# Letters

## Nurse led care

### Comment in This week in the *BMJ* is misleading

EDITOR—Readers of the paragraph in This week in the *BMJ* for the paper by Walsh et al are offered the conclusion that investment in intermediate care in community hospitals may be more cost effective than financing nurse led care for post-acute patients in acute hospitals.[1 2] But the study itself, which confirms existing evidence on the costs of nurse led intermediate care in acute settings,[3 4] tackles neither the effect nor the cost of intermediate care in community hospitals.

How then can such a conclusion be drawn? Walsh et al do not make this assertion. The author of the comment offers no support. Our own review of the evidence on nurse led intermediate care found no quality evidence for either the effect or cost of intermediate care in community settings.[5]

The *BMJ* has been at the forefront of setting standards for the reporting of primary research. However, the editors must be aware that many readers simply pick up a take home message from comment, like this,[1] in the journal. Reviewers of research papers are asked to ensure that the evidence presented supports the conclusions made. Sadly, the same standard does not seem to be applied to editorial comment in the journal. Editorial opinion is one thing but such comment, which implies the support of evidence from the paper, is surely not appropriate.

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Competing interests: PH is the author of much related research and has been identified in the past as an advocate of the nurse led unit model of care.

1 Nurse led intermediate care may not be cost effective in acute hospitals [This Week in the *BMJ*]. *BMJ* 2005;330:0-a. (26 March.)
2 Walsh B, Steiner A, Pickering RM, Ward-Basu J. Economic evaluation of nurse led intermediate care versus standard care for post-acute medical patients: cost minimisation analysis of data from a randomised controlled trial. *BMJ* 2005;330:699. (26 March.)
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### Nurses are autonomous professionals delivering expert care

EDITOR—It is true that non-medical healthcare professionals, mainly nurses, have recently taken on a variety of roles that are traditionally viewed as the province of doctors. Clinical evaluations have generally been positive, indicating that the skills of the healthcare team are being more effectively used and that similar patient outcomes can be achieved by different approaches.[1 2] Unfortunately the thinking of some professionals has been slower to change, as exemplified by Cullum and Spilsbury's editorial on nurse led care.[3]

We object to the statement that doctors are "delegating" their work to nurses, and the subsequent implication that only simple activities will be appropriate for nurse led care. This statement reinforces the commonly held medical view that nurses are appropriate to fill in where junior doctors are in short supply and the required tasks menial, such as pre-assessment clinics and routine procedures, but not to act as autonomous professionals initiating and delivering high quality care. Such outmoded thinking returns nursing to the status of "handmaiden." rather than accepting that nurses have a specific set of skills and their own professional accountability.

Experienced nurses have been undertaking a variety of "medical" tasks for many years, albeit often in a covert fashion. We welcome the acknowledgment of the diverse skills that nursing staff can bring to health care, and the formal introduction of posts such as the nurse consultant, which is able to develop the nursing role while ensuring that the essence of nursing as profession is not lost.

Interdisciplinary teams, not doctors, deliver modern health care. Doctors bring their particular skills to the team, but no longer sit at the apex of a hierarchy, delegating to other professions. Although it may feel uncomfortable to relinquish the traditional notion of medical control, doctors must embrace and support the development of better health care, regardless of the professional training of those who deliver it.

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Competing interests: None declared.

1 Raftery JP, Yao GL, Murchie P, Campbell NC, Ritchie LD. Cost effectiveness of nurse led secondary prevention clinics for coronary heart disease in primary care: follow up of a randomised controlled trial. *BMJ* 2005;330:707-10. (26 March.)
2 Sakr M, Angus J, Perrin J, Nixon C, Nicholl J, Wardrope J. Care of minor injuries by emergency nurse practitioners or junior doctors: a randomised controlled trial. *Lancet* 1999;354:1321-6.
3 Cullum N, Spilsbury K, Richardson G. Nurse led care. *BMJ* 2005;330:682-3. (26 March.)

