AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

FEBRUARY 2015

WHAT'S INSIDE:

- **Bariatric surgery vs the obesity epidemic**
- **HDC consultation on enrolling unconscious patients in clinical trials**
- **Midwife-led care safer than hospital care**
- **NEAC consultation on ethics committee arrangements**
- **"Cracked: Why Psychiatry is Doing More Harm Than Good."**

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BARIATRIC SURGERY VS THE OBESITY EPIDEMIC

Recent calls for the government and DHBs to provide more publicly-funded gastric bands and stomach stapling operations, also known as bariatric surgery, have not presented the general public with good information on the extent of the problem and what would be needed to make a real difference.

Amid claims that New Zealand is on target to become the fattest country in the world within five years, bariatric surgeon Steven Kelly said on *National Radio* on 30 January 2015 that only 400 weight-loss operations were performed in the past year which was half the number that was recommended six years ago. (1) As each operation costs around $20,000 the health system would need to find $16 million to undertake 800 of these operations each year.

Supply and demand

But is this enough to make a significant difference? A 2008 Ministry of Health "Assessment of the Business Case for the Management of Adult Morbid Obesity in New Zealand" stated that 5,000 new people are pronounced morbidly obese each year. Given that there are already 180,000 morbidly obese people in the country, if the health system was given $40 million each year for 2,000 such operations it would still fail miserably to deal with both the obesity epidemic and the resulting tsunami of Type 2 diabetes.

Recently-published research has revealed that the various procedures that make up bariatric surgery are far more effective than drugs for achieving sustained weight loss with people usually losing between half and two-thirds of their excess weight following surgery. An additional benefit is that these stomach-reducing operations are also more effective than drugs at treating Type 2 diabetes. More than half of those who undergo surgery have more control over their diabetes and a significant percentage are even cured of their diabetes. (2)

The results of the study that hit the headlines at the beginning of 2014 were reported at an American College of Cardiology conference in Washington, and were also published online by the *New England Journal of Medicine.* It was a small study of 150 people with researchers being able to follow up 91% of those enrolled three years later.

It is also worth noting that the study was sponsored by an obesity surgery company and that some of the researchers were paid consultants. (3)

Side effects

There are of course side effects to bariatric surgery which include the risk of complications of the actual operation. About 20% of people are readmitted to hospital in the first year after surgery, especially if they overeat. Nutritional deficiencies are common due to the huge reduction in food intake, and then there's something called 'dumping syndrome' that occurs after eating sugary food. When the sugar passes rapidly into the intestine the body floods the intestines in an attempt to dilute the sugars. The affected person may feel their heart beating rapidly, break into a cold sweat and get a feeling of butterflies in the stomach. Diarrhoea may then follow.

Dr Robert Ratner, chief scientific and medical officer for the American Diabetes Association has also been reported as saying that many people who have weight-loss surgery regain substantial weight down the road. (3)

Obesity Prevention

In the wake of the call for the New Zealand health system to fund more bariatric surgery concerns have been expressed that a comprehensive plan is needed to address the obesity problem. This would involve measures to put the brakes on the increasingly obesogenic environment we live in by reducing sales of sugary drinks, and persuading the food industry to reduce the amount of salt and sugar in all their fake food, as well as increasing funding for programmes aimed at preventing obesity. Professor Boyd Swinburn, an anti-obesity campaigner, warned that funding more bariatric operations should not come at the expense of obesity prevention programmes.

Healthy Eating

In Chapter 8 of his book "*Appetite for Destruction: Food – the good, the bad and the fatal,*" Gareth Morgan states "There just isn't the money or the trained staff needed for bariatric surgery to be a complete or even serious answer to the diabetes and obesity epidemic. It's nothing more than a last resort for the most seriously affected." Preferring to focus on obesity prevention strategies he recommends that doctors be able to offer a 'Healthy Eating Prescription' and describes a range of support services that need to be put in place.

"A Healthy Eating Prescription wouldn't be cheap, and it wouldn't be easy to set up the infrastructure to deliver coaching and classes. But then bariatric surgery isn't cheap, either. The difference is that a Healthy Eating Prescription is a more viable solution given the sheer size of the problem that we have to face. It's time to bite the bullet on cost and start offering people help with healthy eating, before they end up on the operating table.

The bizarre thing is that the select few receiving bariatric surgery are given exactly this sort of coaching. They are assessed for mental health issues that might contribute to over-eating, and get coaching on sticking to their new diet. In fact, they usually have to lose weight before the operation to show that they are committed to weight loss. Why the hell don't we try to use these tools much earlier to help people lose weight, before they need such expensive surgery? Not only is bariatric surgery the ambulance at the bottom of the cliff, that particular ambulance is a gold-plated Audi Q7."

He then goes on to describe a few of the effective programmes that are already in place. (4)

The future

The solution to the obesity epidemic that much of the world is facing is not more surgery. Sufficient resources must be provided to support efforts that will prevent New Zealand from becoming "the fattest nation on earth."

