# LETTERS

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UNDER THE INFLUENCE

## England's public health system is in tatters

Gornall's forensic analysis of the coalition government's disastrous alcohol policy calls into question whether England's public health system is still fit for purpose.[1] It is also increasingly clear that this lamentable state of affairs has not happened by accident.

The Department of Health's decision to move industry vested interests to the centre stage of key aspects of public health policy using the mechanism of the ill named "responsibility deal" is one of a series of moves that has left the English public health system in tatters.

Several changes have created a situation where the system that is meant to promote and protect the health of the population is impotent. These include centralisation of most of the public health workforce into the civil service through Public Health England, abolition of regional directors of public health, disappearance of regional public health observatories, lowered status of local directors of public health within local authorities, and the marginalisation and invisibility of the chief medical officer post. Reconstructing what was one of the most effective public health systems in the world will not be easy.

In response to the coalition's disgraceful record on alcohol, the time has surely come for even more vocal opposition to this selling out of our population's health to industry interests. The first step should be the withdrawal of all academics, health professionals, and representatives of non-governmental organisations from all responsibility deal steering groups. To remain involved would smack of being complicit.

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1 Gornall J. Under the influence. *BMJ* 2014;348:f7646. (8 January.)

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## Time for public health community to fight back

The minimum unit price political debacle should act as a wake-up call to the public health community in England.[1] Political influence needs to be exerted in a coordinated way between all relevant public health organisations (Public Health England, Faculty of Public Health, Association of Directors of Public Health, UK Public Health Association, and the chief medical officer). Surely there are enough combined resources to achieve this.

If the competing interests of the alcohol industry are to be truly taken on (within a flawed system that allows them such ease of access to the corridors of power) the public health community must play the industry at its own game. We can either complain about the seemingly unjust system from the sidelines or roll up our sleeves and get on the pitch. Effective lobbying must be a skill developed in earnest within our profession. If we are to tackle the "organised efforts of society," surely that means effectively influencing government itself.

It is time for the public health community to grow up and play with the big kids.

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Competing interests: None declared.

1 Gornall J. Under the influence. *BMJ* 2014;348:f7646. (8 January.)

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SAFETY OF YOUNG DRIVERS

## Green paper on safety of young drivers has stalled

Alcohol minimum unit pricing is not the only evidence based public health policy that has failed to materialise recently.[1]

In January 2013, we believed that the UK government would, as promised, publish its green paper on young driver safety in the spring.

In the UK, motor vehicle crashes account for a quarter of deaths in 15-19 year olds.[2] The green paper was to set out options for tackling the burden of young driver crashes on health and health services, supported by a Department for Transport commissioned evidence review by TRL (Transport Research Laboratory), which would address concerns about graduated driver licensing (GDL). GDL has consistently been shown only to benefit young driver crashes.[3]

The TRL review found compelling evidence for introducing GDL,[4] supported findings of modelling work,[5] and conservatively estimated that GDL would prevent 4471 casualties and save £224m (€273m; $370m) annually.

The green paper was pushed back continually. In late December, the government admitted it was still "wrestling with the issues" and would "issue a paper when we have considered this further."

The government is now looking at alternatives, including telematic driver monitoring. Telematics show promise, but are unproved as a public health intervention. We see telematics as complementary to GDL, not an alternative.

The need for GDL is clear. It is supported by the road safety sector, the insurance industry, public health, the police, road safety charities, and politicians. International evidence is compelling, and to exclude GDL from the green paper would greatly reduce the potential for evidence based change.

We remain hopeful that the green paper will be published and that it will recognise the benefits of GDL, include the recommendations from the TRL review, and that a frank and open public debate will follow.

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Full response at: www.bmj.com/content/348/bmj.g110/rr/682016.

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☒ BLOCKERS AND MORTALITY IN COPD

## Utility of antimuscarinic drugs

Quint and colleagues and Rutten show the benefits of β blockers on mortality in patients with the common combination of myocardial infarction and chronic obstructive pulmonary disease.[1 2] The competitive blockade of β adrenoceptors by β blockers surely negates the beneficial effects of β agonists, such as salbutamol and salmeterol. So wouldn't it be cost effective to stop these agents when β blockade is started and replace them by potentially equally effective bronchodilator antimuscarinic agents, such as tiotropium or aclidinium?

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Competing interests: None declared.

1 Quint JK, Herrett E, Bhaskaran K, Timmis A, Hemingway H, Wedzicha JA, et al. Effect of β blockers on mortality after myocardial infarction in adults with COPD: population based cohort study of UK electronic healthcare records. *BMJ* 2013;347:f6650. (22 November.)
2 Rutten FH, Groenwold RHH. β blockers for adults with chronic obstructive pulmonary disease. *BMJ* 2013;347:f7050. (25 November.)

