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## Why the health secretary's "well note" is not so swell

George Moncrieff

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**Not so happy about  
“well notes”**  
Personal View, p 508

## VIEWS & REVIEWS

# Half bottle or half cut?

PERSONAL VIEW **Trish Groves**

**B**anning supersize meal portions may help to cut obesity rates. Tax hikes, fewer happy hours, and better education may help to cut harmful drinking. But where's the debate on supersize portions of wine? Why does wine have to come in 75 cl bottles?

I like a glass of good wine with my supper. But, once two of us have had a glass each, it's hard to know what to do with the rest. The fridge door is already full of milk bottles, the wine stoppers leak if you lay the bottle on a shelf, and although whites and rosés may not mind sitting in the fridge for another day or two, most reds don't keep well once open. It's all too tempting to finish the bottle there and then to avoid waste. Coupled with the news that wine is getting stronger, with 8 or 9 units in a bottle, it's no wonder Britain's middle aged middle classes are getting wasted.

The North West Public Health Observatory, at Liverpool John Moores University, reported last year that wealthy towns top the league table for hazardous drinking in the UK. They defined hazardous intake as 22 to 50 units a week for men and 15 to 35 for women. Surrey stood out, with Runnymede first (with 26.4% of its population in this category), and Surrey Heath, Guildford, Mole Valley, Waverley, and Woking also in the top 10. Harrogate in North Yorkshire came second. Other northern towns and cities topped the league for very heavy drinkers, but the findings from leafy southern towns were, nevertheless, a bit of a shock. The BMA Board of Science's new report *Alcohol Misuse: Tackling the UK Epidemic* confirms that men and women who are higher earners are more likely than the lower paid to have drunk alcohol at all, and to have drunk on five or more days a week (*BMJ* 2008;336:407, doi 10.1136/bmj.39495.570185.C2). And, while beer

remains Britain's favourite drink, wine consumption rose from 10% of all alcohol in 1970 to 28.8% in 2005.

Wouldn't reducing wine portions reduce some of this consumption and harm? Easier said than done. My local upmarket supermarket in the Thames Valley has row upon row of good looking wines in 75 cl bottles. It also has a few wine boxes—surely a recipe for excess. But it offers only three wines in half bottles, hides them with the dessert wines that hardly anyone drinks, and bumps up the prices prohibitively. Online UK retailers are no better: search for half bottle and you simply get “half case, six bottles.” It's no easier to find a decent half bottle in a UK restaurant. Yes, you can buy wine by the glass, but the overpricing means you may as well pay the extra quid and order a bottle. And how many people stick to one glass, even though they're huge?

Maybe this is a peculiarly British problem. On holiday in France last week I had drinkable wines by the carafe, pichet (small jug), and half bottle in restaurants and cafes, and the local mini market had a good range at 37.5 cl at fair prices. Most French wine websites have a tab for searching by bottle size, and plenty of half bottles to choose from. It's the same in Italy and Spain, and in many US restaurants half bottles are all the rage, according to trade websites such as *Caterersearch.com*. For instance, a fifth of diners at Go Roma, a San Francisco chain described as “fast-casual,” order wine and nearly two thirds of them have half bottles. (Admittedly, US diners may want less wine because their restaurants always provide a big glass of iced tap water too. In the UK you have to beg servers to bring tap water and only last month the National Consumer Council reported that one in five people feel “slightly nervous” or even “too scared” to ask for it.)

There are some technical and economic downsides to producing wine in half

bottles. A quick web search suggests that wine, particularly good red, is more prone to damage from heat and vibration and matures too quickly in half bottles; small bottles are no cheaper than big ones to make; bottlers have to set up extra production lines and use smaller labels; retailers have to reorganise their shelves; and wine racks are the wrong size. Fair enough. If you want excellent wine to lay down don't buy half bottles. But some of the best French Grand Cru houses produce half bottles, not least because they want to reach markets that can't or don't want to spend more. And none of the disadvantages should rule out the production and sale of youngish, drinkable, everyday wines in half bottles.

Banning supersize meals won't stop people from buying two regular burgers, and selling half bottles won't stop some drinkers from simply having two. But there must be at least one supermarket chain willing to give the half bottle market a proper go with a decent range and fair pricing, and to trump their competitors' hands for responsible, healthy retailing. Come on Tesco, Sainsbury's, Waitrose, Morrisons and all—help us out. Cheers.

