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LETTERS

CHRONIC DISEASE TO TOP AGENDA

Legislation trumps individual interventions



MALCOLME WILLETT

Godlee highlights the potentially powerful interventions to prevent chronic disease¹ also recommended in Piot and Ebrahim's editorial. The articles by Reckless, Hingorani and Hemingway, and Khunti and colleagues detail the limitations of tablet based primary prevention of cardiovascular disease, but none mentions what makes population wide policy interventions a “best buy” for rich and poor countries alike. In brief, they are powerful, rapid, equitable, acceptable, and cost saving.

Recent National Institute for Health and Clinical Excellence guidance on cardiovascular disease prevention in populations reviewed the evidence.²

Powerful—The NHS Health Checks scheme is expected to cost over £250m (€298m; \$405m) annually to prevent or postpone around 650 cardiovascular deaths a year.³ This compares badly with the 7000-10 000 fewer deaths achievable by legislation to ban industrial *trans* fats (as in Denmark and elsewhere⁴); over 10 000 fewer deaths after substituting polyunsaturated fats for saturated fats; and 14 000-20 000 fewer deaths after reducing daily salt consumption by 3 g (5 g has been achieved in Finland and elsewhere).²

Rapid—These mortality reductions could occur quickly, within a few years.²

Equitable. Individual based prevention interventions tend to favour affluent groups, thus widening inequalities. Population wide policies tend to narrow the gap.⁵

Acceptable—Few previously “healthy” adults welcome committing to daily tablets for the rest of their lives. Conversely, most people support discreet and usually unnoticed improvements in the salt and fat content of processed food.² Smoke-free legislation has proved acceptable.

Cost saving—Legislative interventions are relatively cheap to implement—witness smoke-free and seatbelt legislation. Given the thousands of cardiovascular deaths that would be prevented every year, billions of pounds could be saved.² Such substantial savings are consistent with studies using different methodologies in Australia and the US.

Simon Capewell professor of clinical epidemiology, Division of Public Health, University of Liverpool, Liverpool L69 3GB, UK capewell@liverpool.ac.uk

Klim McPherson visiting professor of public health epidemiology, New College, Oxford, UK

Competing interests: SC and KMCP were both members of the NICE programme development group on CVD prevention in populations. However this article does not necessarily represent the views of NICE.

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Beware tobacco companies' spurious financial arguments

Despite the economic and health related gains of smoke-free legislation, those who oppose such legislation have suggested that it affects the revenue from the hospitality industry. Countries whose economies are under financial strain, such as Greece and Spain, are vulnerable to such pressure, and efforts should be made to stress that smoke-free legislation has no such effects.^{1 2}

Actions such as those seen in Greece, Cyprus, and the Netherlands to pressurise governments into softening smoking legislation because of financial implications do not reflect regional peculiarities but are well organised campaigns by the tobacco industry, which knows no borders.³ Just as the euro as a currency depends on common EU activities, tobacco control across Europe depends on the actions of each member state. A common front is therefore imperative to protect the population's wellbeing. Resistance to such pressure should be strengthened at the EU and international level.

Whether it is Greece, Spain, or Ireland, the forces attempting to undermine public health

are the same. Health is a fundamental right of EU members that knows no divisions and should not be subservient to the economic development of manufacturers of products that deny their EU customers the fundamental right to a long and healthy life.

Constantine I Vardavas visiting research scientist, Center for Global Tobacco Control, Harvard School of Public Health, Boston, MA 02215, USA
vardavas@hsph.harvard.edu

Panagiotis K Behrakis president, European Network on Smoking and Tobacco Prevention (ENSP) and Harvard School of Public Health

Gregory N Connolly professor, Center for Global Tobacco Control, Harvard School of Public Health, Boston, MA 02215, USA

Competing interests: None declared.