Cite this as: *BMJ* 2014;348:g1108

## Impact of coronary angioplasty

Quint and colleagues investigated the role of β blockers in patients with chronic obstructive pulmonary disease (COPD) having a first myocardial infarction between 2003 and 2008.[1] The primary outcome of all cause mortality after a first ST-elevation myocardial infarction (STEMI)/non-STEMI was lower in patients prescribed β blockers before myocardial infarction or during hospital admission for myocardial infarction than in those who never took a β blocker (hazard ratio 0.45). Analysis of several covariates did not significantly alter the hazard ratio, but the authors did not include primary percutaneous coronary intervention.

The number of primary percutaneous coronary interventions is constantly growing in the UK,[2] and aggressive reperfusion strategies after myocardial infarction, by saving a greater part of myocardium, may reduce the benefits of β blockers. It would therefore be useful to investigate this variable in patients with COPD having a first myocardial infarction before drawing firm conclusions. This paper raises a general issue: conclusions drawn from data collected in the past may not always be applicable to the present owing to rapid developments in medicine that lead to major changes in practice. The changes in this case were the introduction of primary percutaneous coronary intervention for STEMI and early revascularisation in acute coronary syndromes.

SPL

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1 Quint JK, Herrett E, Bhaskaran K, Timmis A, Hemingway H, Wedzicha JA, et al. Effect of β blockers on mortality after myocardial infarction in adults with COPD: population based cohort study of UK electronic healthcare records. *BMJ* 2013;347:f6650. (22 November.)
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## Author's reply

We agree with Wolstenholme that it seems counterintuitive to use β blockers and β agonists in patients with chronic obstructive pulmonary disease (COPD), but most patients in our study were prescribed cardioselective β blockers, so theoretically β blockade would not negate agonist activity in the lungs. Some studies have even suggested that β blockers have beneficial effects on COPD and reduce exacerbations and mortality independent of cardiovascular risk.[1] Although antimuscarinic agents are also effective bronchodilators, caution may be needed in this patient group owing to concomitant cardiac arrhythmias.

Primary percutaneous coronary intervention is indeed an important and increasingly used treatment for ST-elevation myocardial infarction (STEMI). Our data (not published) suggested that patients with COPD are less likely than those without COPD to undergo percutaneous coronary intervention, and in our study the number of patients undergoing this intervention was too small to include in the analysis. We agree that percutaneous coronary intervention is becoming more common and may be an important factor. We are undertaking a large and more up to date study of patients with COPD using data from the Myocardial Ischemia National Audit Project (MINAP) to investigate this and other factors.

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Competing interests: I am the first author of the paper discussed in the response.

1 Rutten FH, Zuithoff NP, Hak E, Grobbee DE, Hoes AW. Beta-blockers may reduce mortality and risk of exacerbations in patients with chronic obstructive pulmonary disease. *Arch Intern Med* 2010;170:880-7.

Cite this as: *BMJ* 2014;348:g1132

EVIDENCE BASED MEDICINE IS BROKEN

## Wanted: humanistic medicine

The conception that "poor regulation" compounds the profit driven pollution of evidence based medicine (EBM) is gaining popularity.[1] Indeed, current regulation is handmaiden to the "polluters," as these examples indicate:

- It allows medical parties to have financial conflicts of interest
- It goes easy on the adequacy of selection criteria, outcome measures, statistical significance, and other variables often used to manipulate evidence
- It allows polluters to test products against placebo or no treatment and show efficacy, but not necessarily over current treatment[2]
- It allows subject recruitment through financial incentives—this can introduce outcome bias
- It allows seeding trials—that is, marketing exercises concealed as scientific research
- It allows manipulative advertising to both doctor and patient inside and outside "scientific" journals
- It allows medicalisation and "me too" drugs
- It does not regard polluted information as a sufficient condition for rendering disclosure inadequate. Thus it reduces informed consent to a legal fiction and respect for autonomy to a cynical farce. The "transparency" it barely insists on makes us trust the untrustworthy[3]
- By allowing the research agenda to be driven by corporate interests rather than patient needs, dangerous products can slip through its sieve
- Worst of all, being ethical, it labels the research it approves as moral.

Having said that, the common belief that there must be some truly humanistic regulation that could help purify evidence based medicine is false and plays into the hands of the polluters. As long as medicine depends on them, such regulation will be rejected wholesale or, more dangerously, co-opted to suit their interests. There is no other option. If we wish to have a truly humanistic ethic, we need a truly humanistic medicine first.

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Competing interests: See full response at: www.bmj.com/content/348/bmj.g22/rr/680463.

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