Editorial

Seeing is not necessarily believing

Thirty years ago, as an elective medical student (E.M.) in a hospital in China, I watched a man with a perforated duodenal ulcer recover in the space of a few days having received no treatment other than acupuncture.

As an experience, this could make one either an advocate of meridians or a cynic. An older British doctor, visiting with a party from one of the Royal Colleges later that week, expressed his disbelief. ‘They faked it’ he suggested. This seemed implausible. Not even the most extreme of method actors can manage an acute abdomen with sub-diaphragmatic gas.

Instead I became a sceptic. Not just about acupuncture, but also about western medicine. About everything. Every perforated ulcer I had seen previously had triggered an operation. The patients recovered and—post hoc ergo propter hoc—the surgery did it. Nature was never left to run its course—merely, since most would not have been as fortunate as my Chinese friend.

That persistent, sceptical ‘How do you know it worked?’ remains one of our favourite (and doubtless most irritating) questions. And too often, even among those who should know better, the answer comes that ‘it is obvious’. Like supposedly ‘doubting’ Thomas, they have seen and therefore believe. Whereas to a sceptic, the blessed are those who have seen but think there are still some viable alternative explanations.

A flurry of optimism about prospects for reducing dementia arose a while ago in the wake of studies showing falling incidence in Rotterdam and Stockholm and falling prevalence in areas of England.1–3 Public Health England’s seven priorities now include ‘reducing the risk of dementia, its incidence and prevalence in 65–75 year olds’.4 The evidence adduced for this is based upon a consensus statement that, in turn, cites the aforementioned study of English prevalence.3–5 Dementia is commonly mixed in origin, with at least some vascular component, and the falling rates of cardiovascular disease and death, driven largely by health improvements rather than treatment, encouraged a consensus that the same primary prevention approach might have led to dementia reduction.5 It seems obvious. . .

Yet now, probably the largest study to date—of some 2 million people—suggests that risk of dementia decreases with increasing BMI.6 It need hardly be said that obesity and over-weight increased markedly in the Netherlands, Sweden and England over the periods when dementia incidence and prevalence appear to have fallen.

So which is it? Do healthy lifestyles and lower weight reduce dementia, or is falling dementia the silver lining of the obesity epidemic? Right now, we cannot be sure.

Dementia advice, however, has become part of the NHS Health Check programme, driven by a combination of political pressure and the often unfortunate principle that ‘something must be done’. Ideally, that something would be better social care provision and home-based support. Instead the national emphasis is on early diagnosis, and an unproven faith in the power of dementia to terrify people into individual behaviour modification (and fear may not be the motivator some assume)—elsewhere in this issue Llanos et al. observe that worry about colorectal cancer was not associated with screening uptake in Ohio.7

For this edition, we invited debate from colleagues leading on implementation of NHS Health Checks at Public Health England and from colleagues in academia and general practice who dispute the adequacy of their evidence base. Along with these, we offer a series of original papers that offer views on implementation, strengths and weaknesses of the approach in practice.8–13

In China in the early 1980s, there was remarkably little heart disease and no noticeable obesity. The local heart surgeon in Xian (very much a non-traditional practitioner) proudly showed off the minimalist facility he had developed. On a shoestring he had done an incredible job. After operating, he slept on the (2 bed) ITU himself until his patients were stable. Did he do bypass grafting? No, he said disappointedly, he had been keen to do some but only found two patients—one had died before he could operate and the other refused.

China has come a long way in terms of economic development, but it has also come a long way in acquiring the diseases of the developed world. Let us become too parochial about the English health check programme, alongside the English Health Check papers we include an exploratory study of cardiovascular risk reduction from China.14 Elsewhere, Jiang et al.15 report on short sleep duration and obesity in Chinese adolescents. The universality of local observation increases with time, technology and economic progress.

Finally, our sceptic of the week has to be ‘the indisputable giant’ Prof Walter Holland, who features not only as an author in our opening debate on health checks, but closes proceedings...
with his reservations about the return of English public health to local authorities, while on page 353 Gabriel Leung reviews his latest book on Improving Health Services.16,17

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References

3 Matthews FE, Arthur A, Barnes LE et al. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: Results of the cognitive function and ageing study I and II. The Lancet 2013;382(9902):1405–12.