

different from those reported in trials. Databases that link prescribing to hospital data and other health records are needed to assess the relative benefits and harms of drugs, say the authors.

## Do antidepressants reduce suicide?

The balance between risks and benefits of antidepressants is not clear. Reviewing available data on these drugs, Gunnell and Ashby (p 34) found it hard to find direct evidence that antidepressants prevent suicide. Most trials are underpowered to detect a difference in the risk of suicide, and time trends analysis of suicide rates at population level are used as a surrogate measure.



BERTRAND DEBIEF/PHOTONICA

Suicides rates have fallen in recent years, but this may not be due to use of antidepressants, say the authors; future trials should be sufficiently long to detect longer term benefits and harms, and should systematically collect data on suicidal thoughts and behaviour.

### POEM\*

#### No long-term benefit shown for bones after HRT

**Question** Does hormone replacement therapy (HRT) continue to provide protection from hip fractures after the treatment is stopped?

**Synopsis** The national osteoporosis risk assessment (NORA) study began in 1997 as a longitudinal observational study of postmenopausal women aged over 50 at study entry. It includes 140 584 women, of whom 48% were taking hormone therapy at study entry and an additional 14% had used postmenopausal oestrogen in the past. Ninety two per cent of the women were white. A total of 53 737 women never used hormone therapy, 8723 had stopped taking it within the last five years, and 10 151 had stopped more than five years ago; the rest of the women were currently using hormone therapy. Unadjusted hip fracture rates per 1000 women per year were 2.24, 2.17, 2.51, and 0.81, respectively. After adjustments for factors including age and race, only the current users had significantly different hip fracture rate (odds ratio 0.60; 95% confidence interval, 0.44 to 0.82;  $P < 0.001$ ).

**Bottom line** Women taking short term hormone therapy for symptom relief cannot expect long term bone protection. The risk of hip fracture is at least as great for women who stop postmenopausal hormone therapy as that of women who have never used it. The loss of protection occurs within five years of stopping treatment.

**Level of evidence** 1b (see [www.infoPOEMs.com/levels.html](http://www.infoPOEMs.com/levels.html)). Individual inception cohort study with >80% follow up; or a clinical rule not validated on a second set of patients.

Yates J, Barrett-Connor E, Barlas S, Chen YT, Miller PD, Siris ES. Rapid loss of hip fracture protection after estrogen cessation: evidence from the national osteoporosis risk assessment. *Obstet Gynecol* 2004;103:440-6.

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\* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

## Editor's choice

### Think harm always

How do you deal with something unpleasant? The commonest way is not to think about it. That, I suspect, is why medicine has paid so little attention to the harm it may cause—despite the ancient instruction “first, do no harm.” Many people try to deal with death by not thinking about it, but Montaigne advises us to do the opposite and think about it all the time. The same advice might apply to thinking about harm: every intervention by a doctor, even a throwaway comment or a test “just to be sure,” carries the potential for harm, whereas many of those interventions have no possibility of bringing benefit. This long overdue theme issue explores some of the many ways in which health care might result in harm.

Very few people attend a doctor thinking that they may come out worse than when they went in. But many do. When referring a patient to hospital should a doctor say: “I must warn you that the simple fact of being admitted to hospital means that you have something above a one in 10 chance of suffering an adverse event and a one in a 100 chance of dying”? I put this point to the Helsinki meeting of the World Medical Association, a body that has made its name (and possibly created harm) by promoting informed consent. The audience looked quizzical, and I’ve never heard of a doctor issuing such a warning. But doctors will regularly warn patients of much less common risks attached to particular interventions.

Imagine an applicant to medical school answering the universal question of “Why do you want to study medicine?” with “My main ambition is to try to do less harm than good” or “I’d like to devote myself to exploring the harms caused by doctors.” The applicant would be thought very odd even though he or she would be enlarging on “first, do no harm.” Yet the balance between doing good and creating harm in a lifelong medical career undertaken with commitment and compassion may be fine. The harm is omnipresent, the benefit sometimes fleeting.

As a junior doctor I dutifully prescribed lignocaine to many patients who had had heart attacks. The logic was, I believe, that the drug would prevent the arrhythmias that might kill patients. It never occurred to me that this might kill patients rather than save them, but I learnt years later that the result of my hard work was more not fewer deaths. As my parents took me to hospital as a 7 year old and left me alone (on the hospital’s instructions) to have my tonsils removed they never for an instant thought that the harm of the procedure might outweigh the benefit—but it probably did. The hospital admission certainly made me miserable and caused me to miss my big break playing the Archangel Gabriel.

Hard and uncomfortable as it may be, we need to think about harm all the time.

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