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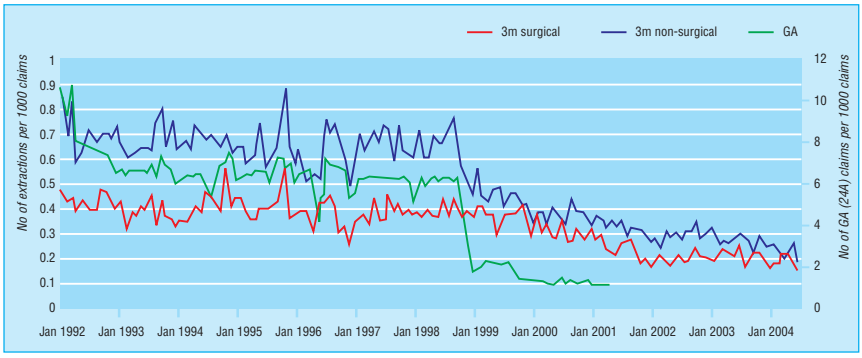
## What's the evidence that NICE guidance has been implemented?

### Analysis is subject to confounding

EDITOR—Sheldon et al show a gradual reduction in the number of wisdom teeth extractions, which they propose indicates a diffusion of guidance from the National Institute for Clinical Excellence (NICE) into clinical dental practice.[1] The first figure in our response on bmj.com shows the annual number of courses of treatment that included at least one extraction of the third molar in the General Dental Service in Scotland.[2] This figure corresponds to the presentation of data in figure 1 of Sheldon et al's paper.[1]

The raw number of claims per year masks some underlying trends in the data that are revealed by weighting the data by the total number of claims made in the General Dental Service over this period and by disaggregating the data into those wisdom tooth extractions that require a surgical procedure and those that do not.

The figure shows the number of surgical and non-surgical third molar treatments per




Numbers of surgical and non-surgical third molar treatments and general anaesthetic treatments per 1000 claims in Scottish General Dental Service. Third molar treatment=at least one type of extraction provided in course of treatments; 3m surgical=extractions requiring division of roots or crown; 3m non-surgical=extractions not requiring division of roots or crown; GA=at least one treatment with general anaesthesia (24(A)) provided in course of treatments

1000 claims in the Scottish General Dental Service, as well as the number of general anaesthetic treatments per 1000 claims in the Scottish General Dental Service (from the Management Information and Dental Accounting System (MIDAS) database, which is used to process, authorise, and store all claims for the General Dental Service in NHS Scotland).

The rate of surgical and non-surgical extractions varies around a constant rate until the end of 1998, when the rate of non-surgical extractions dropped sharply, which is inconsistent with a pattern of guideline implementation by diffusion.

New guidance for the administration of general anaesthesia by dentists in the United Kingdom was issued by the General Dental Council and took effect on 10 November 1998.[3] The reduction in the rates of non-surgical extractions coincides with the change in advice from the dental council to dentists.

Although the evidence in the figure does not establish a causal relation between general anaesthetic treatments and wisdom teeth extractions, it does provide some preliminary evidence that the regulatory framework within which general dental services are provided can affect clinicians' behaviour.

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Competing interests: None declared.

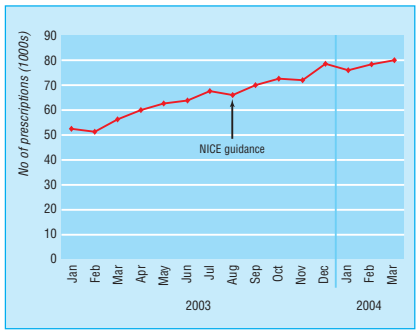
1 Sheldon TA, Cullum N, Dawson D, Lankshear A, Lowson K, Watt I, et al. What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews [with commentary by N Freemantle]. *BMJ* 2004;329:999-1004.
2 Tilley C, Crawford F, McCann M, Clarkson J, Pitts N. Confounding in the analysis of NICE guideline implementation. Electronic response to: What's the evidence that NICE guidance has been implemented? bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7473/999#87787 (accessed 22 Apr 2005).
3 Seward M. GA—end of an era. *Br Dental J* 1998;185:497.

