BLOOD GLUCOSE IN TYPE 2 DIABETES

New QOF glycaemia targets are achievable and evidence based

Lehman and Krumholz suggest that the revised targets for glycated haemoglobin in the quality and outcomes framework (QOF) pose a risk to people with diabetes, many of whom will need insulin if 50% are to achieve values of 7.0% or less. Fortunately, glycaemic control is rather better than they realise: in the 2005-6 national diabetes audit 45% of patients had values of 7.0% or less.

They present an unbalanced view of recent data: tight glycaemic control was associated with fewer non-trivial microvascular complications, reduced cardiovascular risk, albeit only the trial with sufficiently long follow-up reporting significant results, and reduced mortality.

They also completely overlook the incontrovertible evidence supporting tight control in type 1 diabetes. Observational studies show a continuous relation between glycaemia and risk of mortality and cardiovascular events. The reasons for the excess mortality in ACCORD remain unclear.

However, participants had poor baseline glycaemic control and glycated haemoglobin was reduced rapidly (by 1.4% over four months) towards a target of 6.0%, often using rosiglitazone. ACCORD data may not be relevant to the QOF target of 7% for 50% of all diabetic patients.

People with diabetes and their professional advisers should negotiate individually tailored targets but avoid rapid reductions in glycated haemoglobin to below 6.5%. They can have confidence that the modest changes encouraged by the QOF are safe and will lead to further reductions in risk over time.

Simon Griffin assistant director, MRC Epidemiology Unit, Box 285, Addenbrooke’s Hospital, Cambridge CB2 0QQ simon.griffin@mrc-epid.cam.ac.uk

Jonathan Grafy senior clinical research associate, General Practice and Primary Care Research Unit, University of Cambridge, Cambridge

Competing interests: SG and JG were members of the expert reference group providing advice on the QOF diabetes targets.

1 Lehman R, Krumholz HM. Tight control of blood glucose in long standing type 2 diabetes. BMJ 2009;338:b800. (5 March.)

Cite this as: BMJ 2009;338:b1915

When is a target an inducement?

I wrote to the General Medical Council six years ago asking about the matter of incentives, and the reply quoted the paragraph (55) in Good Medical Practice: “you must not ... accept any inducement ... which may affect or be seen to affect your judgement.” Since the incentives are given precisely to encourage doctors to do what they are not doing (even if they should be) the effect of money on practice is intended and manifest.

The GMC, however, “does not regard target payments ... as ‘inducements’... The services do not generally involve decisions about treatment options or referrals which might be influenced by financial inducements ... For these reasons the GMC does not regard accepting target payments as ... improper.”

This is clear sophistry: general practitioners have not been doing what the Department of Health wants them to do so it has had to bribe them to do it. If it is right now, it was right before the payments came in, but not right enough to do it gratis. A bit less hypocrisy by all parties would be welcome.

Harry Hall retired physician, Exeter EX1 2HW h.2@which.net

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1 Lehman R, Krumholz HM. Tight control of blood glucose in long standing type 2 diabetes. BMJ 2009;338:b800. (5 March.)

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DOCTORS AS LEADERS

Leadership is not management

I am one of those doctors who has undergone formal leadership training—having masters degrees in health management and health leadership and experience as clinical director and lead clinician in two trusts, as well as a
If I had a hammer

To a person with a hammer, everything looks like a nail. And to a professor of health economics, “clinical practice should be driven by pursuit of economics based medicine, conditioned by human consideration.”

The concept that economics is the basis of clinical practice, with human consideration as the tempering agent, rather than the other way around—care of human beings tempered by economic considerations—speaks well to the enthusiasm of an economist for his profession, but appallingly when it leads to the demand that clinicians see everything through green (money) coloured glasses.

To a McKinsey consultant, provision of health care is an industry, not too different from energy technology. As he notes the lack of “productivity” among clinicians, he also uses the practice of “gaining buy in” by noting that technical experts—such as doctors—have something to add in determining how health care is provided.

