Everyone knows that exercise is good for you. Physical inactivity is estimated to cause 3.2 million deaths a year globally, making it number four on the list of risk factors. In the United States, inactivity combined with poor diet is second only to smoking as a risk factor for death. There is much evidence showing that regular exercise is one of the most important things you can do for your health, better than any pill that we have.

Brief digression for a small rant: why do experts insist on the term “physical activity,” which sounds clinical and scientific, instead of “exercise,” which only sounds arduous and undesirable? (I guess I answered my own question.) Anyway, physical activity is defined as anything that gets the skeletal muscles moving and that expends energy. The list of benefits of regular physical activity grows each year and includes decreased risk of heart disease, diabetes, some cancers, and depression and dementia, along with help with weight control, bone strength, and, for elderly people, prevention of falls.

Inactivity increasing
So it was disheartening, and even a little shocking, to read that a new survey found that more than 80 million Americans aged 6 years and older—28% of the population—reported that they engaged in no physical activity at all in 2014. Zero. Not one of a list of over 100 activities. No walking or playing catch or mowing the lawn or raking the leaves. No gardening or swimming or kicking a football around. The number of these so called “inactives” has grown each year since the annual surveys began in 2007.

The US Centers for Disease Control and Prevention says that 26.3% of US adults engaged in no leisure-time activity in 2013. Respondents were classified as participating in no leisure-time physical activity if they responded “no” to the question, “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?” CDC also found that less than half of Americans meet the standard of 150 minutes a week of physical activity that was set in 2008.

I understand that some people hate jogging and going to the gym. So do I. Thirty minutes of exercise a day, five days a week, is a pretty high bar for people who don’t like it very much. But how is it that somewhere between 25% and 30% of Americans get absolutely no exercise in a year? I know that today’s society and jobs are conducive to a sedentary lifestyle. Indeed, modern life for many requires it. Previously, many jobs and even housework required at least walking around, if not outright exercise. Now we spend all our time looking at screens of various sizes or behind the wheel of a car. Schools used to encourage, even mandate, physical activity. Now it is hard to find a school that does so, having eliminated or made optional what we used to call physical education. We are paying a high price for our modern habits and convenience.

Needed: strategies
What can we do about this? Some people like to go to gyms and work out and jog or run. Terrific, more power to them. Keep it up. But the rest of us need a strategy or a series of strategies from which we can choose.

These might include shortening the time for exercise by trying a high intensity interval training technique. This gets you out of breath fast but is over mercifully quickly, in a matter of a few minutes. Having low tech equipment such as elastic bands and benches readily available is another way to encourage brief intervals of physical activity. The automated commute can be countered by integrating walking into it: parking at the far end of the car park or getting off the bus or train a stop or two before your destination. At the very least people can stand up several times a day and walk around the office (or the block). Or try microbursts of exercise; one friend never walks short distances, breaking into a jog to go around the corner or catch a bus. Annoying but perhaps effective.

Some people are motivated by measurement. Virtually everyone is carrying a smartphone these days, many of which are equipped to measure physical activity. Pedometers are dirt cheap and easy to use. Noting that you’ve walked only 2500 steps by dinner time is a nice motivator for an after dinner stroll.

Clearly, motivation is the key, and doctors have a role in this too. The lesson of the brief smoking cessation intervention should not be lost on exercise: if the single most important thing smokers can do for their health is to stop smoking, then the single most important thing non-smokers can do may well be to figure out an exercise strategy.
The parasitical profit of journals

Medical publishing is lucrative, but it is a parasitical profit, with rich pickings for the drug industry. The New England Journal of Medicine has set out its industry stall: in 1996 it decided that editorialists and reviewers should lack financial interests in the area under discussion, but it relaxed this policy in 2002. Its editor, Jeffrey M Drezan, recently wrote that he had made it “harder for people who have received industry payments . . . to write editorials or review articles” and asked whether this was in our best interests. “I think not—and I am not alone,” he wrote; he wants more editorialists by people with industry ties.

On this side of the pond, The BMJ offers advertising as the “perfect channel to reach GPs whom pharmaceutical companies have difficulty targeting face to face.” Journals, then, are ideal for pitching products to doctors who want to avoid drug industry reps. Reprints also make big profits, as drug companies order most reprints of studies that they are likely to fund.