## Maybe NICE needs to do more to ensure implementation of guidelines

Editor—Sheldon et al investigated whether guidance from the National Institute for Clinical Excellence (NICE) has been implemented.[1] We found a lack of implementation of newer guidance.

We examined how NICE guidance, published in August 2003, altered prescription rates of glitazones for type 2 diabetes mellitus. NICE recommended that glitazones be used as a second line treatment in combination with either metformin or a sulphonylurea in patients with type 2 diabetes who cannot tolerate metformin and sulphonylurea in combination and for whom these drugs are contraindicated.[2] We postulated that prescription of glitazones would increase on the basis of the advice, since the guidance resulted in a concise framework for the management of type 2 diabetes.[2]

The figure shows the numbers of glitazone prescriptions nationally. We applied an ARIMA (auto regressive integrated moving average) model to the data, which led to no notable changes in prescribing rates as a result of NICE guidance. P values were 0.40, 0.97, and 0.40 for total prescriptions, pioglitazone, and rosiglitazone, respectively.




Numbers of prescriptions of glitazone, January 2003 to March 2004, before and after NICE guidance (ePACT; electronic Prescribing Analysis and Costs)

This absence of difference may be because the impact is slow and falls outside the data capture period; the intervention may have reduced a bigger change; the "before and after" method is too crude to detect changes of this type; or our research was underpowered to detect such changes.

However, our results are another indication that NICE guidance does not affect clinical practice. NICE's premise is commendable, standardising treatments across the health service and promoting evidence based health care, but implementing guidance into clinical practice is another challenge. How the recently assigned "board level implementation executive" will take on this mammoth task will be interesting.[3]

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Competing interests: None declared.

1 Sheldon TA, Cullum N, Dawson D, Lankshear A, Lowson K, Watt I, et al. What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews [with commentary by N Freemantle]. *BMJ* 2004;329:999-1004.
2 National Institute for Clinical Excellence. *Guidance on the use of glitazones for the treatment of type 2 diabetes.* Technology appraisal guidance No21. London: NICE, 2003.
3 National Institute for Clinical Excellence, Special Health Authority. Supporting implementation of NICE guidelines. London: NICE, 2004. www.nice.org.uk/Pdf/boardmeeting/brdmay04item4.pdf (accessed 22 Apr 2005).

## Authors' reply

Editor—Tilley et al are incorrect in asserting that we said that our findings indicated a diffusion of guidance from the National Institute for Clinical Excellence (NICE) into clinical dental practice. To the contrary, we said that the guidance for wisdom teeth was published during a long downward trend in the extraction rate and did not have a discernible additional effect.

The more disaggregated analysis of Scottish data they provide is interesting in showing that one kind of extraction went down faster in response to guidance linked to general anaesthetics. However, the overall trend in the removal of wisdom teeth when using all four sources of data including hospital episode statistics is as we reported. Interestingly, our respondents in oral surgery departments spoke of a marked decrease in removals by general dental practitioners in England that predated the introduction of the advice on general anaesthesia.

Mannan and Jones's data remind us that we cannot assume that recommendations will be implemented. This might be aided by tackling some of the issues that Hine prompts us to consider as NICE's fourth hurdle for the funding of health technologies becomes more embedded.[1]

Firstly, mechanisms are needed to identify technologies for disinvestment,

which can offset the some of the costs of new technologies recommended by NICE, as well as incentives for promoting disinvestment.

Secondly, recommendations for funding of new technologies may crowd out the use of other, possibly more cost effective, technologies and local priorities that have not been appraised by NICE.

Thirdly, the overall efficiency and affordability of NICE guidance should be considered and the need, perhaps, to apply stricter thresholds whereby technologies would have to prove greater cost effectiveness more convincingly before being recommended for mandatory coverage by the NHS.

These may be better dealt with by NICE adopting a virtual NHS budget, in which it has to consider the opportunity costs of its decisions, and by recommending basic cost effective packages of care.

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Competing interests: NC was a member of the NICE Appraisals Committee between 1999 and 2002. KL, PW, DW, and JM work for York Health Economics Consortium, which undertakes work for a range of pharmaceutical companies, the Department of Health, and the NHS and has undertaken a cost effectiveness study for Guidant, which manufactures implantable cardioverter defibrillators. The original study was submitted to NICE as part of the assessment process.

