

how is the GMC to be accountable for a register when entry, removal and prescriptions for remedial action are to lie outside its direct control?

The second issue that raises profound and unanswered questions is over the anglocentricity of most of the report's proposals. The Health Commission, the National Patient Safety Agency and its National Clinical Assessment Service have responsibilities in Wales, but none in Northern Ireland or Scotland. Medical regulation was a function reserved to Westminster at a time when there was a cohesive NHS operating within a common health policy in the four home countries. This is no longer the case and there may be questions raised as to whether it is still appropriate to regulate on a UK basis.

Finally, Donaldson emasculates the existing medical regulator by annexing its power to local NHS structures while, at the same time, denying citizens and patients of the single most important attribute that requires its retention as an independent, vigorous and fearless charitable body. The GMC is the only organisation that stands outside a near monopoly employer of doctors, a near monopoly provider of health services that, of necessity, rations the extent of health provision — the government and its departments of health.

Until now it has been the GMC that has been the final arbiter of what constitutes good medical practice, decisions based not upon that which can be provided within a

treasury budget, but upon what should be provided in the name of best care. The great danger of Donaldson's proposals is that the standards of medical care, the appointment of those who decide them and the parameters upon which doctors will be called to account, will all reside within the control of the government of the day and its civil servants. Those of us who believe in a professionalism mediated by standards rooted entirely within the public good hold serious concerns over that proposed shift in responsibility and accountability.

Good doctors and safer patients are aims earnestly to be desired by all citizens. The danger of fragmenting the existing structure of the GMC is that it could unpick its new cohesion of purpose and policy that naturally acknowledged the tragedy of Shipman, but had greater aims than merely the early discovery of sociopathic criminals among doctors. Even more dangerous, however, is that doctors who have been regulated since 1858 in a professional context are, in future, to be controlled and disciplined through a contract of employment by reference to standards, organisations and personnel that, in the final analysis, owe their power to the department of health and the patronage of its secretary of state. Some believe, wrongly in my view, that the GMC has allowed professional standards to slip in recent years: one can only wonder at a view that doctors would work better, harder and to higher standards for health service managers, than the vast majority currently

do because of pride in their profession. 'British medicine' is a phrase that has held credibility across the world for many generations before 1948 and presently is well placed to survive the demise of the NHS as we know it. That certainty is less secure under some of Sir Liam Donaldson's more controversial proposals and we can only hope that what many see as excess baggage does not compromise what lies at the heart of his report — better and safer medical care.

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Conflict of interest

Elected GMC Medical Member for Scotland, Chairman, GMC Pension Trustees, Deputy Treasurer, GMC and UK elected member, RCGP Council.

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Can early diagnosis and effective management combat the irresistible rise of COPD?

My stoical patient in the oxygen clinic was newly diagnosed with chronic obstructive pulmonary disease (COPD), having presented in a coma with severe hypoxia and hypercapnia. His lungs had been deteriorating for decades, now the potential to help him is severely restricted. Such extreme presentations indicate the problem of late diagnosis. For a disease where decline is largely preventable, the sight of patients dying slowly of COPD should be a

rarity — sadly it is becoming more common. Despite falling smoking rates, with the projected rise in the number of older patients, COPD prevalence is increasing, and the number of people with COPD reaching 85 years of age is projected to rise by nearly 75% by 2025.¹ Under-diagnosis and under-treatment contribute to the growing burden of human misery and healthcare costs. We need to know whether there are effective strategies to stop people

with early disease progressing, and if so, how to detect the disease early.

The natural history of COPD has been dominated by the Fletcher–Peto curve showing accelerated decline in lung function in susceptible smoker and the effects of smoking cessation.² However, it is not at all clear which patients with early airways obstruction will progress to more severe disease. Recent data from Holland showed that over 5 years, 33 of 399 male

smokers developed moderate COPD, a cumulative incidence of 8.3% and an average annual incidence of 1.6%. The risk of developing moderate COPD (reduced FEV1, 50–80% expected, and reduced FEV1:FVC ratio, <70%) was five times higher in those with early airflow obstruction (normal FEV1, ≥80% expected, but reduced FEV1:FVC ratio, <70%) than those with normal spirometry.³ Factors associated with progression include cough or respiratory general practice consultations and a history of childhood smoking. However, only about 20% of smokers show accelerated decline and genetic studies are likely to hold the key to identifying these individuals.⁴ Thus, advice for any individual with early airflow obstruction needs to be that they may be at higher risk, but not that they are at the start of a relentlessly progressive disease whose course can only be changed by stopping smoking.