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Cardiorespiratory fitness is an important risk factor

Our research has shown that schizophrenia is associated with a 25 year reduction in life expectancy.¹ The top four mortality risk factors were low fitness, hypertension, smoking, and diabetes. The World Health Organization identified these same top four risk factors in the general population.² Blair reported that physical inactivity with low cardiorespiratory fitness was the major public health risk for all cause mortality in Western society.³ Moreover, he highlighted a failure of primary care to assess this risk factor, with its focus on traditional risk factors (hypertension, cholesterol, diabetes, and body mass index). Meta-analysis confirms cardiorespiratory fitness as a valuable indicator of cardiac and all cause mortality risk, equivalent at least to traditional risk factors.⁴ Muscular strength is an independent positive factor.

Hingorani and Hemingway reviewed the debate about balancing the individual and population benefits of statins for preventing cardiovascular disease,⁵ and a Cochrane review suggests they have few benefits in primary prevention.

In public health the debate about lowering cardiac risk in the general population in those

at low and high risk should include assessment of cardiorespiratory fitness. A public health campaign to improve fitness would have many benefits, including improvement in cardiac and all cause mortality risk factors. In an ageing population, improved fitness would help to maintain elderly people's independence without the well documented side effects of statins. Prescription of exercise and strength regimens should be routine and may cost little or nothing at all.

Michael Beary consultant psychiatrist, Priory Hospital North London, London N14 6RA, UK bren.mikebeary@gmail.com

Hiram J Wildgust retired neurochemist, Hiram Consulting, Pontefract, UK

Competing interests: None declared.

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Stroke and dementia are also chronic diseases

Piot and Ebrahim argue for a more effective and forceful approach to preventing chronic disease and point out that the weight of the burden is shifting to low and middle income countries.¹ This is particularly important for older people, because the largest numbers now live in these countries and they have more chronic disease.

Definitions of chronic disease are also arbitrary and circumscribed. They seem dated in light of modern understanding of the two most important causes of morbidity and mortality in later life—stroke and dementia—which are often omitted from such discussions.

Stroke is increasingly seen as a chronic disease with acute events,² and the aetiology of the most common form of dementia, Alzheimer's disease, is intimately linked with cardiovascular and cerebrovascular disease.³ Studies show that these diseases are also important causes of morbidity and mortality in low and middle income countries.^{4,5}

Encouragingly, some countries, such as Ireland and the US, are starting to redefine stroke as a chronic disease and this is also reflected by recent iterations of chronic disease by WHO. However, dementia still lags behind in this respect.

This lack of consistency undermines the intellectual coherence of chronic disease as a concept, and it hinders the development of the widest possible coalition of professional and lay advocates to promote better prevention and management. Failure to adopt the principles of geriatric medicine and gerontology for these age related chronic diseases also reduces our ability to factor in effective management strategies to account for the comorbidity and complexity that accompanies chronic disease in the group most affected—older people.

Desmond O'Neill president, European Union Geriatric Medicine Society doneill@tcd.ie

Competing interests: None declared.

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JIM VARNEY/SPL

ANTICOAGULATION IN AF

Anticoagulation uptake remains poor in high risk patients

Olesen and colleagues validate the predictive value of the CHA2DS2VASc score among patients admitted to hospital with atrial fibrillation (AF), showing its superiority to the traditional CHADS2 score in identifying patients at low risk of stroke.¹ However, even among patients with identified atrial fibrillation and identifiable risk factors, the uptake of anticoagulation in the UK continues to be worryingly poor.

A primary care database interrogation tool developed by the West Yorkshire Cardiac Network was used to calculate CHADS2 score among

patients with atrial fibrillation. It was applied nationally in over 310 practices in 48 primary care trusts in more than 47 000 patients with atrial fibrillation; only 51.4% of patients at high risk (CHADS2 >1) were receiving warfarin. A cohort of 228 000 patients in York primary care trust were assessed for contraindications to warfarin. Only 27% of the untreated high risk population had absolute contraindications to warfarin. The commonest reason for not giving warfarin to them was the reluctance of physicians to prescribe it.

