

Alcoholic drinks should come with calorie counts

The law should require labels to make energy content explicit in addition to alcohol content, writes **Fiona Sim**

In 2011 the European Union ruled that packaged foods must be labelled with their ingredients and nutritional information, including energy content (calories). But drinks that contain more than 1.2% alcohol by volume are exempt: consumers do not know what is in them.

The European Commission had committed to publishing a report to consider exclusions from the regulation, including calorie labelling of alcoholic drinks, by December 2014. That report is now several months overdue,¹ and no revised publication date has been announced.

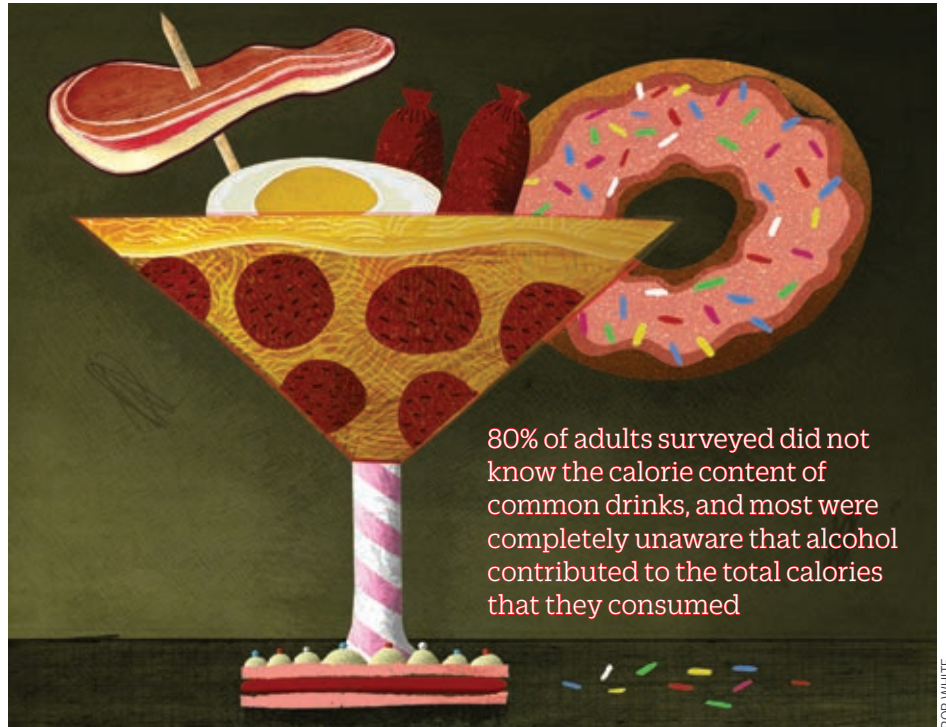
Failure to tackle obesity

It is impossible to ignore our failure to deal with obesity. Daily, in clinical and public health practice, we see its costs to individuals and society. Despite access to an armoury of evidence based public health and behavioural interventions, we increasingly deploy often invasive and expensive downstream clinical interventions for patients with serious yet preventable adverse health consequences of their excess weight.

Drinking alcohol is common and, in excess, harmful. To what extent do the calories consumed in alcohol contribute to the obesity epidemic? In October 2014, the UK Royal Society for Public Health investigated public awareness of the issue. Perhaps unsurprisingly, it found that 80% of the 2117 adults surveyed did not know the calorie content of common drinks, and most were completely unaware that alcohol contributed to the total calories that they consumed. Most respondents were in favour of calorie labelling on alcoholic drinks.²

The survey drew public and media attention to the seemingly hidden calories consumed in alcohol. Television programmes vied to find the wackiest bars in which to test customers on whether their favourite beverage contained more or fewer calories than their favourite burger or doughnut. Hardly anyone interviewed in the media seemed to know much about the calorie content of alcoholic drinks, and most wanted more information.

