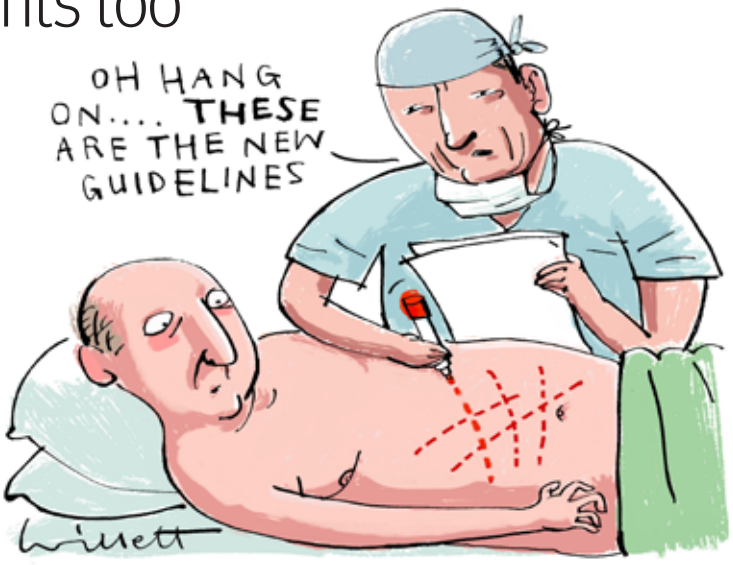
**Health promotion has been a smokescreen allowing successive governments to abdicate responsibility for tackling the vested interests of food and drink corporations**
**Des Spence, p 51**

PERSONAL VIEW **Grant Hutchison**

# Guidelines can harm patients too




The clinical entity of guideline fatigue syndrome has already been described in the *BMJ*: "a debilitating condition characterised by irritability and overwhelming lethargy in the presence of guidelines."[1] My own chronic guideline fatigue syndrome underwent an acute exacerbation recently, with the arrival of another set of guidelines in my email inbox. On reviewing the level of evidence provided for the various recommendations being offered, I was struck by the fact that no relevant clinical trials had been carried out in the population of interest. Eleven out of 25 of the recommendations made were supported only by the lowest levels of published evidence (case reports and case series, or inference from studies not directly applicable to the relevant population). A further seven out of 25 were derived only from the expert opinion of members of the guidelines committee, in the absence of any guidance to be gleaned from the published literature.

Quite deliberately, I'm not naming the particular set of guidelines detailed above. I've no wish to single out the committee responsible, since these guidelines are typical: in large published datasets, it has been found that about half of practice guidelines are based on low level evidence or expert opinion.[2 3]

Although guidelines have been with us for many decades, they have grown in popularity along with the concept of evidence based medicine. Guidelines committees are cast in the role of distilling evidence from the relevant literature to reduce it to a bullet pointed list or flow diagram, allowing busy practitioners to move on from practice based on mere anecdote and opinion. But half of the guidelines currently being published are based on little more than anecdote (case series, extrapolation from other populations) and opinion.

Guidelines, like other therapeutic interventions, should be considered in terms of balance between benefit and risk. The benefit of guidelines based on sound and compelling scientific evidence is large and demonstrable; but the risks associated with the dissemination of poorly founded guidelines must also be considered.

Because bad outcomes are usually rare and therefore difficult to capture in audit data, we increasingly find ourselves being assessed, not on our safety record, but on our compliance with published guidelines. Such compliance is easily measured: boxes are ticked, graphs are plotted, the public reassured, and a warm glow of achievement shared, all in the absence of any demonstrated change in safety or benefit to patients.

If a patient is harmed, the guidelines are often our first point of reference, and they may serve to distract from potentially important lessons. If harm occurred despite punctilious adherence to guidelines, it is easy to be seduced into assuming that the bad outcome was therefore unavoidable. And if guidelines had not been followed it is likewise tempting to look no further for the cause of the adverse outcome.

