Health promotion and children and teenagers

Why it is mainly the government's responsibility

The *Health of the Nation* contains several targets directly affecting the health of present children and teenagers and future adults.¹ These include reducing smoking in 11-15 year olds by one third, reducing the proportion of energy derived from fats to 35%, reducing deaths from accidents by one third in under 15 year olds and by one quarter in those aged 15 to 24, reducing suicides by 15%, and halving the conception rate in girls under 16.

The idea that these targets might simply be achieved by a cosy consortium between the health and education services begins to crack with research reported by Nutbeam *et al* in this issue (p 102).² But how could we believe that health and education services could be the main players in achieving these targets? Was it arrogance and the need to be needed on the part of doctors and teachers or duplicity on the part of the government? Most research suggests that the health of a nation is mainly due to socioeconomic factors with medical and educational interventions accounting for very little. After 13 years of Conservative government this country is in rapid economic decline, and yet the medical and education professions seem intent on bearing responsibility for not being able to avoid the inevitable result—a decline in the nation's health.

Thus Nutbeam *et al* are disappointed that two well tried instruments for preventing children from smoking failed to have any effect, especially when the schemes worked elsewhere. One of their interventions, the family smoking education project, had worked in Norway, but at the same time as the price, availability, and promotion of cigarettes were being controlled.²

Children's motivations for certain behaviours are highly complex. In a study of nearly 650 children aged 14 to 17, 98% knew that smoking harmed their health and 89% knew that passive smoking was harmful—yet one in five were, or had been, smokers.³ This gap between children's knowledge about what endangers their health and how they use this knowledge is largely uncharted territory. What we know is that simple interventions in a single area—like a school health education programme—are unlikely to work on their own. We know that peer group pressure, cigarette advertising,

imitation of parents, boredom, the need to experiment, and self image all affect children's decision to begin smoking. We also have a good explanation of why children continue to smoke: cigarettes are highly addictive. It is the proposed solutions that are simplistic.

To change behaviour requires tactics that match the complexity of the causes. These should include asking the children themselves how to solve the problem, feeding back their own views to them, and enacting effective laws and enforcing them (in a recent survey carried out by the local trading standards department of 54 premises selling cigarettes in Oxford a 12 year old was able to buy cigarettes in 13 of them). In addition, government policies need to be believable; banning cigarette advertising would almost certainly cut consumption.^{4,5} Two papers in this week's journal show how much further ahead Australia is when it comes to implementing government policies that attempt to improve health.^{6,7}

The position of the health professional—doctor, health visitor, or nurse—is not to pretend that their bit of health promotion is going to have more than a small additive effect to all the other necessary inputs, and they should be aware that they may be wasting their time if the other inputs are not there. Rather they should continue to point out that health promotion is mainly the government's responsibility, as are the economy and the laws of the land.

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Drugs, secrecy, and society

Less secrecy about drug regulation is in the public interest

Later this month a private member's bill that would require the government to disclose information on the safety and efficacy of drugs to the public should receive its second reading.¹ The Medicines Information Bill is founded on two main principles: that those who keep secrets should not have the last word on where secrecy begins and ends and that openness should be the rule and secrecy the exception.

Secrecy confers power on those who know the secret while those who do not are at a disadvantage. In pharmaceutical medicine the culture of secrecy is deep and strong,² and much evidence exists of its negative effects on health, organisational performance, and honest scientific inquiry.³ Secrecy hides not

only what is known but how much is unknown. When it threatens the conduct of science and the spirit of democracy it should be curbed.⁴

British law requires the authorities to withhold all information about licensed drug products, including counterfeit medicines.^{5,6} Even government policies on disclosure are secret because the deliberations of the Committee on Safety of Medicines and other parts of the control system are also entirely confidential. At least one member of the committee has no objection to the committee's papers being publicly available and believes that most data in licence applications could, with little loss to anyone, be made publicly available.

