LETTERS

Letters are selected from rapid responses posted on thebmj.com. After editing, all letters are published online (www.bmj.com/archive/sevendays) and about half are published in print
To submit a rapid response go to any article on thebmj.com and click "respond to this article"

MULTIDISCIPLINARY TEAM MEETINGS

Time to review utility of multidisciplinary team meetings

POSED BY MODELS. MBI/ALAMY

Eigenmann is right to question the efficacy of multidisciplinary teams (MDTs),[1] which have become the accepted mode of working despite the flimsy evidence base.[2]

The consensus that MDTs are a good thing is rooted in several presumed benefits, such as standardisation and continuity of care, effective use of resources, improved trial recruitment, and safeguarding of patients (from maverick doctors).

Few of these benefits have been proved. The evidence in favour of MDT working is largely observational,[3] or inferred.[4]

Several unresolved concerns go against the perceived benefits:

- MDTs are large: one study reported an average of 14 attendees. Case discussions lasted four minutes on average,[5] which is unlikely to deliver the level of cross functional consideration that patients may assume their case will receive
- The MDT decides the patient treatment plan without the patient being present, which defies the principle of "no decision about me without me" and risks breaching the GMC good practice requirements to share information and discuss treatment options with patients before making treatment recommendations.

The suggestion that a patient advocate be present at the meeting is unlikely to be an adequate substitute for meeting the above principle. The proposal that patients be present at the meeting during discussion of their case is impractical.

A solution might be for doctors to discuss this with their patients before the meeting. Once referred, the patient's primary relationship is with the consultant, so it would be appropriate for the consultant to discuss the treatment judgment he or she has made to assess the patient's preferences before the MDT meeting.

The current MDT approach is labour intensive, threatens patient autonomy and confidentiality, and lacks substantive evidence of benefit. It is time to reconsider MDT working so that the problems can be resolved or alternatives considered.

Sarah Thornton lawyer commenting in a personal capacity, York, UK Hinyork@yahoo.co.uk

1 Eigenmann F. Multidisciplinary team meetings encourage overtreatment. *BMJ* 2015;351:h4630. (16 September.)

Cite this as: *BMJ* 2015;351:h5295

STATINS FOR PEOPLE AT LOW RISK

N-of-1 approach to determine adverse effects of statins

McPherson finds it shocking that a Cochrane review group is not interested in seeking data on adverse events associated with statins.[1] If he read our Cochrane reviews on statins he would see that findings related to adverse events are reported.[2] What is more shocking is that a systematic review of the adverse effects of statins using observational and randomised trial evidence that we submitted to *The BMJ* was rejected without review. The review was published and concluded: "The absolute excess risk of the observed harmful unintended effects of statins is very small compared to the beneficial effects of statins on major cardiovascular events."[3] Perhaps these findings did not chime well with *The BMJ*'s editors, who have taken a stand against widespread use of statins.

Doctors and patients often attribute adverse effects to statins, but the evidence we have from trials indicates that "Only a small minority of symptoms reported on statins are genuinely due to the statins: almost all would occur just as frequently on placebo."[4] The Cholesterol Treatment Trialists' (CTT) collaboration has developed a detailed protocol for collecting all relevant data from trials for a definitive study of the adverse effects of statins. CTT has engaged with a wide range of collaborators, including the Cochrane Heart Group, in setting up this new study.

This work will take some time to complete. In the meantime, further evidence is available from n-of-1 trials in which eight patients who had experienced myalgia symptoms while taking statins were randomly and blindly swapped between placebo and statin over repeat three week periods.[5] The frequency and severity of symptoms were indistinguishable when these patients were taking statins or placebo, making it unlikely that statins were causal. The authors suggested that doctors might find it helpful to use an n-of-1 approach to determine which patients' adverse effects are caused by statins, a view with which we concur.

Shah Ebrahim honorary professor of public health, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK shah.ebrahim@lshtm.ac.uk
George Davey Smith director, Medical Research Council Integrative Epidemiology Unit, University of Bristol, Bristol, UK

1 McPherson K. Need for proper trial protocols to assess side effects of drugs. *BMJ* 2015;351:h4303. (11 August.)

Cite this as: *BMJ* 2015;351:h5281

FUTILITY OF NAGGING

Value of behavioural medicine in avoiding nagging

McCartney is right,[1] nagging doesn't work: it assumes deliberate non-compliance, undermining patients' autonomy and intelligence. Some people need nudges (as I do to complete the review that has been sitting on my desk for 10 days) and others support (as I do to clear more urgent work to find time for that review), but few respond well to being treated like an ignorant lazy person.

Clinicians need exposure to the appropriate knowledge base of what motivates people to adopt healthy behaviour (health psychology) and to learn attitudes and skills to support motivation (behavioural medicine). Communication skills that are delivered by medical practitioners without a behavioural sciences knowledge base rarely emphasise skill building to spot the teachable moments in the consultation (thereby identifying change talk opportunities) and to respond appropriately to what patients want to do that their condition is stopping them from doing. Practitioners need to learn to help patients set achievable goals and action plans to achieve those goals; this means input from behavioural medicine specialists at all stages of learning.

Nagging someone to change is uncomfortable and ultimately demoralising; anyone with children knows how energy sapping it can be. This is an oft cited reason for burnout among practitioners working with patients with long term conditions.

Those interested in evidence based approaches to behaviour change could read the systematic review of motivational interviewing in long term conditions.[2] To understand the theoretical applications and the basics of skills to support motivation, two other works are recommended.[3 4]

Chris Bundy reader, behavioural medicine, University of Manchester, Manchester M13 9PT, UK
christine.bundy@manchester.ac.uk

1 McCartney M. Nagging people is a futile exercise. *BMJ* 2015;351:h4515. (24 August.)

Cite this as: *BMJ* 2015;351:h5291

Nagging policy makers as part of strategy to effect change

McCartney raises several important points on the futility of nagging patients to be more physically active.[1] Her alternative to nagging patients is to nag policy makers. This strategy has merits, particularly if part of a comprehensive campaign.

