NOGEPA 17e nascholing, Nieuwegein: 20 juni 2019

The challenges of being Oil & Gas UK Medical Advisor

Dr Graham Furnace

OGUK

Disclosure of speaker's interests

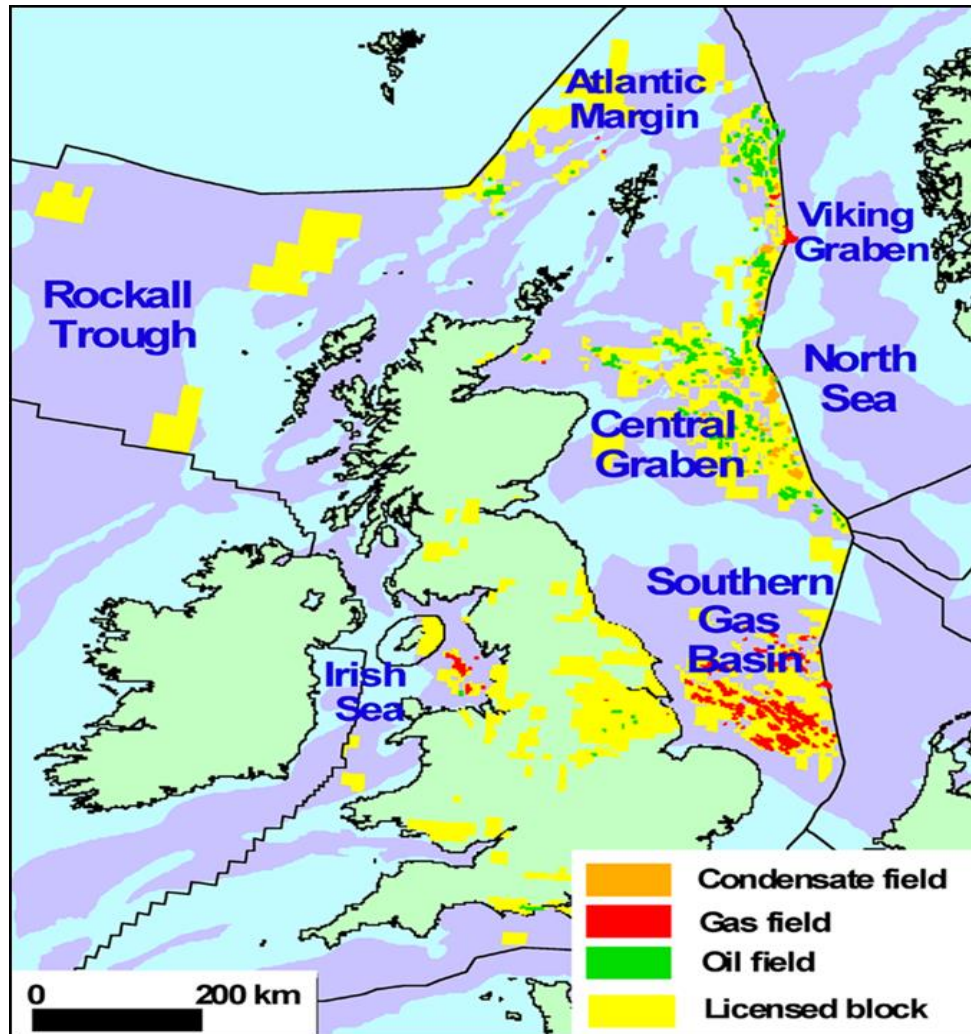| Conflict of Interest	None
Paid medical advisor to Oil & Gas UK	Oil & Gas UK is the representative body for UK oil and gas industry; receives income from registered doctor list and conference
Paid senior occupational physician, International Medical Management, Aberdeen	IMM receives income from supply of OGUK medicals

