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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*¹ 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 whether to do so. Screening after that point can generally be regarded as too late within the framework of this article, in which the flow chart and commentary seem to be looking at screening for, and probable termination of, affected pregnancies.

A greater concern for many 'traditionally minded' cultures, in which the concept of termination is not happily entertained, would perhaps be to identify support available to the parents and future children. An increased rate of pregnancy loss, following on from earlier antenatal screening and consequent chorionic villus sampling, may be seen in such situations as counterproductive.

Later diagnosis would be less risky to the child (and less costly) and still allow ample time for preparation for child care, that may involve technologies such as infant bone marrow transplantation to minimise ongoing childhood and adult illness.

The first step must surely be to decide whether the screening is to eradicate babies

with these haemoglobinopathies or to provide support to the future parents of affected children.

An even better screening programme may be offered before marriage, thus truly allowing the reproductive choice suggested by this article! This approach has been taken in some Asian communities in High Wycombe, and perhaps elsewhere.

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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.^{1,2} 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 is necessary to achieve and maintain good health'. I know club runners and committed footballers who fall short of 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.

I am grateful to my GP colleague Rachel Pryke for drawing my attention to *Let's get moving: a new physical activity care pathway* for the NHS.³ It is true that this 86-page document provides numerous assertions like that of our academic trio that 'the evidence is incontrovertible', but no actual evidence, for which the reader is referred to its 43 references. 'Skimming through' these — time is tight and like Pryke I have my QOF targets to consider, especially as these are now being monitored by the exercise police — I find studies flawed by small scale, short duration, using diverse measures of exercise, and unreliable 'self-reporting', all showing modest effects, even after moving the outcome goal posts to guarantee 'success'. *Let's get moving* is permeated with the jargon and dogma of 'motivational interviewing', reflecting the baleful influence of behavioural psychology in medical practice.^{4,5}

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