ENSURING QUALITY IN PRIMARY CARE

Let’s have some evidence of poor care, please

Clare Dyer’s article is grossly unbalanced and unworthy of a scientific journal.¹ She reports on a Dispatches programme about poor performance by GPs without stating that it focused on GPs who had already been reported to the General Medical Council. It is therefore useless as evidence of the overall performance of UK GPs.

She states that slightly more complaints are made against GPs than against other doctors. But how likely are patients to complain about a microbiologist—for example? GPs have the most direct interaction with patients, so is an excess of complaints surprising? Psychiatrists are even more over-represented in this analysis? Does this mean that we should regulate them more?

Then we hear about the chief medical officer’s report of 2006 and yet again the Shipman inquiry of 2004 (what does Shipman have to do with quality of care?), Why not provide some up to date evidence?

There is modern evidence of course, but it does not fit, so it is left out. A recent survey found that “The UK and Switzerland provide the best all round care.”²

Exposing “bad apples” may make for sensational journalism, but it is an ineffective and costly way of improving quality in any business, and it is likely to adversely affect pride and morale among our profession. Edmund A Willis general practitioner, Brigg, Lincolnshire, UK ted.willis@nlpct.nhs.uk

Competing interests: EAW has been a GP for 35 years.

1 Dyer C. Ensuring quality in primary care. BMJ 2011;343:d7315. (15 November.)

2 Roehr B. UK is the best at coordinating care for sicker patients, Sweden the worst, shows survey. BMJ 2011;343:d7317

Cite this as: BMJ 2011;343:d7903

Are UK revalidation proposals for GPs fit for purpose?

The initial proposals for revalidation were exposed as unfit for purpose in 2004. Since then the plans for a more robust process have evolved, but it seems unlikely that the planned process that starts in 2012 can assure patients and the public, employers, and other healthcare professionals that revalidated doctors are up to date and fit to practise.

How has this happened? The fatal flaw is that searching for evidence of competence cannot prove a doctor was always competent in the past, is competent now, or will be competent in the future. Karl Popper cautions against trying to prove a theory by finding confirming evidence. Instead, we should be searching for the contradictory evidence—evidence to show that a doctor is not competent. Although this reverse strategy may seem challenging, it is the better scientific approach.

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Competing interests: TK is an appraiser for GPs who work for NHS Bristol.

1 Dyer C. Ensuring quality in primary care. BMJ 2011;343:d7315. (15 November.)

Cite this as: BMJ 2011;343:d7906

Every interaction increases the chance of a complaint

Dyer states that GPs are over-represented in General Medical Council fitness to practise panels, strikings off the register, and referrals to the National Clinical Assessment Service.³ One important factor in this comparison is that GPs see a different patient every 10 minutes and tend not to spend large amounts of time sitting on terribly important committees. I would be interested to see the figures with a correction made for the number of clinical contacts, because every interaction with a patient increases the chance of a complaint.

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Competing interests: CD is a GP.

1 Dyer C. Ensuring quality in primary care. BMJ 2011;343:d7315. (15 November.)

Cite this as: BMJ 2011;343:d7909

WORST CASES OF PATIENT CARE

Patients Association aims to improve and support the NHS

The standfirst to McCartney’s Medicine and the media article correctly highlights the lack of balance in much of the wider media.¹ But her main criticism is of the Patients Association. As so often happens, the messenger is attacked while the importance of the message is belittled.

The purpose of the Patients Association is to put forward the patients’ comments and concerns that we hear directly from them but also through our UK-wide volunteers. We also hear from health professionals. Patients’ concerns have grown—exponentially so recently—to the point that any government or national organisation ignores them at their peril.

McCartney is critical of how our charity is funded, particularly the funding from our corporate partners who respect the value of our work. We also get funding from members and grant giving bodies, which she doesn’t mention.

We are transparent about funding. All of our corporate supporters sign a principle of understanding that they have no influence on our activities. They give us small amounts of money to help us to function efficiently. These funds pay for our small but dedicated staff, without whom we would founder, as applies to the volunteer only patient organisations proposed by the government.

The Patients Association is independent of government funds, and we comment independently when anything is said about or done to the NHS. We, of course, also work closely with the NHS to help it to improve. We are able to do so especially when local NHS trusts appreciate the importance of the patient’s voice and invite us to help in their forward planning and service implementation. Our aim is to help to improve but also support a safe and caring NHS.