References

1. http://www.radionz.co.nz/news/national/264871/nz-'set-to-become-fattest-nation'
2. http://www.nejm.org/doi/full/10.1056/NEJMoa1401329
3. http://www.nydailynews.com/life-style/health/weight-loss-surgery-helps-obese-patients-overcome-diabetes-article-1.1741631
4. Gareth Morgan & Geoff Simmons. "*Appetite for Destruction: Food – the good, the bad and the fatal*." 2013.

ENROLLING UNCONSCIOUS PATIENTS IN CLINICAL TRIALS

At the end of 2014 Health and Disability Commissioner Anthony Hill advised the AWHC that the time had come "to commence a more fulsome public information and consultation process" on the vexed issue of "research involving incompetent consumers" and whether Right 7(4) requires amendment.

This follows the revelations in the *Herald* in May 2014 that one of the ethics committees had given approval for an antibiotics trial on patients in intensive care units at Auckland and Christchurch hospitals without prior consent being obtained from the patients, most of whom would be unconscious. While the prior assent of relatives would be sought, and the consent of the patients involved would be obtained once they had recovered sufficiently to be considered competent to make an informed decision, it was revealed during an ethics committee meeting that this was not always carried out.

In a letter to the AWHC dated 5 December 2014 the Commissioner stated that he had been monitoring these two issues with a view to deciding whether a specific consultation process is warranted. It appears he has finally decided that it is time to take some action.

The Commissioner said he is in the process of finalising details on the consultation process that will be undertaken and expects to release details for this early in the New Year.

WATCH THIS SPACE!

MIDWIFE-LED CARE SAFER THAN HOSPITAL CARE

In December 2014 the UK National Institute for Health and Care Excellence (NICE) released its revised guideline on "*Intrapartum Care: Care of healthy women and their babies during childbirth."* (1) The evidence now shows that midwife-led care is safer than hospital care for women having a straightforward, low risk pregnancy. The rate of interventions, such as the use of forceps or an epidural is lower and the outcome for the baby is no different compared with an obstetric hospital.

The NICE guidelines reverse a generation of misinformation about birth, especially birth in secondary and tertiary hospitals. There was never any evidence that hospital births were safer. As one mother who had had a caesarean birth wrote, we have known for quite some time that "treating all women as though they were a hair's breadth from disaster raised stress levels among women in labour exponentially, and caused the need for interventions."

"Suddenly women who had shown no signs of problems were being given drugs to induce their labours, were being hooked up to machines that restricted their movement during labour (and movement is extremely helpful in a normal labour) and were being plied with painkillers which had a knock-on effect on the straightforward progress of the birth. The result, we now know, was that the number of "complicated" deliveries – caesareans, forceps, ventouse – rose dramatically, and many mothers who could have had a straightforward birth ended up having a dramatic,

emergency intervention to get their now distressed unborn child safely delivered," she wrote. (2)

The guidelines begin by stating that giving birth is a life-changing event and "the care that a woman receives during labour has the potential to affect her – both physically and emotionally, in the short and longer term – and the health of her baby. Good communication, support and compassion from staff, and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her birth companion(s)."

Home births are equally as safe as midwife-led units (birthing centres) and all healthcare professionals should inform women of all the options available to them and advise them that they have the freedom to choose where they give birth. Professor Mark Baker, NICE's clinical practice director, said: "Where and how a woman gives birth to her baby can be hugely important to her. Although women with complicated pregnancies will still need a doctor, there is no reason why women at low risk of complications during labour should not have their baby in an environment in which they feel most comfortable. Our updated guideline will encourage greater choice in these decisions and ensure the best outcomes for both mother and baby."

A summary of the guidelines also featured in a recent issue of the *British Medical Journal*. (3) The *BMJ* paper listed four points as being what the authors described as the bottom line:

The bottom line

- The care that a woman receives during labour can affect the woman herself (physically and emotionally) and the health of her baby in the short and longer term
- Maternity services should provide a model of care that supports one-to-one care in labour
- Low risk mothers and babies do not benefit from birth in hospital obstetric units or from many previously "routine" but unindicated labour interventions
- Clinicians need to be familiar with the evidence and able to talk non-judgmentally to women about their choices

Hopefully, this will be repeated in numerous journals throughout the world, especially those read by obstetricians, GPs and midwives. The increasing amount and rate of interventions in the birth process have never been based on good evidence, and it is going to take lots of journal articles to get the message through to the healthcare professionals involved that unnecessary interventions have the potential to cause short term and long term harms to both mothers and babies.

NICE has also updated their guidelines on cord-clamping (avoid clamping the cord immediately after the birth), and the association between co-sleeping and SIDS (Sudden Infant Death Syndrome).

References

1. https://www.nice.org.uk/guidance/cg190/resources/guidance-intrapartum-care-care-of-healthy-women-and-their-babies-during-childbirth-pdf
2. http://www.theguardian.com/society/2014/dec/03/hospital-childbirth-misconception-home-reversing-nice-guidelines
3. http://www.bmj.com/content/349/bmj.g6886

NEAC CONSULTATION ON ETHICS COMMITTEES

The National Ethics Advisory Committee (NEAC) has released a discussion document "on cross-sectoral ethics arrangements for health and disability research."

