Letters

Reactions to the chief medical officer's report

The GMC has changed fundamentally


MARK THOMAS

Sir Liam Donaldson

EDITOR—I have stated publicly and often that the GMC enthusiastically supports the principles underpinning *Good Doctors, Safer Patients*—protecting patients, raising public and professional confidence in the regulatory system, setting clear standards for entry to the profession, and maintaining those standards throughout doctors' careers. An independent and accountable system of medical regulation commanding confidence is our common aim.

The public and profession have welcomed the new edition of *Good Medical Practice*. The attributes of a good doctor and the need for revalidation are clear. It is a mark of success that we have made such progress without rancour. Whatever the outcome of the current consultation, the responses I have seen, both lay and professional, have been constructive and indicate similar solutions to real problems.

It is, however, surprising that Irvine should criticise members of the current council, few of whom are known to him and whose deliberations he has never witnessed.[1] They have been in post for three years, expect to serve for four, and cannot remain for more than eight years. Limiting members' terms of office to ensure that the council is continually refreshed was but one part of our reform programme. Donald Irvine was a member of the GMC for 22 years.

We must learn the lessons of the past without fighting again the battles of yesteryear. The GMC has changed fundamentally—as I have indicated and as our formal response to *Good Doctors, Safer Patients* will show. Donald Irvine's article warns not of impending doom but rather that it remains ever more difficult to remain up to date as the years pass—even for a past president of the GMC.

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Competing interests: None declared.

1 Irvine D. Success relies on winning hearts and minds. *BMJ* 2006;333:965-6. (4 November.)

Less attractive than death or taxes

EDITOR—I oppose the imposition of an untested system of "revalidation" that is incapable of defining a good doctor and that imposes bureaucratic burdens on the 95% of us seen as good doctors as punishment for the regulator's inability to address the other 5%.[1]

Sir Liam's analysis of the problem is reasonable, but his conclusions are fundamentally flawed. He recommends a system to support doctors with health concerns—yet he recommended the same thing seven years ago, and has done nothing to deliver it, despite train drivers and pilots having similar support for a quarter of a century.

He recommends a rigorous training system. Yet he has destroyed the old system, to introduce Modernising Medical Careers—which has never been tested and is still incomplete. He recommends using "appraisal," as part of a summative process—yet when it was introduced three years ago we were all promised that it was a "formative" process.

The failings are manifest, and widespread. Individual General Medical Council affiliates will clearly be as vulnerable to corruption and influence as the GMC itself, and so will fail, and be seen to do so.

Revalidation and reaccreditation must fail, because there are no reliable criteria to separate good doctors from bad—and yet we will all waste time and effort jumping through hoops. The bureaucracy he proposes is incredible and will consume 5-10% of clinical time and many other resources. A rational approach would be to identify what you wish to measure (in this case a good doctor), and then design, test, and validate your measures, before using them in practice. A sensible person would focus on the "problems."

A scientist, particularly one with some knowledge of public health, would design a screening process to identify bad doctors by using the World Health Organization's criteria for screening—yet Sir Liam's proposals fail every test bar one.

His premise is based on a paper he himself wrote, suggesting 5% of doctors were problems over a five year period—yet this is surprisingly close to the proportion of doctors referred to the National Clinical Assessment Service (NCAS). The problem repeatedly presented is of doctors who are known to NCAS as problem cases, yet not at a point where GMC sanction is appropriate. So why is Sir Liam, and the others who are with him, failing to put forward proposals to give NCAS more teeth, instead of burdening us with this monstrosity?

He believes the medical establishment has been corrupt in the past, and so supports appointment, yet the NHS appointments commission is appointed by the government, so he is placing us in the hands of politicians, despite his denials.

The medical establishment may well be corrupt. The only people who speak in favour of these proposals are those who may benefit—the educationalists who have left practice, and who hope to be the well paid affiliates, the lay members who stand to be appointed to more sinecures, and the college leaders, whose colleges will rake in profits from being monopoly providers of accreditation.

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Competing interests: None declared.

1 Godlee F. Concerns about revalidation [Editor's choice]. *BMJ* 2006;333. (4 November.)

Overegging the pudding

EDITOR—"Professor Sir Liam Donaldson's report offers a realistic possibility that, for the first time, every patient in the United Kingdom will have the guarantee of a good doctor," so said Donald Irvine.[1]

This country has a large number of doctors. The idea that every single one of these doctors will be a good doctor is completely unrealistic. No doubt some system of reappraisal and revalidation will emerge eventually from the protracted navel gazing, argument, and counter-argument that

have been going on for the past few years. All the words will have been wasted if this system does not mean that far more patients than before will have a good doctor. But to imagine that everyone will have the "guarantee of a good doctor" is akin to the idea of a risk free life.

