Effectiveness and Efficiency shortcomings as reflected in the influential Cochrane's arguments about medicine's being altered" (2). It may well be the wrong parameter that is more good than harm. In mature diabetes 'normalizing' the distribution must do some biochemical parameter is abnormally treated. Unsystematic approaches have led to advice on some highly effective forms of health care being delayed for many years (4), whereas other recommended forms were proven to be deleterious once a systematic review was accomplished (5).

Twenty years after Cochrane's initial reflections, these concepts crystallized in the Cochrane Collaboration. The Cochrane Collaboration is an international nonprofit organization whose aim is to make up-to-date accurate information about the effects of health care readily available worldwide. The purpose of this international network is to prepare, maintain, and disseminate systematic reviews of the effects of health care, thus providing an extremely valuable source of evidence on the validity of health care interventions. Within the Collaboration, individuals sharing an interest in assessing evidence related to specific health problems have organized themselves into review groups. The activities of the Collaboration are directed by an elected steering group and supported by staff in Cochrane centers around the world. Over the last 10 years, the growth of the Collaboration has been exponential. The Collaboration has a current membership of several thousand active participants worldwide and 50 review groups covering virtually all aspects of health care.

The major output of the Collaboration is the Cochrane Library (updated quarterly), which is distributed both on CD-ROM and via the internet (http://www.update-software.com). In particular, the Cochrane Library consists of the Cochrane Database of Systematic Reviews, which is prepared mostly by health care professionals. Currently, 795 complete reviews are available. Furthermore, information on an additional 1,634 quality-assessed systematic reviews is provided. The Cochrane Controlled Trials Register offers more than 260,000 RCTs or controlled clinical trials (CCTs) (i.e., no clear-cut randomization procedure was applied) compared with ~170,000 identified when searching for RCTs/CCTs on MEDLINE (January 2000 estimate). This important difference results from the Collaboration's efforts to collate all detected RCTs/CCTs from MEDLINE, EMBASE, and other databases. It is augmented by each collaborative review group's commitment to search by hand its own specialist literature as a contribution to the development of a comprehensive international trials register and to try to identify unpublished trials.

A Cochrane diabetes group was registered as early as 1994 and started with much enthusiasm. Unfortunately, in 1998, its activities had to be terminated due to lack of funding. Revival efforts by the Department of Metabolic Diseases and Nutrition, Heinrich-Heine-Universität, Düsseldorf, Germany, led not only to a continuation of the work of the old group, but also to an expansion of its scope to that of a Cochrane Metabolic and Endocrine Disorders (CMED) Group (http://www.uni-duesseldorf.de/WWW/MedFak/MDN/Cochrane), which was officially registered in February 2000. The CMED Group's primary concern is the evaluation of RCTs and other controlled comparisons of health care interventions relevant to the prevention, treatment or management, and rehabilitation of metabolic, nutritional, and endocrine disorders.

The CMED Group considers a wide range of outcomes, but patient-oriented end points, such as health-related quality of life, morbidity and mortality, specific indicators of well-being, and cost-utility/benefit issues, have to be integral parts of every review. A plethora of studies reporting surrogate end points are expected, and these may still con-
tain valuable information regarding adverse effects, which should also be evaluated in every review. These data, usually presented as incidental findings (e.g., reasons for dropping out of a study), contribute valuable details that might otherwise be overlooked (6).

The CMED Group values consumer input highly; therefore reviews are prioritized, questions formulated, and results presented in a way that is most useful to the people most concerned—the patients. The editorial base in Düsseldorf will offer any reviewer maximal support from title registration to review updates. This includes training, team-building facilitation, help with trial searching, as well as methodological and statistical support. Quality is controlled by the editorial board, which ensures internal and external multidisciplinary and international peer-review feedback through every stage of a Cochrane review. A comments and criticism editor deals with queries after the publication of a systematic review in the Cochrane Library. Responses eventually become part of the review itself, thus elucidating the dynamic character of an electronically produced database for improving health care.

Collaboration between the American Diabetes Association and the CMED Group could occur in several areas: Cochrane reviews could be used for the development of adequate evidence-based guidelines. Once relevant public health issues are dealt with, orientation for practicing diabetologists is facilitated on a national and international basis, especially when cultural/ethnic differences and distinguishing characteristics of developing countries are taken into account (e.g., by specific examination of heterogeneity between trials). Because patient synopses will soon be part of every Cochrane review and consumers will play a pivotal role, Cochrane reviews will be an important element for patient-informed decisions. Undoubtedly, many systematic reviews will demonstrate research gaps. This is not a “negative” finding but an invaluable identification of areas requiring allocation of resources.

The tasks undertaken by the Cochrane Collaboration and the CMED Group are enormous. They will be achieved because people will offer their skills and time, but such tasks also require firm funding structures. Beyond reviewer participation, there are many ways to get involved (e.g., as an editor, referee, consumer representative, methodology expert, handsearcher, translator, etc.). Ultimately, all efforts are directed to contribute to improving patient care. The health of present and future generations depends on our ability to identify and apply affordable forms of health care that do more good than harm. With regard to the Cochrane Collaboration, this is diabetology’s second and, maybe, last chance. Let us use it.

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