAST WORDS

EDUCATION

CLINICAL REVIEW


Abnormal vaginal bleeding, p 28

PRACTICE

RATIONAL TESTING

A PATIENT'S JOURNEY

ENDGAMES

MINERVA


Longstanding arguments over use of digoxin continue, p 40

BMJ

8 June 2013 Vol 346

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
Email: membership@bma.org.uk
Tel: +44 (0)20 7383 6955
BMJ CAREERS ADVERTISING
Email: sales@bmjcareers.com
Tel: +44 (0)20 7383 6531
DISPLAY ADVERTISING
Email: sales@bmjgroup.com
Tel: +44 (0)20 7383 6386
REPRINTS
UK/Rest of world
Email: ngurneyrandall@bmjgroup.com
Tel: +44 (0)20 8445 5825
USA
Email: mfogler@medicalreprints.com
Tel: + 1 (856) 489 4446
SUBSCRIPTIONS
BMA Members
Email: membership@bma.org.uk
Tel: +44 (0)20 7383 6955
Non-BMA Members
Email: support@bmjgroup.com
Tel: +44 (0)20 7111 1105
OTHER RESOURCES
For all other contacts:
resources.bmj.com/bmj/contact-us
For advice to authors:
resources.bmj.com/bmj/authors
To submit an article:
submit.bmj.com

BMJ Group

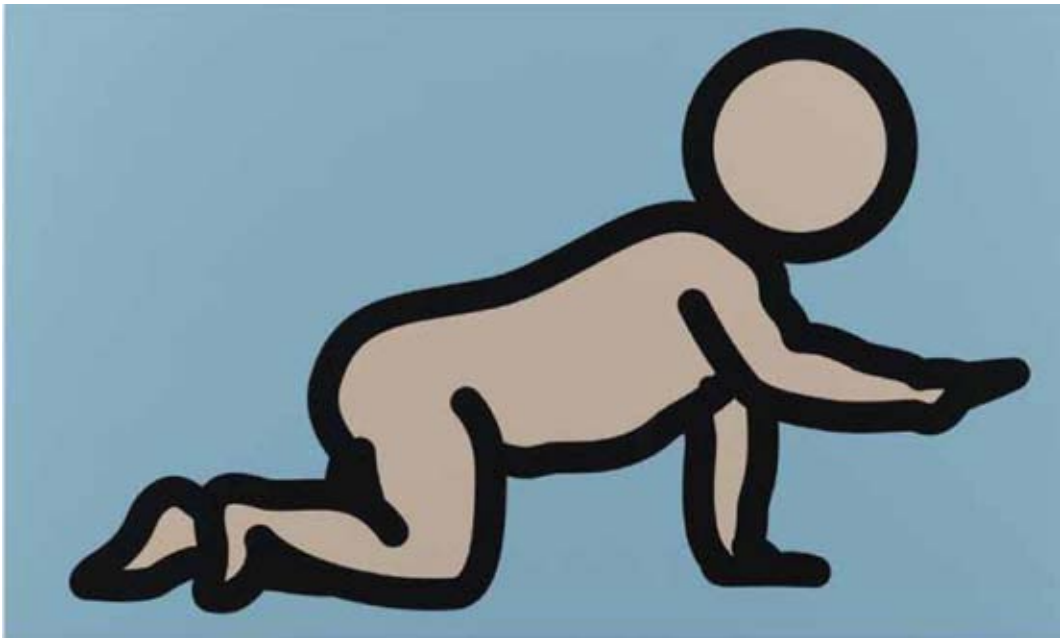
The BMJ is published by BMJ Publishing Group Ltd, a wholly owned subsidiary of the British Medical Association.

The BMA grants editorial freedom to the Editor of the *BMJ*. The views expressed in the journal are those of the authors and may not necessarily comply with BMA policy. The *BMJ* follows guidelines on editorial independence produced by the World Association of Medical Editors (www.wame.org/wamestmt.htm#independence) and the code on good publication practice produced by the Committee on Publication Ethics (www.publicationethics.org.uk/guidelines/).

The *BMJ* is intended for medical professionals and is provided without warranty, express or implied. Statements in the journal are the responsibility of their authors and advertisers and not authors' institutions, the BMJ Publishing Group, or the BMA unless otherwise specified or determined by law. Acceptance of advertising does not imply endorsement.

Published weekly. US periodicals class postage paid at Rahway, NJ. Postmaster: send address changes to *BMJ*, c/o Mercury Airfreight International Ltd Inc, 365 Blair Road, Avenel, NJ 07001, USA. $796. Weekly.

Printed by Polestar Limited



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?

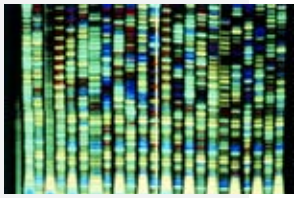
Such an approach keeps the useful parts of examination, saves time by allowing unhelpful components to be jettisoned, and allows rational selection of further investigation. Unthinking, undirected investigation already imposes huge costs in terms of time, resources, and iatrogenic harm; abandoning clinical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

BMJ.COM POLL

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



70% voted no (total 1112 votes cast)

Head to Head:
Yes *BMJ* 2013;346:f2270
No *BMJ* 2013;346:f2426

This week's poll asks:

"Is clinical examination dead?"

BMJ 2013;346:f3442

Vote now on bmj.com

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?

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

Cite this as: *BMJ* 2013;346:f3666

To receive Editor's Choice by email each week, visit www.bmj.com/newaccount

Twitter

Follow the editor, Fiona Godlee, at twitter.com/fgodlee, and the *BMJ* at twitter.com/bmj_latest

Sign up today using your smartphone

—follow these steps:

- Download a free QR reader from your handset's app store
- Hold your smartphone over the QR code
- You will then be forwarded to the email sign up page