These arrangements include:

- Responsibility for the ethical design, review, conduct and monitoring of health and disability research
- The standards, processes and structures that facilitate and support this responsibility.

The 44-page discussion document summarises NEAC's analysis of the current ethics arrangements, some of the issues with these arrangements, and current responses to issues. There are six sections:

- The complex research ethics landscape
- Maori and health research
- Alternative ethical review structures
- Peer review for scientific validity
- Audit and audit-related activity
- Innovative practice

Responses to this discussion document will both inform NEAC's review of *Ethical Guidelines for Observational Studies* (2012) and *Ethical Guidelines for Intervention Studies (*2012), as well informing "advice to the Associate Minister of Health on current issues and how these may be addressed."

The deadline for feedback is due by 27 February 2015.

http://neac.health.govt.nz/cross-sectoral-ethics-arrangements-health-and-disability-research-consultation

CRACKED

In 2013 James Davies, a qualified psychotherapist with a PhD in medical and social anthropology, published his second book. "*Cracked: Why Psychiatry is Doing More Harm Than Good*" is a compelling account of how psychiatric treatments and beliefs about mental distress have affected how we understand and manage our emotional lives. In the preface to his book he writes:

"In this book … I will investigate three medical mysteries: why has psychiatry become the fastest-growing medical specialism when it still has the poorest curative success? Why are psychiatric drugs now more widely prescribed than almost any other medical drugs in history, despite their dubious efficacy? And why does psychiatry, without solid scientific justification, keep expanding the number of mental disorders it believes to exist – from 106 in 1952 to 374 today?"

This is a thought-provoking book that is difficult to put down once started. It is very well written, referenced and full of interviews with patients, professionals and some of the leading lights of the psychiatric world. Each chapter focuses on a different part of the story – "how the process of creating new diagnostic categories regularly strays from scientifically accepted standards; how antidepressants actually work no better than placebo (sugar) pills for most people; how negative drug trials are routinely buried and research is regularly manipulated to convey positive results; how numerous doctors have been enticed by huge rewards from pharmaceutical companies into creating more disorders and prescribing more pills; how mass-marketing has been unscrupulously

employed to conceal from doctors, patients and the wider public the ethical, scientific and treatment flaws of a profession now in serious crisis."

The Organisation for Economic Co-operation and Development (OECD) 2014 report "*Health at a Glance*" states that consumption of anti-depressants has almost doubled since 2000: "Greater intensity and duration of treatments are some of the factors explaining the general increase in antidepressant consumption. In addition, rising consumption can also be explained by the extension of the indications of some antidepressants to milder forms of depression, generalised anxiety disorders or social phobia. These extensions have raised concerns about appropriateness." (2)

Outside the USA, Iceland, Australia and Canada are the top three countries in terms of the consumption of antidepressants. (3)

New Zealand has followed suit, and as in other countries has seen a worrying increase in the prescriptions of antidepressants to children and teenagers. In the four years from 2006 to 2010 there was a 31% increase in the prescription of these drugs to New Zealanders under 18 years of age. In 2010 1855 prescriptions were written for children under the age of 13, a 20% increase from 2006. Most of these prescriptions were for Prozac which is subsidised by Pharmac through a generic brand named Fluox. (4)

As James Davies points out in his latest book, increasing numbers of children are being diagnosed with mental disorders. For example, around 5% of children in the North America and Europe have received a diagnosis of ADHD (attention deficit hyperactivity disorder) and put on a cocktail of toxic drugs. (1)

Cracked ends with a disturbing appendix on the effects of antipsychotic medications.

References

1. James Davies. "*Cracked: Why Psychiatry is Doing More Harm Than Good*." Icon Books 2013.
2. http://www.oecd-ilibrary.org/docserver/download/8114211e.pdf?expires=1423436559&id=id&accname=guest&checksum=8F3352379F63131E2F37C2D467B5D1CA
3. http://www.oecd-ilibrary.org/sites/health_glance-2013-en/04/10/index.html?contentType=&itemId=/content/chapter/health_glance-2013-41-en&containerItemId=/content/serial/19991312&accessItemIds=/content/book/health_glance-2013-en&mimeType=text/html
4. "Antidepressant Use in NZ Children." AWHC Newsletter August 2012.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for February/March 2015:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 25 February 2015 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 18 March 2015.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 18 February 2015 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 4 March 2015 at 19 Lambie Drive, Manukau City.

The Hospital Advisory Committee meeting will be held at 9am on Wednesday 25 March 2015 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

ETHICS COMMITTEE meetings – dates for the four MOH ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

MICHEL ODENT will be speaking on the future of birth at two workshops to be held in New Zealand in May. Organised by CAPERS Bookstore the “Childbirth and the Evolution of Homo Sapiens” workshops will be held in Wellington 14 May and in Auckland on 15 May.

Further information is available at:
www.capersbookstore.com.au/product.asp?id=1959&t=Michel+Odent+Seminar+-+Melbourne%2C+Sydney%2C+Wellington%2C+Auckland