Guidelines provide a means by which the opinion of a small group of like minded and highly motivated experts can drive the practice of an entire specialty in one direction. Guidelines decry one intervention and champion another. Some practitioners, expert and comfortable with the deprecated intervention, will nevertheless move away from that practice simply because the guidelines have pronounced against it. Others may continue to practise as they have always done but will stop recommending their approach to trainees. An area of medical practice therefore withers and dies, perhaps in the absence of any scientific evidence against it.

These changes are acceptable, even desirable, when there is robust scientific evidence to support one practice and to deprecate another. Guidelines issued with the support of good quality research are a means by which evidence based medicine gains traction in the world of everyday clinical practice. But guidelines issued without strong supporting evidence incur all the risks I've outlined without offering compensatory benefit to patients.

This is not to say that I dismiss the opinion of my expert colleagues: I am always glad to hear what others are thinking and doing. But there are means by which opinion and low quality evidence can be disseminated without incurring the risks associated with issuing a guideline: that's one function of the learned editorial, for instance.

But the lure of the guidelines committee is strong, especially when like minded individuals are drawn together. Guidelines have been requested; guidelines must therefore be issued. Has any guidelines committee ever come together, reviewed the evidence, and then disbanded after issuing a statement that the evidence is simply insufficient to justify any definitive statement on the topic under consideration? Until that becomes a regular occurrence, I fear that guideline fatigue syndrome will remain endemic in the medical community.

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**Competing interests**: The author is married to Marion E T McMurdo, whose letter to the *BMJ* discussed guideline fatigue syndrome.[2]

References are in the version on bmj.com.

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BETWEEN THE LINES **Theodore Dalrymple**

# Dictators and their doctors

There is something fascinating about the memoirs of the servants or confidants of great dictators. They allow us to see raw power close up, and to thrill to its horror. Personally, I can never resist a book with the title *I Was X's Y*, where X was a dictator and Y was his maid, secretary, or chauffeur.

Doctors have written memoirs of dictators. Among the most famous, or infamous, are those of Dr Li Zhisui, *The Private Life of Chairman Mao*. When they were published there was a controversy as to how genuine they were, with both translator and publisher accused of spicing them up to attract sales. The author himself was accused of claiming a closer relationship than he really had with the Great Helmsman, whose insatiable sexual appetite and deficient personal hygiene, an unfortunate combination, he describes in horrifying detail.

Hitler's doctor, Theodor Morell, kept a secret diary in which he recorded his master's manifold symptoms and his unconventional treatment of them (he was known sarcastically as the chief Reich injection officer)—treatment which is thought by many to have hastened Hitler's physical deterioration. Once in US captivity, Morell himself claimed to have applied such treatment precisely for that end; but then he would, wouldn't he?

Franco's dentist, Julio Gonzalez Iglesias, wrote a memoir called *Los Dientes de Franco* (*Franco's Teeth*), a dental biography of the Caudillo, in which we learn the effect Franco's continual dental problems—he suffered greatly from toothache—had upon his temper and hence upon his decisions.

REUTERS

**Revolution in Tunisia**

**[Tunisia's] Ben Ali had chemotherapy, which made him look so ill that he had to be heavily made up; he began to dement at more or less the same time**

It is not surprising that even those memoirs of dictators not written by doctors should contain medical details of some importance. Recently, for example, I read *In the Shadow of the Queen*, the memoirs of Lotfi Ben Chrouda, butler to Zine El Abidine Ben Ali, the recently deposed Tunisian dictator. The author served the president and attended to the vulgar pharaonic whims of Leila Trabelsi, his second wife, for more than 20 years. According to his coauthor, the Tunisian journalist Isabelle Soares Boumalala, "the past still weighs on Ben Chrouda, but he began to free himself from Leila from the first day of the revelations he made for this book, which was a kind of release for him."