The proposed new European Medicines Evaluation Agency may decide to publish in outline its reasons for granting licences, which would match long established practice in the United States and elsewhere. Yet there has been no suggestion that this agency should say why licences are refused (as in Norway) or hold public inquiries when unsafe drugs are withdrawn (as in the United States). Despite a series of drug disasters no public inquiry has ever been held in Britain. Why is openness reserved for disasters involving trains, stadiums, boats, and planes?

The main reason is to protect the commercial interests of pharmaceutical companies, but in Britain (and many countries of the European Community) this has led to blanket secrecy because of the failure to distinguish between legitimate trade secrets (such as manufacturing processes useful to a competitor) and commercially sensitive information (including data on drug safety and problems with efficacy).

Officials believe that the public tends to make impossible demands⁷ and would be alarmed by disclosure. For example, a senior drugs regulator said that the recent scare over human insulin had led to 100 or so patients stopping their drugs, with predictably disastrous results. If this is true, and evidence for it is hard to come by, we must find better ways of avoiding such problems. Perhaps it is the aura of secrecy, rather than the disclosure, that causes most difficulties.

But there are now stirrings for more openness⁸ and increasing awareness that secrecy is a problem, even from the

Medicines Control Agency.⁹ At the agency's recent annual meeting the Nobel laureate Sir James Black urged that the drug regulatory process should become an integral part of drug development—which it could be if the authorities opened up. In the meantime, he complained of the waste of experimental data that were locked away and the emphasis on compliance rather than scientific inquiry. "The main enemy in drug development is ignorance," said Black, and more openness is needed to overcome it.

Openness is a tough discipline but essential to the development of trust. In the long run, therefore, it should make business sense and may be the only thing that brings peace of mind.

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GMC in the dock again

The council should investigate unscientific treatments

"The jury is still out on whether self regulation by doctors is adequate," says Ian Kennedy, a professor of law and a member of the General Medical Council (GMC).¹ The approval last year of a mechanism to deal with doctors whose performance is consistently poor² was greeted by most observers as a step likely to sustain self regulation (although at least one former member of the GMC disagreed³). But a paper we publish today will not help the council's case (p 122).⁴ Professor Barry Kay describes a case in which the council avoided investigating what many would have expected to be the central issue—was the accused doctor offering a treatment that could undoubtedly do harm but for which there was no scientific evidence of benefit?

Dr Keith Mumby, a clinical ecologist, faced five charges when he appeared before the GMC last summer, but the charges did not include practising an unscientific form of medicine. Indeed, the chairman of the professional conduct committee instructed it that the hearing was not a trial of alternative medicine or the provocation-neutralisation test, which lies at the centre of clinical ecology. Yet clinical ecology has been severely criticised in the High Court⁵ and castigated by the Royal College of Physicians⁶ and the American College of Physicians⁷; and the provocation testing used by clinical ecologists has been argued in a paper in the *New England Journal of Medicine* to be unscientific.⁸

The GMC was founded to protect the public against quacks. Its contract is to guarantee that the doctors consulted by members of the public are properly qualified and will give competent treatment. If a doctor offers a treatment which may be risky and has not yet been scientifically proved to be beneficial the GMC surely owes it to the public either to stop the doctor

offering that treatment (outside scientifically valid trials) or to stop the doctor practising at all.

The council may demur for two reasons. Firstly, it might argue that so much of what doctors do lacks solid scientific support that it would be ludicrous to try to insist that all doctors practise scientifically valid medicine all the time. But surely there may be a whole order of difference between inserting grommets for glue ear (a much criticised treatment⁹) and injecting people with extracts of gas and petrol fumes. Secondly, the council may balk at the costs of determining whether a treatment is scientifically valid. The courts often sit for months over scientific questions—for example, whether whooping cough vaccine caused brain damage—and the GMC may fear cases lasting months and costing millions. But doctors may be able to make swifter judgments than a lay jury, and anyway self regulation cannot be bought on the cheap.

To protect the public, to uphold the standing of the medical profession, and to safeguard self regulation the GMC needs to be willing to investigate treatments offered by doctors that may be risky and whose value has not been scientifically proved.

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