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1 Irvine D. Success relies on winning hearts and minds. *BMJ* 2006;333:965-6. (4 November.)

Where are patients' voices?

Editor—With reference to Irvine's first sentence,[1] isn't it time that patients speak out in support of their general practitioners? Or quote findings back at staff of the Picker Institute and other self appointed, so called patient advocates, such as "92% [of patients] said they were treated with dignity and respect by the doctor" or "76% said they had complete confidence and trust in their doctor"?[2] Which other profession commands such respect, and, in Britain, rightly so?

Where is the forum where satisfied patients (they do exist) can make their voices heard?

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Competing interests: RW has diabetes and is looked after very well by his general practitioner and all members of her team.

1 Irvine D. Success relies on winning hearts and minds. *BMJ* 2006;333:965-6. (4 November.)
2 Coulter A. What do patients and the public want from primary care? *BMJ* 2005;331:1199-201.

How to measure renal function in clinical practice

Eating cooked meat alters serum creatinine concentration and eGFR

Editor—Traynor et al state that serum creatinine concentration, and therefore eGFR, may only be slightly affected by ingestion of meat.[1] In the data from the modification of diet in renal disease study that were used to generate the eGFR equations,[2] samples were taken from predominantly fasting subjects (AS Levey, personal communication, 2006). In clinical practice, however, samples for serum creatinine concentration and eGFR are generally used in situations where the patient's recent dietary intake is not considered.

We investigated the impact of meals on serum creatinine concentration and eGFR.[3] Participants (n=32; median age 54.5, range 18-86) had blood samples taken before and after normal helpings of meat-containing meals supplied by our hospital canteen. Median serum creatinine concentration rose from 80.5 μmol/l before eating to 101.0 μmol/l 1-2 hours after eating ($P<0.0001$), and 99.0 μmol/l 3-4 hours after eating ($P<0.0001$). Furthermore, median eGFR fell from 84.0 ml/min/1.73 m^2 preprandially to 59.5 ml/min/1.73 m^2 1-2 hours after eating ($P<0.0001$) and 64.0 ml/min/1.73 m^2 3-4 hours after eating ($P<0.0001$).

This led to apparent changes in staging of chronic kidney disease.[4] In 12 of the 32 participants (six men aged 47-76; six women aged 36-84), the lowest eGFR in the postprandial period fell into a worse category than the preprandial eGFR. In 11 cases, chronic kidney disease staging was altered from better than stage 3 (which includes normal GFR, stage 1, and stage 2) to stage 3. In these cases, preprandial eGFRs ranged from 67 ml/min/1.73 m^2 to 97 ml/min/1.73 m^2 and the 60 ml/min/1.73 m^2 threshold was crossed. In the other case, staging changed from stage 3 to stage 4.

Our results suggest that the risk of misdiagnosis or incorrect staging of chronic kidney disease is high after a meal containing cooked meat. We recommend that national guidelines incorporate the advice that serum creatinine measurement, for the purpose of eGFR calculation and staging of chronic kidney disease, should be carried out when a patient has fasted or specifically avoided a cooked meat meal on the day of blood sampling.

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Competing interests: None declared.

1 Traynor J, Mactier R, Geddes CC, Fox JG. How to measure renal function in clinical practice. *BMJ* 2006;333:733-7. (7 October.)
2 Levey AS, Coresh J, Greene T, Stevens LA, Zhang Y, Hendriksen S, et al. Using standardized serum creatinine values in the modification of diet in renal disease study equation for estimating glomerular filtration rate. *Ann Intern Med* 2006;145:247-54.
3 Preiss DJ, Godber IM, Lamb EJ, Dalton RN, Gunn IR. The influence of a cooked meat meal on estimated glomerular filtration rate. *Ann Clin Biochem* (in press).
4 K/DOQI clinical practice guidelines for chronic kidney disease: evaluation, classification, and stratification. Kidney Disease Outcome Quality Initiative. *Am J Kidney Dis* 2002;39:S1-246.

Stage 3 chronic kidney disease is not a consequence of normal ageing

Editor—Bhandari suggests an estimated glomerular filtration rate (eGFR) <60 ml/min/1.73 m^2 may be normal in patients older than 70.[1] The study he cites as evidence showed a decline in creatinine clearance at 0.75 ml/min/year reaching a mean of 107 (SD 22) ml/min in the eighth decade of life.[2] His comment, that an 80 year old may be normally expected to have an eGFR of 45-50 ml/min/1.73 m^2, is at odds with the evidence. Even allowing for the fact that creatinine clearance overestimates GFR, stage 3 chronic kidney disease is abnormal in elderly people. Importantly, stage 3 chronic kidney disease is associated with increased cardiovascular risk independent of age.[3]

Bhandari also states that eGFR is not validated in subjects with stage 3 chronic kidney disease and a "normal" serum creatinine.[1 4] The study he cites did not calibrate serum creatinine to the modification of diet in renal disease laboratory, which may substantially increase the inaccuracy of eGFR, particularly in patients with low serum creatinine.[5] Clinicians should be reassured that most UK laboratories reporting eGFR do calibrate their creatinine assays to an international reference standard.

