Guidelines, ‘scandals’, and supporting clinicians in providing care for patients with diabetes

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We discuss guidelines and similar documents. Questions include who should construct them, sign them, their content, and for whom they are written. We comment on content and some effects of public statements on audits of use, which may encourage or discourage clinicians who care for people with diabetes.

What’s in a name?
Various terms are used to describe guidance for clinicians and ‘guidelines’ is not the only term. Other words used are ‘protocols’ and ‘checklists’, which often deal with non-clinical aspects of teamwork. Connotations can differ. NICE guidelines are ‘guidelines not tram lines’ (Haslam, NICE Chairman, personal communication, 2014), whereas compulsion may occur with surgical checklists. Some consultant surgeons were not enthusiastic about using the WHO surgical checklists. However, irrespective of clinicians’ attitudes, it is the outcomes for patients which matter. Haynes et al2 showed that the surgical death rates fell from 1.5% before using checklists to 0.8% after use and the complication rate fell from 11% (before use) to 7% (afterwards).

Who should construct guidelines?
Commonly, hospitals and general practices operationalise national/international guidelines – for example, clarifying follow-up advice or the use of Read codes – and are often called ‘protocols’ designed to help staff at departmental level deal with important or common problems. They may have only local institutional applicability, but usually have the great merit of practicality and relevance, and their authorship is usually clear. They may be less rigorous than national guidelines in using the research literature.

Two important points with national guidelines are authorship and conflicts of interest.

Sometimes the NHS and national charities issue unsigned guidelines. However, there are at least two reasons why guidelines should be signed. First, anonymous letters irritate and anonymity may reduce clinicians’ opinions on validity. Second, sadly, there have been several examples in recent years when those constructing guidelines have had conflicts of interest, sometimes serious. A systematic review3 reported that: ‘...the majority of guideline authors had industry affiliations... of more than 200 guidelines, 98 had included no conflict information and, of those, only 31 were free of industry.’

In some settings, guideline writers can publicly declare their conflict but, wrongly, still be allowed to continue participating. We think that no one with any significant financial conflict of interest should sit on any guideline group and if some people have special expertise, which is judged to be essential, then they should be interviewed. As an American judge once famously said: ‘Sunshine is the best disinfectant!’

Guidelines for patients
Most guidelines are for clinicians, but patients expect full access to guidelines and to be consulted. However, in the 15-point Diabetes Essentials guideline, although specifically aimed at patients, the National Association for Patient Participation was not consulted.

Content of the guideline
The 15 Healthcare Essentials is a 15-point guideline issued by Diabetes UK for patients. It is disappointing that it does not start by stating that patients should as far as possible take responsibility for their own care, as in the guideline of the Royal Australian College of General Practitioners and Diabetes Australia. Since having a good working relationship with a member of a primary health care team is associated with significantly better diabetic care, this should also be encouraged.

Operationalising guidelines
There is a tension between simplicity of clinical accuracy and measurement of performance by the NHS on guidelines. Working doctors need a stronger voice at the standard-setting table.

Our practice in 2013 was reported in the National Diabetes Audit to be achieving only 23% for diabetic eye screening, but practice records revealed a documented 79% rate, later accepted by the audit team. Who guards the guards? How are clinicians to be protected against system errors of such magnitude? Should authorities be subject, like clinicians, to the duty of candour and apologise after errors?

Commenting on clinical audits
Both national and local audits are important to inform patients and professionals about the quality of care. Intra-organisational medical audits are important, as they are a key form of professionalism. They apply in all specialities and, when done by a general practice or a hospital department, they enable a team to see how they are doing and in particular to make any necessary improvements, in private.

National audits are important7 to provide a national picture and enable significant geographical variations in performance to be identified.

What is more controversial are the comments that some national bodies, both government and national charities, sometimes make based on audit results. There is a tendency to pour scorn and seek press headlines, which sometimes can be seen as a measure of success. For example, general practitioners (GPs) and their teams found their care of people with diabetes being described as a ‘scandal’.8,9

The prime aim of the NHS, Diabetes UK and health professionals is to help patients with diabetes receive the
best possible care. Does calling the work of professionals a ‘scandal’ encourage those professionals or not? Generals never publically criticise their infantry and general practice is the infantry of the NHS. Elsewhere, leaders who identify weak performance respond by reviewing staffing levels and arranging education. Rubbishing the work of staff rarely improves productivity or morale.

Scandal-calling raises questions about whether Diabetes UK is in touch with and understands the role of modern general practice in the care of people with diabetes.

Key facts are that 90% of the people with diabetes in the UK have type 2. Some 75% of all care for type 2 diabetes is provided in general practice. This high percentage has further increased since 2000, as the number of people diagnosed has risen progressively. In Exeter, the consultant diabetologists have asked the GPs to manage all uncomplicated patients with type 2 diabetes and leave them with patients with type 1.