1 Hine CE. Being NICE has advantages. Electronic response to: What's the evidence that NICE guidance has been implemented? bmj.com 2004. http://bmj.bmjjournals.com/cgi/eletters/329/7473/999#85904 (accessed 22 Apr 2005).

*Details of the eight other authors are on bmj.com*

### More recent data on NICE implementation show different picture

Editor—The National Institute for Clinical Excellence (NICE) has not recently woken up to the issue of implementing its guidance, as Freemantle alleges in his commentary on the paper by Sheldon et al.[1] The institute from its inception was acutely aware of the importance of its guidance being incorporated into routine clinical practice.[2]

In retrospect it was probably a mistake for NICE not to have been given explicit responsibility for monitoring the implementation of its guidance at the outset.[3] Nevertheless, the institute's own concerns, from the beginning, led NICE to ask the NHS research and development programme to commission research in this area. In June 2004 the institute launched an implementation support strategy,[4] headed by an executive director. In addition, the Healthcare Commission will put in place an inspection regime specifically for NICE guidance.

The study by Sheldon et al covers the earliest period of the institute's existence and pre-dates the direction now requiring trusts to fund NICE's appraisal guidance.[1 5] More recent studies—of which Freemantle seems to be unaware—give a somewhat different picture.

The most extensive has been that undertaken by Abacus International (www.nice.org.uk/pdf/Abacus_report.pdf), which covered 28 appraisals, for at least a year and included ones published after the direction came into force. The results show that 12 appraisals were implemented fully, 12 were incompletely implemented, and four over-implemented. More reviews are available on the NICE website (www.nice.org.uk/implementation).

NICE accepts that more needs to be done to secure full implementation of its guidance—hence its implementation support programme. But the facts show that Freemantle's incomplete commentary is very wide of the mark.

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1 Sheldon TA, Cullum N, Dawson D, Lankshear A, Lowson K, Watt I, et al. What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews [with commentary by N Freemantle]. *BMJ* 2004;329:999-1004.
2 Rawlins M. In pursuit of quality: the National Institute for Clinical Excellence. *Lancet* 1999;353:1079-82
3 Department of Health. *A first class service*. London: DoH,1998.
4 National Institute for Clinical Excellence. *Supporting the implementation of NICE guidance*. London: NICE, 2004.
5 Department of Health. Directions to primary care trusts and NHS trusts in England concerning arrangements for the funding of technology appraisal guidance from the National Institute for Clinical Excellence (NICE). DoH: London, 2003.

### Author's reply

Editor—Despite a spirited defence of the effectiveness of the National Institute for Clinical Excellence (NICE), the facts as described by Rawlins and Dillon do not add up. Using appropriate quasi experimental methods, Sheldon et al failed to identify good evidence that NICE has had an important impact on clinical practice, at least for the appraisals that they included in their review.[1]

This point seems to be accepted by Rawlins and Dillon, who direct us towards a review by Abacus International,[2] which they claim is more complete and up to date. This review is a simple audit of NHS activity and lacks the methodological rigour that characterises the paper by Sheldon et al and fails completely to use appropriate methods to examine the important issue of causation. Thus simply choosing areas where NHS practice was already changing to mirror NICE guidance would be sufficient for NICE to appear a success in the Abacus work.

In addition to concerns on the methodological weaknesses of the Abacus review,[2] some may question whether Abacus International provides objective and unbiased evidence or makes the best case possible for NICE. Abacus International is a for profit agency whose usual work entails providing services for industry. For example, the Abacus brochure describes how Abacus can create arguments that:

- Demonstrate that a product is more cost effective than its competitors
- Facilitate policy decision making despite shortfalls in long term outcomes data.[3]

Whatever the truth, two months ago the then secretary of state for health announced changes in the organisation of so called arm's length bodies, which amount to cuts of £3.5m ($6.4m; €4.9m) to NICE, to "free up funding for frontline care."[4] This, coming from the political masters, is hardly an unequivocal vote of confidence in the ability of NICE to influence clinical practice in line with evidence based guidance on effective and cost effective care.

