The health of the nation

Sir,—The chief medical officer has called on doctors in England to respond to the government’s green paper The Health of the Nation. Its main thrust is away from the intractable problems of the NHS towards preventive medicine, particularly with regard to the big killers (coronary heart disease, stroke, cancers, and accidents) which are thought to be suitable for mass intervention. Other factors such as smoking, diet, and alcohol are also highlighted. I wish to query some of the unstated assumptions of the thesis.

Breast cancer—The green paper accepts that screening for breast and cervical cancer is effective. The argument is to reduce deaths from breast cancer in the screened population by 25% by 2000 compared with 1990. The contrary view, based on a recent seven year study in Edinburgh, is that “there is no statistically sound evidence that breast cancer screening has ever saved a life in the United Kingdom...the only trials of screening in this country have been reported as statistically non-significant.”

Carcinoma of the cervix—The target is to screen all eligible women for carcinoma of the cervix by the end of 1993. The view that such screening harms women by causing increased anxiety in those with positive results while falsely reassuring those whose results are negative is not heeded. Holland and Stewart’s review on screening notes that 25 years after its introduction screening for cervical cancer has failed to reduce the 2000 deaths caused by this disease annually in the United Kingdom. Skrabanek, reviewing Holland and Stewart’s book, is more blunt: “In the UK, after some 60 million cervical smears, there is nothing to show in ‘lives saved’. ...by this monumental folly.” My comment is that for a disease that is largely preventable by good personal hygiene to screen all adult women is a flawed strategy.

Coronary heart disease—The target is to reduce deaths from coronary heart disease among people aged under 65 by 30% between 1988 and 2000. The package for healthy living includes consuming less saturated fat, less fat overall, and less alcohol and reducing salt and sugar. I would suggest that the official policy on coronary heart disease and blood cholesterol testing is that priority should be given to opportunistic measurement of blood cholesterol concentration in people at high overall risk of the disease. All risk factors, including smoking, raised blood pressure, and obesity, should be tackled together with blood cholesterol concentration. Unfortunately, many members of the general public have been persuaded to place undue weight on cholesterol alone. The problem is that merely reducing the blood cholesterol concentration does not help. Oliver stated: “At present, available data indicate that total mortality is unchanged when hypercholesterolaemia is lowered; the fall in cardiac mortality is offset by an apparent increase in non-cardiac deaths.” Jones said: “Unfortunately, evidence that lowering cholesterol concentrations lowers mortality does not exist.” An editorial in the Lancet concurred with these appraisals.

The ideology of the consultative document is preventive medicine and screening; it is doomed to failure. The risks and dangers of screening are not addressed. The ratio of harm to benefit in screening is much more unfavourable than that in “ordinary” medicine. For screening for breast cancer one estimate was a ratio of 62:1. The plan to reduce coronary heart disease may produce some benefit provided we can get away from the obsession with cholesterol. There is now a danger that public health experts will do to medicine what sociologists have done elsewhere: impose their ill conceived ideology, without regard to the facts, on an unsuspecting public.

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Surgeons who are hepatitis B carriers

Sir,—We read with sympathy Mr Stewart Kennedy’s description of his investigation, and the outcome in terms of his career, after a woman on whom he had operated developed hepatitis B.

We had a colleague with a similar history. During investigation of a personal medical problem he was found to be positive for hepatitis B e antigen. Coincidentally, a 69 year old woman on whom he had performed a small bowel resection five and a half months earlier presented with acute hepatitis B. Further inquiries revealed two other patients of his, without other risk factors, who had developed jaundice after surgery. One, a 63 year old woman, had developed jaundice six years earlier after a cholecystectomy, and the other, a 30 year old woman, had developed it after a subtotal thyroidectomy four years before. Our surgical colleague did not ignore the risk of infection with hepatitis B virus in that he had sought vaccination seven years before, had completed the course, and had been given at least two booster doses. At no time did he have detectable antibody to hepatitis B surface antigen. Because of the prevailing view that staff should not...