Screening for sickle cell and thalassaemia in primary care: a cost-effectiveness study

Better schemes for providing screening for sickle cell and sickle diseases are to be commended. However, I am concerned that the article by Bryan et al. is based too heavily upon a cultural paradigm that is white, Anglo-Saxon, agnostic, and pro-choice. This is revealed by the early statement implying that screening later than 10 weeks will be ‘too late to make reproductive choices’.

In many Mediterranean and Asian cultures, the first and most important reproductive choice is to get married, and this very often happens a long time before conception. The intent thereafter is to have children, not later. In many Mediterranean and Asian communities in High Wycombe, and perhaps elsewhere.

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REFERENCE

Olympic absurdities

My column on the promotion of exercise in the shadow of the Olympics has provoked an upsurge of moral indignation and a flurry of references from an international group of elite specialists and academics. Their response suggests a remoteness from the realities of primary health care, indeed from the real world. I do not claim the authority of scientific evidence or that of prestigious medical institutions, but from the perspective of a jobbing GP point out three self-evidently absurd propositions in the arguments of the exercise zealots.

1. ‘Inactivity is a major cause of ill-health’. Over the 30 years in which I have been a GP, the most dramatic change in the health of my patients has been the increase in life-expectancy in old age, most spectacularly confirmed by the growing ranks of centenarians. This increase in longevity has taken place in a population in which only a tiny minority engage in any form of exercise (this is, of course, particularly true of women, who make up the greater proportion of this thriving elderly cohort).

2. At least 30 minutes a day of at least moderate intensity activity on five or more days a week and the exercise standard now being promoted by the Department of Health and endorsed by the Chief Medical Officer. Indeed, a brief survey of friends, relations, and colleagues reveals nobody who meets it. I do recall a patient with obsessive compulsive disorder and anorexia who met this target, but he was quite ill.

3. ‘A brief intervention by a GP can transform a couch potato into an athlete’. A belief in the magical powers of GPs to change established patterns of behaviour (including alcohol consumption as well as inactivity) in the course of a routine consultation (in 3–5 minutes in a popular Australian model) has become widely established in the world of health promotion. But it could not possibly be true that a chat with a doctor could achieve such transformations — and solve, at a stroke, major social problems such as those associated with alcohol. This faith in the power of brief interventions reveals wishful thinking and professional hubris on a cosmic scale.

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