At the same time, health care is increasingly oriented towards the “patient centred” model because patients—and their health problems—are individual. This is in opposition to industrial models where a similar mindset would have “light bulb centred models” or “washing machine centred models.”

Care of people must lead the way. Ideally it would be clinician based, with acknowledgment of the importance of the economic and industrial aspects and not the other way around.

Joan McCusky medical writer, New York, NY 10003, USA joanmccusky@gmail.com

Competing interests: None declared.

1 Maynard A. This House believes doctors are neglecting their duty to lead health service change: Proposer. BMJ 2009;338:b1578. (21 April.)

Cite this as: BMJ 2009;338:b1901

OBAMA’S TEAM ON HEALTH CARE

Rationing is needed in the US

A public plan by President Obama’s team may reduce the number of uninsured people in the United States but seems unlikely to curb rising healthcare costs.1 Indeed, Medicare is a federal programme whose escalating costs are as unsustainable as the private sector’s. The problem lies deeper: an unwillingness to accept the need for rationing.

When an expensive drug becomes available in the US (which the National Institute for Health and Clinical Excellence (NICE) in the UK would refuse on the basis of poor cost effectiveness), it is in no one’s interest to prevent it from being prescribed. The patient wants “the best available,” fuelled by advertisements from the pharmaceutical industry and the fact that someone else is paying for it (the insurance company). The doctor is driven to overprescribe because of the fee for service reimbursement system and fear of litigation. The pharmaceutical company wants its product to be delivered, and, since Medicare cannot negotiate drug prices, the pharmaceutical company can effectively charge what it likes, setting a precedent for other companies to overprice their drugs.

Once Medicare has adopted a new drug, commercial insurers feel obliged to follow suit, passing the cost on to customers as higher premiums, which people cannot afford and so join the ranks of the uninsured. Implementing measures such as information technology is the easy part. Tackling the vicious circle of unaccountability is far more difficult because every dollar saved is a dollar that someone else stands to lose. The US healthcare system may be in crisis but the US healthcare industry has never been stronger—and it will not give up its riches without a fight.

Adam M Ali Frank Knox fellow, Harvard University, Cambridge, MA 02138, USA aadamali@fas.harvard.edu

Competing interests: None declared.

1 Roehr B. Obama’s team hopes to lower healthcare costs and increase insurance coverage. BMJ 2009;338:b1580. (17 April.)

Cite this as: BMJ 2009;338:b1903

DEPRIVATION AND PROGNOSIS

Home based cardiac rehabilitation and outcomes

Denvir and Zamvor cite practical problems in attending cardiac rehabilitation after cardiac surgery as a barrier for uptake in poorer patients.2 Two recent randomised controlled trials compared a six week, nurse facilitated home based programme with group based hospital based rehabilitation and found similar clinical and cost outcomes.2 4 Through offering patients a choice of these methods we have been able to meet the coronary heart disease national service framework target of 85% of suitable patients taking part in cardiac rehabilitation, a strategy explicitly recommended in the latest commissioning guidance from the National Institute for Health and Clinical Excellence (NICE).3

Home delivery of cardiac rehabilitation solves several practical problems in attending a hospital programme and may ameliorate the effects of inequity.

Hasnain M Dalal general practitioner, Lower Lemon Street Surgery, Truro TR1 2LZ hmdalal@doctors.net.uk

Jenny Wingham research nurse, Royal Cornwall Hospital, Truro TR1 3LJ

Philip Evans senior clinical research fellow, Peninsula Medical School (Primary Care), Exeter EX1 2LU

Rod Taylor associate professor in health services research, University of Cambridge, Cambridge, UK

John Campbell professor of general practice and primary care, University of Cambridge, Cambridge, UK

Competing interests: None declared.