UK Oil & Gas Industry

Fields and Discoveries

> 300 producing fields

> 400 undeveloped discoveries

Infrastructure

250+ production platforms

21 floating production systems

280+ subsea production systems

~ 25,000 km pipelines

> 10,000 wells

UK Offshore Workforce Nationalities

In 2016, 85% of the offshore workforce was British

In total over 160 nationalities were represented offshore

Medical Aspects of Fitness for Work Offshore:
Guidance for Examining Physicians

Oil & Gas UK
the voice of the offshore industry

Issue 6
March 2008

Examining doctors 2010-2018

	2010	2015	2016	2017	**2018**
Countries	37	55	60	67	**64**
Doctors	796	1047	1014	1033	**1067**
% in UK	54	49	44	40	**40**

Country	Doctors 2018
UK	423
Australia	80
USA	62
Germany	39
Trinidad & Tobago	35
Philippines	34
India	31
Singapore	25
Malaysia	24
UAE	21
Thailand	20
Azerbaijan	19
Ghana	18
Denmark	18
Ireland	16
South Africa	16
Canada	14
Indonesia	14
Nigeria	10
Angola, Georgia	9
Italy, Spain	9
Brazil	8
France	8
Netherlands	8
Egypt, New Zealand	7
Saudi Arabia	7

OGUK Medicals 2008-18

Year	Total	Fail (%)
2008	39780	503 (1.2)
2011	59900	665 (1.0)
2012	93219	1284 (1.4)
2013	113006	1333 (1.2)
2014	118597	1285 (1.1)
2015	111651	1125 (1.0)
2016	99104	1125 (1.1)
2017	87923	1082 (1.2)
2018	**127474**	**1298 (1.0)**

OGUK Medicals 2018

Country	No. medicals
UK	39316
Azerbaijan	10261
Trinidad & Tobago	6032
Angola	5552
India	5387
USA	5274
Australia	5037
Indonesia	4887
UAE	3652
Saudi Arabia	3574

OGUK Medicals 2018

Country	No. docs	Medicals/doctor
Angola	6	925
Saudi Arabia	4	894
Azerbaijan	19	540
Indonesia	14	349
Georgia	9	332
Qatar	3	331
Poland	5	278
Romania	6	275
Côte D'Ivoire	2	263
Netherlands	8	249
UK	349	113

'There are too many 'unfit' (=fat?) people offshore'

'There are too many medevacs for heart problems'

'There are too many avoidable medevacs because of medications'

