the only effective sanction would be to switch off the radio and television and not to read newspapers. Like the flavours in some junk foods, they possess habituating constituents – scandal, bad news – and their hold over the population is likely to increase. If they cannot curb themselves and promote further the credulousness and self-regarding selfishness of society they will destroy what they claim to champion. Baroness O'Neill has performed an important service for British society; its impact may be gradual and we must be patient. However, greater forces are marshalled against her. The House of Lords is being modernised – too independent, Oxbridge Colleges are too elitist, philosophers live on a different planet and medical royal colleges need taking into public ownership in the Postgraduaute Medical Education and Training Board. Nonetheless, when going into the jungle I know whom I – and most of the population – would wish to accompany us. Trust the people.

## References


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2 O'Neill O. *Autonomy and trust in bioethics: the Gifford Lectures 2001*. Cambridge: CUP, 2002.
3 Black DAK. Book review, autonomy and trust in bioethics. *J R Soc Med* 2002;**95**:423–4.


# letters TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk.

### Are preventive drugs preventive enough

Editor – The study by Trewby *et al* (*Clin Med* November/December 2002, pp527–33) is a thought-provoking investigation of patients' expectation of benefit from preventive drugs. The authors demonstrate a mismatch with the actual benefit that can be calculated from the major clinical trials of cardioprotective drugs. However, it may be argued that it is not valid to compare the 'expected' and 'actual' benefit directly in this way.

Clinical trials are designed to determine whether a drug has any statistically significant benefit to the population in question. The statistical power of the trial increases with the number of subjects; the primary outcomes studied are usually the 'hard' statistics such as myocardial infarction and mortality. The absolute and relative risk reduction are derived figures that relate only to the outcome measure. However, absolute risk reduction may not 'answer the individual's main questions' as the authors assert.

In reality, benefit is not a binary outcome. A drug that lowers cholesterol and reduces the risk of myocardial infarction and death may well also reduce the risk of angina, cardiac failure, stroke, renal failure and many other outcomes which a patient may consider important. The risk of adverse effects is also important; for example, a statin would be less likely than a beta-blocker to produce the 'awful side effects' cited by one subject. A patient may summate all these potential benefits and adverse effects in a non-linear and highly individual way; to present a numerical 'benefit' relating to a single outcome is an oversimplification.

The populations studied in the large trials are heterogenous, and no trial has the power to provide reliable figures on the likelihood of all possible outcomes given any possible combination of relevant risk factors. However, in clinical decision-making a clinician combines quantitative with qualitative information to provide patients with recommendations that may be much stronger than figures derived from clinical trials may suggest.

'Taking the patient's views into account when prescribing' could also be misinterpreted by the patient as lack of conviction on the doctor's part. As doctors, our ethical responsibility is to advise our patients as best we can, clearly stating which measures will give the patient the best chance of health in the future. Whether the patient dislikes the idea of taking tablets is a separate issue; in fact, the patient holds the ultimate power in choosing whether or not to follow medical advice. It could be argued that medical paternalism and other power metaphors are less important in today's information-loaded society, and that the most important aspect of a patient-centred, evidence-based approach is to explain to the patient the scope and limitations of the evidence, rather than simply to provide the available data.


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### Diagnosis and management of gastrointestinal causes of chest pain of uncertain origin – 'oesophageal angina'

Editor – The helpful account by Dr de Caestecker (*Clin Med* September/October 2002, pp402–5) draws attention to a