Among adults who drink, an estimated 10% of their daily calorie intake comes from alcohol.² With the insidious increase in the size of wine glasses in bars and restaurants in the past decade, it seems likely that many of us have unwittingly increased the number of “invisible” calories we consume in alcohol. Most women, for example, do not realise that two large



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glasses of wine, containing 370 calories, comprise almost a fifth of their daily recommended energy intake, as well as containing more than the recommended daily limit of alcohol units.³

No commercial disadvantage

Some alcoholic drink manufacturers have already begun to introduce nutritional labelling. The multinational conglomerate Diageo is proposing to work with the EU to develop standard labelling on alcoholic drinks,⁴ which suggests that it foresees no commercial disadvantage in such a move. However, its proposed standard serving size for wine labels is 148 mL (5 US fluid ounces)—much smaller than the large 250 mL glass typically served in UK bars.

The US Food and Drug Administration has mandated calorie labelling on alcoholic drinks from December 2015 in US restaurant chains with 20 or more outlets.⁵ On this side of the Atlantic the Public Health (Alcohol) Bill 2015 will, if passed, make Ireland the first EU country to insist on calorie labelling on alcoholic drinks.⁶

Information provided to consumers must be honest and useful; recently published evidence does not instil confidence that the alcoholic drinks industry will take its responsibilities to public health seriously enough.⁷ To be clear: alcohol content (in units) and energy content (in

calories) should be included both on drink labels and menus.

We must wait for robust evidence to understand the effect on alcohol consumption of labelling that shows calories as well as units. Meanwhile, accurate, prominent, and meaningful nutritional information, particularly calorie content, should be mandatory on all alcoholic drinks as a matter of urgency, as the Royal Society for Public Health is calling for. There is no reason why calories in alcohol should be treated any differently from those in food.

Finally, those of us in clinical practice regularly ask patients about their weight, eating habits, and exercise in the context of primary or secondary prevention, but how many of us routinely ask about their calories from alcohol? It is time that we started.

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BODY POLITIC Nigel Hawkes

The dangers of rising indemnity insurance costs

Soaring subscription fees could discourage new entrants to general practice

General practitioners reeling back in frank disbelief at their annual subscription renewal for indemnity insurance must be tempted to echo Oscar Wilde: when the gods wish to punish us, they answer our prayers. Many blamed the legal aid system for fomenting medical negligence claims: the BMA itself asserted in 1997 that, by funding worthless cases, legal aid was draining millions from patient care. The money, said Mac Armstrong, BMA secretary, “was going into lawyers’ pockets.”

Its wishes were in due course granted, with changes enacted that scrapped legal aid for almost all clinical negligence cases in England and Wales. In future, said the then justice secretary, Kenneth Clarke, all claimants would have to use the “no win, no fee” provisions that were already used by those too well off to qualify for legal aid.

Lawyers warned that the removal of legal aid would make it harder for people to find lawyers willing to launch complex negligence cases.

There’s little evidence of that. The medical protection organisations and the NHS Litigation Authority warn of a tsunami of claims funded by no win, no fee agreements that shows little evidence of abating. Plenty of the money awarded by the courts is still going into lawyers’ pockets, and it’s a struggle to see that removing legal aid has made much difference.

The annual subscriptions needed to sustain the system are eye watering. An unnamed out-of-hours GP in Derbyshire was quoted £30 000 for indemnity cover, *Pulse* reported, despite never having been subject to any formal complaints procedure. The figure had risen from £8000 a year in just two years.

While this may be exceptional, all GPs have seen big rises. Mark Steinberg, managing partner of a north London practice, wrote to the Medical Protection Society (MPS) after being sent a renewal notice for 2015-16 of £8530. For 2010, he

said, it had been £4930. He pointed out that under the amended no win, no fee rules, there was no longer an augmented “success fee” levied against defendants when they lost a case.