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See **EDITORIAL**, p 455, and  
**CLINICAL REVIEW**, p 496



# Why the health secretary's "well note" is not so swell

PERSONAL VIEW **George Moncrieff**

Everyone agrees that the United Kingdom's state benefit system is in a mess. The cost to the taxpayer has escalated out of control, and the annual bill is now in excess of £13bn (€17bn; \$26bn). The public is outraged by stories of malingering and inappropriate claims, and the government has appointed Carol Black, as national director for health and work, to investigate alternatives to the current flawed system.

Most GPs would like to be removed from their current central role in signing patients off work—not because we are lazy, but because we recognise that it is impossible to be the patient's advocate on health matters at the same time as being responsible for deciding whether they are entitled to incapacity benefit. Furthermore, most of us have no experience of occupational health and really know little more about our patients' work environments than anyone else. Instead of policing the system effectively, honest GPs admit that they nearly always simply ask their patients whether they think they should be at work

and how long they think they should be off work. At most we may suggest that work is generally good for health and that usually you don't need to be completely fit before returning.

It is the naive assumption that GPs can police the system, together with one of the lowest levels of occupational health advice in the European Union, that accounts for the UK's current problem. I estimate that I have signed about 20000 people off work in my career so far, yet I doubt that I have ever made any significant useful contribution.

Talking to other GPs shows that my experiences are shared. I have yet to meet a GP who would be prepared to fall out with their patient over this. Besides, what could a GP

gain by insisting that patients return to work against their wishes? At best, an upset patient; at worst, the likelihood that the patient would seek further opinions or even sue the GP if any perceived harm resulted from returning to work prematurely. Interestingly, most employers would like to scrap the present system as well. It is the unions, representing the employee, that are most eager to maintain the present system. Why? I am amazed, though, how few employers ever challenge a certificate or seek further information, even when it is blatantly inappropriate for their employee to be signed off.

Sadly, rather than acknowledge this straightforward fact, health secretary Alan Johnson now somehow imagines that GPs will be able to extend their role and start to provide "well notes" (see News, p 468). This lack of insight into the relationship between patients and their GPs and the blinkered insistence on maintaining the current failing system are lamentable.

For the 60 years of the NHS, patients have had in their GP a trusted health adviser and advocate. Ninety per cent of doctor-patient encounters are in primary care, and the modern GP manages complicated, multisystem diseases with the benefit of a long term relationship. Remarkably, this government seems hell bent on destroying this arrangement, once described as the jewel in the NHS crown. The introduction of Ara Darzi's polyclinics (*BMJ* 2007;335:61), a matter of utmost priority for this government, will seriously undermine existing primary care. But far more alarming will be the insidious destruction of any opportunity for GPs to maintain long term relationships with patients and thus to be able to encourage them to return to work, particularly against their wishes. Nothing would stop patients shopping around until they found a doctor willing to accept the reward of a simple consultation and the offer of an off-work certificate. The introduction of a parallel private system, intended to undermine current primary care, will make this new role completely impossible.

The solution is straightforward. GPs should

**GPs should be removed from their central certifying role, and properly independent occupational health services should be made available to all employees**

be removed from their central certifying role, and properly independent occupational health services should be made available to all employees. With £13bn to play with, this should be eminently affordable. As a GP in a town with about 30 GPs, not only do I have no real concept of the issues in a workplace, but I also have only a very small part of the whole picture. My town has about 30 GPs. An occupational health adviser, working with all the doctors and practices, would see trends in the workplace that could never be apparent to one GP, whose main interest is only the patients he or she looks after. The only role for a GP then would be to provide an occasional factual statement of a medical condition, perhaps with some functional interpretation if necessary. Deciding whether the patient is capable of some work, or any work, could then be made by the occupational health adviser, who would have insight into the work environment, an opportunity to make changes, and, crucially, no ongoing commitment to the employee in a caring role.

Perhaps, more controversially, employees who are off work could be fast tracked through secondary care for investigations and treatment, if their return to work is delayed by a medical condition.

Until we start to think in such radical ways the problem will only deteriorate. GPs are already angry over demands to increase patients' access and feel undermined by Lord Darzi—this is hardly the time to ask us to take on a difficult task that we have already demonstrated cannot be done.

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**Competing interests:** GM is one of the GPs on the "Sounding Board" with Carol Black.

**From the archive:** See Personal View, "Patients, doctors, and sickness benefit" (*BMJ* 2003;327:1057 doi: 10.1136/bmj.327.7422.1057).