Examination of any guides on how to influence policy finds that relationship building is key. The public health and medical communities have come a long way from the idea that the cold presentation of facts will hold sway—undoubtedly a positive sign. Although progress may be slow, reverting to nagging alone is not the way forward.

Recent public health successes, such as legislation on standardised packs for tobacco (passed in England in March 2015), have relied on multiple elements of the public health community coalescing around a single goal. The campaign was built around constructive dialogue with policy makers, haranguing from the side lines, and the building of public support. Current campaigns such as Action on Sugar and the subsequent Scientific Advisory Committee on Nutrition recommendations on halving sugar intake illustrate the potential of nagging policy makers combined with constructive engagement. Further evidence comes from Smith's summary of Hochschild's excellent book *Bury the Chains* on the campaign to abolish slavery.[2] Key elements of that campaign included a business-like strategy, constant action on many fronts, and cooperation between policy insiders and external agitators. The MP William Wilberforce was a friend of the prime minister and acted as a powerful insider to complement Thomas Clarkson, an activist who travelled the country giving powerful public speeches and vociferously agitating for change.

Anthony Laverty research fellow, School of Public Health, Imperial College London, London W6 8RP, UK a.laverty@imperial.ac.uk
Simon Capewell professor of clinical epidemiology, Department of Public Health and Policy, Institute of Psychology, Health and Society, University of Liverpool, Liverpool, UK

Cite this as: *BMJ* 2015;351:h5293

RESPONSE

Rachel Clark and colleagues reply to Eleanor Barry and colleagues

Eleanor Barry and colleagues' editorial relays their concerns about the NHS Diabetes Prevention Programme (DPP).[1] Key concerns are dealt with here. The NHS DPP will offer people already identified as being at high risk of developing type 2 diabetes an opportunity to lower their risk through provision of an evidence based behavioural intervention. By failing to implement such a programme, people with known non-diabetic hyperglycaemia are deprived of consistent and evidence based support that would empower them to reduce their risk of type 2 diabetes, questioning our commitment to the public's health and wellbeing.

We agree that there is a need for multi-level action. Both NHS England and Public Health England (PHE) published plans last year with a focus on improving diet, increasing levels of physical activity, and obesity prevention and treatment.[2 3] We are looking forward to seeing the government's promised strategy for tackling childhood obesity. The NHS DPP provides an opportunity to target people at high risk of diabetes as part of a population level approach to prevention. We recognise that the programme alone will not provide an answer to the growing incidence of diabetes, but it should make an important contribution.

Concerns raised about our intervention and our "five doubtful assumptions" are speculative: people at high risk of diabetes are already being identified through blood tests based on guidelines set by the National Institute for Health and Care Excellence (NICE) in 2012[4]; we anticipate that there will be lessons to learn on recruitment and retention of participants and will work to optimise these areas; we will look at how best to support maintenance of challenging lifestyle changes; and our economic modelling for the programme suggests it will be both affordable and cost effective.

Claims about how PHE "justifies its proposed policy" are inaccurate. PHE's meta-analysis supporting the development of the NHS DPP was peer reviewed before publication.[5] Its methods were largely derived from a previous meta-analysis, which was published in a peer reviewed journal[6] and used to inform NICE guidelines.[4] The review provides the most up to date evidence available regarding the effectiveness of DPPs targeting high risk groups and supports the proposition from controlled clinical trials that such interventions can be effective.[7-9]

Meta-analysis findings were scrutinised and used alongside NICE guidelines,[4] in close consultation with a group of external experts, to develop the first draft of a service specification. Evidence from implementation of DPPs was also drawn upon.[10 11] We are consulting on this draft specification with the public, health professionals, and potential providers,[12] and we are working with seven demonstrator sites to generate local evidence on practicalities associated with programme implementation through independent formative evaluation.

Implementation of the programme will be iterative, with integrated evaluation and ongoing adaptation to ensure that the programme reaches those who need it most and to maximise effectiveness. We will work with researchers to generate new evidence and fill gaps in the existing evidence base. Design of the NHS DPP will evolve in parallel, ensuring it is as robust as possible

The commitment of the NHS to the DPP is a pivotal moment in public health. It is the first national behaviour change programme in England and could lead to broader investment in prevention in the longer term. In prioritising the NHS DPP, the NHS—in partnership with Diabetes UK and PHE—has prioritised prevention. PHE has responded accordingly through supporting NHS England in developing an evidence informed intervention that will be continuously improved and evaluated appropriately over coming years.

For anyone interested in contributing to the NHS DPP we encourage you to get in touch by emailing diabetesprevention@phe.gov.uk.

Rachel Clark evidence lead, NHS Diabetes Prevention Programme, Public Health England, London SE1 8UG, UK
Jonathan Valabhji national clinical director for obesity and diabetes, NHS England, Leeds, UK
Alison Tedstone national lead diet and obesity and chef nutritionist, Public Health England, London SE1 8UG, UK
Louise Ansari director of prevention of type 2 diabetes, Diabetes UK, London, UK
Jim O'Brien national programme director, NHS Diabetes Prevention Programme, Public Health England, London SE1 8UG, UK

Full response at: www.bmj.com/content/351/bmj.h4717/rr-2.

1 Barry E, Roberts S, Finer S, et al. Time to question the NHS diabetes prevention programme. *BMJ* 2015;351:h4717. (7 September.)

Cite this as: *BMJ* 2015;351:h5301