A time of change and changes

A distressing feature in the life you are about to enter, a feature which will press heavily upon the finer spirits among you and ruffle their equanimity, is the uncertainty which pertains not alone to our science and art, but to the very hopes and fears which makes us men.

William Osler, Acquanimitas (1889)

This might almost have been a quotation from Michael Frayn’s new play Copenhagen, in which Niels Bohr struggles with life’s uncertainties. Many issues of our own times are set to ruffle our equanimity. While advances in science and technology linked to improvements in clinical methods must make this one of the most exciting of all times in the practise of medicine, there are so many forces moving to initiate change that many people are confused, some angry, and some, both early and late in their careers, have prematurely left the profession. It is, therefore, crucial to understand and harness the many innovations to the benefit of our patients and the improvement of our clinical practice.

Issues of clinical relevance affecting practice are the chief components of the JRCPL and in many ways make it unique amongst British medical publications. David Kerr, its editor during the last four years, fostered these aims during his tenureship and has developed the journal into a thoroughly readable publication of true clinical importance which is also a pleasure to open and read. His introduction of prestigious and very attractively presented CME reviews was a major step forward, devoted as they are to instructing in particular ‘general physicians and the more numerous specialists with general medical responsibility’.

It is the new editor’s intention to continue the existing philosophy of the JRCPL but giving even more emphasis to CME and to the rapidly evolving changes in today’s society that are affecting clinical practice and forcing change at a considerable pace. I will seek in particular to publish submitted and invited contributions in the following areas:

- Ethics of medical practise
- Evolution of clinical governance
- Prioritisation and rationing in health care
- Problems of changing styles of practise and team working
- Relationships with the law
- Regulation of the profession
- Innovations in practise
- Implications of government proposals
- Issues in training
- Impact of developments in primary care.

I will encourage ‘doctors as patients’ views, and draw on the immense historical wealth of the College where it is relevant to clinical practice today.

I hope readers will submit illustrations or short texts as attractive ‘fillers’ for small (half page) spaces which are left in the text from time to time.

In presenting these proposals for the future, I salute David Kerr’s editorship now as he retires. The breadth of his vision was manifest in the subjects of his many editorials with their astonishing range – talking to patients, the role of the general physician, truth, cows, medicine in Hong Kong and Princess Diana – to mention just a few. A hard act to follow. His stewardship will be greatly missed and his advice and guidance much needed.

continued overleaf
Setting health priorities

Our daily national press increasingly raises issues that demonstrate the serious lack of any framework for decision making in setting health priorities. Almost everyone in Britain has heard of the farce over the prescribing of Viagra, the problems surrounding the pharmacology of weight reduction, and the new treatments for Alzheimer’s disease. The huge cost (and marginal benefit) of using Interferon in the treatment of multiple sclerosis, and the emotive distortions in addressing the sad ‘Child B’ case have been widely publicised.

The recent 2nd International Conference on Priorities in Health Care held in London on 8–10th October 1998 was opened by Baroness Hayman, Parliamentary under-Secretary of State in the Department of Health. She declared the need for a stronger national framework to guide local decision making. This is exactly what the Royal College of Physicians (RCP) recommended in its 1995 working party report Setting priorities in the NHS, together with the need for a National Council for Health Care Priorities to establish such a framework. This idea has steadily gained support but has not yet become a reality. Lady Hayman stated that the National Institute for Clinical Excellence (NICE) will perform this role. This is a cause for concern – not because they may not have the ability but more because the work of NICE is still shrouded in a mist, and its potential workload is enormous. Whether it will have the stomach, time or expertise to handle these issues as well, remains to be established.

While there are some (Professor Rudolf Klein) who believe that the debate is incapable of complete resolution and, therefore, ‘muddling through’ is the only way forward, most at the conference took the view that this approach is beginning to undermine public confidence. Involvement of the public in discussion of priorities is essential, though it can distort and also destabilise the process.

Confusion reigned when the debate even questioned the meaning of the words ‘public’ and ‘health’. New Zealand’s National Health Committee now has been involving the public in discussion for the past six years, and has begun to establish on the one hand some community priority programmes and, on the other, graded criteria for the urgency (or lack of it) in prioritising the need for coronary artery bypass graft operations. Some countries have launched ‘low priority’ schemes with public agreement while others are developing criteria where treatment may be denied on the basis of ‘no benefit shown’. Several have moved from stark lists to more discursive methods which may be more appropriate.

The issues around prioritisation ranged across vast areas of discussion – local approaches, national approaches, involvement of the public, the media, ethics, public accountability, and health technology assessment. Meanwhile the major issues of national policy in England and Wales remain unresolved. RCP proposed a ‘National Council for Health Care Priorities’, although obviously we would support an effective alternative – such as NICE – if it works. What is clear is that we need national guidance on prioritisation – we should not have to rely either on idiosyncratic local decisions or the individual physician having to make rationing decisions whilst interviewing a patient. Views of fellows and members in our correspondence column would be greatly valued.

The UKPDS.

A model for gathering the evidence for the management of chronic diseases.

The management of many of the common chronic diseases has developed on the basis of the pragmatic experience of astute clinicians. Determining the natural history of chronic diseases is by definition a lengthy process which may take years or even decades. To gather the evidence for the effect of any intervention therefore requires a similar period of observation. A range of diseases which includes diverse conditions such as rheumatoid arthritis, multiple sclerosis, all forms of peripheral vascular disease and diabetes come into this category. Proper long-term observations are scarce, difficult to conduct and so costly that grant-giving bodies can rarely afford them.

However, such a study, the UK Prospective Diabetes Study (UKPDS)2–6 was undertaken in the UK, and a review will be published in the JRCPL’s CME section on diabetes during 1999. This large study, which may become a model for gathering the evidence for the management of other chronic diseases, took over 20 years from inception to completion, needed to recruit 5,102 type 2 diabetic patients and cost an estimated £23 million – relatively much less expensive that its American counterpart on type 1 diabetes (Diabetes Control and Complications Trial).

Its key message is that morbidity and mortality of diabetes increase progressively with an increase in blood pressure and blood glucose, that there is no threshold level, and that the risks of both together
are additive. The actual increased hazard ratios reach alarming levels. Importantly for patients, reduction of both blood pressure and blood glucose towards normal reduces the risks of both macrovascular and microvascular damage by a more or less predictable amount, though myocardial infarction itself resists significant change.

Reduction of blood pressure (mean value achieved was 144/82, systolic pressure 10mmHg less than in the less tightly controlled group) had particularly impressive effects, not only on diabetes related deaths (reduced by 32%) and stroke (reduced by 44%), but also on retinopathy with reduction of the need for photocoagulation and protection of vision by prevention of maculopathy (47% reduced risk of vision decline by 3 lines). Tight control of glycaemia also reduced the risk of retinopathy and albuminuria. Thus it is now clear that tight blood pressure control as well as tight blood glucose control reduce risks both to the eye and the kidney.

Translation of the findings into practice is less simple than the message itself, not least because, as UKPDS shows, glycaemic control inexorably deteriorates over a decade, making optimal treatment ever more difficult. Yet we must make the effort both in terms of resources and development of new methods of treatment to make optimal control a reality. We will need to alert our patients to what they can achieve for themselves and alert the public to a better understanding of diabetes itself.

The success of UKPDS was due to the considerable perseverance and tenacity of those at the helm, namely Professor Robert Turner and Professor Rury Holman who, from their hospital base in Oxford, coordinated the 23 centres in which the clinical observations were made. The work represents a major achievement of British clinical medicine and epidemiology and should be widely read and effectively implemented.

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