



VIEWS AND REVIEWS

PRIMARY COLOUR

Helen Salisbury: When policy doesn't match evidence

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GPs, at least the ones I know, are conscientious people who try to keep up to date with developments in medicine and are well aware that much of what they were taught in medical school is no longer true.

We try to keep an eye on research, follow new guidelines, and go on courses that promise to deliver all the latest developments in one convenient—but hard to swallow—CPD day. But what should we do when the headlines and the guidelines conflict?

This year we are being encouraged by NHS England to diagnose pre-diabetes in patients with slightly raised blood sugar and then invite them to attend a course to help them make lifestyle changes to prevent or delay the onset of type 2 diabetes. (That word “lifestyle” always makes me think of interior décor and holiday destinations, though I know it means diet and exercise choices in this context.) There is a cost to the patient in such a diagnosis, in shifting their image of themselves as someone in good health, though possibly a bit overweight, to someone at risk of a serious illness. This may well be a price worth paying if that label is accurate and there is something we can do to help.

Sadly, a systematic review of the evidence shows that we don't have a good way of identifying the people at risk of diabetes, as the three standard measures—HbA_{1c}, fasting glucose, and impaired glucose tolerance—pick up different groups.¹

Furthermore, although people who complete intensive programmes lasting three to six years do reduce their risk, in studies only 27% of the identified population engaged with an intervention, and the diabetes prevention programme we can refer to lasts only 10 months.

I am very pleased that my patients can access weight loss and exercise groups without charge, and, although I shudder at the thought of joining one personally, I know they work to improve

health. However, this approach to preventing the diabetes epidemic, predicted to affect one in 10 of the population by 2034, seems a narrow and feeble response to a major threat. Learning lessons from the success of the smoking ban, we should stop focusing purely on personal choice and individual responsibility and look to transport policy, tax, and food regulation.

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Meanwhile, back in the surgery, I need to balance my own doubts about the whole programme against the chance that it may help the patient in front of me. As a good doctor, should I follow the policy or the evidence? And how much of my scepticism should I pass on to my trainees, who have a whole future of navigating these conflicts ahead of them but, in the short term, have exams to pass?

Competing interests: I am a GP partner, I teach medical students at Oxford University and St Anne's College, Oxford, and I answer readers' medical problems for *Take A Break* magazine. I am also a member of the National Health Action Party and serve on its national executive committee.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Barry E, Roberts S, Oke J, Vijayaraghavan S, Normansell R, Greenhalgh T. Efficacy and effectiveness of screen and treat policies in prevention of type 2 diabetes: systematic review and meta-analysis of screening tests and interventions. *BMJ* 2017;356:i6538. 10.1136/bmj.i6538 28052845

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