Thus the barrier to prescribing anticoagulants even to high risk patients must be overcome. Ironically, the current iteration of the Quality and Outcomes Framework for atrial fibrillation does not indicate the value of any risk stratification. Even among high risk patients, it rewards equally treatment with aspirin or warfarin, despite considerable evidence of the superiority of warfarin at no excessive risk of bleeding.²

The undoubted value of a CHA2DS2VASc score in detecting patients at low risk should not deflect from the main task of appropriately treating high risk groups, however they are identified.

Campbell Cowan national clinical lead for arrhythmias, NHS Improvement—Heart, General Infirmary at Leeds, Leeds LS1 3EX, UK campbell.cowan@leedsth.nhs.uk

Matthew Fay national clinical lead for stroke prevention, NHS Improvement—Stroke, Westcliffe Medical Centre, Shipley, West Yorkshire BD18 3EE, UK

Kathryn Griffith president, Primary Care Cardiovascular Society, Dr Price and Partners, York YO10 4DU, UK

Damian Jenkinson national clinical lead for stroke, NHS Improvement—Stroke, Royal Bournemouth Hospital, Bournemouth BH7 7DW, UK

Competing interests: None declared.

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GENERALISED ANXIETY DISORDER

Recommendation on sertraline

The National Collaborating Centre for Mental Health and the National Institute for Health and Clinical Excellence point out that one of the recommendations in the summary of NICE guidance on the management of generalised anxiety disorder in adults was reworded before publication of the guideline but after acceptance of the *BMJ* manuscript.¹ The recommendation in the guideline now reads:

“If a person with generalised anxiety disorder chooses drug treatment, offer a selective serotonin reuptake inhibitor. Consider offering sertraline

first because it is the most cost effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. Monitor the person carefully for adverse reactions.”

Tim Kendall director, National Collaborating Centre for Mental Health, Royal College of Psychiatrists, London E1 8AA, UK
tim.kendall@shsc.nhs.uk

Competing interests: None declared.

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RESEARCH REGULATION

Limits of anonymisation in NHS data systems

Smyth discusses the recent report from the Academy of Medical Sciences on research regulation.¹⁻² The expert group's reliance on anonymity to protect participants in research was based on assumptions about key NHS patient data systems that may no longer be justified in an era of ubiquitous data generation and sharing. The report also pays insufficient attention to patient autonomy. Patients are not currently being adequately informed about possible secondary uses of their medical data for medical research; are not asked to give clear, specific, free, and informed consent; are not offered unambiguous and effective opt-outs; and are misled about the degree of anonymisation of their data and the likelihood of re-identification.³

Extraction of medical data through the NHS Secondary Uses Service for “health research” requires neither the consent of patients nor authorisation by the National Information Governance Board if the data are pseudonymised. The House of Commons Health Committee distinguished between “fully” and “partially” pseudonymised data, noting claims from various scientists that full pseudonymisation of data would seriously hamper important medical research.⁴ This argument is repeated in the academy's report.

However, “partial pseudonymisation” is nothing of the sort: it is a euphemism to describe measures that might prevent immediate identification of individual patients by the person using the data but which do not make re-identification impossible or even difficult. Indeed, they are specifically aimed at keeping data that will open up the possibility of re-identification of patients.³ Such limited measures mean that, in data protection law, the data remain identifiable, and thus as “personal data” are subject to UK and European data protection rules.

To insist that regulation should not interfere with researchers' access to health records or

record linkage capabilities is irresponsible. Though important, anonymity alone cannot be relied on to protect the interests of participants. Providing choices about participation in research through consent remains the most appropriate mechanism to protect people's privacy. We welcome the report's calls for engagement with the public on these issues. This engagement must be meaningful and take account of serious public concerns over the use of patient records without individual consent⁵ if public trust in the NHS is to be maintained.