Patients with chronic kidney disease should not be ignored simply because they are older than 70.

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Competing interests: MSM has received lecture and consultancy fees and support to attend academic conferences from companies which manufacture drugs relevant to chronic kidney disease.

1 Bhandari S. How to measure renal function in clinical practice: age affects estimated glomerular filtration rate. *BMJ* 2006;333:918. (4 November.)
2 Lindeman RD, Tobin J, Shock NW. Longitudinal studies on the rate of decline in renal function with age. *J Am Geriatr Soc* 1985:33:278-85.
3 Go AS, Chertow GM, Fan D, et al. Chronic kidney disease and the risks of death, cardiovascular events, and hospitalization. *N Engl J Med* 2004;351:1296-305.
4 Verhave JC, Fesler P, Ribstein J, Du CG, Mimran A. Estimation of renal function in subjects with normal serum creatinine levels: influence of age and body mass index. *Am J Kidney Dis* 2005;46: 233-41.
5 Coresh J, Astor BC, McQuillan G, et al. Calibration and random variation of the serum creatinine assay as critical elements of using equations to estimate glomerular filtration rate. *Am J Kidney Dis* 2002;39:920-9.

Authors' reply on Cochrane reviews *v* industry supported meta-analyses

Editor—Tostad and Deeks are concerned about the impact of space restrictions on our findings.[1-3] Firstly, we believe space restrictions should not be an excuse for omitting important details on the methods used, as it is the authors who decide what to report within any given space, and as many journals allow additional material on the web. Secondly, our research reflects what is available to the readers, and not what could have been available, and it is therefore valid from a pragmatic perspective. If relevant details are not reported—for example, methods used to ensure adequate allocation concealment and blinding—readers may be unable to make their own assessments and conclusions, which may be different from those of the authors. Thirdly, we found several additional interesting differences between Cochrane reviews and other meta-analyses as well as those related to methods.

Deeks mentions that reservations were made in his industry supported review. That is correct, but the reservations were made in the body of the discussion. There were no such reservations in the abstract or in the conclusion, neither in the short, nor in the long, web based version of the review, which was the one we assessed.[4] We evaluated the abstract and the conclusion for all the reviews when we judged whether the conclusions were without reservations and

believe this is most relevant thing to do, as most people read only the abstract.

We agree with Tostad and Coyne that some Cochrane reviews are not of good quality,[5] and we gave examples of this. We urge readers who find problems with Cochrane reviews to submit a comment to be published as part of the review. This is very easy to do. Use "Add/View Feedback" in the index to the left of each review. Such feedback is most welcome as we constantly try to improve the quality and relevance of our reviews.

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1 Tostad M. Cochrane reviews v industry supported meta-analyses. *BMJ* 2006;333:916. (28 October.)
2 Deeks JJ. Word limits best explain failings of industry supported meta-analyses. *BMJ* 2006;333:1021. (11 November.)
3 Jørgensen AW, Hilden J, Gøtzsche PC. Cochrane reviews compared with industry supported meta-analyses and other meta-analyses of the same drugs: systematic review. *BMJ* 2006;333:782-5. (14 October.)
4 Deeks JJ, Smith LA, Bradley MD. Efficacy, tolerability, and upper gastrointestinal safety of celecoxib for treatment of osteoarthritis and rheumatoid arthritis: systematic review of randomised controlled trials. *BMJ* 2002;325:619.
5 Coyne J. Cochrane reviews v industry supported meta-analyses. *BMJ* 2006;333:916. (28 October.)

Delayed cord clamping may be beneficial in rich settings

Editor—Delayed cord clamping reduces infant anaemia in resource poor settings.[1] There are, however, other implications, and neonatal anaemia is still important in developed countries. In Darlington we have a guideline to delay cord clamping for at least 40 seconds.[2]

It was a pragmatic decision to make 40 seconds the interval, and the rather longer time as suggested by van Rheenen and Brabin is likely to be closer to the physiological interval. We have also developed a method of resuscitation of the neonate at caesarean section with the cord intact. Although this method has not been included in the guideline there are plans to do so.