There have also been increases in court fees for claims over £10 000, payable up front by litigants, and changes to the system used by plaintiffs to insure against losing and having to bear the other side’s costs as well as their own, which add an additional hazard to litigation. Had none of these well meant changes had any effect?

Claims on the rise

It would appear not—or not yet. The MPS made it clear in its annual report that it sympathised with GPs facing steeply rising subscriptions. But it and the other bodies that provide indemnity cover have seen steady increases in claims. The society estimated that, by the end of 2013, cases it was already aware of could cost more than £840m to settle and incidents that had already occurred but of which it had not yet been informed could account for another £1.1bn.

One reason for the increase in claims, said the NHS Litigation Authority in its 2013-14 report, was the entry of new law firms into the market. Changes in the regulation of personal injury claims made life much harder for solicitors’ firms that had made their money there, and some switched to the medical negligence market, the last remaining area where claimant solicitors can charge an hourly rate. The 18% rise in claims in a single year was mainly due to these new firms entering the market and by a rush of claims funded by no win, no fee agreements signed before 1 April 2013, when the 2012 act came into force.

If so, then the surge of cases should tail off as older ones are concluded and the firms that hastened to join in find that there’s



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no gold at the end of the rainbow. That’s the optimistic view.

Solicitors are usually characterised as the villains in litigation culture, and they certainly know how to charge. Of the £1.2bn spent in settling clinical negligence claims by the NHS Litigation Authority, claimant solicitors took £259m, defence solicitors only £92m. The MPS’s annual report did not provide this level of detail, but the society said that it had seen “extraordinarily high levels of costs” being claimed in cases before April 2013.

The lawyers’ response is that if doctors don’t want to pay the price of clinical negligence, they should cease being negligent.

That’s a perfectly good lawyer’s point, but there’s no evidence that the rise in claims is driven by a rise in the number of incompetent doctors. What has changed is the expectations of patients, a decline in deference, and the focus by the NHS in England on improving quality by spotlighting failure, such as at Mid Staffordshire and Morecambe Bay. The Care Quality Commission’s new inspection regime, though well intentioned, is unlikely to restore confidence any time soon. The fact that complaints to the General Medical Council have also risen sharply indicates that not all the blame can be attributed to cash hungry lawyers, though they have helped to create the climate.

The danger is that rising subscriptions, especially for out-of-hours GPs, will discourage new entrants, intensify the pressure on those that remain, and lead to worse care, creating a cycle that could end with nobody willing or able to provide a service at all.

That’s in nobody’s interest, so it would be a paradox if legal challenges designed to hunt down bad doctors ended up with no quarry left to hunt.

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LETTER FROM NEW ENGLAND David Loxterkamp

Fishing upstream: health and the social history

It's important that doctors determine the social determinants of health

It is now fashionable for doctors to talk about social determinants of health. Polls show that access to healthy and affordable food, controlling drug misuse, and cleaning up the environment are seen as more important to people's health than access to high quality medical care.¹

Writers on health have sounded the alarm that unmet psychosocial needs have led to overuse of the healthcare system, largely because emergency departments and hospital wards have become society's safety net.^{3,4} Others have focused our attention on "upstream doctors" who look beyond the symptoms of disease to their source in the community.⁵ They estimated that the conditions under which people lived and worked had five times the effect on health and disease as all the pills and procedures in our medical quiver.

Challenges for family medicine

Of course, family doctors have long felt the weight of this, if only in the frustration and challenge of caring for patients we cannot help. We never knew the enemy by name; we were often clueless about its root cause. But our high rate of job dissatisfaction and burnout reflected the limitations of even the best practiced primary care.

Several years ago, our community health centre hired a nurse care manager to coordinate transitions from the emergency department, hospital, and rehabilitation facility. Increasingly, we asked for her help in caring for the most challenging patients—those who could not control their diabetes, quit smoking, or lose weight despite the negative effects on their health.

