effectiveness and cost effectiveness of many non-surgical treatments—such as self care, analgesia, anti-inflammatory drugs, and physiotherapy directed exercise—is lacking. We cannot assume that generic programmes are the best way to achieve changes in confidence, attitudes, and other psychosocial variables in all patients with osteoarthritis, or that such changes will be large enough to alter the future course of the disease. The government is committed to increasing the number of places on the expert patient programme, which is similar to the challenging arthritis programme, from the current capacity of 12 000 to 100 000 by 2012. The growing body of evidence about self management programmes stresses the need to question whether this policy will achieve its desired outcomes, namely long term gains in health coupled with reduced use of healthcare services.

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Advance care planning in primary care

Uncomfortable, but likely to engender hope rather than dispel it

Of the various trajectories of physical decline, organ failure is often the most difficult to plan for in advance because of its unpredictability. The qualitative study by Davison and Simpson in this week’s BMJ challenges the notion that early discussion of planning for the end of life will destroy hope rather than create it. Rather, it allowed patients dying of end stage renal failure and their carers to reflect on and reorient their aspirations.

A wealth of evidence indicates that many elderly patients want to discuss these issues with their healthcare professionals, but this rarely happens even when (as in the United Kingdom) continuity of care with a trusted general practitioner is the way to achieve changes in confidence, attitudes, and other psychosocial variables in all patients with osteoarthritis, or that such changes will be large enough to alter the future course of the disease. The government is committed to increasing the number of places on the expert patient programme, which is similar to the challenging arthritis programme, from the current capacity of 12 000 to 100 000 by 2012. The growing body of evidence about self management programmes stresses the need to question whether this policy will achieve its desired outcomes, namely long term gains in health coupled with reduced use of healthcare services.

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Age related macular degeneration

Better tools are needed to measure quality of life and visual outcomes

Wet (also known as neovascular or exudative) age related macular degeneration is a common condition of poorly understood aetiology that affects around two million elderly people in Europe.¹ In the United Kingdom, in about a quarter of a million people wet macular degeneration causes bilateral visual impairment of sufficient severity that they are registered as partially sighted or blind.² If only one eye is affected the onset of disease may go unnoticed by the patient. Wet macular degeneration is usually bilateral though, and when the second eye becomes affected the impact on the patient is devastating.³

Good vision is often taken for granted. It is an important prerequisite for a socially fulfilling and active lifestyle. Wet macular degeneration affecting both eyes has serious consequences for quality of life. The psychosocial and functional impact of sight loss due to this condition is reviewed in a paper by Davison and Simpson.⁴ Their findings need to be confirmed in other populations (the patients studied were almost exclusively white) and through implementation studies to evaluate how best the proactive approach improves outcomes of patients. That said, considerable evidence supports the integration of advance care planning into routine practice as part of good care for all people with progressive life threatening illnesses. Planning for death with our patients may be an uncomfortable concept but is likely to engender hope rather than dispel it.

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