AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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AWHC ON FACEBOOK

At the end of September the AWHC finally joined the rest of the world by establishing its own Facebook page.

It will come as no surprise that the idea of establishing a Facebook page was proposed by the youngest member of the AWHC committee and supported by her colleague. After some discussion about how this would be managed given the lack of experience of Lynda, the AWHC's co-ordinator, with Facebook, the decision was made to go ahead. After some work by the two enthusiastic committee members, the AWHC launched itself on Facebook in late September. It was agreed that Lynda would supply the comments and links to be posted to the AWHC's expert Facebookers who would post them.

Since then postings about a variety of women's health issues, challenges to our health system, consultation documents and links to current news items of interest have been made on AWHC's Facebook page once or twice a week.

So do check us out at -

www.facebook.com/womenshealthcouncil.org.nz

E-cigarettes – an effective method of quitting smoking

Electronic cigarettes (e-cigarettes) have been on the market since 2001 when Hon Lik from China designed an e-cigarette to help him quit smoking. Since Hon Lik designed this first generation e-cigarette, which looks like a cigarette and is called a 'cig-a-like', second and third generation e-cigarettes have been designed. These second and third generation e-cigarettes deliver nicotine to the user (vaper) more effectively and are more effective stop smoking aids.

E-cigarettes can contain nicotine or not. In New Zealand e-cigarettes that do not contain nicotine can be legally sold in supermarkets, pharmacies and other retail outlets but the liquid for e-cigarettes (e-liquid) that contains nicotine cannot be sold. If vapers want to buy nicotine for their e-cigarettes they have to buy it online.

The rise in popularity of e-cigarettes among smokers has been phenomenal. Smokers worldwide are turning to them to help them stop smoking. Public health people the world over have been taken by surprise. It has always been envisaged ending smoking would happen over time, as we increment-ally moved towards smokefree with the help of tax increases, smokefree environments, plain packaging and, in New Zealand, smokefree cars. Smokefree environments have helped reduce smoking in the past but we are running out of options of what to do next – plain packaging has been shown to be effective in Australia and annual tax increases do help.

Other than these usual standard interventions there is uncertainty about what the focus should be to achieve the Smokefree 2025 goal of less than 5%. Most public health units and non-government organisations working in tobacco control are spending 90% of their time lobbying local councils to get parks, malls, streets (particularly outside bars and restaurants), snowfields, golf courses etc smokefree. Banning smoking in cars carrying children under the age of 12 years old is high on their list of priorities and councils have now requested Government make areas outside bars and restaurants non-smoking. Whilst smokefree environ-ments provide a backdrop to achieving our Smokefree 2025 goal they will not actually reduce the prevalence rate of smoking.

Most smokers need more than smokefree environments to get them off smoking. In the flurry to get a perfect non-smoking world we seem to have forgotten about smokers. We continue to ply them with nicotine replacement products and other medications that are generally unappealing and not very effective. The pharmaceutical industry has been unbelievably slow at bringing new and innovative products onto the market and smokers have largely been left to struggle alone in their bid to quit smoking.

You would think that public health people would be ecstatic at the emergence of e-cigarettes as another tool for smokers to quit smoking but unbelievably 'no'. Some are even committing all their time trying to prevent more accessible nicotine for e-cigarettes. Initially their concern was about the safety of e-cigarettes but now that we know they are at least 95% less harmful than smoking[1] their concern has shifted to non-smokers potentially taking up vaping, particularly young people, who may then go on to start smoking. There is very little evidence that adult non-smokers are taking up vaping but some evidence that some young people are. However, we do not know whether they go on to smoke, and if they do would they have taken up smoking anyway? Recent research suggests that in areas where e-cigarettes are freely available smoking rates among young people are decreasing.[2]

Addiction to nicotine is another concern among public health experts and not just for young people, who it is perceived could get addicted to nicotine in e-cigarettes and if e-cigarettes weren't easily accessible they would then start smoking. However, it is quite likely that young people who are vaping are using e-cigarettes that do not contain nicotine. Many studies ask partici-pants about their vaping but do not clarify whether the e-cigarettes they are using actually contain nicotine or not. Many vapers (particularly new vapers) do not actually know if their e-cigarettes contain nicotine or not. Health professionals worry that smokers who switch to e-cigarettes to stop smoking will use the e-cigarette as a

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[1] McNeill, A, Brose, LS, Calder, R, Hitchman, SC, Hajek, P, and McRobbie, H. E-cigarettes: an evidence
update. Public Health England. August 2015. https://www.gov.uk/government/publications/e-cigarettes-an-evidenceupdate (Accessed 11 September 2015))

[2] Friedman A. How does Electronic Cigarette Access affect Adolescent Smoking? Journal of Health Economics. Available online 19 October 2015.In Press, Accepted Manuscript.

replacement product and will continue to be addicted to nicotine. However, they are currently happy to prescribe NRT endlessly to patients or clients to get them off smoking, so why can't an e-cigarette be a de facto nicotine replacement product?

