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PICTURE OF THE WEEK

Daisy, a genetically modified calf, was engineered by New Zealand scientists to produce milk containing a greatly reduced amount of β -lactoglobulin, a protein that is not present in human breast milk and can cause allergic reactions. The resulting calf was born without a tail; however, the researchers do not believe it was caused by the genetic modification. The team now wants to breed from Daisy and to determine the milk composition and yield from lactation.

MOST READ ON BMJ.COM

Benzodiazepine use and risk of dementia
 Clinicians' gut feeling about serious infections in children
 Cardiovascular disease risk in healthy children and its association with body mass index
 Diagnosis and management of headaches in young people and adults

BMJ.COM POLL

Our last poll asked:
 "Does celebrity involvement in public health campaigns deliver long term benefit?"

53.5% voted no (total 535 votes cast)

► Head to Head
 Yes: (*BMJ* 2012;345:e6364)
 No: (*BMJ* 2012;345:e6362)

This week's poll asks:
 "Would a 'tan tax' on indoor tanning salons be an appropriate deterrent?"

► Editorial, p 7 (*BMJ* 2012;345:e6101)
 ► Research, pp 14, 15 (*BMJ* 2012;345:e4757 and *BMJ* 2012;345:e5909)
 ► Personal View, p 31 (*BMJ* 2012;345:e6550)
 ► Vote now on bmj.com

RESPONSE OF THE WEEK

As a pediatrician for 50+ years, I cannot agree more—call it "gut feeling," instinct, or whatever. It is extremely important in a busy sick patient pediatric practice, and there are some physicians who do not have it (and cannot learn it). The ability to walk into an examining room and immediately "sense" that there is something serious going on is what differentiates a pediatrician from an excellent pediatrician. I have worked with many pediatric residents, and some have "it" and are good, and some do not have "it" and are average and will never learn it.

Horst D Weinberg, paediatrician, Sacramento, California, USA, in response to "Clinicians' gut feeling about serious infections in children: observational study" *BMJ* 2012;345:e6144

MOST COMMENTED ON BMJ.COM

Good medicine: homeopathy
 The UK needs office dermatologists
 Making a diagnosis in patients who present with vertigo
 Cardiovascular disease risk in healthy children and its association with body mass index
 Is bioethics a bully?

EDITOR'S CHOICE

Overtreatment, over here

Instead of asking your next patient "What's the matter?" you could ask "What matters to you?"

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How much of what we offer to patients is unnecessary? Worse still, how much harm do we do to individuals and society through overtreatment? In the 30 years since Ivan Illich wrote his seminal and, at the time, shocking book *Medical Nemesis*, the idea that medicine can do clinical and societal harm as well as good has become commonplace. But are we doing enough to bring medicine's harmful hubris under control?

The answer, in the United States at least, is no. Earlier this year, concerned individuals from a range of backgrounds met in Cambridge, Massachusetts, to explore the problem of overtreatment. As Sharon Brownlee explains in a video on bmj.com, her starting point for concern—and the inspiration for her book on overtreatment in America—was the realisation that, alone among developed nations, America's per capita spending was rising sharply while life expectancy was not. The problem is complex and the list of potential contributing factors long. As Jeanne Lenzer reports (p 19), reasons for overtreatment identified at the meeting include fear of malpractice lawsuits, supply driven demand, knowledge gaps, biased research, profit seeking, patient demand, financial conflicts of guideline writers, failure to fully inform patients of the potential harms of elective treatments, and the way American physicians are paid by a fee for service.

Are other parts of the world similarly affected? Growing evidence of practice variation in other developed countries suggests that they are, though possibly to a lesser extent. As Margaret McCartney writes in an accompanying commentary (p 20), England and Wales benefit from the National Institute for Health and Clinical Excellence (NICE), which insulates them against some of

medicine's excesses. But she warns that the GP contract and non-evidence based awareness campaigns are fuelling polypharmacy and overdiagnosis. The latest health service changes have, she says, "given permission for the dissolution of the NHS into a mere brand."

Nigel Crisp, in his essay this week (p 22), also holds up the NHS as a small beacon of light. As its former chief executive officer, he points out that the NHS is not "a mere health insurance system" but one in which patients' and doctors' interests are largely aligned within a framework of shared values and expectations. But even with the NHS, the United Kingdom has failed—as have all countries, he says—to give people a truly central role in improving health and shaping healthcare delivery. He calls for a new intellectual framework that challenges the dominant economic mindset and our over-reliance on the views of professionals. "The doctor doesn't always know best," he says.

Neither the meeting in Massachusetts nor Crisp in his essay provide easy, or indeed any, solutions. Further meetings and research are planned. But if overtreatment is in part due to a failure to place the patient's perspectives and interests at the centre of everything we do, perhaps there's one simple phrase that could help. Speaking at the International Forum on Quality and Safety earlier this year, Maureen Bisognano, chief executive officer of the Institute for Healthcare Improvement, suggested that instead of asking your next patient "What's the matter?" you could ask "What matters to you?"

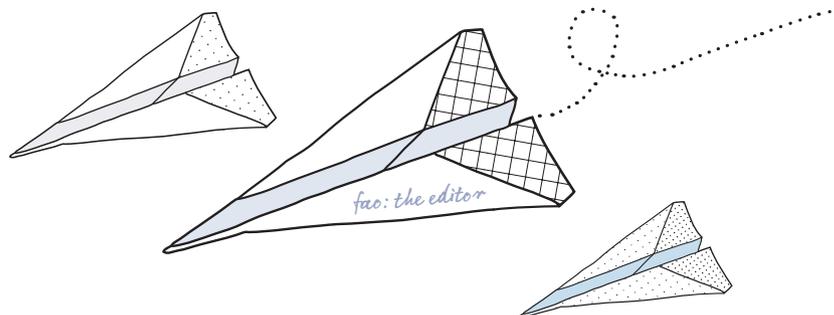
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