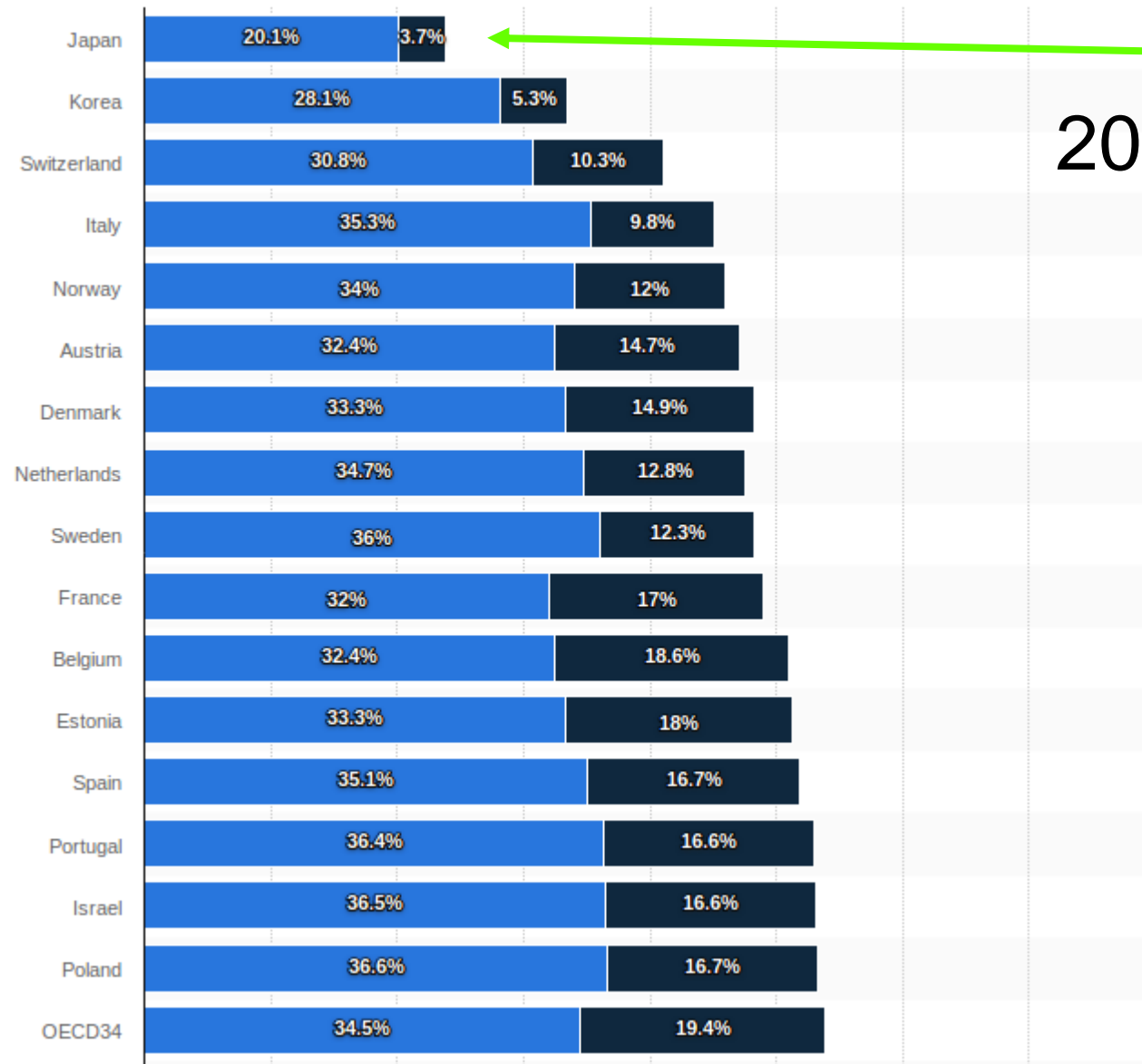'Inaccurate medical history' at medicals is a problem

'OGUK doctors don't follow the guidelines!'

'E-cigarettes are not allowed offshore – why not?'