Looking back at the history of tobacco control in New Zealand and probably elsewhere it would seem that from the early 1990s the concern of public health people has been more about non-smokers than smokers. Isn't it time we made smokers a priority? They are the ones that are dying in their thousands – around 4,500 per annum in New Zealand. Our concern should be evidence-based but in the case of e-cigarettes the evidence for continuing a ban on nicotine for e-cigarettes is sadly lacking. There is evidence that e-cigarettes containing nicotine help smokers quit smoking.[3] Non-smokers are not taking up vaping in their droves and where young people are taking up vaping there is emerging evidence that smoking is decreasing.

There is some support among public health people for e-cigarettes containing nicotine to be made accessible to smokers, but generally they want the health sector to take control of them, medicalise them, turn them into boring pharmaceutical-like products that smokers will not be interested in using. I'm told by vapers that one of the reasons they like e-cigarettes is that they're fun. They don't feel like they're quitting smoking and they can choose whatever colour, size, shape they want. Many serious vapers have an array of e-cigarettes of all different shapes and colours – one for every occasion. This is exactly what many health professionals find difficult – quitting smoking is not a fun activity!

Public health people have worked for years to reduce smoking and have always expected that it would be their role to end it. However, e-cigarettes have come from left field threatening smokefree environments and other strategies that have been really important in reducing smoking. Has all that work gone to waste?

I do not believe it has. Smokefree environments should be maintained in the future for smoking but not for vaping. After all vaping is not smoking, it's a separate activity which produces a lot of hot air. Vapers should not be forced outside to vape in smoking areas, where they may be tempted back into smoking.

Lastly I can only imagine how wonderful it would be if public health people, vapers' alliances and vaping retailers all came together to create a world where vaping was acceptable. E-cigarettes that contain nicotine should be made readily available as a consumer product and smokers should be encouraged to transition to e-cigarettes.

As a starting point End Smoking has produced a leaflet offering pragmatic information on supporting smokers to switch to vaping – http://www.turanga.org.nz/node/346

Trish Fraser

Global Public Health, and
AWHC executive committee member.

[3] McRobbie H, Bullen C, Hartmann-Boyce J, Hajek P. Electronic cigarettes for smoking cessation and reduction. Cochrane Database of Systematic Reviews. 2014;12:CD010216

"*Less Medicine, More Health*"

In 2015 Dr H Gilbert Welch wrote another book, "Less Medicine More Health," a book he says he hopes patients will share with their doctor. "A little nudge from patients may help more physicians do the right thing," he writes. (1)

Dr Welch is a primary care physician, a health services researcher and a professor at the Dartmouth Medical School in Hanover, New Hampshire, USA. His two previous books were "*Should I be tested for cancer?*" and "*Overdiagnosed*." He believes that questioning assumptions about the value of medical care is the key ingredient for a more sustainable health care system.

His latest book lists seven assumptions that drive too much medical care and a chapter is devoted to each one.

Assumption 1 is the belief that all risks can be lowered. As Dr Welch explains with the aid of fascinating stories and reliable data, risk reduction is challenging and before you have anything done to you in order to lower the risk – an intervention like a drug, test or procedure – you need to know whether the benefits are real and will outweigh the inevitable harms. The disturbing truth is that risks can't always be lowered – and trying creates risks of its own.

His prescription is to stick to reducing big risks, and for the risks that are average or below, leave well enough alone.

Assumption 2 is the belief that it's always better to fix the problem. This chapter uses the speciality of cardiology to demonstrate that trying to eliminate a problem can be more dangerous than managing one. "Most people assume that a medical intervention directed to fix a problem will be more beneficial than one that simply manages it," Dr Welch writes. This may or may not be true.

His prescription is to ask about options – there are always options – and start slow.

"It's also good to be clear about exactly what you are trying to fix – what the goal is. In my simple view of the world, there are only two reasons to subject patients to interventions: (1) to help them live longer and (2) to help them feel better. So if you feel good now, you have every reason to demand high-quality evidence from a randomized trial that fixing your "problem" will help you live longer."

Assumption 3 is the widespread belief that sooner is always better. Dr Welch challenges the misconceptions about screening, especially cancer screening in this chapter. Screening is not always a good idea, eg prostate cancer, thyroid cancer and oral cancer screening. The disturbing truth is that early diagnosis can needlessly turn people into patients.