1 Denvir MA, Zamvor V. Social deprivation and poor prognosis after cardiac surgery. BMJ 2009;338:b721. (2 April.)


5 National Institute for Health and Clinical Excellence. Cardiac rehabilitation service. Available at: www.nice.org.uk/usingguidance/commissioningguides/cardiarehabilitationservice/CardiacRehabilitationService.jsp

Cite this as: BMJ 2009;338:b1921
Palliative angioplasty sneaked under the radar

Pagano and colleagues sensibly recommend rehabilitation as a means of maximising the benefits of expensive cardiac interventions, especially death rates after cardiac surgery in socially deprived areas, and rehabilitation has long been recommended as a means of avoiding expensive cardiac interventions. New money is unlikely to appear during a recession, but rehabilitation services could easily expand if resources were reallocated from avoidable cardiac interventions.

All studies of angioplasty versus continued medical treatment for stable angina show that at best angioplasty only temporarily improves quality of life. The small overall benefit is so costly (£100 000–200 000 per QALY) that it exceeds the cost effectiveness barrier of the National Institute for Health and Clinical Excellence (NICE) (£30 000 per QALY) by between threefold and sixfold. In 1997, at the beginning of the study period, European guidelines on stable angina recommended comprehensive rehabilitation as a way of avoiding revascularisation and reducing drug costs. Following this lead and that of the American Heart Association and American College of Cardiology, this centre has consistently argued that rehabilitation would render many expensive cardiac interventions unnecessary. Despite this, current provision of rehabilitation before palliative revascularisation is practically non-existent, partly because commissioners are more driven by activity targets than by guidelines.

Palliative angioplasty for stable angina sneaked under the radar in prosperous times. Its case is not helped by either the weak evidence base or present economic conditions. It is time to review unaffordable palliative revascularisation targets.

Michael R Chester professor of rehabilitation and preventive health education, National Refractory Angina Centre, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool L14 3LB

John Bridson clinical ethicist

Competing interests: None declared.


2 European Society of Cardiology. ESC stable angina management guidelines Eur Heart 1997;18:394-413.


Cite this as: BMJ 2009;338:b1924

HEALTH PROMOTION
Cycle to work scheme in the NHS

Byberg and colleagues’ study on mortality and physical activity convinces us of the importance of health promotion. The Department of Transport’s cycle to work scheme, which allows a tax exempt loan to purchase a bicycle and associated equipment, should be made available to all NHS employees.

Cycling reduces the risk of heart disease, high blood pressure, obesity, and type 2 diabetes. New cyclists covering short distances can reduce their risk of death by as much as 22%, primarily owing to the reduction in heart disease. It can assist in weight loss, burning around 300 calories an hour. Thirty minutes of cycling a day meets the government’s target on exercise. Regular cycling also has a positive effect on mental health. The strength and coordination that regular cycling brings make injuries from falls less likely. Cycling is one of the few physical activities that can be undertaken by most of the population as part of a daily routine. Cyclists and pedestrians take in positive effect on mental health.

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Sharing medical research data

Financial conflicts should be included in online abstracts

There should be not only data transparency but also financial transparency. Most major medical journals have made financial disclosure mandatory. Yet, now that the internet allows free access to any biomedical abstract, readers of abstracts may be blinded to papers’ relevant financial disclosure unless they have a paid subscription to the journal.

I reviewed the ICMJE uniform requirements, the author instructions for 20 journals, including the BMJ, JAMA, the nine current Archives journals, New England Journal of Medicine, and the Lancet journals. None of them required, recommended, or even mentioned financial disclosure for structured or unstructured abstracts. Thus, readers might think that there was no potential financial conflict of interest when one exists. This is particularly important when the reader is a layperson attempting self education on the internet.

Of course, a reader could access a paper by paying a fee. One time access to the New England Journal of Medicine costs $10, to JAMA $15, and to Plastic and Reconstructive Surgery $30. Thus, many peer reviewed journals may have a potential financial conflict by not providing free access to the financial disclosure portion of the paper.

