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LETTERS



ASPIRIN "RESISTANCE"

What is the risk of cardiovascular morbidity?

The increased risk of vascular disease in a subgroup of patients judged to be "resistant" to aspirin led Krasopoulos et al to propose that there could be beneficial effect of aspirin of greater than 50% in aspirin sensitive patients.¹

The problem is identifying subjects "resistant" to aspirin. Krasopoulos et al accepted evidence from the authors of 20 reports of randomised aspirin trials of an inhibition of the expected platelet response to aspirin, however measured. The platelet tests had been done in hospital before the patients were admitted to the trials. The authors therefore dismiss the possibility that the lack of benefit during the trial was simply due to poor compliance with aspirin taking.

Compliance could still partly explain the findings. In one study only one of the 17 patients who had been judged to be aspirin resistant failed to show the expected platelet response to aspirin when aspirin was taken under close supervision.²

Paradoxically, although platelet aggregation showed a large range in men in a large cohort, there was no evidence that the degree of platelet aggregation is predictive of subsequent heart disease events.^{3,4}

The authors' estimate of the beneficial effect of aspirin in sensitive patients is remarkably close to the 51% reduction reported for the doctors in the US physicians health study who claimed that they had taken aspirin regularly, compared with a 17% reduction in those who admitted that they had taken the drug on less than half the days.⁵

The application of the term increased risk to the patients with aspirin resistance (at the foot of fig 3) is unfortunate. Whether aspirin "resistance" carries an increased vascular risk cannot be judged in trials without placebo groups.

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BENIGN PROSTATIC HYPERPLASIA

α 1 adrenoceptor antagonists and cataract surgery

In their review on managing benign prostatic hyperplasia (BPH), Wilt and N'Dow,¹ do not mention that oral α ₁ adrenoceptor antagonists, in particular tamsulosin, can cause intraoperative floppy iris syndrome.¹² The syndrome, which can persist long after the cessation of treatment, is characterised by iris flaccidity and poor pupillary dilatation, both of which can complicate cataract surgery and necessitate change in surgical technique.

Given the association of both BPH and cataract with increasing age, ophthalmologists should ask whether patients have ever received medical treatment for BPH, and referring doctors should state this fact when referring those who have. Whether stopping treatment preoperatively is beneficial is not known, but tamsulosin should not be started in those awaiting cataract surgery. In both the United Kingdom and the United States, labelling of tamsulosin has changed to include this guidance.^{3,4}

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SAFETY IN HEALTH CARE

Saying sorry is not admission of liability

Adverse incidents are often the result of systems or other errors, rather than the fault of one individual, but if your correspondent is suggesting that it is an admission of liability for doctors to admit they have made an error and to apologise,¹ that is not correct. The Medical Defence Union encourages members to tell patients if something has gone wrong and to apologise.

Section 2 of the Compensation Act 2006 says: "An apology, offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty." In other words, an apology will not itself amount to an admission of liability.

If something goes wrong, patients are entitled to a prompt, sympathetic, and above all truthful account of what has happened. This should be accompanied by an explanation by the clinician of what he or she proposes to do to put the matter right, and an apology, where appropriate. This is also stated in paragraph 31 of the GMC's *Good Medical Practice* (2006).

Doctors should be reassured that offering an apology does not constitute an admission of liability, and it may be that this is all the patient wants to hear.

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DOCTORS AND CLIMATE CHANGE

Impact of medical ethics

At some point, the developed world's ethical framework will surely have to change.¹ The primary focus of ethical decision making in medicine is the patient and his or her immediate environment. Beneficence, non-maleficence, justice, and dignity are subservient to autonomy. Good of the community is obscured within the principle of justice. However, when self

interest and inadequate resources harm others, autonomy loses integrity.

As local resources fail, fertility treatments that bring more life into an overpopulated community; or resource intensive treatment of individuals that prevents cheaper and easier treatment of very many others; or heroic life prolonging treatments in a climate of mass death naturally become harder to justify or provide. Hopefully we will soon wake up to the fact that this is becoming the global situation. When we do, let us hope that all that is good about humanity comes to the fore and that the relatively safer communities do not continue their highly disproportionate use of resources while more vulnerable ones struggle and even die. Such insularity could ultimately be the death of us all.