Ian Brown senior research fellow, Oxford Internet Institute, University of Oxford, Oxford OX1 3JS, UK
ian.brown@oi.ox.ac.uk

Lindsey Brown research associate, School of Social and Community Medicine, University of Bristol, Bristol BS8 2PS, UK

Douwe Korff professor of international law, Faculty of Law, Governance, and International Relations, London Metropolitan University, London E1 7NT, UK

Competing interests: None declared.

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GETTING WELFARE TO WORK

How the DWP sees GPs

McCartney's investigation into the role of Atos in providing medical reports to the Department for Work and Pensions (DWP) draws attention to the disregard shown to the advice of claimants' GPs in deciding benefit eligibility.¹ This raises issues for the medical profession.

A DWP submission to an appeal tribunal in Scotland in early 2009 said: “Commissioners have stated that the evidence of a medical adviser is both disinterested and informed and is normally to be preferred to that of the claimant's GP because the GP is likely to be subject to pressure from the claimant.”

Thus, DWP decision makers almost inevitably rubber stamp the reports of “approved healthcare professionals,” because they are explicitly directed to distrust the advice of GPs. Moreover, the DWP's view that “worklessness” is harmful implies that GPs tend to harm their patients, whereas the “tough love” of the DWP and Atos “rescues” them.

The reality is different. In doing research with Oxfam and the Clydebank Independent Resource Centre, I encountered the inappropriate, wasteful, and counterproductive operation of the Welfare to Work programme under Labour.² It seemed to



be primarily about getting welfare to work for the likes of Atos and the members of the Employment Related Services Association. The whole warped process was often so traumatic that people ended up more ill and further from being able to work, despite the best efforts of GPs.

The coalition government has been intensifying the operation of Welfare to Work. McCartney rightly highlights the vital questions of ethics and fairness this poses for the medical profession.

But perhaps the most surprising thing is the level of tolerance displayed by the profession towards the DWP's pointed challenge to the status, legitimacy, and integrity of GPs.

Chik Collins senior lecturer, School of Social Sciences, University of the West of Scotland, Paisley PA1 2BE, UK
chik.collins@uws.ac.uk

Competing interests: None declared.

- 1 McCartney M. Well enough to work? *BMJ* 2011;2011;342:d599. (2 February.)
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Health professionals' advice: the ethics

When the speakers at the Atos recruitment evening told McCartney that they describe the assessment for the Department of Work and Pensions (DWP) as being of claimants, not patients, they were not talking about nuance of language or “sending a message.”¹ The claimants are not the medical assessor's patients. Therefore the over-riding ethical principle of the General Medical Council, “make the care of the patient your first concern” does not apply here. Medical ethics requires general probity on the part of doctors in any situation, and this applies here too, of course. But the first duty of the assessor is to supply, with the consent of the claimant, honest advice to the DWP on the most likely correct numerical score for the statutory descriptors in the test, or whether in his or her judgment defined exceptional circumstances apply, which should exempt the claimant from needing a score.

The Atos health professional does not decide whether the claimant has “limited capability for work”—this has been defined by

parliament—but only what he or she has scored on the descriptors for reasons that should be made explicit. There is scope for a judgment by the assessor on whether being found capable of any kind of work would be risky, and this judgment is, I find, often not made as boldly or as wisely as it should be, at least in cases that come to appeal. The assessor also generates an awkward sentence, thanks to the preformed phrases of the computer generated report: “I advise that a return to work could be considered within [n] months.” This looks silly when the claimant is not being assessed as incapable of work in the first place, but it is not absolutely illogical or ungrammatical.

The DWP decision maker then makes the decision, using the assessor’s advice. As the Harrington report says, this is made too much of a rubber stamping exercise, but it is still the DWP’s decision to make.

I write to help to clarify thought, not to justify the tests, their standard of performance, the benefits, Atos, the DWP, the law, the government, or parliament. That would be a very different matter.