The BMJ should lead the way by mandating that abstracts have financial disclosure. Requiring a yes/no financial conflict statement in the structured abstract and allowing a free view of the financial disclosure part of the paper online will give readers valid information to make more reasoned decisions about the validity of abstracts’ conclusions.

M Felix Freshwater voluntary professor of surgery, University of Miami, 9100 S Dadeland Boulevard, Miami, FL 33156-7815, USA mfelix.freshwater@gmail.com

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The BMJ’s new way of abridging original research articles for the print BMJ is essentially an extended abstract. It’s called BMJ pico and it gives the research question, study design, and findings, along with details of funding and competing interests.

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INCREASING ACCESS TO MEDICINES

Time for category of pharmacist consultation and supply

Finch and Gamer are rightly concerned that bacterial resistance will increase when drugs such as azithromycin become available over the counter.1 And there is a more general problem about switching a prescription only medicine (PoM) to pharmacy status (P).

Drugs that have switched from PoM to P have traditionally been used in treating minor ailments or injuries, health promotion, or palliative care. However, in recent years, in political response to a perceived public demand for readier access to medicines, increasing numbers of medicines have been switched. At the same time, medicines have become readily available to the public by direct purchase over the internet, giving them the chance to bypass the prescription only barrier, without guarantee of quality, safety, and efficacy. Categories of drug that pose particular problems when switching is demanded include lifestyle drugs such as sildenafil, which is currently being considered for P status, and long term treatments such as simvastatin, which has been given P status in too low a dosage formulation to be fully effective.

There is now a case for creating an intermediate category, pharmacist consultation and supply (PCS).2 Briefly, a PCS medicine would be available for purchase from pharmacists, who would monitor its use and either repeat the order if they considered it appropriate or refer the patient back to the doctor. Pharmacists who supplied PCS drugs could be required to inform the patient’s doctor. Pharmacists, who would monitor its use and either repeat the order if they considered it appropriate or refer the patient back to the doctor.

These patients would be treated as such (J Howick et al, unpublished data). Abandoning placebo use will free researchers to focus on how to maximise the potentially therapeutic benefits of the various distinct (and real) factors currently lumped together under the chimerical placebo banner.

Jeremy Howick
MRC/ESRC interdisciplinary postdoctoral fellow, Centre for Evidence-Based Medicine, University of Oxford, Oxford OX3 7LF Jeremy.howick@dhpcx.ox.ac.uk

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1 Nunn R. It’s time to put the placebo out of its misery. BMJ 2009;338:b1568. (20 April.)

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PLACEBO MISERY

Escaping from placebo prison

Nunn is correct: there is no such thing as the placebo.3 People slap the label placebo on treatments that have a host of distinct factors with potentially therapeutic effects, including:

- Hawthorne effects (potential therapeutic benefit resulting simply from participants knowing that they are taking part in a trial)4
- Effects of empathetic patient-doctor interaction5
- Effects of a patient’s belief that a treatment is powerful, expensive, or has a brand name6
- Other features, including colour, method of administration,4 and content.5

Thinking in terms of the all inclusive placebo blurs the distinction between these very different factors, which, in turn, blinds researchers to how to maximise therapeutic benefits.

Worse, placebos are rarely described in sufficient detail, and they might contain ingredients that are clearly non-placebogenic. One example is olive oil used as a bulking agent in placebo controls for cholesterol lowering drugs.2

It is time to recognise placebos as treatments in their own right that must be described and treated as such (J Howick et al, unpublished data). Abandoning placebo use will free researchers to focus on how to maximise the potentially therapeutic benefits of the various distinct (and real) factors currently lumped together under the chimerical placebo banner.

Jeremy Howick
MRC/ESRC interdisciplinary postdoctoral fellow, Centre for Evidence-Based Medicine, University of Oxford, Oxford OX3 7LF Jeremy.howick@dhpcx.ox.ac.uk

Competing interests: None declared.