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PRIVATE SOCIAL ENTERPRISE

Circle Health is not like the John Lewis Partnership

It is nonsense to describe Circle Health as a “John Lewis style social enterprise.”¹ As the Observer has described in some detail, it is a loss making private business with financial arrangements that are far more complex than this article portrays. Staff shares amount to only 4% of the total number of shares, and the staff’s decision making powers are far less than even this suggests.² It would have been more helpful if, instead of trotting out the official line on this bizarre exercise, we could have had a serious discussion about how Circle Health can possibly make any money from this venture—given that this has baffled many independent commentators—and why so many hedge fund managers have rushed to invest in it. Is it simply a loss leader for richer pickings elsewhere? Something doesn’t add up.

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Competing interests: None declared.

1 Hawkes N. NHS hospital is taken over by a private social enterprise. BMJ 2011;343:d7341. (11 November.)

Cite this as: BMJ 2011;343:d7897

DABIGATRAN v WARFARIN

Take real world issues into account

Pink and colleagues’ analysis of the economics of dabigatran is flawed by several real world issues that were not considered.¹

Firstly, the price of dabigatran will fall as competitive drugs are licensed.

Secondly, the cost of stopping international normalised ratio (INR) monitoring depends on whether warfarin clinics continue to run but at a lower workload (thereby increasing unit cost) or close completely (allowing resource redeployment).

Thirdly, not all patients with poor adherence to warfarin will have better adherence with dabigatran.

Fourthly, the analysis did not adjust for reduction of drug related hospital admissions, cost of transport to clinics, or renally compromised patients staying on warfarin.

Fifthly, some patients currently take (much less effective) aspirin because they will not attend clinics or it is unsafe to vary their warfarin doses. Dabigatran cannot ethically be denied to them.

Sixthly, there is still no satisfactory NHS mechanism for transferring resources from secondary care to the primary care prescribing budget. Without this, warfarin clinic resources may disappear into the secondary care black hole.

Lastly, once sanctioned by the National Institute for Health and Clinical Excellence and publicised (as a breakthrough) by the media, GPs will be overwhelmed by demand for dabigatran, because few patients enjoy regular monitoring.

It would be premature to recommend the wholesale closure of warfarin clinics without more long term safety and efficacy data, but the conclusion that dabigatran is “unlikely to be cost effective in clinics able to achieve good INR control with warfarin” takes insufficient account of actualities.

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Competing interests: None declared.

1 Pink, J, Lane S, Pirmohamed M, Hughes DA. Dabigatran etexilate versus warfarin in management of non-valvular atrial fibrillation in UK context: quantitative benefit-harm and economic analyses. BMJ 2011;343:d6333. (31 October.)

Cite this as: BMJ 2011;343:d7716

Authors’ reply

Zemansky and Khatib raise several points regarding our economic evaluation of dabigatran. In line with accepted health economic methods,¹ we used the current list price of dabigatran. Although the availability of generics affects future pricing, new entrants have little effect on the price of the first to market drug.²

We assumed that dabigatran would have no effect on anticoagulation clinics. The marginal cost of international normalised ratio (INR) monitoring will fall only in the unlikely event of dabigatran displacing warfarin. If wholesale closure of anticoagulation clinics...
occurred, these resources would presumably be redeployed in other cost effective ways.

We agree that not all poorly adherent patients will improve their adherence with dabigatran and made no such assumption in our analysis. The longer half life of warfarin means that missed doses have less of an effect.

There is currently no basis to assume a reduction in drug related hospital admissions. Warfarin is the third highest cause of such admissions, but the RE-LY study found no significant differences in major bleeding event rates between warfarin and dabigatran 150 mg twice daily. Our analysis adopted an NHS costing perspective and therefore correctly ignored costs to patients, such as clinic attendance for INR monitoring.

We made no provisions for renally compromised patients to remain on warfarin, but as with the case of switching current aspirin users to dabigatran, there were insufficient data to inform the analysis.

The National Institute for Health and Clinical Excellence’s endorsement of dabigatran should be viewed cautiously. Although it is undoubtedly effective, evidence on its safety in the real world is lacking and its cost effectiveness is questionable. The 256 spontaneous case reports costing perspective and therefore correctly ignoring costs to patients, such as clinic attendance for INR monitoring.

