

A life in three parts

'I divided my life into three parts: in the first I learned my profession, in the second I taught it, in the third I enjoy it'

(Sir John Bland-Sutton (1855–1936); President of the Royal College of Surgeons, England)

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This quote rang a bell for me, because it is as true for general practice as it was for Sir John Bland-Sutton in his surgical career.

A recent response to Professor Sir John Tooke's investigation into the 2007 junior doctors' recruitment disaster provides a unified vision for the profession that has been supported by the British Medical Association (BMA) and all four chief medical officers, as well as many other medical organisations. The consensus¹ on the role of the doctor provides a charter for the whole profession.

- The doctor's role must be defined by the best interests of their patients and the wider population.
- Doctors must supervise the implementation of care and treatment plans by other members of the healthcare team and conduct medical research.
- All doctors must be committed to educating and training the next generation of clinicians.
- Doctors must have strong intellectual skills, be able to assimilate new knowledge and be capable of dealing effectively with uncertainty, ambiguity and complexity. It goes on to say that doctors alone, among healthcare professionals, must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well-developed clinical judgement. We also need good communication skills, the ability to work in teams and to show non-judgemental behaviour and empathy (not a characteristic of some surgeons I have worked with in the past!).

The Queen's Speech, which heralds a new legislative year, announced the NHS reform bill. The Royal College of Physicians' response to this bill,² which has the NHS Constitution as its centrepiece, welcomes the emphasis on the central role of patients, but highlights the need for caution regarding the creation of new rights, such as the right to choose where and when they are treated, because this may not necessarily confer benefits to patients over and above those opportunities that already exist.² 'Choose and Book' is also causing similar concerns among many of us in primary care!

Reflecting on clinical developments over the past year

Controversies are also causing us to rethink some areas of clinical practice in cardiovascular medicine and diabetes. Studies reported in 2008 saw the conventional wisdom regarding glycaemic control and the use of antiplatelet agents in diabetes being challenged. Diabetes imparts a two- to four-fold increased risk of cardiovascular disease (CVD). CVD is the greatest cause of death in people with diabetes, and microvascular complications cause significant morbidity and premature mortality. Therefore, much interest has focused on how tight the control of blood glucose should be in patients with diabetes.

Two major studies of intensive versus standard therapy published last year, Action to Control Cardiovascular Risk in Diabetes study (ACCORD)³ and Action in Diabetes and Vascular Disease (ADVANCE),⁴ were unable to identify significant improvement in important patient-orientated outcomes with intensive glucose-lowering therapy. And, even more worryingly, ACCORD showed that intensive therapy was associated with an increased risk of death.

Nevertheless, we should not throw the baby out with the bath water. Ten-year follow-up data from UKPDS⁵ suggest that the vascular tree has a glycaemic memory, and early control is very important in preventing long-term complications from occurring in the future. Ian Campbell charts the impact of UKPDS on clinical practice in primary care in this issue's key trial review on page 48. The secondary analysis of the original trial showed a continuous relationship between the risk of microvascular complications and glycaemia extending into the normal range of haemoglobin A_{1C} (HbA_{1C}), with no glycaemic threshold. The bottom-line is that any reduction in HbA_{1C} towards the agreed target of 6.5% should be seen as advantageous to future health, but that highly intensive management to levels of less than 6.5% should be avoided.⁶

The benefits of intensified, multifactorial interventions in type 2 diabetes, however, are that they not only reduce complications, but are also very cost-effective. The Steno-2 study, which compared intensive with conventional therapy

for eight years, showed that, from a health payer perspective, intensive therapy was more cost-effective than conventional treatment, assuming that patients in both arms were treated in a primary care setting. In this setting, intensive therapy became not only cost-effective, but also life-saving.⁷

2008 also saw confusion over the use of aspirin in patients with diabetes. The prevention of progression of arterial disease and diabetes (POPADAD) trial⁸ looked at the use of aspirin in subjects who had diabetes and early peripheral arterial disease, with negative results. However, this needs to be put in perspective because the trial was seriously underpowered (the annual CVD event rate was 3.2%, while the expected rate had been 8 to 12%). A confounding uncertainty in this trial concerns the effects of statins. In addition, the results contrast markedly with the results of a similar trial conducted by the CLIPS (Critical Leg Ischaemia Study) group,⁹ which showed benefit.

Therefore, the jury remains out on the use of aspirin in patients with diabetes. Certainly, patients with diabetes need lifelong aspirin after any sort of vascular problem, or if they have additional high-risk factors such as hypertension (assuming it is well controlled), hyperlipidaemia, smoking or a positive family history of cardiovascular disease. However, there may well be some low-risk patients with diabetes who do not benefit from aspirin. For a further general practice view on this important issue, see Alan Begg's review on page 54 of this issue of *PCCJ*. Two trials are currently in progress that will hopefully answer these dilemmas - ASCEND (aspirin +/- an omega-3 fish oil) and ACCEPT-D (statin +/- aspirin).

New series on smoking cessation

Smoking cessation is one of the most cost-effective healthcare interventions available, costing less than £1,000 per life-year gained,¹⁰ and starting in this issue of *PCCJ*, we will be running a series of articles on this topic throughout 2009. Most smokers want to stop smoking and intend to stop at some point, according to cross-sectional studies. Nearly half of all smokers expect not to be smoking in a year's time, but only two to three in every hundred actually stop smoking permanently each year. It is widely recognised that healthcare professionals have an important role to play in helping patients to stop smoking, but what is the best way to achieve this? Paul Aveyard, National Institute of Health Research Career Scientist, UK Centre for Tobacco Control Studies, Department of Primary Care and Clinical Sciences, University of Birmingham, Birmingham, UK, reviews how to choose the right pharmacotherapy for smoking cessation. In a second article, he looks at how primary care physicians can help smokers get more from nicotine replacement therapy (NRT).

At the more technical end of patient management, around 2.5 million percutaneous coronary intervention (PCI) procedures are now performed worldwide every year. However, in 2007, the landmark Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) study suggested that medical therapy was just as effective as angioplasty in patients with stable coronary artery disease. This caused widespread debate in the cardiac community and furore in the world of interventional cardiology. If angina is managed just as well medically as with intervention, why should any primary care physician refer these patients to a cardiologist? Smriti Saraf and Diana Gorog provide some answers to the question 'When is coronary revascularisation superior to medical therapy in patients with angina?' in their practical review of this issue on page 25.

"It is extremely difficult for a physician who puts too much trust in what he reads, to form a proper decision from what he sees!" warned Andrew Boorde (1490-1549), an English physician and Carthusian monk several hundred years ago. Hopefully, what you read in the *PCCJ* will help you take the right course when making those difficult decisions, in situations of clinical complexity and uncertainty - something GPs meet every day in their work in primary care!

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