Human and animal health: strengthening the links

Animal and human case for reforming current food policies

EDITOR—The avian flu threat shows the importance of links between the medical and veterinary professions, but the debate needs to extend into the hidden costs of current food policy.

Food policy is still excessively reliant on market efficiencies, by minimising price and maximising choice.¹ Although the obesity epidemic has brought the Food and Agriculture Organization (FAO) and World Health Organization (WHO) together on the socioeconomic costs of the nutrition transition,² the associated animal health and welfare costs are easily overlooked. In 2003 the WHO and FAO emphasised the adverse health impact of cheap, convenient, energy dense foods that are high in fats but drew back from the implications for the meats and dairy fats industries.^{2,3} The point was not lost on industry, however, which funded defensive economic assessments.⁴

Historically, a good public health case existed for reducing the price of foods, particularly meats. Vets have helped deliver that policy. Today, vets help farmers control the diseases and other welfare concerns that intensive farming inadvertently promotes. Doctors, in turn, deal both with farmers' health, as farmers struggle to remain in business, and with the public's health, damaged by the modern diet.

So, should vets and doctors join together to examine the case for radically reforming current food policy? The links between reduced human health and farm animal welfare are matters of public interest that lie across and within the professions' respective purviews. Considerable cultural pressure exists to rethink food policy, not least to internalise the public health costs of industrialised food processing and distribution systems.⁵ Moreover, many consumers now tend to

associate good human health with good animal welfare,⁶ and the health professions are being asked to encourage a dramatic shift in national diets.³ Thus, the time is right for joint veterinary and medical debate about food policy, and even a shared position.

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New foundation will help bring two disciplines together

EDITOR—The United Kingdom is strong in veterinary science. However, the same reassuring state of affairs does not obtain in one area in particular: comparative clinical science. The British Veterinary Association suggested that the first of these weaknesses could best be addressed by using the Medical Research Council (MRC) as a channel for funding.

In 2000 the MRC therefore agreed to establish a comparative clinical science panel, using new funds, for an initial trial period of five to seven years. The trial period was to protect the council from any possible criticism that it was "diverting" funds away from human research and to accumulate the evidence for the benefits for human medicine that could result from collaborative research in comparative clinical science.

Now, the Comparative Clinical Science Foundation has been established to raise the first £25m towards the MRC starting this project. Leading medical and veterinary organisations, as well as individuals, have generously contributed the working capital to establish the appeal.

In recent years minimally invasive quantitative techniques have strengthened the relation between comparative medicine and comparative clinical research, especially by using the spontaneous disease models encountered in veterinary medicine. The MRC panel will attach particular importance to collaborative projects including veterinary clinicians based in practice, as well as institutes and schools, both medical and veterinary. This will ensure large and representative populations of patients, rather than the small groups available to single establishments, and it will maximise cross fertilisation between basic and clinical science and between human and veterinary medicine. It will also raise the quality of veterinary clinical research and provide the evidence base essential for the future credibility of veterinary medicine. And it will encourage practitioners to become involved in clinical research, reducing the traditional damaging division between a career in practice and a career in research.

After centuries of division, human and animal medicine are coming together. I hope that those interested in promoting scientific progress will support the Comparative Clinical Science Foundation, as the veterinary and medical professional bodies have done. In particular, animal charities, which have led the way in animal welfare, have large funds at their disposal. I hope it would not be too impertinent to suggest that their support could achieve an immense amount for animal welfare, over and above what they do already.

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Combined courses for vets and doctors?

EDITOR—Although over the years differences between human and veterinary medicine have narrowed, particularly with respect to therapeutic options within ubiquitous economical constraints,¹ doctors' responses to the present day sophistication of veterinary medicine can sometimes border on the condescending. The fundamentals of medical physiology and pathophysiology are the same, and many disease syndromes are similar enough to warrant numerous animal models for human conditions. The consequences of this can be profound when the medical fates of humans and animals can be inextricably entwined through emotional bonds, economic necessity, and zoonotic potential.²

Perhaps medical and veterinary schools should facilitate combined programmes for certain motivated individuals. Given the universal underpinning of medicine this should be no more or less challenging than combined medical and dental or research degrees.

