

EDITOR'S CHOICE

Patient outcomes at both ends of the stethoscope

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Politics influences health policy and practice. With the European and local council election results just out, questions of priority setting may well be at the front of our minds.

Within that context, a longitudinal study in this week's journal seeks to assess whether targeted spending in deprived areas has reduced the health outcomes gap. The study by Barr and colleagues (doi:10.1136/bmj.g3231) looks at the impact of a government initiative that saw the NHS resource allocation formula adjusted to achieve this objective across the 324 local authorities in England.

The authors examined the association between NHS spending and changes in mortality from avoidable causes. Their review of the data over a 10 year period (2001-11) found that there was a reduction in absolute health inequalities between deprived and affluent areas. Differences in mortality amenable to healthcare between deprived and affluent areas decreased from 95 deaths in males and 47 deaths in females per 100 000 in 2001 to 54 and 28 per 100 000, respectively, in 2011.

In a linked editorial, Azeem Majeed and Michael Soljak (doi:10.1136/bmj.g3388) confirm that the study results are encouraging, adding that it provides evidence for continuing to target NHS resources at deprived areas. However, they suggest that the wider determinants of health such as education, housing, and employment all have a part to play in a strategy to reduce health inequalities.

Also in the journal this week, a retrospective analysis of large in-hospital data registry by Donnino and colleagues focuses on the timing of delivery of adrenaline (epinephrine) during in-hospital cardiac arrest in patients with an initial non-shockable rhythm (doi:10.1136/bmj.g3028). The study found a stepwise decrease in hospital survival for every minute that adrenaline was delayed. But a linked editorial by Gavin Perkins and Jerry Nolan (doi:10.1136/bmj.g3245) highlights the impact of confounders such as the reasons for causes of delay in time to

administration of adrenaline, which makes the effectiveness of the intervention more difficult to disentangle within this study. So what then are the implications for clinical practice? Perkins and Nolan suggest that adrenaline should continue to be used if currently included in protocols and, if not, they advise waiting for the results of ongoing clinical trials.

From long established treatments to advances in technology, a feature by Marc Wittenberg suggests that ultrasound scanners could replace the stethoscope as the symbol of the medical profession in the future (doi:10.1136/bmj.g3463). This is because of exciting improvements in their portability, reliability, and cost. To reduce the risk of false positives and false negatives, however, the Royal College of Radiologists warns that ultrasound scanners should be used only by those trained to use them.

And finally, two compelling articles focus on the key to getting it right in the consultation. An analysis article by Natalie Joseph-Williams and colleagues (doi:10.1136/bmj.g3178) challenges clinicians to draw on patients' knowledge and considerable expertise to achieve success jointly when managing long term conditions. The authors say that patients need to know that their input is valued, and they highlight that there are two experts in the clinical encounter.

A personal view by Anya de Iongh (doi:10.1136/bmj.g2973), a patient and self management coach, asks how often do doctors ask their patients, "What are you doing at the moment to manage your health?" She says that helping patients to find quality of life in difficult circumstances by developing tools such as problem solving and goal setting are essential skills that can be used to great effect by everyone, and as she says, to "manage life at both ends of the stethoscope."

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