Data from the Lung Health study indicate that once the FEV1 falls below 50% of expected, smoking cessation has little effect on subsequent decline in lung function.⁵ This is congruent with recent research which shows that the innate immune defence system is damaged in early COPD, which then allows bacterial colonisation of the lower airways and more severe airflow obstruction to develop.⁴ Key interventions such as smoking cessation are most likely to be successful in early disease.

At the other end of the severity spectrum, there are interventions that change prognosis.⁶ It is well established that long-term oxygen therapy reduces mortality and admissions in patients with respiratory failure. Likewise life-threatening respiratory failure during acute exacerbations can be effectively managed by non-invasive ventilation, and this is being made available more widely in the UK. Furthermore, lung volume reduction surgery will also improve outcomes in selected cases.⁶

For the majority of our patients falling between asymptomatic airflow obstruction and respiratory failure, there is growing evidence that we may be able to improve their prospects. Physical activity declines faster in patients with COPD than in age-matched controls.⁷ Inactivity results in reductions in muscle strength and bulk.⁸ Muscle bulk, measured by lean body mass or BMI, correlates with mortality, but this association has been shown to be reversible with nutritional therapy and exercise: if those

with low BMI put on weight their prognosis improves.⁹ Potentially, keeping physically active is not just about exercise capacity, it will improve mortality. Furthermore, lack of activity after an exacerbation is associated with early readmission.¹⁰ Patients should be made aware of the advantages of changes like exercise, diet and smoking. To change their behaviour patients need specific education, sadly optimum advice in primary care is rare.¹¹ Pulmonary rehabilitation has a Grade A evidence base,¹² improves symptoms, exercise capacity and quality of life, it causes few adverse effects. It can be life transforming in some patients, but is accessible to only 2% of those who need it in the UK.¹³

Drug treatments may affect disease progression. While the ISOLDE study failed to show that rate of lung function decline was slowed with inhaled steroids, there was a difference in the rate of decline in quality of life.¹⁴ Equally, the data on drugs reducing mortality is tantalising, but an effect is not proven — meta-analyses from pooled trial data suggests that inhaled steroids and long acting bronchodilators may reduce mortality.¹⁵ The definitive answer should come from a study on over 6000 patients and full results are due to be published shortly.¹⁶

Exacerbations affect patients in terms of quality of life and lung function, those with more frequent exacerbations have a faster long-term decline in these parameters.¹⁷ Early treatment improves outcomes of exacerbations and optimal drug treatment of the exacerbation itself prolongs the time to the next exacerbation.¹⁸ Inhaled steroids, long-acting bronchodilators and mucolytics can all reduce exacerbation frequency.¹³ To make the most of these treatment benefits, patients need to know how to recognise an exacerbation and what to do about it — unfortunately patient education is suboptimal.¹¹

Thus, smoking cessation, physical activity, diet and optimal drug management, including for exacerbations, can improve the prognosis for patients with COPD. The optimal benefits from smoking cessation and exercise will come if instituted early.

Currently, diagnosis occurs late if at all. The disease is present in representative samples in about 9% of adult populations.^{19,20} In the UK, it is detected in less than 2% of the population.¹² In a large survey in US, 72% of subjects with a mild airflow limitation and half of those with moderate-to-severe

obstruction remain undiagnosed.²⁰ COPD has an insidious onset with asymptomatic loss of lung function and it is only when the damage is advanced that classic symptoms of dyspnoea and cough occur. By this stage pulmonary reserves are damaged and, with a natural decline with time, patients can expect long-term problems.