"Screening is the systematic search for abnormalities in those who have no symptoms of disease. It is a systematic effort to detect disease early." In this chapter Dr Welch describes the turtles, birds and rabbits of cancer and how cancer screening is finding mostly turtles. [See article in the July 2015 issue of the AWHC's newsletter.(2)] It is also important to

remember that it is the turtles that make screening look good.

With its false positives many cancer screening programmes cause an epidemic of overdiagnosis which is just one way of turning healthy people into patients.

“Cancer screening is not a public health imperative, it is a choice. The reason is that it is a close call: a delicate balance of benefits and harms that different individuals – facing the same situation – can rationally make different decisions about based on their values and preferences,” Dr Welch writes.

His prescription is to ask for data about both the benefits and harms, and know that it is a choice.

Assumption 4 is the belief that it never hurts to get more information. Using the stories of several patients Dr Welch demonstrates how seeking more clinical data in patients who already have a medical problem often does not result in any useful information. “More clinical data not only can create anxiety for patients, they can also initiate cascades that lead to unneeded medical care.”

His prescription is to be wary of fishing expeditions, and ask how more data will change what you will do.

Assumption 5 is the belief that action is always better than inaction. Sometimes doing nothing is exactly the right thing to do as it allows the body to heal, something it is remarkably good at. “The fact that healing without intervention is possible can be lost on a highly medicalized society. Some problems will disappear on their own. Others persist, but we adapt to them – and feel better. And still others wax and wane. Ironically, medical care may obscure our capacity to heal: people who have a problem seek care – and get better. These stories of “success” lead us to conclude that healing was not possible without medical care.”

His prescription is to consider the option of doing nothing.

Assumption 6 is one the pharmaceutical industry is very fond of and ceaselessly promotes – newer is always better. The disturbing truth is that new interventions are typically not well tested and often wind up being judged ineffective or even harmful.

Whether it is a new drug, a new medical device or a new procedure, “new” often does not represent a genuine medical breakthrough. “We’ve gotten really good at marketing: medical care and laundry detergent can be equally overhyped,” Dr Welch writes. “There are reasons to be cautious about new drugs, new procedures, and new devices. Each may not really work: each may bring unexpected harm.”

His prescription is to stick with the tried-and-true.

Assumption 7, the final assumption is the belief that it’s all about avoiding death. In describing his own experiences in dealing with the death of family members and patients, Dr Welch reveals the disturbing truth that a fixation on preventing death diminishes life. “We’ve been taught to fear death – or view it as some sort of failure. I fear medical care has had some role in this, as it often proceeds as if extending life is the only goal. It’s a paradigm based on a number of

assumptions that you may want to question," he writes. These three assumptions are that extending life is always a desirable goal, or is always an achievable goal, and finally that it is the only goal of life.

His prescription is to strive to live life, not avoid death. As he points out other things do matter more. "Your life is not all about avoiding death. Consider whether you want your medical care to reflect that. When it comes to anticipatory medicine, you need to make your own decision about what else matters to you. But if becoming medicalised while you feel well is not high on your list, you need to say so.

Embrace life. And don't dwell on death – recognise that it's part of life."

References

1. Dr H. Gilbert Welch. "Less Medicine, More Health: 7 Assumptions driving too much medical care." Beacon Press. 2015
2. http://www.womenshealthcouncil.org.nz/Features/Hot+Topics/Cancer+Screening.html

NEW ZEALAND HEALTH STRATEGY

The Ministry of Health is revising its 2000 "New Zealand Health Strategy." It has not been revised over the past 15 years and is therefore overdue for an update. Consultation opened at the end of October and submissions are due by **5pm on 4 December 2015**.

For further information on the draft document and/or to join the discussion about the future direction of New Zealand's health and disability system, go to – www.health.govt.nz/about-ministry/what-we-do/new-zealand-health-strategy-update

AWHC GENERAL MEETING 29 October 2015

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- Ethics committee meetings
- AWHC on Facebook
- DHB meetings
- Lynda's future

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

AWHC NEWSLETTER SUBSCRIPTION

The newsletter of the Auckland Women's Health Council is published monthly.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for November/December 2015:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 16 December 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 25 November 2015.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 9 December 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 Hospital Advisory Committee meeting will be held at 9am on Wednesday 2 December 2015 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 16 December 2015 at 19 Lambie Drive, Manukau.

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

White Ribbon Campaign events

The annual White Ribbon Day Parade in Central Auckland will take place on **Wednesday 25 November 2015.** Gather at Queen Elizabeth Square at 10.30am for the 11am start of the parade.

For events in other centres, go to http://whiteribbon.org.nz/95525-2/