Last month we reviewed her caseload and found that her more than 100 patients could be sorted into four general categories: those with unstable mental illness, those with cognitive impairment, those having problems with mobility or transportation, and those

needing care that required multiple consultants. There was Rita, 83 years old and morbidly obese, who had been admitted to hospital for an infected panniculus. She was able to manage her weight, blood sugar, bare pantry, and high electrical bill until an ice storm and power outage curtailed her hygiene. Andrew is 75 and has panic disorder and suicidal thoughts. He took an ambulance to the emergency department every week until his daughter introduced him to the director of a nursing home down the street, where he now volunteers. Nicholas is 34 with type 2 diabetes and an HbA_{1c} that consistently hovered above 10%. His severe leg shaking had been a distraction to both of us. Once his severe anxiety was treated, Nicholas could finally focus on diet and exercise and lowered his HbA_{1c} to 5.4%.

It is not just poverty, mental illness, and social isolation that make us sick. Elizabeth Bradley and Lauren Taylor recently explored the US healthcare spending paradox: why does the US spend twice as much as other Western nations on healthcare yet rank so low in measures such as life expectancy and maternal and infant mortality?² Because, they concluded, we spend half as much as other similar countries on social services such as transportation, job training, unemployment benefits, maternity leave, and safe housing. They reported that involuntary job loss in middle age could double or triple the risk of heart attack and stroke over 10 years. A 1% rise in unemployment is associated with an increase in the suicide rate of 0.99%. Joining a club halves the risk of dying within the next year.⁶

Doctors (alone) cannot change society. We are not public health experts, city planners, or community activists. But at the very least we should be aware of the social conditions that affect our patients' lives. A recent article in the *New England Journal of Medicine*



“Upstream doctors” look beyond the symptoms of disease to their source in the community



advocated for the adoption of an expanded social history.⁷ We should ask, the authors contended, whether our patients feel safe and supported in their primary relationships, if their children are struggling, and if they worry about paying their bills. Do they face legal or housing or insurance problems or find it difficult to access reliable transportation, green space, or fresh and affordable produce?

In short, are patients happy or depressed, care free or anxious? Do we even know their preferred name or the name of their spouse? Being understood and having your doctor (or any caring person) take an interest in you and in the most guarded, frightening, and intimate parts of your life is therapy itself.

What next?

The real question is what to do next. Doctors may broadly know the effects of social determinants but not the cost or likelihood of success of a particular intervention. Cigarette smoking is one exception: people who quit before the age of 35 can add 10 years to their life expectancy,⁸ and the odds of quitting rise from less than 3%, unaided, to more than 30% with optimal treatment.⁹

But comprehensive randomised trials of specific interventions have not been done. Curiously, we might learn much by partnering with the commercial insurance industry. It has made an (actuarial) science out of understanding the effects of lifestyle and other factors on illness and mortality and on what motivates people to modify their behaviour.

Until then, primary care doctors are left with an urgent and ambitious research agenda and a mandate to expand our list of necessary colleagues and consultants to those well placed in the community, not just in the hospital.

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NO HOLDS BARRED Margaret McCartney

Bad language

Whether it's related to remnants of paternalism or to the universal rise of the public relations industry, healthcare is littered with terminology that inadvertently or otherwise misleads, by concealing or distorting crucial information. From lazy language to deliberate doublespeak, some of my most loathed examples are below. Don't we need a clear-out of this bad language?