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Preventing dog bites

See Reviews p 1278

EDITOR—Dog bites are a serious health issue. For example, in Belgium each year 1% of the general population needs medical attention after a dog bite.¹ Epidemiological data indicate that 50% of bites are not reported to medical or legal authorities.² Children seem to be more at risk of being bitten by a dog than any other age group.³ In children under 16 years of age, the incidence is estimated at 2.2% each year.² Injuries in children are often to the face and neck and may be life threatening.⁴

Most dog bites happen at home and involve the family pet.⁵ At the same time, dogs remain very popular as pets, and

evidence for the physical, psychological, and social benefits of dog ownership is growing.^{w1 w2} Data from pet food companies indicate that about one third of families in Europe, and more than 5 million families in the United Kingdom, own a dog.^{w3}

A dog's tendency to bite depends on several interacting factors,^{w4} and measures such as breed specific legislation, as adopted by some governments, are inappropriate.^{5 w4 w5} Tackling the problem requires a multifactorial, multidisciplinary approach.^{3 w4 w6}

In 2001, I participated in a collaborative study with paediatricians in Belgium into the circumstances surrounding dog bite incidents in children, at home and in public places.⁵ One of the findings was that most bites at home were triggered by an interaction from the child towards the dog. Many of these incidents might have been prevented if the parents and children had been more aware of how dogs react in certain situations. Much could therefore be achieved through improved education of parents and children.^{3 5 w4} On the basis of these findings, interactive educational material is being developed for use by children and their parents in families who own dogs.

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References w1-w6 are on bmj.com

Classification of stillbirth

Classification is not explanation

EDITOR—Gardosi et al report that under the ReCoDe classification "only 15.2% of stillbirths remained unexplained."¹ But if the most common "condition" was fetal growth restriction, and 43% fell into this category, then at least 58% are still unexplained under this system. To classify something falls well short of explaining its cause.

There are many different known causes for fetal growth restriction and doubtless many unknown or at least unidentifiable ones. Some of these may not even contribute to a risk of stillbirth when present. The goal should be a clear understanding of the underlying cause of every stillbirth. The fetal postmortem examination, despite its lack of effect on classification in this study, remains a vital part of this effort and has repeatedly been shown to have an important impact on

counselling to parents about the risks of recurrence.

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- 1 Gardosi J, Kady SM, McGeown P, Francis A, Tonks A. Classification of stillbirth by relevant condition at death (ReCoDe): population based cohort study. *BMJ* 2005;331:1113-7. (12 November.)

Reclassification obscures things

EDITOR—Gardosi et al say that any classification system that results in a high proportion of cases being defined as unexplained is not fulfilling its purpose.¹ If it is true, however, that the mechanism or cause leading to death in an individual case cannot be determined with more than speculative certainty, it is entirely correct to classify the case as unexplained rather than to assign a potentially erroneous or artificial cause of death in order to create the impression of knowledge.

The main finding of this study is the reclassification of numerous apparently previously unexplained cases as fetal growth restriction, such classification being on the basis of an estimated customised weight for gestation below the 10th centile. The clinical relevance of growth restriction according to these criteria remains controversial in ongoing pregnancies, and therefore to attribute the cause of death to fetal growth restriction in the absence of other specific findings may well be incorrect. It is, of course, entirely possible that growth restriction is an important contributory factor to stillbirth. However, the issue in these cases is primarily to try to understand why a minority of fetuses with mild growth restriction should die in the womb, whereas 10% of all pregnant women will show a similar degree of fetal growth restriction but will result in livebirth.

Current antenatal management detects only a small proportion of intrauterine fetal growth restriction, and improved detection methods may be associated with improved outcomes. Nevertheless, the suggestions of this study have the potential to lead to both misleading interpretations of the cause of death in future cases of stillbirth, and to a falsely inflated sense of understanding of the underlying mechanisms leading to such intrauterine death in the absence of an apparent pathophysiological basis.

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Cause, condition, or mechanism?