So why do we have journals? For quality control? Peer review is prone to abuse: one publisher, the Public Library of Science (PLoS), recently sacked a peer reviewer when he was accused of sexism for suggesting that authors “find one or two male biologists to work with” to improve a paper.4

For decades we have known that peer review contains “bias and parochialism,” and a Cochrane review found “little empirical evidence” that it ensured quality.5 No surprise, then, that “peer reviewed” publications such as the Journal of Natural Pharmaceuticals have accepted grossly flawed research in sting operations.6

In fact, the entire construct of contemporary medical publishing is unfair and unsustainable. Researchers are usually funded through tax money. Research is usually done in universities or the health service, with volunteer patients, and is submitted to journals. Peer reviewers read and comment, usually unpaid. The research is edited and published—either with open access, where the researchers pay for it to be available to all, or behind a paywall.

Access may be available to people with a password from a university, research facility, or the NHS, but access to paywall content is likely to be unavailable to the people who took part in the study. These taxpayers probably funded the research but would have to pay again to get access. In the United States access varies widely, and commercial publishers charge as much as 10 times what non-profit organisations charge.8

We don’t need the thousands of journals that are being published. Peer review after publication may be just as good as, or better than, before publication. Journals are merely expensive conduits for financial interests and publishers’ profits.

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Assisted dying is about more than autonomy

I’ll See Myself Out, Thank You is the pithy title of a collection of essays on the subject of assisted dying. Some of the essays were specially written for the collection; others were taken from speeches or previously published articles, but, as the title suggests, all argue for assisted dying to become legal.

This is not a book that carefully toes a diplomatic line. Several contributors argue that assisted dying should extend beyond terminally ill people, in opposition to the six month prognosis currently stipulated in Charles Falconer’s bill. This six month line in the sand is arbitrary and meaningless (and impossible to predict with any accuracy), and it is refreshing that many of the writers in this book explicitly state this. Other punches not pulled are the economic case for assisted dying, the pressure on society from our ageing population, and family convenience. There is no hinting behind rose tinted glass here.

Throughout the book the focus is on autonomy. Few people would argue that autonomy is not important, but is it the highest ethical principle? We are not and cannot be wholly autonomous. None of us has the autonomous right to rob a bank or even to receive antibiotics when we have a cold. The question of how far our autonomy should stretch is fundamental to the assisted dying debate but is not explored here. The other side to the autonomy coin—the potential for harm and the need to protect the most vulnerable in society—gets little more than a passing glance beyond the confidently asserted but entirely ambiguous mention of “safeguards.” These safeguards, as in Falconer’s bill, are never defined.

Within and without the House of Lords the assisted dying debate will continue. Such are the

We are not and cannot be wholly autonomous

passionate and firmly held views of supporters and opponents that the “debate” can resemble a shouting competition, each side trying to drown out the other by yelling louder. As this book shows, supporters of assisted dying certainly include some strong voices. The trouble is, when everyone is shouting, it’s impossible to hear anything.

If the intention of this book is to stimulate debate it has failed. There will be (and perhaps can be) no resolution to the argument between autonomy and vulnerability. A more enlightened tactic would be to focus not on these fundamental and potentially irresolvable differences but on common ground.

The book’s title betrays its fundamental flaw: it is a collection of autonomous voices talking about autonomy. Individually, the essays are powerful, persuasive, and moving. But this power becomes diluted through repetition. The focus on who might benefit from assisted dying is understandable, but the absence of proper consideration of who might be harmed and how to negate this is an omission.

In response to the issue of vulnerability the philosopher John Harris asserts, “Those who might be encouraged to die are and remain free to refuse. They are not victims unless they make themselves victims.” This book will do little to appease concern for people who are less able to govern themselves.