**“Patients systematically and repeatedly lie to get drugs to be sold into the black market”**  
Des Spence, p 510

## REVIEW OF THE WEEK

# Sport and public health—an Olympian challenge?

Are major sporting events such as the Olympics a force for good health or a diversion of public funds for the enjoyment of a privileged few? **Karim Khan** and **Ken Crichton** examine a new book

For some people, mass gatherings provide the high point of a lifetime: kissing the black stone at Mecca alongside a million pilgrims; kissing a complete stranger at Wembley to celebrate an FA Cup victory. For others, mass gatherings are seen as a locus for illness, injury, and death. Although the diseases that spread at the 1969 Woodstock music festival most probably caused greater inconvenience than incapacity, jolting memories of the Hillsborough football stadium disaster in 1989 and the massacre at the 1972 Olympic Games in Munich remind us of the inherent risks associated with major public events.

For seven years Agis Tsouros and Panos Efstathiou carried the responsibility for the safety of all involved in the 2004 Olympic Games in Athens. Their experience provides the content of this book. Their detailed technical and practical information will benefit not only the public health officers of future Olympic Games but also those involved in world championships and other major sporting events. Given the potential seriousness of providing for the 3.5 million people who attend the Olympic Games, that contribution is no small feat.

In addition to this invaluable public service the authors also contribute to the larger argument about whether the Olympics are a force for good health or an inappropriate diversion of public funds for the enjoyment of a few. Before Vancouver was awarded the 2010 winter Olympics, many cars in the city carried bumper stickers saying “Health care not Olympics.” This is a typical response in cities that host delegates from the International Olympic Committee. However, Tsouros and Efstathiou provide data to show that the Athens Olympics increased the standards of public health care, promoted interagency cooperation, and established a wonderful environmental health system. The athletes’ clinic subsequently became a model primary care clinic. The legacy is a community with experience in handling big events, better hospital preparedness, and international collaborators in the event of major infection outbreaks or bioterrorism.

On the public health front, the organisers of the Olympics held a mass participation fun run through Athens. During the smoke free period of the games free condoms were given out, the public was warned of the dangers of sun and dehydration, and HIV edu-

cation packs were given to athletes so that they could be universal ambassadors on their return home. Is that enough?

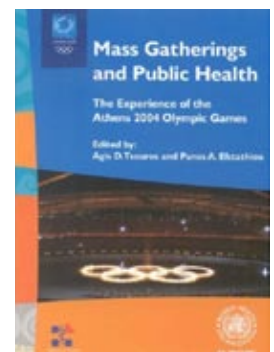
To their credit, in answering this question the book’s authors conclude that the Athens games failed in this respect. They tell us that the budget for promoting public health was only 0.08% of the overall cost of the Olympics. They argue for an earlier start to the process of promoting public health in association with the Olympic Games and for a dedicated professional committee with appropriate ringfenced funding. This committee must be separated from the organisational component of the games and deal with health promotion to ensure “a more balanced investment of energy, efforts, and outcomes,” say the authors.

Do events such as the Olympics inspire people to be more active? An article in the *Journal of Physical Activity and Health* (2007;4:193-202) analysed data to test the hypothesis that mass sporting events inspire people to take more physical exercise. They found plenty of rhetoric but sparse evidence that mass sporting events have any effect at the individual, community, or environmental levels. A major limitation was the lack of evaluation of such events, the article found. Tsouros and Efstathiou also say that more should be spent on evaluation of the promotion of public health, which should be part of the core business of the Olympic Games.

Interestingly, the World Health Organization’s web page about this book says that it “highlights that mass sports gatherings such as the Olympics can be powerful platforms for promoting health messages, especially physical activity and active living, healthy nutrition and avoidance of smoking,” despite the authors’ message that the Athens games failed on this front.

The health sector needs to engage with the opportunities provided by major sporting events to market the physical activity message. It is only when such connections are made that mass events might contribute to health promotion and grow beyond providing short term public entertainment.

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## Mass Gatherings and Public Health: The Experience of the Athens 2004 Olympic Games

Agis D Tsouros,  
Panos A Efstathiou

World Health  
Organization, £37, pp 377  
ISBN 978 92 890 7288 5

Rating: ★★☆☆

**Before Vancouver was awarded the 2010 winter Olympics, many cars carried bumper stickers saying “Health care not Olympics.”**

## Drugstore cowboys

FROM THE  
FRONTLINE  
Des Spence



The tears streamed down her face as she clutched her trophy. She was a character actress of impossible quality, completely immersed in her role. She would always hit you when you were at your most vulnerable, arriving unannounced, playing to a full waiting audience for maximum dramatic effect. She would often be supported by an equally talented supporting cast of concerned and insistent “family members.” Such is the exhausting daily matinee performance in which doctors are stung for prescription drugs (diazepam, temazepam, nitrazepam, dihydrocodeine) to be sold on the street outside pharmacies.

