

even though prices have dropped considerably in the past few years. Trained practice staff who have the skills and time to fit and maintain spirometry of sufficient quality into the daily practice routine⁹ may also be in short supply.¹⁰ In addition to the practical issues, GPs' lack of confidence in their ability to interpret the test results is a crucial barrier—often neglected in the guidelines to effective implementation of spirometry.⁸ Many GPs view spirometry as a complex diagnostic tool, like electrocardiography. This fact was clearly illustrated in a recent UK study that reported low levels of self confidence in interpreting spirometric tests in 160 general practices where GPs and nurses had been trained for half a day—only a third of these professionals trusted their own interpretative skills.⁸ Confidence about how to proceed once the test results are available is a crucial part of building GPs' confidence in their capacity to diagnose and manage the disease.

Ideally once GPs have had initial spirometry training they should receive continuous advice and support. This could be done in various ways—by another GP with a special interest in respiratory diseases in the same practice or in another practice nearby; by means of a computerised clinical decision support system (SpidaXpert software; www.spixpert.com); or by consultation or feedback from a chest physician. Although intuitively a promising idea, empirical studies on the effects of ongoing expert support on the interpretative capacity and self confidence of GPs are lacking.

So what needs to happen next? For guidelines on chronic obstructive pulmonary disease to be implemented, concrete working agreements between GPs and chest physicians need to be developed. Chest physicians can act as coaches for their local primary care colleagues in two ways—through patient oriented support (specific feedback for specific patients) or through practice oriented support (as teachers in postgraduate training programmes). This will be beneficial for both parties, as referrals will be more structured and based on agreed criteria, GPs who have performed spirometry will have better insight into the patient's lung function, and chest physicians will benefit from having the results at the initial consultation.¹¹ More

broadly, coordinated efforts by health policy makers and the medical profession will be needed to provide the right equipment, training for staff who use it, and continuing quality assurance and support for test interpretation. The burden of chronic obstructive pulmonary disease is sufficiently large to warrant such an approach.

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A European alcohol strategy

Will the opportunity be missed?

This month the European Commission must decide whether to adopt a strategy to deal with the adverse health consequences of alcohol. The strategy has been awaited eagerly by Europe's public health community since it was first mooted five years ago, but it could fall at the last hurdle. It may be the victim of a carefully planned attack by representatives of the alcohol industry, using tactics associated with tobacco manufacturers.

Alcohol related disease accounts for almost 8% of the overall burden of disease in Europe.¹ One factor contributing to the current level of consumption is the single European market, testified to by the existence of

vast retail outlets around Calais that thousands of British travellers visit each week. Yet the single market has implications that go far beyond this type of cross border trade. Countries such as Sweden and Finland had longstanding stringent controls on alcohol sales that restricted access to low cost alcohol. After they joined the European Union in 1995 they had to dismantle important parts of their policies,² and over the next decade death rates from cirrhosis in Finland rose by 50%.³ The industry has also used the single

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market to justify attacks on labels being introduced in France to warn pregnant women of the hazards of drinking.⁴ Consequently, national health ministries widely recognise the need for European support to tackle the growing threat to health posed by the liberalisation of the alcohol sector, and in June 2001 they asked the commission to prepare a comprehensive strategy to reduce alcohol related harm.⁵

The directorate general of the European Commission responsible for public health began by commissioning a thorough assessment of the health impact of alcohol in Europe. The resulting report catalogued the adverse effects on health in detail and showed how alcohol attributable disease, injury, and violence cost the health, welfare, employment, and criminal justice sectors £84bn (€125bn; \$157bn) each year, including £40bn in lost production, while the intangible costs of suffering and lost life added a further £182bn each year.⁶

The draft strategy that emerged is now being considered by all the commissioners and a decision on whether to adopt it is expected at the end of October. Although it is not yet in the public domain, its key features can be ascertained from the consultation that informed it. It is expected to have five main themes. These are protection of young people and unborn children; reduction of deaths from alcohol related traffic accidents; reduction of alcohol related harm among adults, especially as it affects their work; increasing awareness of the impact of harmful consumption; and the creation of a better evidence base for future policies on alcohol in Europe.

The strategy foresees several actions at the European level, such as monitoring drinking habits among young people as well as ensuring that alcohol related harm is taken into account in sectors where the European Union can legislate, such as cross border advertising, road safety, and consumer information. It also envisages support for comparative research and data collection across Europe. However, its main thrust will be to support collaboration among member states, encouraging them to implement policies that are evidence based and proportionate.

Given the magnitude of the threat to health posed by hazardous drinking, some may argue that the strategy should go much further.⁵ Nevertheless, the key issue is that the scope for European action on public health is limited by the treaties that establish the EU's legislative powers.

Unfortunately, even these modest proposals may now fail. Emerging evidence indicates that some elements of the alcohol industry have been engaged in a massive and highly effective exercise to derail them.⁷ Their approach is exemplified by a report commissioned by the trade organisation, The Brewers of

Europe, which argues that there is no need for Europe wide action.⁸ It was written by the Weinberg Group, an American company previously involved in the tobacco industry's campaign to undermine evidence on the harmful effects of passive smoking⁹ and those by the chemical industry to challenge evidence on the harmful environmental effects of substances such as agent orange.¹⁰ Its content is remarkably similar to the tobacco industry reports that contended there was insufficient evidence that its products caused any harm or that preventive measures would be effective. For example, it concludes that "there is not enough evidence to substantiate a link between alcohol advertising and consumption," which raises the question of why the industry spends so much money promoting its products, and that "violence is a subjective term which is fairly nebulous and elastic," a view unlikely to be shared by those scarred by bottles wielded by drunks.

Now that the methods used by the tobacco industry have been exposed, few serious commentators believe what they say. Unfortunately, the alcohol industry seems to be going down the same path. European commissioners will miss a valuable opportunity to improve the health of their fellow citizens if they are taken in by the alcohol industry's arguments.

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