According to the butler, the balance of power between husband and wife changed in her favour as he became ill, and it was Leila Trabelsi's unbounded kleptocratic ambition that caused the downfall of the regime and the hatred of the population. Ben Ali had cancer of the prostate and was treated with chemotherapy, administered by German doctors, which made him look so weak and ill that he had to be heavily made up every time he appeared in public; he began to dement at more or less the same time. When he fled Tunisia, he could hardly grasp any more where he was or what was happening around him.

As with all palace memoirs, no one knows how much of this is true. Some say that the book is a long exercise in self justification, that the author benefited from the regime, and now that it has fallen ignominiously wants to present himself as a prisoner or victim of it rather than a collaborator. But if his story is true, then Ben Ali's illness had a profound effect on world history. For no prostate cancer and dementia, no ascendancy of Leila Trabelsi; no ascendancy of Leila Trabelsi, no Tunisian revolution; and no Tunisian revolution, no Arab spring.

Theodore Dalrymple is a writer and retired doctor

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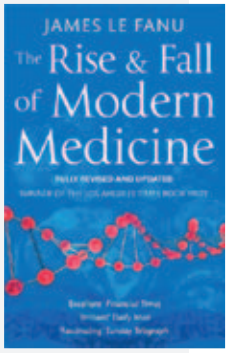
# MEDICAL CLASSICS

**The Rise and Fall of Modern Medicine**

By James Le Fanu; first published in 1999




James Le Fanu is a general practitioner and medical journalist well known during the 1990s for his exposures of the follies and pretensions of the drive to regulate lifestyle in the cause of promoting public health. In 1999 he raised the polemical stakes in this magisterial survey of modern medicine. Le Fanu boldly insists that "much current medical advice is quackery," and recommends "the simple expedient of closing down most university departments of epidemiology," which "could both extinguish this endlessly fertile source of anxiety-mongering while simultaneously releasing funds for serious research."

As its title suggests, *The Rise and Fall of Modern Medicine* is a book in two halves. In the first Le Fanu tells the stories of 12 definitive moments in the triumph of scientific medicine in the second half of the 20th century. His list includes the discoveries of penicillin and cortisone, the developments of kidney transplantation, hip replacement, and test tube babies. The key theme running through these accounts is the prevalence of luck and serendipity over scientific insight—of accident rather than design in the emergence of these diverse discoveries and developments. Although some of these stories are familiar they are told with a journalistic flair and with insights gained from clinical practice.

Turning to the fall, Le Fanu identifies the onset of the current malaise of medicine as the 1970s, when "the revolution faltered," and "the age of optimism" came to an end. Clinical science went into decline, the flow of new drugs slowed, and technological innovation stalled. The resulting intellectual vacuum was filled by what Le Fanu calls the "new genetics" and the "social theory" that blames lifestyle, pollution, and poverty for much current ill health. He views the twin influences of genetics and epidemiology as leading modern doctors (and their patients) down blind alleys.

Le Fanu's exposures of the pretensions of the genetic revolution and of the hype surrounding the human genome project, and of all the claims for imminent dramatic developments in genetic engineering and gene therapy, have been vindicated over the past decade. As he observes, we have witnessed "a relentless catalogue of failed aspirations." Despite a massive investment of energy, resources, and hope the practical benefits of the new genetics in our surgeries are "scarcely detectable."

The social theory has had even more baleful consequences. Bolstered by the dubious science of risk factor epidemiology, it has encouraged moralising, scaremongering, and the medicalisation of vast populations. The drastic measures recommended by Le Fanu in this remarkable book, such as curtailing academic epidemiology and public health, are long overdue.

Michael Fitzpatrick, general practitioner, Hackney, London
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FROM THE FRONTLINE **Des Spence**

# Bad medicine: health promotion

Research is flawed and open to the bias of the authors because people don't invest time and energy to prove themselves wrong. So if research conclusions don't make intuitive sense, it is prudent to question the validity of the research. So it is with the conclusions of research into health promotion, because I don't believe that educating (that is, lecturing) patients to change lifestyle works. It is simply not how people operate. Patients are aware of risks but wantonly choose to ignore our advice. But governments ignore this: health promotion in England costs £3.7bn (€4.5bn; $5.9bn) a year.[1] The coalition government is promoting the slogan "every contact counts."[2] We are to weigh in and nag about diet and smoking in every health contact because "brief interventions" work. Indeed, outreach health missionaries are storming door to door with so called health promotion propaganda, sticking the foot in whether people want it or not.