EDITOR—Gardosi et al illustrate the inadequacy of current classification systems and emphasise the preponderance of fetal

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growth restriction, which, presumably, is not diagnosed before the death occurs.¹ Although definition of relevant conditions at death may mute the debate about its cause, the distinction between conditions, causes, or mechanisms of death is still not clear in this paper. Clear definitions or guidelines are not provided. Asphyxia is a non-specific final common pathway of death, not a cause or condition. The authors intend to identify as many conditions as possible for a case.

This would be a powerful tool to stop debates about the cause where conditions overlap or where several entities coexist, such as fetal growth restriction, pre-eclampsia, placental insufficiency, and oligohydramnios. However, the paper describes one condition as primary (cause?) and one as secondary. Interestingly, in the primary group of fetal growth restriction only 53/1129 (4.7%) have placental insufficiency as a secondary condition. This unexpected low number illustrates the loss of insight into the pathway to death.

The issue of using a hierarchy is motivated to "reflect clinical relevance." Although it seems preferable, a classification system for perinatal mortality cannot be strictly hierarchical because of the cognitive process of how doctors make a diagnosis.² Any system restricted to stillbirths neglects the issue of iatrogenic preterm delivery with neonatal death in cases with the same relevant conditions. We welcome any suggestion for better classification of perinatal mortality, since this is essential for both patient care and prevention. The value of ReCoDe needs to be proved.

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Competing interests: The authors are developing a classification system themselves.

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Author's reply

EDITOR—We developed the new classification to get away from the limitations of seeking the cause of stillbirth, in favour of determining the conditions which could explain what had happened. This allowed a number of categories to be included which may have undetermined underlying causes, but which in themselves are relevant for an understanding of the events preceding and surrounding the demise.

For instance, cord prolapse is a relevant category even though it may have a number of underlying, spontaneous, or iatrogenic causes. Fetal growth restriction is another example, being associated with a fivefold

increase in risk for a fetus below the 10th customised centile, and an 11-fold risk for a fetus below the 2.5th centile.¹ There are indeed many different causes for fetal growth restriction, although we are not aware of any evidence that some types might not be a risk for stillbirth, as Kirk suggests. Constitutional smallness has no increased risk, but we corrected for constitutional variation by using customised centiles. A low customised centile indicates that that fetus was failing to reach its growth potential.

Kirk mentions the importance of establishing the risk of recurrence for purposes of counselling. This reasoning ought to be extended to fetal growth restriction, which has a high risk of recurrence, but which is currently not recognised in many classification systems. Sebire questions the relevance of a category for fetal growth restriction, as most fetuses with this condition do not die. This is not a convincing argument, as many other conditions used in ReCoDe and in conventional classification systems are not lethal either—for example, most fetuses do well in pregnancies complicated by maternal hypertensive disease.

Postmortem examinations, when agreed to by the bereaved parents, are important for establishing causes. However, pathologists are often not rewarded for their efforts by an outdated classification with which they still end up with many "unexplained" reports. The proportion of stillbirths classified as unexplained under the old system has in fact been on the increase in relation to other causes (figure 3.2).² In addition, overall stillbirth rates have increased,³ which means that more and more women are being told that they have had an unexplained stillbirth. Reducing the proportion of stillbirths which are classified as unexplained will, we believe, not only improve clinical care but allow a sharper focus for research into causes.

Erwich et al recognise the difficulties with trying to establish a cause, especially in areas of overlapping pathophysiology. They question the need for hierarchy, but we believe that this is essential for reproducibility, an important criterion for a good classification system. Wherever possible, ReCoDe categories are mapped to ICD 10 codes, and the conditions are assigned and ordered by means of a computer algorithm. The secondary classification softens the hierarchy and increases descriptiveness by allowing another relevant condition to be coded. The example they quote (fetal growth restriction with few secondary codes for placental insufficiency) shows a strength of our system: growth restriction was recognised retrospectively, even though placental insufficiency may not have been established on histological grounds. Many placentas are also not sent for examination, a continuing problem which pathologists are seeking to address.

Erwich et al point out that a separate classification for stillbirths might obscure related neonatal mortality due to iatrogenic preterm delivery. This is an argument for looking at stillbirth and neonatal death rates

separately as well as in combination—that is, as perinatal mortality rates. However, the conditions which led to the death and their implications may be substantially different, and the quality of neonatal care may have contributed. Thus stillbirths need their own classification system.