Drug seeking behaviour is endemic in health care. Patients systematically and repeatedly lie to get drugs to be sold into the black market. Techniques vary, from expert dramatic performance that presses all the most emotive buttons to evoke sympathy to crude pantomime intimidation (“He’s behind you!”). Other simpler methods are to abuse the repeat prescribing system with frequent requests and to “lose” or alter prescriptions.

Patients target certain practices, certain doctors, and certain times of day but are ever flexible to adapt to new

business opportunities. I would like to say that I wasn’t that doctor or that practice—but that too would be a lie.

Is this crime? I suppose it must be. But the doctor-patient relationship is fundamentally one of trust, and we are taught to believe our patients. Confronting patients is almost impossible without any evidence, leaving us largely powerless to police this situation. We either simply accept that many of the drugs we prescribe are sold on or use the time honoured tradition of denying that it happens. But this isn’t a victimless crime, as these drugs are absorbed into a supersaturated drug taking society, precipitating enormous misery.

What are our options? Certainly, doctors should be educated about cues that indicate when patients are acting and be trained in how to cope with such situations. Closer liaison with local pharmacies might help. But many of us have tried this.

Perhaps it is time to consider voluntary bans in certain localities on drugs that are commonly diverted. This drama is real.

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## We’re all pharmacologists now

DRUG TALES AND  
OTHER STORIES  
Ike Iheanacho



Endlessly repeated, a half truth can mutate to dogma and then unquestioned “fact.” So, having become what everybody thinks they know, the half truth is free to distort thought, discussion, and action.

Into this category falls the notion that the drug industry conducts most of the key testing of its products. This is sort of true but only from the narrow perspective that equates research with steering committees, consent forms, confidence intervals, and publication.

Such “official” research may, of course, be far removed from everyday clinical care. And jobbing doctors rarely think of themselves as research scientists. But it is obvious that they are: each of their prescriptions, particularly for new drugs, initiates an experiment, the results of which influence practice.

Where an experiment with a drug seems to be a success the prescriber’s faith in that treatment may grow. Results shared with colleagues further swell the treatment’s reputation, however the drug has performed (or been tested) in official

research. On the other hand a single experiment with a disastrous outcome (such as a death from an idiosyncratic reaction) may mean that the prescriber never uses the treatment again, however unlikely another calamity seems from clinical trial and pharmacovigilance data.

Unstructured and open to bias, this informal research is at least open to scrutiny, because prescribers record and talk about their work. Contrast that with a much more secret world, one untroubled by professional regulation or peer pressure. Patients have always experimented on themselves with prescription only drugs, to seek benefits beyond those promised or achieved by their doctors. Examples include changing the dosage, trying unsanctioned drug cocktails, or quietly disposing of a prescribed drug to see whether symptoms resolve anyway.

Sometimes the patient may feel vindicated through such experimentation. A person who finds that cutting a tablet in half provides a dose that avoids

unwanted effects yet controls symptoms might be thought brave and resourceful—or foolhardy. But simply calling such investigation “wrong” is a cop-out if official research and professional care have not provided as good a solution.

The official research world has little time for self investigating patients, generally seeing them as a menace. This contempt is evident in the negative terms often used to describe such people if they’re discovered (“defaulters,” “protocol violators,” “dropouts”) and in the way they are systematically excluded from or inadequately represented in trial results. In the real world such dismissal will ensure only that self experimentation remains a largely covert and potentially dangerous business. Those seeking a better way forward need to acknowledge the blurring of traditional distinctions between researcher, prescriber, and patient—we’re all pharmacologists now.

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# Those were the days

T S Eliot was not the most accessible of writers, to put it mildly, but he wanted to show that he could write plays that would please the general public. Reading the products of his attempted demonstration rather puts me in mind of the duke who, reproached for never having ridden on a bus and for therefore being out of touch with the common people, promptly jumped on a bus to prove the accusation false and said to the driver, “Grosvenor Square, and quick!”

Oddly enough, however, Eliot’s plays were a success (the script of *The Cocktail Party* even became a bestseller in America), which suggests that the tastes of the public may have changed in the intervening years; I will not say in which direction.

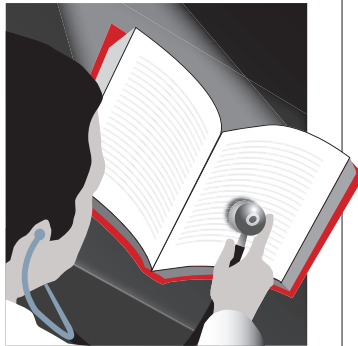
Doctors have big parts in *The Family Reunion* (1939) and *The Cocktail Party* (1949). Indeed, some of the action in the later play takes part in Sir Henry Harcourt-Reilly’s rooms in Harley Street.

