

LETTERS

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DEMENTIAGATE

Spend the Dementiagate money on dementia services and research

The origins of the farcical initiative to bribe GPs to encourage “early diagnosis” of dementia are puzzling.¹⁻³ Whether the policy is a calculated attempt to downplay the potential harms of screening and inflate the benefits of early treatment far beyond the evidence or just a well meaning but misguided effort to help people with dementia and their families,⁴⁻⁵ it sets the stage for a massive betrayal of public trust.

Opportunistic cognitive testing may lead to early diagnosis of “mild cognitive impairment,” which has about a 20% risk of progressing to dementia within five years,³ with no reliable means of predicting or preventing such progression. Let us hope that GPs will resist the temptation to jump the gun and only one in five patients will come back, expecting confirmation of the diagnosis to unlock effective treatment and support. What they will actually get is a prognosis of inexorable deterioration and annihilation of the person, with death often coming as a final relief. The other 80% will be left to worry.

Medical treatment may transiently slow the rate of memory decline, but no one knows whether it will improve quality of life or simply prolong the course of a devastating terminal illness. Even the most

overstretched care services may be a godsend to families who have struggled without support, but the extra demands made by earlier “diagnosis” will only highlight their limitations. Negative perceptions will not be helped by the knowledge that resources that could have been used for care have been given to GPs for diagnosis.

The clinical and economic arguments for early detection cannot be applied to progressive degenerative conditions with no effective means of arresting the disease process. Until we have something better to offer, every available penny should be spent on providing better dementia care services and training.

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- 1 McCartney M. Dementiagate—how politicised pay diverts GPs from working for patients. *BMJ* 2014;349:g6446. (24 October.)
- 2 Kmietowicz Z. Doctors condemn “unethical” £55 payment for every new dementia diagnosis. *BMJ* 2014;349:g6424. (23 October.)
- 3 NHS England. Enhanced service specification: dementia identification scheme. 2014. <http://bit.ly/1rmlWvy>.
- 4 UK National Screening Committee. UK NSC policy on screening for dementia. www.screening.nhs.uk/dementia.
- 5 Lin JS, O'Connor E, Rossom RC, Perdue LA, Burda BU, Thompson M, et al. Screening for cognitive impairment in older adults: an evidence update for the US Preventative Services Task Force. Agency for Healthcare Research and Quality, 2014. www.uspreventiveservicestaskforce.org/uspstf/uspdsdeme.htm.

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Alzheimer's Society's response to Dementiagate

By next year, 850 000 people in the UK will have dementia. The Alzheimer's Society has long campaigned for all people with dementia to access a timely diagnosis and we will not stand by while more than 400 000 people living with dementia are left in the dark, to struggle in isolation because they do not have a diagnosis. We have a long tradition of supporting GPs in neglected areas of care.

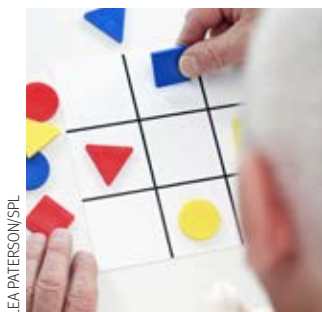
To look at this issue through the lens of one announcement, without considering the wider actions being taken by NHS England and others—as Longman does in his rapid response to McCartney's article¹⁻²—is oversimplistic and very unhelpful. Every day people with dementia tell us about the heartache and immense struggle they have had to

get a diagnosis. Surely any measure aimed at reducing this time should be looked at positively, rather than voicing false accusations of conspiracy.

It is for the NHS and the government to determine how doctors are paid for the work they do, and the Directed Enhanced Service payment related to the diagnosis of dementia is far from unique. The only interest that the Alzheimer's Society has is that people affected by dementia get a timely diagnosis. We diagnose other diseases. Why not this one?

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Competing interests: I am co-chair of the prime minister's dementia friendly communities champion group and a member of the Department of Health's dementia programme board.



Testing times for dementia policy

- 1 Longman HJA. Re: Margaret McCartney: Dementiagate—what was the role of Alzheimer's Society? [electronic response to McCartney M. Dementiagate—how politicised pay diverts GPs from working for patients]. *BMJ* 2014. www.bmj.com/content/349/bmj.g6446/rr/778747.
- 2 McCartney M. Dementiagate—how politicised pay diverts GPs from working for patients. *BMJ* 2014;349:g6446. (24 October.)

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OVARIAN CANCER RISK MODEL

Cancer risk model needs more meaningful clinical parameter

The IOTA-ADNEX model is a useful tool for the management of women with an adnexal mass and will eventually help to improve the outcome of ovarian cancers.¹ Although the model is well designed and validated, the parameter “Oncology centre (specialised referral centre for gynaecology and oncology)” lacks clinical meaning. The authors stated, “We included the variable ‘type of centre’ because the risk of a malignant tumour is likely to be higher in oncology centres than in other centres, even after adjustments for the characteristics of patients and tumours.” The affirmation is statistically correct; the prevalence and distribution of malignant tumours differed between oncology centres and other hospitals. However, the reasons behind the differences were not explored.