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Competing interests: None declared.

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Reassessing strategies for improving health

Strategies should include nutrition

EDITOR—That the call for reassessing health outcomes by Evans et al is limited to a disease model as linked to millennium development goals 4, 5, and 6 alone is surprising.¹ The World Health Organization listed child underweight as the leading risk factor contributing to the global burden of disease²; and Pelletier et al have clearly shown that malnutrition underlies over 55% of all mortality in under 5s in developing countries.³ These results, which indicate that mild to moderate malnutrition is associated with higher mortality and that an epidemiological synergism exists between malnutrition and morbidity, have been substantiated by several other studies.

So long as the global community continues to aim to tackle health as a disease model divorced from nutrition, as Evans et al propose, it will continue to fail in achieving the millennium development goals. Malnutrition represents the non-income aspects of poverty and a malnourished population cannot aspire to achieve the health goals without also dealing with nutrition. Furthermore, many nutrition interventions that can be made mainstream through the health sector are among the most cost effective best-buys in development as assessed by the Copenhagen consensus and others.^{4 5} Any future efforts at achieving the millennium development goals must incorporate these nutrition interventions.

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- 1 Evans DB, Adam T, Edejer TTT, Lim SS, Cassels A, Evans TG, et al. Time to reassess strategies for improving health in developing countries. *BMJ* 2005;331:1135-6. (12 November.)
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Strategies in West and Central Africa need to be revised

EDITOR—The first seven millennium development goals are mutually reinforcing and directed at reducing poverty in all its forms, and the last goal provides a framework for the attainment of the first seven. The countries in West and Central Africa remain the major outliers relative to this line.

All of the 16 “desperately deprived” countries in the 2004-5 chronic poverty report are in sub-Saharan Africa; 12 are in West or Central Africa.¹ Even the most optimistic estimates acknowledge that the goals will not be achieved in the stated time frame in these African regions.

Given the current realities, a reassessment of the strategies to improve the goals in these regions should include:

- Setting realistic targets and indicators that can be achieved within the next decade. For example, the goal of universal basic education in these regions is obviously unrealistic given high rates of long term poverty, high illiteracy among women, and poor funding of the education sector. Setting realistic goals for the next decade in these regions has a potential to motivate national governments and funding agencies to work towards achieving them²

- Working in partnership with the World Bank to implement strategies suggested in the 2005 report (anchor reform efforts in country led strategies, improve the environment for private sector led economic growth, scale up human development services, dismantle barriers to unfair trading practices, and substantially increase the level and effectiveness of development assistance)³

- Incorporating family planning activities into the millennium development goals in these regions, and provide adequate funding for promoting the goals’ adoption.

Although the third strategy is politically sensitive and vulnerable to “neo-Malthusian” criticisms, it is long overdue in these regions, where women have the highest parity in the world, making it increasingly difficult to deliver human development initiatives to those most in need.

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Competing interests: NA is keen to work with governments and non-governmental agencies to facilitate progress with regard to implementation of millennium development goals in West and Central Africa.

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Transitional care for elderly people

At what cost?

EDITOR—Crotty et al show that off-site “transitional care” facilities for elderly patients already assessed as needing residential care placement, only reduce length of hospital stay at the expense of delaying eventual transfer to a long term care facility.¹ However, their assertion that such transfer resulted in no difference in mortality, rates of readmission, or the proportion of patients who eventually returned to their own homes is potentially misleading, as the study was not powered to detect such differences. Sample size was calculated only to detect “a mean reduction in length of stay of 10 days (SD 25) in the treatment group”—that is, to test the hypothesis that opening a new off-site facility and transferring inpatients to this facility would reduce length of stay (arguably a “given”).

Over the four month follow-up, patients in the treatment group had a 12% relative increase in readmissions (28% in treatment group *v* 25% in the control group), a 22% relative reduction in chances of returning to their own home (7% treatment *v* 9% controls) and nearly 4% relative “excess” mortality (28% treatment *v* 27% controls). As these (and other) potentially adverse outcomes are the basis of much of the controversy that surrounds this area, the results by Crotty et al contribute to the debate in terms of the design, and powering, of future studies.