Sir Henry is a slightly sinister *deus ex machina* of uncertain medical specialty who seems to know all about the other characters without having to have made inquiries.

Dr Warburton, in *The Family Reunion*, is an old fashioned family doctor whose authority has little to do with his medical efficacy (indeed, is inversely proportional to it) and who is able to order a formidable dowager duchess around like a servant. His threat to decline to treat her further is enough to bring her into line. Those were the days when doctors were doctors and patients were patients.

Dr Warburton is a little like one of those disillusioned doctors in

BETWEEN  
THE LINES  
Theodore Dalrymple



**Dr Warburton is an old fashioned family doctor who is able to order a formidable dowager duchess around like a servant**

Chekhov, worn out by the existential inevitability of death: “I used to dream of making some great discovery/To do away with one disease or another./Now I’ve had forty years of experience/I’ve left off thinking in terms of the laboratory./

“We’re all of us ill in one way or another:/We call it health when we find no symptom/Of illness. Health is a relative term.”

One of the speeches by Agatha, a maiden aunt, started a strange chain of associations for me. She says: “In a world

of fugitives/The person taking the opposite direction/Will appear to run away.”

Now in my copy of *The Family Reunion* I happened to find an inscription offering the book as a Christmas gift to a well known physician who was not universally loved and who was irreverently known to his juniors by the description of the stools of some of his patients with coeliac disease—namely, Pale, Bulky, and Offensive. But the signatory of the note was another physician who, in March 1938, was a co-signatory of the famous letter in the *BMJ* calling attention to the plight of Jewish and other doctors after the Anschluss. The letter ended with some noble words:

“We beg our colleagues in all countries to watch the progress of events with the closest attention and to do all in their power, whether by public protest or by public or private assistance, to stand by any members of our profession who may suffer hardship under the new regime.”

Theodore Dalrymple is a writer and retired doctor

## MEDICAL CLASSICS

**Sakhalin Island** By Anton Chekhov

First published in 1895

This book is an account of the remarkable study that Chekhov made of the conditions in the Russian penal colony on the barren Sakhalin Island off the east coast of Siberia. In 1890 the 30 year old Chekhov was an emerging figure in Moscow literary circles. He was also a qualified doctor and was building up a medical practice in the city. He had also been beset by tragedy: his elder brother, his sister in law, and a close friend had all recently died of tuberculosis. Chekhov, too, had already recognised the haemoptysis caused by the tuberculosis that would kill him at the age of 44.

It was a surprise to family and friends when he announced his plan to travel nearly 10000 km to Sakhalin. Among several motives, he wanted to produce a scientific work of substance, something that would “repay his debt to medicine” and be a serious academic study to set alongside what he had then come to regard as his more frivolous literary work.

The gruelling three month journey across Siberia included some 4800 km on a horsedrawn cart. On arriving at Sakhalin Island he set about interviewing almost all of the population and recording their details on 10000 structured index cards. Chekhov took particular interest in the ability of the colony to reform convicts and to equip them with new skills. He assessed each settlement for its ability to sustain profitable farming. In sending prisoners to Sakhalin the state’s aim was that they would, after completing their sentence,

remain as “settled exiles” and establish a colony that would secure the land as Russian territory. Unfortunately, the harsh climate and the parcelling out of inadequate areas of the infertile land meant that the efforts to make a living from farming were often hopeless.

As well as the starving families in the poorer settlements, Chekhov observed the universal squalor,

the backbreaking labour, and the brutality of many prison officials. As a doctor he recognised and condemned the lack of care in the infirmary, where he found neglected wounds, blunt and broken instruments, stocks of obsolete drugs, and ignorant staff.

The book is clearly based on scientific method. Chekhov carefully describes his data cards, the methods, and the difficulties of data collection. He presents his findings systematically, settlement by settlement. The second part of the book discusses his findings, laid out under the headings of the various aspects of Sakhalin life. Here are tables of figures and comparisons with data from other regions of Russia. At one point he analyses the paradox of the apparent longevity of Sakhalin’s residents and observes the misleading effect of a population that is low in numbers of vulnerable children and elderly people.

In 1885 a survey by an American of the mainland Siberian labour camps had been damning. When published in 1895 Chekhov’s book drew more attention to the previously obscure Sakhalin colony and added to the growing pressure to reform Russia’s penal system.

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