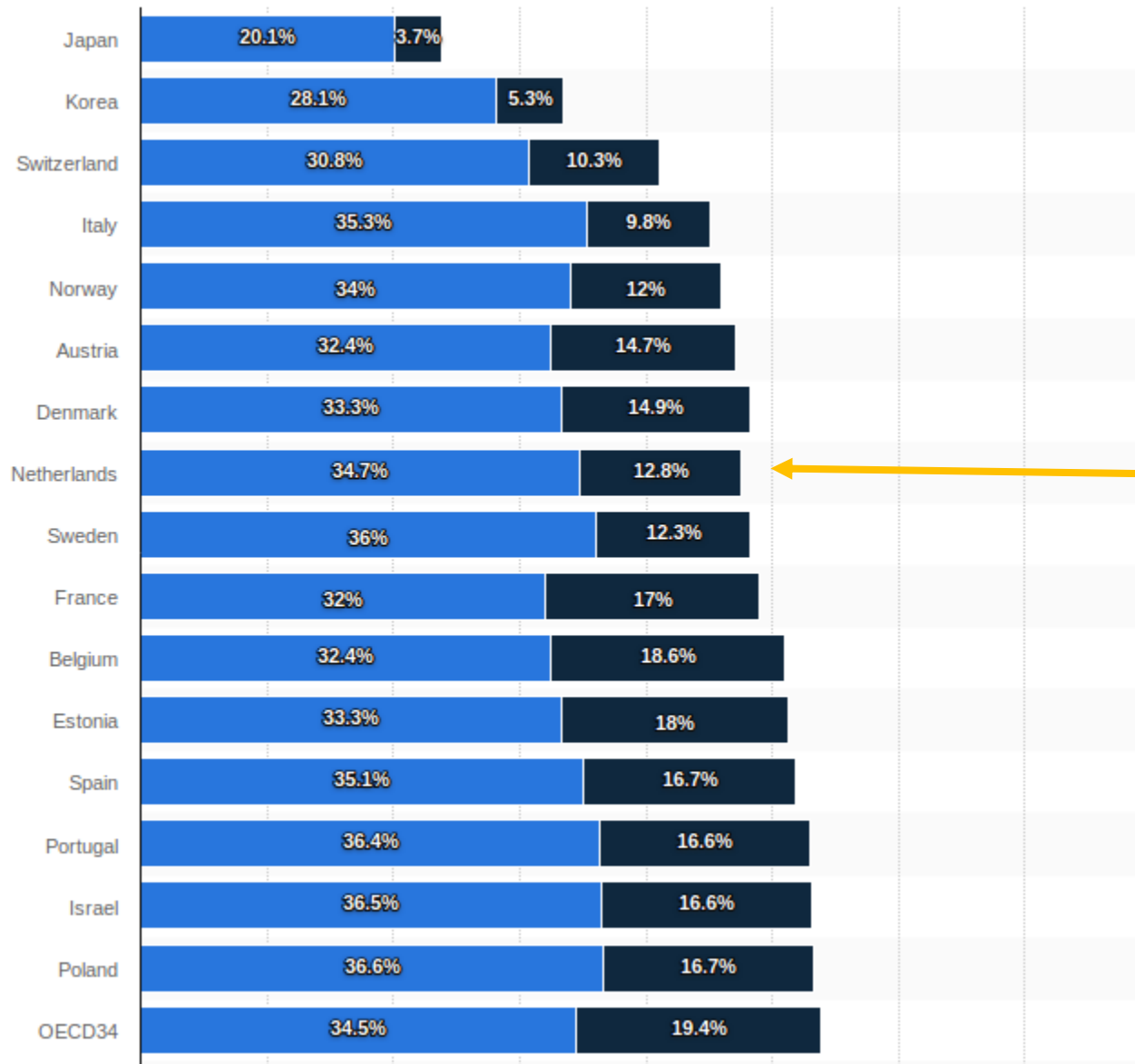# Prevalence of overweight and obesity in adults - OECD countries 2015