Edward S Cooper part-time tribunal member, Tribunals Service, Ministry of Justice, London, UK
edcooper@doctors.org.uk

Competing interests: As a medically qualified member, ESC has a paid judicial role, helping the tribunal judge in deciding appeals against benefit decisions by the DWP. He is writing entirely on his own behalf.

- 1 McCartney M. Well enough to work? *BMJ* 2011;342:d599. (2 February.)

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POOR HEALTH AND NHS REFORM

Diagnosing cancer still needs more resources

The way that cancer patients in the UK gain access to treatment is a topical area for debate; its invocation in the debate on the proposed reforms is important because it shows a major weakness in the NHS.

Although Appleby glosses over some of the discussion on cancer statistics, the points he makes must be challenged.¹ For example, the poor survival of people with colorectal cancer in the UK is associated with higher stage at diagnosis than in comparator countries.² Timeliness of diagnosis is a defining characteristic of high quality cancer care, and higher stage at diagnosis means that the UK is diagnosing bowel cancer late, not that others are diagnosing it early.

To bring forward diagnosis, more patients than actually have the disease must be investigated. The present cost to the NHS of such an approach is 35% of the cost of managing colorectal cancer.³ To improve our survival rates will require the absolute numbers to increase, with more patients incurring costs of treatment.

It is not clear how the reforms will bring this about.

S Michael Crawford consultant medical oncologist, Airedale General Hospital, West Yorkshire BD20 6TD, UK
michael.crawford@anhst.nhs.uk

Competing interests: None declared.

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Disinformation and distraction

The coalition should stop knocking the substantial progress made by the NHS in the past decade.¹ Appleby’s meticulous demolition of the misleading comparison between mortality in the UK and France reminds us of Henderson’s earlier exposé of Cameron’s shameful attempts to contrast NHS cancer care with the service in Bulgaria.^{2 3}

With the longest sustained improvement in levels of public satisfaction with the NHS since surveys began,⁴ the battle against hospital acquired infections being won,⁵ and mortality from major causes falling,^{1 2} there is nothing necessary about the reforms that have been proposed.

Tom A Yates academic foundation programme doctor, Oxford Deanery, Oxford, UK
thomas.yates@medsci.ox.ac.uk

Guppi Bola graduate, MSc in global health science, University of Oxford, Oxford, UK

Danny McLernon Billows fourth year medical student, Peninsula Medical School, UK

Competing interests: None declared.

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ASSISTED DYING DEBATE

Time to be neutral?

The correspondence on assisted dying is going nowhere.¹⁻⁴ For us still to be arguing about the definitions of single words is not a good sign.

We have different views, and I don’t expect us to agree, but it need not stop us respecting some of our differences. I have not come across anyone on the “change” side who wants to interfere with or influence the decisions of those who want to wait for nature’s time of death. I mention this because some people, particularly those with significant physical disability, fear being pressurised to die before they want to. I don’t know how that idea came about, but I hope the rumour stops.

Similarly, there is nothing in the reasoning or publications from those who want the law changed to suggest that they are against palliative care, or that they want other people to end their own lives sooner.

The medical profession can hold two positions. Some wish to end their own lives if they are incurably ill and some don’t; some are willing to assist the dying of another and others are not. That’s all right isn’t it?

I can see no reason for those who want themselves and others to wait for nature’s time to seek to forbid those who want to die when they choose. It’s a permissive bill we are after. Other people would be able to continue their lives as long as they want to. Some may think it morally wrong to take your own life; but if that is the case, I expect they can respect the “right” of others to be morally wrong.

We as doctors sometimes tend to give opinions too freely and on too many things. The Royal College of Nursing, with many members having strong views on one side or the other of this matter, decided last year to be neutral. Perhaps we in the BMA should follow that example.

Peter Bruggen retired psychiatrist, Institute of Family Therapy, London, UK
pbruggen@blueyonder.co.uk
Competing interests: PB is a member of the British Humanist Association.

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