Good of the global community deserves highlighting in its own right as an ethical principle. Autonomy must bow to justice. Such a sea change applied across all human activity is surely the right medicine to counteract some of the damage of manmade global environmental change.

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Too many people

It goes without saying that climate change will have a dramatic impact on health—personal, global, and planetary. Yet I disagree that climate change is the defining issue for public health in the 21st century.¹

What can be done to promote sustainable population growth? Reducing poverty, eliminating gender inequalities, and increasing access to education and family planning are essential. The diversity of these endeavours teaches us about the need to employ a multidisciplinary perspective when addressing population growth. Failure to achieve sustainable population growth by concerted action will lead to population policies such as those implemented by China. The one child per family policy, draconian though it was, resulted in 400 million fewer people in a country whose current economic growth (driven in large part by the needs of the 1.3 billion people currently living in China) is causing enormous environmental harm. Had the one child per family policy not been implemented, one can only imagine the greater negative impact that 400 million additional people in China would have had on individual health and on the environment (and not just in China: pollutants released into the atmosphere by coal burning



KONSTANTINOS KOKKINIS/PHOTOLIA

plants in China travel around the world).

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CONDOMS IN PREVENTING STIs

No magic bullet

The data from Alberta reported by Genuis (massive promotion of condoms followed by upsurges in gonorrhoea and chlamydia) are mirrored in Spain.¹

Spain, together with Greece, stands out as the European country with the highest levels of condom use among young people, with 90% of sexually active young people reporting using a condom the last time they had sexual intercourse.² Nevertheless, the rates of sexually transmitted infections (STIs) are increasing year after year, despite more than a decade of intensive official educational campaigns transmitting the message to young people that condoms and only condoms are the magic bullets to prevent all STIs and unintended pregnancies.³

There is no room for dissent, no consideration for the accrual of persuasive scientific evidence strongly supporting that other behaviour changes, such as partner reduction, should be promoted as a priority.⁴ The ideologies, prejudices, stigma, and social agenda of some governing officials seem to precede the scientific evidence when building public health policies. The escalating figures for youth pregnancy and abortion in Spain⁵ also demand criticism of the apparently sacred “condoms and only condoms” dogma.

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- 1 Genuis SJ. Are condoms the answer to rising rates of non-HIV sexually transmitted infection? No. *BMJ* 2008;336:185. (26 January.)
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Not used in oral sex

Despite widespread availability of condoms, people are still having unprotected sex, which is reflected in increased sexually transmitted infections (STIs) and unintended pregnancies.¹

People simply don't use condoms for oral sex. We have had outbreaks of syphilis in gay men in London followed by Manchester, and the enhanced surveillance that followed suggested transmission of syphilis through oral sex. I have also seen several cases of gonorrhoea acquired through unprotected oral sex both in men and women. Many GUM clinics now routinely take oral swabs for culture of gonorrhoea in all suspected cases of gonorrhoea. We have seen rises in genital herpes predominantly caused by herpes simplex virus (HSV) type 1, or the “cold sore” virus, again owing to increases in oral sex.

Young people consider it “uncool” to carry condoms. The condoms available in vending machines in clubs are expensive, and many people simply hate condoms. We must look at other issues such as change in behaviour and use of alcohol and drugs, in addition to sex education and safe sexual practices.

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Sex is fun, remember?

Genuis suggests that young people have risky sex because they are trapped in miserable lives.¹ I'm not sure how long it is since Genuis was a young person, but I would suggest that most young people have sex for the same reasons most old people do: because it is lots of fun. As others have pointed out, sex often goes hand in hand with other things that are fun, like going out dancing with your mates, taking drugs, and getting plastered.

I don't wish to lower the tone of this debate; it is certainly useful to have all the evidence of condom efficacy and effectiveness brought together so clearly. But so long as we expect rational responses to the most irrational area of human experience, we will be disappointed.

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- 1 Genuis SJ. Are condoms the answer to rising rates of non-HIV sexually transmitted infection? No. *BMJ* 2008;336:185. (26 January.)