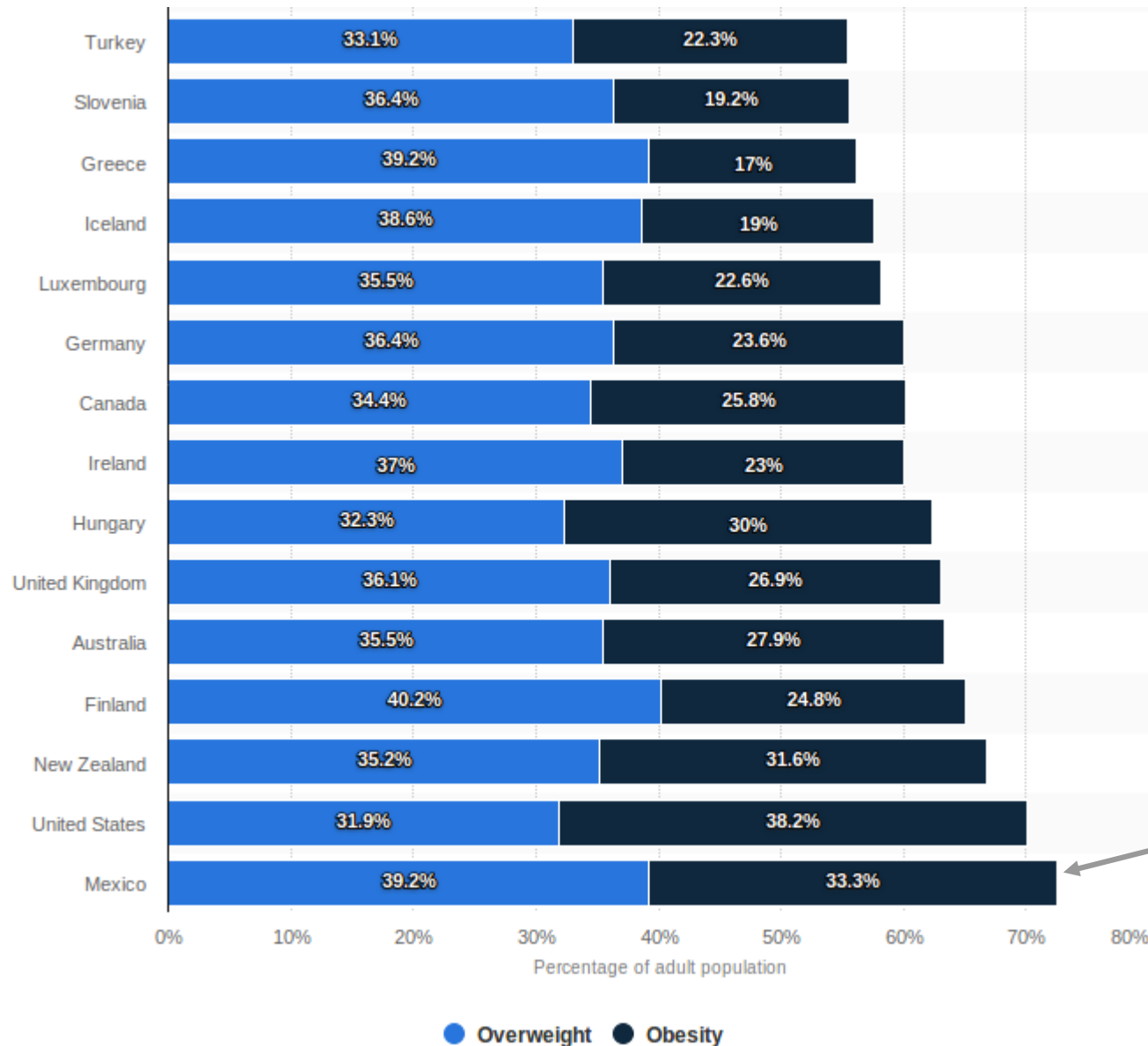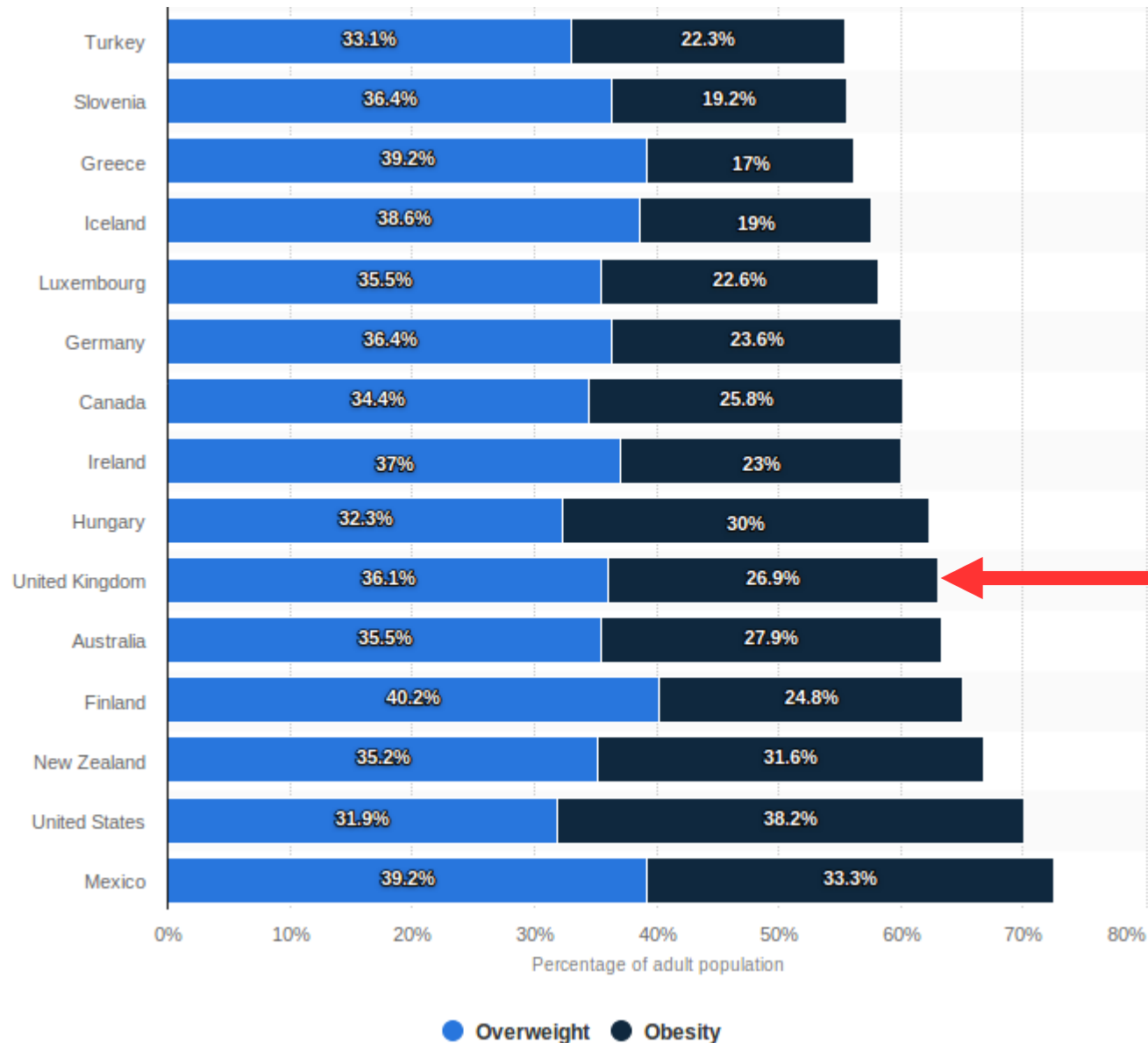# Prevalence of overweight and obesity in adults - OECD countries 2015

