LETTERS

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Hard power: waging war on disease

LEARNING FROM SOFT POWER

Rebranding public health as "soft healing" is not necessary

Mozaffarian and colleagues propose an interesting concept of "soft healing," as opposed to "hard healing," which is what goes on in primary care (GP practices) and secondary care (NHS hospitals).[1]

Although they refer to the limits of "hard power" they do not mention the shortcomings of "soft power." We think it is important to acknowledge that soft power, although admirable and beneficial, does have limitations.

In principle, it is hard to disagree with the concept of soft healing. However, the extensive list of examples of soft healing is hard to differentiate from what most UK readers would call "public health." The uncontroversial list of health promotion measures such as tobacco and alcohol control, good nutrition, physical exercise, and seat belts are all fundamentals of public health medicine in our opinion. Many of these measures are already entrenched in UK public health policy, sometimes backed by legislation.

Thus, we agree with these soft healing measures, individually and collectively, but do not think that these common sense public health interventions need to be rebranded.

The only advantage of rebranding would be to create eye catching headlines. A disadvantage of rebranding is that it would distract from the nitty gritty of developing and implementing the kind of sensible public health measures the authors have cited. In this era of limited and sometimes declining resources, that is a distraction we can ill afford.

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1 Mozaffarian D, Blashek JA, Stavridis J. Learning from soft power. *BMJ* 2015;351:h4645. (1 September.)

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SHARPS INJURIES

Risk of sharps injuries in the community

Riddell and colleagues highlight the importance of risk assessment in the management of healthcare related sharps injuries.[1] The relatively high risks in the healthcare setting are often misapplied to community acquired sharps injuries, which are most common in young children. This causes unnecessary anxiety in families and doctors, compounded by further investigations, and sometimes inappropriate prescription of HIV post-exposure prophylaxis (PEP).

We reviewed the risk from more than 1500 adult and paediatric incidental community acquired needlestick injuries in published reports and found no cases of HIV, three cases of hepatitis B (one child), and three cases of hepatitis C virus transmission.[2] None of those with hepatitis B were fully immunised or received adequate PEP, and an alternative route of infection could not be ruled out in any of these patients. We concluded that the risk of blood borne virus transmission in such a scenario to an immunised child (or after adequate hepatitis B PEP) is "so low as to possibly be negligible."

Only the most exceptional community exposures could meet the requirements for virus transmission. In a typical case of a child pricking his or her finger with a discarded needle found in a public place it is therefore only necessary to ensure the child has been appropriately immunised against tetanus and to consider hepatitis B PEP. In such a situation, where the risk is practically negligible, risk assessment can be used to reassure patients and parents and thereby avoid unnecessary follow-up testing for blood borne virus transmission.

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1 Riddell A, Kennedy I, Tong CYW. Management of sharps injuries in the healthcare setting. *BMJ* 2015;351:h3733. (29 July.)

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ASSESSING THE RISK OF DIABETES

The need for frank discussions about weight

Two recent articles in *The BMJ* have confirmed my suspicions that we are losing our sense of direction in medicine. McCartney implies that we should not share stories about patients.[1] Shah says "ask him if it is OK to talk about his weight" in assessing the risk of diabetes.[2]

I often see patients with unexplained shortness of breath and fatigue. They have extensive medical records but there is no clue anywhere in the notes or reports. Their morbid obesity has somehow been completely overlooked. Doctors seem perfectly capable of providing objective data about everything else, but the best you will get for a body mass index over 40 is "slightly overweight." A common comment from patients is "my weight can't be a problem because none of my doctors have mentioned it." Why haven't they?

I see patients who are unable to lose weight go for years, until their daughter's wedding, when 25 kg seems to be the typical amount of weight loss before they can face the photographer. For many the most effective motivator is stigma. Is that really such a bad thing if it is the only thing that works?

When I discuss obesity with patients, I use stories about other patients to help illustrate the risks, the ways to change lifestyle, and the successes. Is this really so wrong? Surely the art of medicine is to have those difficult consultations, not avoid them, and to use narrative and personal experience in teaching. Political correctness has been immensely damaging to society in recent years; is it about time we spoke up for common sense?

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1 McCartney M. The power of patients' stories. *BMJ* 2015;351:h4259. (10 August.)
2 Shah R. Assessing the risk of diabetes. *BMJ* 2015;351:h4525. (3 September.)