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Help for retired armed forces and merchant navy staff

The National Institute for Health and Clinical Excellence guidance on improving outcomes for people with skin tumours recommends that all patients and carers should have access to high quality information about their condition and its management and to relevant support services. As doctors we focus predominantly on diagnosis and management, sometimes not appreciating fully the support networks available to patients—for example, the Veterans Agency war pensions scheme.

Retired armed forces and merchant navy staff are eligible to claim a war disablement pension under the war pensions scheme if they have sustained injury or disability as a result of service before April 2005. The Veterans Agency provides information and support on eligibility and assists in the completion of applications. Melanotic and non-melanotic skin cancers are listed in the synopses of causation of disability by the Ministry of Defence and are subject to compensation. Exposure to ultraviolet light is cited as a significant aetiological factor in the development of these cancers.

Informal feedback from colleagues in our plastic surgery unit suggests that recognition of the relevance of overseas work in the armed forces, knowledge of the scheme, identification of eligible patients, and knowledge of how to access the information are poor. Once these factors are considered, however, clinicians regularly assessing skin cancers, particularly general practitioners, dermatologists, and plastic surgeons, can easily provide oral or written information on the scheme to veterans.

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Competing interests: None declared.

1 Spence D. Bad medicine: melanoma. BMJ 2011;343:d5477. (31 August.)

Cite this as: BMJ 2011;343:d7733

INHERITED CARDIOMYOPATHIES

Role of cardiac magnetic resonance imaging

Raju and colleagues did not elaborate on the established role of cardiac magnetic resonance imaging in their clinical review of inherited cardiomyopathies. In hypertrophic cardiomyopathy such imaging allows accurate measurement of wall thickness, location of hypertrophy, and assessment of left ventricular outflow tract obstruction and systolic anterior motion of the mitral valve. Cardiac magnetic resonance imaging further identifies areas of fibrosis with late gadolinium enhancement, which in recent longitudinal studies is strongly associated with sudden cardiac death in hypertrophic cardiomyopathy.

Similarly, in dilated cardiomyopathies cardiac magnetic resonance imaging distinguishes between causes and can identify mid-wall fibrosis, which is prognostic in predicting ventricular tachycardia and sudden cardiac death. It is helpful in diagnosing arrhythmogenic right ventricular cardiomyopathy with regional right ventricular akinesia or dysynchrony in combination with either dilatation of the right ventricle or impaired right ventricular function. It also has a role in imaging cardiac sarcoidosis, amyloidosis, Anderson-Fabry’s disease, and non-compaction.

These strong indications have firmly established cardiac magnetic resonance imaging as mainstream in cardiomyopathy.

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Competing interests: None declared.


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INVESTIGATION OF LOWER RESPIRATORY TRACT INFECTION

As a doctor returning from 16 years in rural practice in the Gambia, I appreciated how Chalmers and Hill discouraged wasteful investigation of presumed lower respiratory tract infection. Throughout these years I worked beyond reach of chest radiography and blood or sputum culture facilities and used World Health Organization guidelines, which stipulate the importance of temperature, pulse, and timed respiratory rate over 60 seconds to diagnose lower respiratory tract infection, before considering the need for precious antibiotics.

Any serious inflammation of the lower respiratory tract causes some degree of hypoxaemia, leading to tachypnoea and raised pulse rate. The absence of raised resting respiratory rate (a cut off point of 15 breaths/minute in a previously well 49 year old non-smoker) almost completely excludes serious infection.

Without an abnormal respiratory rate, pulse, and temperature, why was lower respiratory tract infection diagnosed? Absence of “focal” chest signs is inevitable. A four day history of real pneumonia would have made progression to a highly symptomatic state almost certain. The absence of signs virtually excludes the diagnosis.

In this case clinical examination was reported as “unremarkable”—reminiscent of the term NAD, “nothing abnormal demonstrated,” which used to appear in hospital notes. We were taught to infer the alternative expansion “not actually done.”

Respiratory rate measured over a minute, radial pulse, and measured temperature should be required and recorded to justify diagnosis or treatment of lower respiratory tract infection in a previously healthy patient. Cough alone is non-specific—it relates to all forms of upper and lower respiratory tract infection.

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Competing interests: None declared.

1 Chalmers JD, Hill AT. Investigation of “non-responding” presumed lower respiratory tract infection in primary care. BMJ 2011;343:d5840. (13 October)

Cite this as: BMJ 2011;343:d7727