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- 1 Crotty M, Whitehead CH, Wundke R, Giles LC, Ben-Tovim D. Transitional care facility for elderly people in hospital awaiting a long-term care bed: randomised controlled trial. *BMJ* 2005;331:1110-3. (12 November.)

Intermediate care can be safe and reduce hospital use, but is it and does it?

EDITOR—Crotty et al show that transitional, or intermediate, care facilities can be used to divert older people safely from hospital to a care home setting.¹ Our randomised controlled trial had similar findings,² but we could not exclude the possibility that such transitional care increases long term institutionalisation over a longer period of follow-up (12 months, compared with four months in the study by Crotty et al). Young et al’s whole sys-

tem study in Leeds showed that intermediate care services increased admissions to hospital.³ So, intermediate care can sometimes reduce hospital admission and sometimes it does not. It is not guaranteed to lead to outcomes that are equivalent to those of the services being replaced.

This inconsistency of the evidence base raises the question of whether findings obtained in controlled research studies of services can be generalised to other times and settings. If not, the fears previously raised about the quality of care for older people in intermediate care services¹⁻⁵ cannot be put to rest simply because some demonstration projects have shown acceptable findings.

We need high quality randomised controlled trials, such as that reported by Crotty et al, to show what is possible, but we also need to establish the conditions that are necessary for success—those conditions that when not met lead to ineffective or unsafe care.

This is likely to require a wide range of descriptive research methods such as systems analyses and case studies undertaken alongside controlled studies. Once these conditions for success have been established, we need a systematic quality assurance exercise to ensure that they are being met.

If we do not do this then we may find ourselves so blinded by policy pressure to keep older people out of hospital that we fail to do our jobs as clinicians as we collude with the provision of substandard care.

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Including care home residents in clinical research is fraught

EDITOR—Funders need to take account of issues related to including older people in clinical trials,¹ but including care home residents poses additional problems.

We have just completed a large clinical trial of a pharmacist conducting clinical medication reviews of elderly residents of care homes. Obtaining consent presented particular problems in this population with an average age of 85 and a standardised mini-mental state test score of 13. Even those residents who seemed to understand what was being asked of them had often forgotten all about it when our research assist-

ant returned the following day to seek their signature. We needed to seek the assent of the nearest relative for half of our study population.

Not only is obtaining consent time consuming, but we also needed the agreement of home managers before we could even approach their residents. Arranging to see the residents was fraught because of the limited time window in their short day when they are not eating, sleeping, dressing, or washing, or attending outpatients. The interview process is also prolonged, because of the time the residents take to walk to their room, as well as the communication difficulties during interview. We also had to exclude some patients who had given consent from the trial because their doctor did not agree to their inclusion. This interfered with the autonomy of patients who had agreed to participate.

The implications for our (already generously funded) project were that we had to seek additional finance to complete the recruitment process and still failed to achieve our recruitment target of 1600 after approaching virtually all elderly care home residents in Leeds. Interpretation of results is further complicated by the high mortality of this population—in six months, over 14% of our population had died (in intervention and control groups). Research in care homes is essential but surprisingly expensive in both time and money.

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1 McMurdo MET, Witham MD, Gillespie ND. Including older people in clinical research. *BMJ* 2005;331:1036-7. (5 November.)

Rates of exception reporting need to be addressed

EDITOR—Kenny notes that 93% of general practices achieved the maximum points for diabetes care.¹ A matter of concern is the apparently inconsistent manner in which the targets were reached.

Data in the public domain (www.ic.nhs.uk/services/qof/data/) show that some practices that achieved maximum points had excluded a sizeable proportion of their target population, using the exception reporting facility that allows individual patients to be declared unsuitable. The wide disparities in exception reporting between some neighbouring practices may sometimes have a valid explanation, but satisfaction with the quality and outcomes framework will hinge on clarification of what is acceptable and the adoption of uniform standards.

Options available to primary care trusts range from provision of supportive advice to the use of the post payment verification sys-

tem. Unless this is done, a substantial number of patients may receive suboptimal care, and practices that have hit their targets without resorting to extensive exception reporting may become disillusioned.