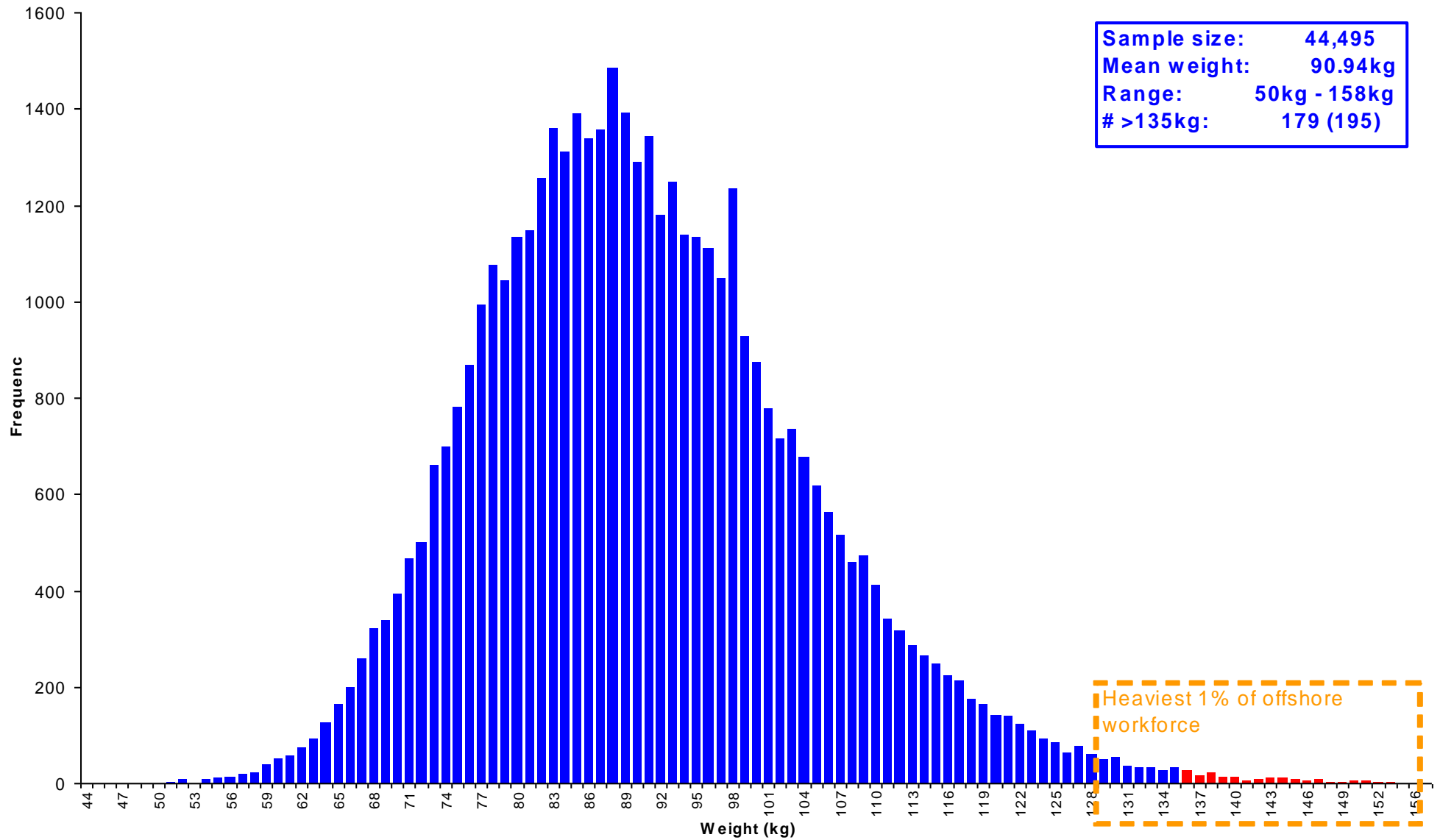| Country	Overweight	Obese
Japan	20.1%	3.7%
Korea	28.1%	5.3%
Switzerland	30.8%	10.3%
Italy	35.3%	9.8%
Norway	34%	12%
Austria	32.4%	14.7%
Denmark	33.3%	14.9%
Netherlands	34.7%	12.8%
Sweden	36%	12.3%
France	32%	17%
Belgium	32.4%	18.6%
Estonia	33.3%	18%
Spain	35.1%	16.7%
Portugal	36.4%	16.6%
Israel	36.5%	16.6%
Poland	36.6%	16.7%
OECD34	34.5%	19.4%
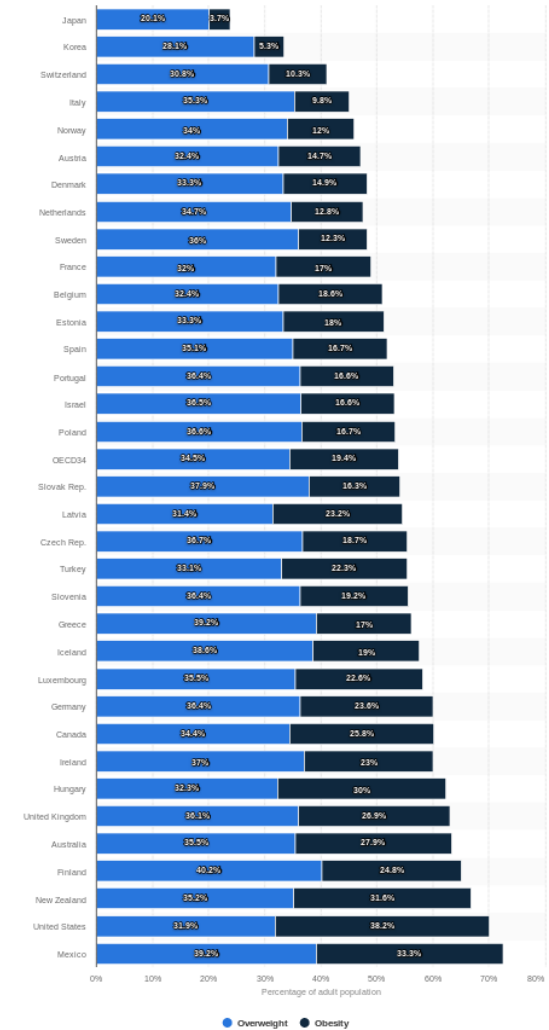
Japan:
20% overweight
4% obese