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thebmj.com
Feature: In support of assisted dying (BMJ 2015;350:h1828)
A seriously flawed and inflammatory attack on conflict of interest policies and regulations appeared recently in a most unexpected location: the venerable and trusted New England Journal of Medicine (NEJM). In a series of rambling articles, one of the journal’s national correspondents, Lisa Rosenbaum, supported by the editor in chief, Jeffrey Drazen, tried to rationalise financial conflicts of interest in the medical profession.1-4 As former senior editors of the NEJM, we find it sad that the medical journal that first called attention to the problem of financial conflicts of interest among physicians would now backtrack so dramatically and indulge in personal attacks on those who disagree.

Physicians and the public rely on journals as unbiased and independent sources of information and to provide leadership to improve trust in medicine and the medical literature. Yet financial conflicts of interest have repeatedly eroded the credibility of both the medical profession and journals.5 6 As the Institute of Medicine explained in its 2009 report, a conflict of interest is “a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest.” The key issue is that “a conflict of interest exists whether or not a particular individual or institution is actually influenced by the secondary interest.”7 The report drew heavily on a 1993 NEJM article by Dennis Thompson, not cited by Rosenbaum, which made clear that the rules “do not assume that most physicians or researchers let financial gain influence their judgment. They assume only that it is often difficult if not impossible to distinguish cases in which financial gain does have improper influence from those in which it does not.”8

The NEJM has now sought to reinterpret and downplay the importance of conflicts of interest in medicine by publishing articles that show little understanding of the meaning of the term. The concern is not whether physicians

Doctors might wish it were otherwise, but none of us is immune to human nature

and researchers who receive industry money have been bought by the drug companies, as Drazen writes, or whether members of guideline panels or advisory committees to the US Food and Drug Administration with ties to industry make recommendations that are motivated by a desire for financial gain, as Rosenbaum writes.1 7 The essential issue is that it is impossible for editors and readers to know one way or the other.6 7

Yet Rosenbaum and Drazen seem to think it is insulting to physicians and medical researchers to suggest that their judgment can be affected. Doctors might wish it were otherwise, but none of us is immune to human nature.

Straw men

Rosenbaum’s arguments for the purported harms of conflict of interest policies and regulations are fanciful and data-free. No one is proposing that “we prevent the dissemination of expertise, thwart productive collaborations, or dissuade patients from taking effective drugs,” or allow “true experts to be replaced – on advisory panels, as authors of reviews and commentaries, in other capacities of authority – by people whose key asset is being conflict-free.”9 Where is the evidence of “a loud chorus of shaming,”2 or “a stifling of honest discourse,”3 or that “the license to trample the credibility of physicians with industry ties has silenced debate?”4 Silliness and fear mongering about straw men are masquerading as scholarly analysis.

In 2014, under the Open Payments programme (the Physician Payment Sunshine Act which is part of the Affordable Care Act), the Centers for Medicare and Medicaid Services in the United States published 4.45 million financial transactions from healthcare industries to physicians and teaching hospitals over just the last five months of 2013; the total value was nearly $3.7bn (£2.4bn; €3.4bn).7 When full data for 2014 are reported later in 2015, the amounts may well exceed $9bn. Drug and device companies are businesses that maximize profits by any legal means. These companies expect to get something in return for all the largesse; the evidence is that they do, and it is naive to explain the situation otherwise.

Put simply, financial conflicts of interest in medicine are not beneficial, despite strained attempts to justify them and to make a virtue of self interest. Unmistakably, collaborations between academe and industry can speed medical progress and benefit patients. Such partnerships, however, can flourish with far less money in aggregate flowing from drug and device manufacturers to physicians and their institutions, and without the web of other lucrative ties between industry and physicians that lack a clear scientific or medical purpose.

Few exceptions

There are few reasons for physicians and other investigators to have financial associations with industry other than research support and bona fide consulting related to specific research programmes and projects. Physicians who develop products and hold patents or receive royalties should not evaluate the product. Other types of payments, such as speakers’ and other personal fees, payments to be ghost authors of review articles, and ill defined consulting arrangements, distort physicians’ work and undermine our independence, as has been repeatedly documented. And there are no excuses for outright gifts, such as meals, travel, lodging expenses, and entertainment.

The articles by Rosenbaum and the supportive editorial by Drazen could presage a further weakening of the conflict of interest policy at the NEJM, or they could serve as a wake-up call for all medical journals and the profession. It is time to move forward, not backward.

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