**Isn't this all really just well intentioned but oversimplistic, mechanistic nonsense?**

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But health promotion is hardly new, being the stock in trade of doctors since Hippocrates. This expensive initiative is just another in a long line of central governmental programmes to promote health dating back decades. What is the evidence for health coaches, brief intervention, motivation training, and the so called cycle of change? Isn't this all really just well intentioned but oversimplistic, mechanistic nonsense?

In the landmark study in general practice for individualised health promotion led by nurses, the absolute benefits were tiny: reductions in cholesterol of 0.1 mmol/L and in blood pressure of 3-7 mm Hg (with the strong possibility that these benefits were artefacts).[3] There is certainly no mortality data. As for other outcomes on smoking, exercise, alcohol, and diet, any results are confounded by the dark art that is the self reported questionnaire. It is only human to tell people what they want to hear, especially those in authority. This is not cynicism but realism—for example, in pregnancy, self reported smoking by mothers underestimated true prevalence by 25%.[4] We should be sceptical of all evidence based on self reporting, however pseudoscientifically it may be dressed up.

The hard facts are contradictory: weight has increased,[5] activity declined, fast food chains expanded, and alcoholic liver diseases increased,[6] despite decades of health promotion. Smoking rates have fallen, but perhaps it is little wonder as the dangers of smoking are crystal clear, smoking may cost a smoker £3000 a year, and smoking has been banned in public and private spaces. Health promotion is the weakest of all medicine. Worse, health promotion has been a smokescreen allowing successive governments to abdicate responsibility for tackling the vested interests of food and drink corporations and wealth inequalities. Now that is truly bad medicine.

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References are in the version on bmj.com.

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THE BEST MEDICINE **Liam Farrell**

# Good doctors being bad

"My heart aches, and a drowsy numbness pains my sense . . ."

"I get it Mr Keats," I said. "You're a bit depressed."

" . . . and I feel like drinking hemlock, or some dull opiate emptying to the drains," he said, a trifle sharply, as if annoyed that I had interrupted his flow. Hey, I'm a busy man, and at 6 to 10 minutes per consultation, just call me the GP from Porlock.

"Probably makes you want to jump on the viewless wings of Poesy," I said, quickly getting up to speed with the whole poetry gestalt; family doctors have to be able to do this kind of stuff. His eyes narrowed, and he furtively took out a pen and scribbled something down.

I was faced with a dilemma. His melancholic disposition was obviously the essence of his muse. Treat it successfully and I'd be depriving the world of some of the great works of English literature. The common good, said Pierre in *War and Peace*, is the only kind of good there is, but sometimes even good doctors just have to be bad.

Ever the alert clinician, I had also noted the lily on his brow and the fading rose on his cheek, so I reckoned we hadn't much time, which ruled out cognitive behavioural therapy and its billion year waiting list.

So I gave him some general lifestyle advice: no more getting loaded on cups full of the blushful Hippocrene; the only beaded bubbles winking at the brim were to be from cans of Pepsi. Get out more, meet people, nix on the palely loitering. And you need more exercise, I said, a vigorous half hour's walk every day.

**I reckoned we hadn't much time, which ruled out cognitive behavioural therapy and its billion year waiting list**

"And take time to smell the flowers," I said.

"Smell the flowers?" he said, with a condescending smirk. "What are you, one of those pre-Raphaelite bird brains?"

I was reassured by this show of spirit, but as he had revealed a propensity to self harm, I also started him on an antidepressant and arranged an early follow-up. Had I committed a crime, I wondered; would his literary genius survive my clumsy biochemical manipulations?

Two weeks later he returned.

"I wandered lonely as a cloud," he simpered.

Forgive me, Melpomene, I thought.

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