Cite this as: *BMJ* 2015;351:h5003

APOLOGISING FOR ERRORS

Difficulties in apologising for a medical error

Because statements of sympathy and regret can be used to prove legal liability in medical malpractice cases, lawyers routinely advise

doctors against apologising and being open about what happened.[1 2] Doctors who admit errors may face the discredit of their peers, the anger and disappointment of their patients and their patients' families, legal involvement, and financial loss. Saying I'm sorry, from a legal perspective (according to different laws), may be considered an admission and may lead to the loss of malpractice insurance coverage. A law that precludes an apology from admission in a malpractice case can help resolve the problem. Regulations that prohibit insurance companies from using an apology to avoid coverage or increase premiums would also encourage honesty and openness.[3 4]

Other barriers might include the culture of medicine and the inherent psychological difficulties in facing our mistakes and apologising for them. Despite these barriers, incorporating apology into conversations between doctors and patients can cater to the needs of both parties and can play a role in the effective resolution of disputes related to medical error.[5] Several institutions have now had positive experiences with policies that involve disclosing and apologising for medical errors. Programmes of disclosure and apology at the Lexington (Kentucky) Veterans Hospital, the University of Michigan Health System, and Johns Hopkins, among others, have resulted in large reductions in legal expenses.[6] Future research and regulations will dictate doctors' decisions about when and how to apologise.

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1 Godlee F. It's time to apologise. *BMJ* 2015;351:h4695. (2 September.)

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RESPONSE

Ann McNeill and colleagues reply to Martin McKee and Simon Capewell

McKee and Capewell recently criticised Public Health England's position on e-cigarettes (ECs)[1] and our underlying report[2] in the *Lancet*,[3] the media,[4] and now *The BMJ*.[5] Their statement "directors of public health and the wider community desperately need advice on EC that is evidence based and free from any suspicion of influence by vested interests"[5] is offensive.

We have an extensive track record of research dedicated to understanding smoking behaviour and population and individual approaches to help smokers stop and prevent uptake of smoking; we have published hundreds of primary research articles on smoking, nicotine, and ECs; and we have years of clinical experience in smoking cessation. We have never taken any tobacco or EC industry funds. By contrast, McKee and Capewell are not experts in this field—they have carried out no nicotine dependence, smoking cessation, or EC research—but they have a history of warning smokers and health professionals about EC dangers.[6-10] This may explain their efforts to undermine the message that vaping is much safer than smoking.

McKee and Capewell's analysis did not take into account several earlier responses.[11-15] Space constraints allow us to address only a few errors in this latest piece in *The BMJ*.

Their "analysis" states that EC supporters "focus narrowly on existing smokers, comparing the device effects with those of smoking conventional cigarettes" while EC opponents compare vaping with non-smoking and believe that it should be discouraged because of "concern about the uptake of ECs among people, especially children and adolescents, who would not otherwise smoke and about their long term health effects."

Comparing vaping with smoking is not a narrow focus. The task of tobacco control is to reduce death and disease caused by smoking. Switching from smoking to vaping avoids most of the risks of smoking. The charge that ECs should not be promoted because there is no clear evidence that they are more effective than current stop-smoking drugs is a non-sequitur because ECs are currently more popular,[16] and hence have a wider reach and potential impact.

We would be concerned if ECs were taken up by those who would not otherwise smoke, but our report found that regular vaping in non-smokers is extremely rare.[16 17] The danger of ECs luring children to smoking seems to be core to the authors' opposition to ECs. Our report carefully examined the evidence and noted the continuing decline in cigarette smoking, which is the only test of whether ECs are "renormalising" smoking that matters. They present a study suggesting that the same young people who try vaping also try smoking,[18] whereas the study's authors acknowledged that their research provided no evidence of causation.

The estimate of relative risk is a matter of logic. Risky chemicals in tobacco smoke are either absent from EC vapour or present at much lower levels, and the key chemicals present in ECs only are not expected to pose serious health risks. We explained this previously,[11] and accusations about the work of Nutt and colleagues and conflict of interests have been dealt with elsewhere.[15] The authors highlight the dangers of formaldehyde—our report covered this false alarm extensively.

Overall, we believe that there are much stronger grounds for criticising the stance of McKee and Capewell than for attacking Public Health England's position. The evidence of relative safety of ECs and of the lack of any gateway effect is much stronger than any evidence to the contrary; misinforming smokers and health professionals about the relative risks of smoking and vaping is wrong; and discouraging smokers from using ECs is irresponsible, however much the safe sounding "precautionary principle" is invoked. Indeed a consensus has now emerged in the public health community in England concerning EC.[19]

We agree, however, as stated clearly in our report, that there remain areas of uncertainty and that ongoing careful monitoring of EC safety and population impact is necessary. If problems emerge, regulatory solutions need to be ready.

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Full response at: www.bmj.com/content/351/bmj.h4863/rr.

5 McKee M, Capewell S. Evidence about electronic cigarettes: a foundation built on rock or sand? *BMJ* 2015;351:h4863. (15 September.)

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