Clinical data have long been used by general gynaecologists to classify adnexal masses as suspicious of cancer and to refer patients to oncological centres for diagnosis and treatment.² Depending on the extent of clinical data available, it would be interesting to know whether “Oncology centre” is a surrogate for clinical signs of cancer. Prospective data collection is needed to obtain a complete symptom index.³ However, even if complete clinical data are not available, a simple parameter such as mode of detection (imaging method or symptoms) would sound more meaningful for generalist users.⁴

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Competing interests: None declared.

- 1 Van Calster B, Van Hoorde K, Valentin L, Testa AC, Fischerova D, Van Holsbekeet C, et al; International Ovarian Tumour Analysis (IOTA) Group. Evaluating the risk of ovarian cancer before surgery using the ADNEX model to differentiate between benign, borderline, early and advanced stage invasive, and secondary metastatic tumours: prospective multicentre diagnostic study. *BMJ* 2014;349:g5920. (15 October.)
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Authors' reply

We appreciate Candido-dos-Reis's feedback and agree that the variable "oncology centre," which we defined as "tertiary referral centres with a specific gynaecology oncology unit," is unconventional. We anticipated that it would raise some questions. The variable was included because it is a predictor of prior risk of malignancy and because it is still predictive after controlling for the other eight patient specific predictor variables. It is the weakest of the nine ADNEX predictor variables, suggesting that patient specific predictors explain most but not all of the differences in outcomes between oncology centres and other hospitals. In practice this variable is easy to use, because clinicians have to decide only once in what type of centre they work.

The prevalence of adnexal masses is much higher in ultrasound units linked to specialised gynaecological oncology centres than in regional hospitals. This is because patients with more suspicious looking masses are referred for assessment and treatment in specialised centres. We agree that symptoms may add important information and that women with symptoms suspicious of ovarian cancer are more likely to be referred to cancer centres. However, the IOTA study started in 1999 and indices to report symptoms were developed more recently, so we don't know whether patients in oncology centres present with different symptoms and whether the presence or absence of certain symptoms could replace the variable "oncology centre." We are examining symptoms as part of phase 5 of our study and should be able to answer this question once this is completed.

We found that almost all "oncology centres" have a more than 22% prevalence of cancer in adnexal masses, whereas this is below 22% for other centres. However, we took the view that clinicians will always know their type of centre but might not know the prevalence of cancer in the masses seen in their department.

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FLIPPING HEALTHCARE

Catchy phrases, irrelevance, and rise of the medical tabloid

On careful reading, Bisognano and Schummers's main conclusion from their article about flipping healthcare is that they have nothing to offer the average reader and policy maker in the UK.¹ They probably have no idea about the irrelevance of their article to anyone outside the US; otherwise they would probably seek advice, not offer it.

They suggest two innovations in healthcare. The first is of a doctor-pastor providing counselling sessions, diet, and exercise advice to his parishioners. The second is of a "new" model of community nursing care. The first does not apply to secular countries with universal and comprehensive healthcare systems and the second exists in the UK already.

On the basis of an example of one high school they recommend "flipping the classroom." The US is below the UK (and many other countries, including Vietnam) in literacy, numeracy, and science—why would any educational establishment in the UK need such advice from a country below its own ranking?

The authors also recommend flipping healthcare. They reason that doctors should know what matters to patients and not just try to work out what is wrong with them. Evidently the authors are not aware that this approach is part of the GP curriculum or that, although worded differently, it is in the Hippocratic Oath. What does a country that spends a staggering 18% of gross domestic product on healthcare (10% in the UK)—yet has the same life expectancy and worse infant mortality than Cuba—have to teach others on this subject?

The fact that this paper is not just published, but is given the same space as research plus a mention on the cover, tells us about the difficulties *The BMJ* has in attracting credible research and reviews and how shallow it has become.

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Competing interests: None declared.

- 1 Bisognano M, Schummers D. Flipping healthcare: an essay by Maureen Bisognano and Dan Schummers. *BMJ* 2014;349:g5852. (3 October.)

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New health services platform for patient centred care

We support Bisognano and Schummers's article on flipping healthcare.¹ The 2002 Wanless report made us realise that without a change in approach the NHS would become financially challenged and that we needed a way to engage patients. We used an evidence based, patient centred approach to enable patients with long term conditions to take control of their health through shared decision making.²

Patients were seen in care planning clinics where they could speak about their problems, including social, health, and economic ones. Patients set their goals and action plans—guided and coached by the clinician—and took home a print out of their care plans. Analysis showed a 40% reduction of service utilisation costs in these patients.^{3 4}

However, large scale deployment of this approach presented organisational challenges. Turning digital, we incorporated the innovation into an internet delivered service called VitruCare, a scalable and integrated digital health services

platform that can present different service packages to suit the patient.⁵ Patients can set goals, action plans, and see real time changes in their health status while connected to and coached by their clinician. Early outcome data show improvements in weight, blood pressure, and glycosylated haemoglobin through lifestyle changes. This type of approach provides a route for individuals, families, and communities to engage

and enables the cultural change in approach that the NHS desperately needs to thrive.

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Competing interests: We are all directors of Dynamic Health Systems, which created and designed VitruCare.

- 1 Bisognano M, Schummers D. Flipping healthcare: an essay by Maureen Bisognano and Dan Schummers. *BMJ* 2014;349:g5852. (3 October.)
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