DiabetesDIGEST
The easy way to stay up to date with developments in diabetes

Editorial

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Editor

Data equals power: Ensuring medications 'do what they say on the tin'

'It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts'
– Sir Arthur Conan Doyle

Driven by the intoxicating brew of politics, money and self-interest, diabetes care as we know (and used to love) is self-destructing. 'Move everything, including the specialists, into primary care' is the rallying call of the economically inclined. With this in mind it is not surprising that the speciality has an image problem. Maybe one should take a different view, starting with the future, moving to the present and learning from the past. For example, in the not-too-distant future there will be available a bewildering array of new treatments, insulin delivery systems and monitoring devices including:

- incretin mimetics
- dipeptidyl peptidase IV (DPP IV) inhibitors
- inhaled insulins
- pramlintide
- glucagon antagonists
- patch pumps
- interstitial glucose monitoring systems.

These will become available in addition to what is currently in use, although may not all successfully pass over the NICE hurdle. However, one needs to remember that there are two practical questions related to any new treatment:

- Which patients should have them?
- In which order or combination should they be used (if at all)?

There is also the question of whether they actually work and continue to be effective in routine clinical care, where patients are often very different to those recruited into clinical trials. Clearly, if the manufacturers are asked the above questions, their answers will be blindingly obvious…! Moreover, with the increasing complexity of diabetes care, it is self-evident that no single individual or small group of individuals can be expected to know everything.

The future seems to be one of people with diabetes agreeing their goals of treatment with the healthcare professionals, having access to whatever it takes to reach those goals (provided they are cost-effective). At the same time professionals need to have the courage to withdraw treatments that are not producing any benefit – that is, 'contracting' with service users (sorry, patients) at the outset. However, cost-effectiveness is not usually recognised by the service user as an outcome of diabetes care that matters to him or her.

For any new development, we would encourage companies to provide sufficient (although, likely to be small) resources to prove prospectively that their new treatments 'do what they say on the tin', that is, work in routine clinical practice. There will have to remain levels of expertise among healthcare professionals but without barriers to accessing specialists. Simply introducing choice may not improve standards of care. For professionals, prove that what you do works; the philosophy is simple – data equals power.