Fetal distress is a common reason for instrumental delivery or caesarean section. The fetal compromise is often due to cord compression associated with a nuchal cord. A nuchal cord results in compression of the low pressure venous return of oxygenated blood from the placenta. Blood continues to be pumped out by the fetal heart, and the obstructed return from the placenta results in a congested placenta and a depleted fetal blood volume.

If the cord is clamped immediately at delivery, although the return from the placenta is now relieved, the excess blood, which is oxygenated blood, never has any opportunity to return to the newborn. In these circumstances it is particularly important to be able to resuscitate the baby with the cord return still intact. Preparation for neonatal resuscitation needs to be made at the same time as preparation for the caesarean section. Every maternity unit in the UK needs to adopt these guidelines.

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Competing interests: None declared.

1 Van Rheenen PF, Brabin BJ. A practical approach to timing cord clamping in resource poor settings. *BMJ* 2006;333:954-8. (4 November.)
2 Guideline for the management of caesarean section deliveries. www.hutchon.net/NFMMSIG/cordclamp.htm (accessed 9 Nov 2006).

Scotland *v* England deal on prescribed drugs

Scottish Medicines Consortium responds

Editor—We were disappointed to read the recent news article by Watts.[1] On what seems to be no more evidence than an article in the *Daily Mail* he argues that application of the Barnett formula allows Scotland, through higher per capita funding, to be more free and easy in its approval of new medicines. A good story—the only problem is that he is completely wrong in his analysis.

The National Institute for Health and Clinical Excellence (NICE) and the Scottish Medicines Consortium (SMC) use similar approaches in their assessment of medicines.[2] What we don't use is any measure of the overall NHS budget or the budgets of individual NHS boards (affordability) in making our recommendations on new medicines so the Barnett formula is irrelevant.

By way of direct comparison, over the past four years, NICE has made decisions through its multiple technology assessment process on 28 new medicines that have also been assessed by SMC. In all but three cases there has been complete agreement between NICE and SMC, and in the three where there has been disagreement it is NICE that has approved the use of the medicines, not SMC.

For single technology assessment, which SMC has been undertaking for some years, and which has been taken up by NICE this year, there have so far been only four final determinations. In one case, the decision was made before SMC was established and so outside of its remit. In the other three, the decision was the same between the two bodies. No real differences there then.

The main difference is around the timing of decisions. SMC's remit is to provide a decision on all new medicines, and new indications and formulations of existing medicines, within three months of launch. It is this difference that is crucial, in that decisions on new medicines are made very early after launch, allowing Scottish patients early access to new products, where these seem to offer reasonable value for money. Returning to the comparison between NICE and SMC, for those 23 medicines we both approved, the decisions were made on average 10 months earlier in Scotland, though introduction of single track assessment by NICE may well narrow this gap in future.

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Competing interests: The authors are members of the Executive of the Scottish Medicines Consortium.

1 Watts G. Are the Scots getting a better deal on prescribed drugs than the English? *BMJ* 2006;333:875. (28 October.)
2 Cairns J. Providing guidance to the NHS: The Scottish Medicines Consortium and the National Institute for Clinical Excellence compared. *Health Policy* 2006;76:134-43.

Author's reply

Editor—I am sorry to learn that Webb et al were disappointed to read my piece prompted by the decision of the National Institute for Health and Clinical Excellence (NICE) on bortezomib—and also puzzled. The word "disappointed" would seem to imply that I was critical of the Scottish Medicines Consortium (SMC) and its actions. Far from it.

In the first place—and in contrast to the *Daily Mail* story quoted—I went out of my way to minimise the disparity between the decisions of NICE and SMC. The difference between the actions of the two bodies is nothing like as great as the *Mail* had implied.

That said, when it comes to playing fast and loose with other people's meanings, Webb et al could teach the *Mail* a thing or two. Yes, I explained how the Barnett formula gives more cash per head to the Scots. Yes, I said that since devolution this cash can be spent howsoever the Scottish Executive likes. But to put those two together and suggest that I was therefore specifically arguing that the Barnett formula "allows Scotland . . . to be more free and easy in its approval of medicines" is a misrepresentation that will be apparent to anyone with nothing better to do than go back and read what I actually wrote.

My point in writing the piece was to suggest that although the differences between NICE and SMC had on this occasion been exaggerated, Scotland does now have the capacity to go its own way, and uses it. And why not? Differences in local policy—whether the area in question is a postcode or a devolved administration—have never worried me personally. But they do upset a lot of people. I was drawing attention to this state of affairs, and illustrating it.

Finally, one *mea culpa*. On reflection, I do feel that the title and introduction—in spite of the question mark and the qualifier ("seem")—are arguably out of kilter with the rest of the piece. Perhaps this biased Webb's reading of the rest of the article. If so, I apologise.

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