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Competing interests: NF has received funding for research and consultancy from a variety of government, industrial, and charitable sources.

1 Sheldon TA, Cullum N, Dawson D, Lankshear A, Lowson K, Watt I, et al. What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews. *BMJ* 2004;329:999-1004.
2 National Institute for Clinical Excellence. *NICE guidance implementation tracking. Data sources, methodology and results.* www.nice.org.uk/pdf/Abacus_report.pdf (accessed 20 Mar 2005).
3 Abacus International. www.abacusint.com/downloads/abacus-Brochure.pdf (accessed 20 Mar 2005)
4 Department of Health. Reid confirms £150m savings from NHS efficiency drive. 18 March 2005. www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4106452&chk=eudPQe (accessed 20 Mar 2005).

## Influence of guidelines in determining medical negligence

Editor—In his article on the influence of evidence based guidelines in determining medical negligence Hurwitz argues to reject guidelines in favour of a "responsible body of medical opinion," the fundamental principle laid down in the Bolam test on the standard of care, as he cites.[1]

Eighty eight per cent of specialty guidelines did not give any information on searches,[2] yet they are accepted by most practitioners as the yardstick of clinical practice. A change in clinical practice on the basis of evidence based medicine is a recent phenomenon.[3] In 1957, when Bolam was pronounced, evidence based medicine, specialty guidelines, and institutions such as the National Institute for Clinical Excellence were not known. Therefore the principle laid down in the Bolam test, that of an ordinary skilled man exercising and professing to have a special skill, was important to the court's decision then.

The General Medical Council recommends following the guidelines. The Supreme Court of Western Australia rejected the responsible body of medical opinion principle in the Bolam test on the basis of a minority opinion.[4] In 1993 a court rejected that principle by replacing it with a test of reasonableness as in Bolitho (also cited by Hurwitz). Farquharson said that, although the judge may be guided by the

expert evidence, he or she is not on this issue to be directed by it. A responsible medical opinion should be rejected if it is unreasonable and does not stand up to critical analysis. Hurwitz then argues that guidelines are hearsay, and such evidence is not accepted in criminal courts or criminal jurisdiction, but the Bolam test and the current discussion are a civil matter. Hearsay evidence is always accepted in civil court proceedings.

Guidelines such as those issued by NICE allow Bolam principles in their grade A to grade D recommendations.[5] Guidelines are therefore better than a responsible body of medical opinion.

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Competing interests: None declared.

1 Hurwitz B. How does evidence based guidance influence determinations of medical negligence? *BMJ* 2004;329: 1024-8.
2 Grilli R, Magrini N, Penna A, Mura G, Liberti A. Practice guidelines developed by specialty societies: the need for a critical appraisal. *Lancet* 2000;388:103-6.
3 Guyatt G, Cook D, Haynes B. Evidence based medicine has come a long way. *BMJ* 2004; 329:990-1.
4 Cranley v Medical board of Western Australia (Supreme Court WA) [1992] 3 Med LR 94-113.
5 Bartlett J, Gallant JE. *Medical management of HIV*. Baltimore, MD: Johns Hopkins University, 2003.

## Sit up and take notice about avian flu

Editor—Gottlieb's report that research confirms human to human transmission of avian flu highlights what is now a true threat to the world's population.[1]

The tsunami in Asia illustrated one acute natural trauma with thousands of deaths. That catastrophe pales into insignificance when compared with an influenza pandemic. Hundreds of millions will die if the world does not act to prevent this developing pandemic. Development of vaccines against H5N1 needs government pump priming, as will the stockpiling of neuraminidase inhibitors, which should be effective against avian flu.

General practitioners and other prescribing practitioners must learn the practicalities of treating epidemic or pandemic influenza and be prepared to prescribe appropriately in all cases of true influenza, to gain experience with the available drugs as well as encouraging increased pharmaceutical company capacity.

It is many years since a pandemic struck, and people have become complacent in that time. For governments to bury their heads in the sand may have some benefits in many political areas but it will be disastrous in terms of pandemic planning.