General practice management of type 2 diabetes
All medical audits need to be considered in context. Comparisons with comparable countries are a good way to identify big-picture performance and review whole health systems. Unfortunately, comparisons of NHS performance against comparable countries are disappointing. For example, the Organisation for Economic Co-operation and Development (OECD) has recently reported that on many clinical outcomes the UK fares badly. In the seven conditions in a recent OECD table, the UK was in the bottom tertile in four and in the middle tertile in two. For stillbirth rates, the UK ranks the lowest in the OECD: the only disease group in this table with diabetes was 21.6 years, so they were diagnosed within the seventh year of life. Diabetes UK is the report of the admission rate of hospitalisations of type 2 diabetes made within our practice were achieved before the patients had reported any symptoms of diabetes. Encouragingly, these patients had a significantly lower ($p<0.01$) HbA1c at diagnosis compared with the 32 people diagnosed after reporting diabetic symptoms.

Most clinicians, are not concerned with others’ failures, but instead with how much colleagues in ordinary service settings can achieve. Diabetes UK could play a big role in reporting good performance in both generalist and hospital practice, and valuing it.

Comorbidity
We make suggestions derived from the characteristics of the 399 people with type 2 diabetes registered in our general practice in 2014. First, the age profile is that 89% of patients are over 50 years of age, 33% over 75, and 10% (39) are over 85. The key message is that in clinical practice this is an older group of patients, who will inevitably have substantial comorbidity. In fact, 13% (50) also have malignant cancers and 6% (25) have had a stroke.

Generalist doctors nowadays have 33% of their consultations for multiple morbidity (Salisbury, personal communication, 2015) and must listen to their patients carefully and then judge where the medical priorities lie.

The 13 Healthcare Essentials states that every item of recommended care for diabetes should be provided to every patient. But if patients are very ill, or dying, then following a guideline rigidly lacks compassion. Specialist teams are also calling for flexibility, i.e. individualisation of treatment.

How well do GPs know their patients? In the St Leonard’s practice, using personal lists, our 399 patients with type 2 diabetes have a median duration of registration of 24.6 years. These patients, on average, have consulted within the practice, 50 or more times. Their median duration of registration at diagnosis of diabetes was 21.6 years, so they were diagnosed within long-standing patient–doctor relationships.

In an unequal society, general practice is the branch of the medical profession best able to reduce socio-economic disadvantage. More than a quarter (27%, 108) of our 399 patients are in the two highest national deciles of social deprivation on the English Index of Multiple Deprivation.

The rising incidence of diabetes demands prevention and early diagnosis. Prevention is best achieved through society initiatives, whereas very early diagnosis of type 2 diabetes can now be achieved in general practice.

Clinical opportunistic screening exploits the substantial knowledge GPs have of their patients and their computerised records. In the years 2012 and 2013 combined, 100 out of 132 (75.8%) of all the new diagnoses of type 2 diabetes made within our practice were achieved before the patients had reported any symptoms of diabetes. Encouragingly, these patients had a significantly lower ($p<0.01$) HbA1c at diagnosis compared with the 32 people diagnosed after reporting diabetic symptoms.

Conclusions
Ninety percent of people with diabetes have type 2 diabetes and about 75% of their medical care is exclusively in general practice. The common objective of patients, professionals, the NHS and Diabetes UK is to improve the quality of that care. Everyone involved, national and
local, patients and professionals, needs more understanding and respect for each other’s role and to collaborate together to obtain the best outcomes for patients.

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Declaration of interests

Sir Denis Pereira Gray is Patron of the National Association for Patient Participation. The other authors have no declarations to make.

References


POEMs

Metformin minimally beneficial, if at all, when added to insulin in overweight adolescents with type 1 diabetes

Clinical question

Is the combination of metformin plus insulin versus insulin alone beneficial in overweight/obese adolescents with type 1 diabetes?

Bottom line

The addition of metformin to insulin in overweight adolescents with type 1 diabetes did not result in improved glycaemic control. The combination did result in a significantly decreased need for insulin and less weight gain compared with placebo plus insulin. More patients in the metformin group than in the insulin-only group dropped out because of adverse gastrointestinal side effects. It remains uncertain whether metformin-insulin combination therapy results in improved long-term, patient-oriented outcomes.

Reference


Synopsis

These investigators identified adolescents, aged 12–19 years, diagnosed with type 1 diabetes for at least one year that required treatment with either an insulin pump or at least three daily injections of insulin. Additional eligibility criteria included an HbA1c level of 7.5–9.9% and a BMI in the 85th percentile or higher for age and sex. Patients (n=140) randomly received (concealed allocation assignment) either metformin (titrated to 2000mg daily) or matched placebo in addition to continued insulin dose as judged by their individual clinicians. Complete follow up occurred for >99% of participants at 26 weeks (six months). Using intention-to-treat analyses, no significant differences occurred at 26 weeks in mean change in HbA1c level from baseline. Mean total daily insulin dose was significantly lower in the metformin group than in the placebo group. Patients in the metformin group also gained significantly less weight than the placebo group (mean difference -2kg; 95% CI -3 to -1). Gastrointestinal side effects, as expected, were significantly more common in the metformin group.