Risk factors for COPD include current or previous cigarette smoking with at least 10 packs years, those with recurrent bronchitis or chest infections, symptoms of persistent productive cough or dypnoea.¹³ Screening patients by spirometry in primary care on the basis of smoking history and symptoms yielded a detection rate of 18% and 27% respectively, and was deemed cost effective.^{12,21} Active case finding does seem justified, but the case for large-scale screening of asymptomatic smokers remains contentious.

In general practice, getting spirometry performed and interpreted correctly is the first priority. It does not help having different severity grades in the different national and international guidelines. In the UK there are differences between NICE and Quality and Outcomes Frameworks in their conflicting advice on diagnostic criteria and reversibility testing. Primary care has much experience of living with conflicting advice and must, perforce, adopt a common-sense approach, until the advice is harmonised.

The Department of Health has now become increasingly exercised by the disease, belatedly some would say. Reports with emotive titles have now placed COPD centre stage, started by the Chief Medical Officers Annual Report 2004 *It Takes Your Breath Away*,¹³ and the Healthcare Commission's hard-hitting report *Clearing the Air — A National Study on Chronic Obstructive Pulmonary Disease* released to coincide with announcement of a new National Service Framework (NSF) for COPD.²² If that were not enough reports, the British Lung Foundation released the findings of their survey of patients' views on health care²³ and the British Thoracic Society released the second *Burden of Lung Disease* report.²⁴ Previously neglected, COPD has shambled, blinking and disheveled, into the limelight.

The NSF provides a major opportunity to change working practices in the NHS. The NSF will identify evidence-based good practice for the prevention, identification and management of COPD and its major

complications; put in place underpinning programmes to facilitate the NHS to deliver better quality services; and establish outcome measures against which local health communities can measure progress.

In the turbulent modern NHS, COPD provides a real test case for government policy on long-term conditions — a common disease, distressed and neglected patients, and potential for savings through avoiding admissions. COPD is the fourth leading cause of death worldwide and set to rise,²⁵ but we now have the evidence as to how to combat this global problem. Early diagnosis and active management can make real differences to the millions suffering to breathe.

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Obesity and the overworked GP

Almost the whole world has a problem — and for the UK, it is worse than most. The World Health Organisation has described obesity as one of the most blatantly visible, yet most neglected, public health problems threatening both developed and developing countries.¹ The prevalence of obesity in England almost tripled between 1980 and 1998, from 8% of women and 6% of men, to 21% of women and 17% of men.² Today, 59% of women, and 67% of UK men are overweight or obese, and the UK has one of the fastest growing rates of obesity in the world.³ The close correlation between increasing weight and incidence of diabetes, hypertension, dyslipidaemia and cardiovascular disease (CVD) contributes to the estimated annual cost of obesity to the NHS of over £500 million, and the annual

cost to the wider economy of £2 billion.²

It is imperative that we target high-risk patients for primary CVD prevention if long-term costs — and spiralling morbidity — are to be limited. It is equally essential to manage cardiovascular risk factors in patients with diabetes aggressively from an early stage, if we are to limit the long-term morbidity of the fastest-growing condition in the UK.

In terms of body mass index (BMI), a BMI above 25 is generally considered as overweight, and over 30 as obese. However, in recent years there has been a move towards considering lower thresholds of BMI for overweight and obesity for South Asians, because of their higher prevalence of obesity-related complications at lower BMI. Studies such as the INTERHEART study⁴

have emphasised the closer correlation between cardiometabolic risk and abdominal obesity (the definition of which is also subject to debate, but which is ascribed in the International Diabetes Federation (IDF) definition of metabolic syndrome as abdominal circumference >94 cm in Europoid men and >80 cm in Europoid women) rather than BMI.⁵

Of course, the obesity register can be put to good clinical use. The JBS2 guidance⁶ recommends that all patients over 40 years be assessed opportunistically for CVD risk. This is a daunting prospect, and simply unachievable in the short term. But do it we must — 40% of patients who suffer a CVD event have, at present, no indication that they are at high risk until they suffer sudden death from a myocardial infarction; 50% of