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INCREASING ACCESS TO MEDICINES

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Drugs that have switched from PoM to P have traditionally been used in treating minor ailments or injuries, health promotion, or palliative care. However, in recent years, in political response to a perceived public demand for readier access to medicines, increasing numbers of medicines have been switched. At the same time, medicines have become readily available to the public by direct purchase over the internet, giving them the chance to bypass the prescription only barrier, without guarantee of quality, safety, and efficacy. Categories of drug that pose particular problems when switching is demanded include lifestyle drugs such as sildenafil, which is currently being considered for P status, and long term treatments such as simvastatin, which has been given P status in too low a dosage formulation to be fully effective.

There is now a case for creating an intermediate category, pharmacist consultation and supply (PCS).2 Briefly, a PCS medicine would be available for purchase from pharmacists, who would monitor its use and either repeat the order if they considered it appropriate or refer the patient back to the doctor. Pharmacists who supplied PCS drugs could be required to inform the patient’s doctor, via linked electronic records if available, thus controlling the extent of supply and facilitating research into outcomes. A PCS scheme would be comparable to the pharmacist only scheme in Australia and the restricted medicines scheme in New Zealand.3,4 It would provide safeguards and improve the availability of some medicines under more careful control than is currently available for over the counter medicines.

Jeffrey K Aronson
reader in clinical pharmacology,
Department of Primary Health Care, University of Oxford, Oxford OX3 7LF jeffrey.aronson@clinpharm.ox.ac.uk

Competing interests: None declared.

1 Finch R, Gamer S. Increasing access to medicines. BMJ 2009;338:b1397. (7 April.)
3 Emmerton L. The “third class” of medications: sales and purchasing behavior are associated with pharmacist only and pharmacy medicine classifications in Australia. Am Pharm Assoc 2009;49:31-7.

Cite this as: BMJ 2009;338:b1899

1 Finch R, Gamer S. Increasing access to medicines. BMJ 2009;338:b1397. (7 April.)
3 Emmerton L. The “third class” of medications: sales and purchasing behavior are associated with pharmacist only and pharmacy medicine classifications in Australia. Am Pharm Assoc 2009;49:31-7.

Cite this as: BMJ 2009;338:b1899

PELVIS

Feasibility study

Thank you, BMJ, for alerting thousands of doctors to the latest proposal from the secretary of state for work and pensions1: to remove benefits from “alcoholics” so they “get sober, get their life back and get back to work.”2 The government is also going to stimulate some new research on using such financial penalties to “help” to turn suitably reformed drinkers back into productive workers.

An obvious feasibility study comes to mind. There are some 646 people of working age sitting in parliament, mostly men. Assuming they are no more prone to alcohol dependence than their constituents (in spite of the cheap, long hour workplace availability of alcohol in Westminster), about 50 will currently use alcohol in a disordered, disabling way and another 50 will have a history of similar problems. The alcohol disorders among members of parliament will range from episodic loss of control over their pathological drinking to chronic and overwhelming dependence.

Now a busy Job Centre Plus might assess 646 customers in one week, so we could easily ask such Department of Work and Pensions staff to assess all the MPs for a history of “alcoholism” so they can “get back to work.” Those judged to be unfit for work owing to alcohol would lose their income, accommodation, and expenses until they sobered up to the satisfaction of those employer aims. In the words of the secretary of state, how many of his 100 or so colleagues will easily “conquer their problems”?2

Woody Caan
professor of public health, Anglia Ruskin University, Cambridge CB1 1PT woody.caan@anglia.ac.uk

Competing interests: WC has had some involvement in alcohol research over three decades.

1 O’Dowd A. Doctors warn government against removing benefits from alcoholics who refuse treatment. BMJ 2009;338:b1591. (17 April.)

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1 O’Dowd A. Doctors warn government against removing benefits from alcoholics who refuse treatment. BMJ 2009;338:b1591. (17 April.)

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