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Competing interests: None declared.

1 Kenny C. Diabetes and the quality and outcomes framework. *BMJ* 2005;331:1097-8. (12 November.)

Invest in people, not restructuring

EDITOR—O'Dowd reports mixed views but palpable overall concern from health service managers about current proposals to merge primary care trusts.¹ Some argued that such restructuring would put trusts back 18 months or more, but others thought not.

The little evidence available shows that restructuring is often futile, fails to achieve its objectives (usually, of saving money), causes disruptions that may last beyond 18 months, and has unintended consequences such as pushing people into new relationships they may not want and causing others to leave because they dislike the new arrangements.²⁻⁴ It is not difficult to imagine this: many organisational relationships are built up over years, and wholesale restructuring can perturb them. Some relationships never recover, and morale suffers. Fulop et al's work on NHS trust mergers underscores this view.⁵

One peculiarity of restructuring is what it tells about those who sponsor it. Advocates of restructuring are promoting a simplistic idea, assuming that if they alter the formal arrangements such as the boxes on the organisational chart, and the official reporting arrangements, they will achieve meaningful improvement of health systems. Few organisational scholars believe that this enhances performance, arguing that it is much more sustainable to try to change other aspects of systems such as the way teams work together or the clinical and organisational cultures and subcultures.

Perhaps we could encourage those in authority to look beyond the formal structure of the NHS, and concentrate instead on what really matters—the way in which people provide services to patients, how they relate to each other and their clients, and how teams work. The money spent on restructuring could be turned into investment in people delivering care.

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1 O'Dowd A. Health service managers play down fears over primary care trust reorganisation. *BMJ* 2005;331:1104. (12 November.)

2 Fulop N, Protopsaltis G, Hutchings A, King A, Allen P, Normand C, et al. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *BMJ* 2002;325:246-9.

3 Braithwaite J, Westbrook J, Iedema R. Restructuring as gratification. *J R Soc Med* (in press).
4 Relman AS. Restructuring the US health care system. *Issues in Science and Technology Online* 2005;summer 2003. www.issues.org/issues/19.4/ (accessed 17 Nov 2005).
5 Fulop N, Protopsaltis G, King A, Allen P, Hutchings A, Normand C. Changing organisations: a study of the context and processes of mergers of health care providers in England. *Soc Sci Med* 2005;60:119-30.

Criminal proceedings will hamper calls for open culture

EDITOR—The National Patient Safety Agency urges healthcare staff to adopt an open culture where they admit to errors in order that the organisation can learn from them and treatment be made safer. Recently, 14 senior doctors candidly described their own experiences of medical errors.^{1,2}

However, we have previously pointed out that if doctors and others who err are charged with manslaughter, then exhortation to openness is likely to fail.³ When we examined cases due to errors in administering anaesthetics and in prescribing and giving medicines, we found a marked increase in the number of doctors charged between 1970 and 1999. We have now extended our analysis to consider all doctors charged, including surgeons, between 1970 and 2004, using the newspaper database Lexis Nexis, the Times digital archive, and the Medline and Embase databases. We discovered 36 cases, including 43 doctors, where the outcome was known (table). In the five years subsequent to our original publication, 17 doctors were charged with manslaughter.

Doctors charged with manslaughter in the course of medical practice

Years	No of doctors
1970 to 1974	0
1975 to 1979	4
1980 to 1984	1
1985 to 1989	1
1990 to 1994	10
1995 to 1999	10
2000 to 2004	17

Error is unavoidable in the course of medical care. Criminal prosecution after a medical error may be an emotionally satisfying way to exact retribution, but it will not address the root cause of errors within a complex system such as the NHS. Charging doctors with manslaughter will make health care more dangerous, not safer.

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Competing interests: REF has provided medico-legal reports for healthcare professionals charged with manslaughter

1 National Patient Safety Agency, Medical Defence Union, Medical Protection Society. *Medical error*. London: National Patient Safety Agency, 2005.

2 Coombes R. Senior doctors admit mistakes in campaign for more open culture. *BMJ* 2005;331:595. (17 September.)

3 Ferner RE. Medication errors that have led to manslaughter charges. *BMJ* 2000;321:1212-6.