- **Bed blocker:** Patient who has been failed by funding cuts to the social care sector
- **Social admission:** Outcome of a lack of social care funding (see above)
- **Avoidable admission:** Hospital admission which, in retrospect and with adequate social and primary care funding, could have been managed in the community
- **Inappropriate admission:** Admission to hospital that was necessary because of a lack of capacity elsewhere, usually because of insufficient funding
- **Integration of health and social care:** This will be "disintegration" without enough funding

Words that demean patients:

- **Attention seeking behaviour:** Attention needing behaviour, rather —because attention is something these people have probably lacked for much of their lives
- **Failing to cope:** Hasn't been able to obtain enough resources, either personally or in the environment, to be able to self manage. Where is the failure?
- **Poor historian:** Change to "Doctor didn't try hard enough"
- **Failure to progress or dilate:** Less blame, please. It didn't work out as someone had hoped
- **Non-compliant:** How do you know that the patient isn't simply making a different choice from you?

Words that interrupt the doctor-patient relationship:

- **Clients:** These can be fired if they are too demanding or unprofitable. Patients, on the other hand, are owed a professional relationship of trust



"Clients" can be fired if too demanding or unprofitable

- **Customers and consumers:** Ditto. It's relatively easy to pick between two sweaters when shopping. If we are afraid, in pain, or distressed we need relationships with professionals that are based on ethics and trust—not sales pitches
- Finally, words that disguise the sell-off of the NHS:
- **Outsourcing:** Privatisation
 - **Health and Social Care Act 2012:** An act that has no care in it, which has fragmented and destabilised services, wasted money on tendering processes and reorganisation, and needs urgent repeal
- What terms are on your list? Send a rapid response and let me know.

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BLOG Richard Smith

Australians fire an editor of the *MJA* for the fourth time

The Australian Medical Publishing Company (AMPCo), a creature of the Australian Medical Association, has just fired another editor of the *Medical Journal Australia*; that's at least four (and probably more) in my professional lifetime. Over the same period the Canadian Medical Association has got rid of two, and the American Medical Association one. The BMA has never fired one, although it's come close.

Stephen Leeder, a friend of mine, was fired because he disagreed with AMPCo outsourcing production of the journal to Elsevier, the world's largest scientific publisher and owners of the *Lancet*. Leeder is a former medical school dean and one of Australia's best known clinician scientists. Deputy editor Tania Janusic is also reported to have resigned along with several members, even most, of the editorial board.

Leeder argued that AMPCo had failed to understand the

Who would want to edit a journal where editors last no longer than Premier League football managers?

"collegiality" of the process of producing a journal. Others argued that Elsevier was an "unethical company" in that it published a fake journal in Australia paid for by the drug company Merck. Another concern is that the research in the journal, which has been open to all, will go behind access controls.

AMPCo's argument is financial. The journal depends financially on the AMA, and AMPCo says that the current production system is "extremely costly and inefficient." It says that "the future viability of the journal was at risk." It had to act.

I spoke at the centenary meeting of the *MJA* last year, and my core argument was that the time of journals as conduits for publishing science is coming to an end. They've done well to survive for

400 years, but the advent of the internet means that they aren't needed any more.

Most of those at the meeting didn't agree with me, but the future of the medical journals of smaller countries is especially uncertain. The *New Zealand Medical Journal* ceased to publish in paper some time ago and is a skinny beast, heading towards being nothing more than obituaries, news, gossip, clinical yarns, and extracts from the journal of a hundred years ago. What is the point, we might ask?

The main sources of income for journals like the *MJA* are subscriptions and advertising, and both have long been declining. This means that the members of the AMA have to support the journal, and as their numbers diminish the cost per member rises. Eventually they ask "Do we need this journal? Is it worth it?" The next step is to go electronic, cutting the substantial costs of producing a paper journal,

but for many journals that's probably a step towards oblivion.

So I have some sympathy with AMPCo, but firing a highly distinguished editor two years after firing the previous editor doesn't seem like a smart move. *JAMA* and *CMAJ* have recovered despite the high emotion and drama surrounding their editors being fired, but have the Australians gone too far? Who would want to edit a journal where editors last no longer than Premier League football managers (and without the handsome pay off), one of the country's medical leaders has been led out of the building, an "unethical publisher" is taking over, and the journal is probably headed for extinction?

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