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1 Gottlieb S. Research confirms human to human transmission of avian flu. *BMJ* 2005:330:211. (29 January.)

## Long term sickness absence

### Sickness absence, stress, and disaffection are linked

Editor—A great deal of sickness absence, as mentioned in the article by Henderson et al,[1] arises from the worrying trend to medicalise life. Much absence due to work related stress is in fact disaffection rather than disease. It manifests itself as unhappiness and anxiety with the working environment and becomes a withdrawal from work legitimised as a medical problem through certified absence.

Most healthy people of average fortitude who are given work that is interesting, satisfying, properly resourced, and professionally managed will turn up to do it. There is abundant evidence that such work is good for long term health. The reverse is also true. The common belief held by bad employers and some politicians that people are naturally work shy is an urban myth.

We need better management rather than better medicine. Good occupational physicians should use their influence to encourage good management in their own organisations, to make sure that stress risks are systematically and professionally assessed and be at the heart of rehabilitation in concert with the general practitioner. Good general practitioners will work with us to get their patients back to work.

With an ageing workforce and a difficult and rigorous pensions climate we are all going to be at work for much longer than before. Long term incapacity due to stress and early retirements, often on tiny pensions, are not sustainable options for the economy, pension funds, the NHS, or the future.

We have warehouses full of research and policies all saying the same things. What we now need is action on behalf of employers who believe that decency in the workplace makes good health and therefore business sense matched with action by doctors who believe that work should be part of their patients' solution, not their problem.

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Competing interests: None declared.

1 Henderson M, Glozier N, Elliott KH. Long term sickness absence. *BMJ* 2005;330:802-3. (9 April.)

### Motivation rather than ability to work may be key

Editor—Henderson et al write that sickness absence is a major public health and economic problem.[1] Undoubtedly, it is a major economic problem, but apparently it does not serve as an appropriate tool to measure public health.

Norway has some of the highest incidences of sickness absence in the world, but only 10% of the working population is responsible for over 80% of the absence.[2] Disorders of various origins that often lead to disability and unemployment have largely been neglected in medical research. The core complaints are often subjective and cannot be demonstrated by objective testing.

Apparently reasons for sickness absence have been considered political problems and have not gained sufficient attention from the medical and scientific communities. Methodologically rigorous, longitudinal, and interventional studies are needed to determine characteristics that are associated with the motivation to work rather than the ability. Interventions that seem effective in restoring this interest are needed in most industrialised countries. Such studies need to be directed towards the 10% that contribute to 80% of the absence, and not towards the entire working population.

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Competing interests: None declared.

1 Henderson M, Glozier N, Elliott KH. Long term sickness absence. *BMJ* 2005;330:802-3. (9 April.)
2 Nielsen PT. Exercise did not lead to less sickness absence [in Norwegian]. 22 October 2002. www.forskning.no/Artikler/2002/oktober/1035182667.9 (accessed 19 Apr 2005).

### General practitioners have crucial role but need political support

Editor—I believe that general practitioners, with their records and knowledge of these common conditions, are in the best position to make decisions on absence from work.[1] However, the system needs to change to reflect the greyness of most of these decisions. In some conditions there are no issues about absence—for example, severe angina. However, in many conditions prompting a review of the fitness to work, the clarity of the need to refrain can vary from reasonable to dubious/not indicated. These descriptions would change depending on how long the patient has been off work already.

Is there some way the general practitioner could indicate that status which would allow the employer or the benefits agency to add their opinion and even make the decision? The general practitioner can give an opinion that it is not clear whether the patient should work and whether working is unlikely to seriously impair the patient's health and then the employer or the benefits agency could use their knowledge of the job or jobs available to make a decision.

We need a more sophisticated system that retains decisiveness and speed. We need a system that does not put someone who is blind and has had both legs amputated in the same group as a young man with mild chronic depression. That system also needs to use the general practitioner's skills and knowledge in a way that does not threaten the general practitioner's therapeutic relationship with the patient.

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Competing interests: None declared.

1 Henderson M, Glozier N, Elliott KH. Long term sickness absence. *BMJ* 2005;330:802-3. (9 April.)