Prevalence of overweight and obesity in adults - OECD countries 2015

Country	Overweight	Obese
Japan	20.1%	3.7%
Korea	28.1%	5.3%
Switzerland	30.8%	10.3%
Italy	35.3%	9.8%
Norway	34%	12%
Austria	32.4%	14.7%
Denmark	33.3%	14.9%
Netherlands	34.7%	12.8%
Sweden	36%	12.3%
France	32%	17%
Belgium	32.4%	18.6%
Estonia	33.3%	18%
Spain	35.1%	16.7%
Portugal	36.4%	16.6%
Israel	36.5%	16.6%
Poland	36.6%	16.7%
OECD34	34.5%	19.4%

Netherlands:
35% overweight
13% obese

Prevalence of overweight and obesity in adults - OECD countries 2015

Country	Overweight	Obesity
Turkey	33.1%	22.3%
Slovenia	36.4%	19.2%
Greece	39.2%	17%
Iceland	38.6%	19%
Luxembourg	35.5%	22.6%
Germany	36.4%	23.6%
Canada	34.4%	25.8%
Ireland	37%	23%
Hungary	32.3%	30%
United Kingdom	36.1%	26.9%
Australia	35.5%	27.9%
Finland	40.2%	24.8%
New Zealand	35.2%	31.6%
United States	31.9%	38.2%
Mexico	39.2%	33.3%

Percentage of adult population

● Overweight ● Obesity

Mexico:
40% overweight
33% obese

Prevalence of overweight and obesity in adults - OECD countries 2015

Country	Overweight	Obesity
Turkey	33.1%	22.3%
Slovenia	36.4%	19.2%
Greece	39.2%	17%
Iceland	38.6%	19%
Luxembourg	35.5%	22.6%
Germany	36.4%	23.6%
Canada	34.4%	25.8%
Ireland	37%	23%
Hungary	32.3%	30%
United Kingdom	36.1%	26.9%
Australia	35.5%	27.9%
Finland	40.2%	24.8%
New Zealand	35.2%	31.6%
United States	31.9%	38.2%
Mexico	39.2%	33.3%

Percentage of adult population

● Overweight ● Obesity

UK:
36% overweight
27% obese

Average weight of males travelling offshore in the UKCS

Sample size: 44,495
Mean weight: 90.94kg
Range: 50kg - 158kg
>135kg: 179 (195)

Heaviest 1% of offshore workforce

Frequenc

Weight (kg)

Average weight of males travelling offshore in the UKCS

Sample size:	44,495
Mean weight:	90.94kg
Range:	50kg - 158kg
# >135kg:	179 (195)

Heaviest 1% of offshore workforce

Frequenc

Weight (kg)

1990

2015

1990

2015

DEBESTE
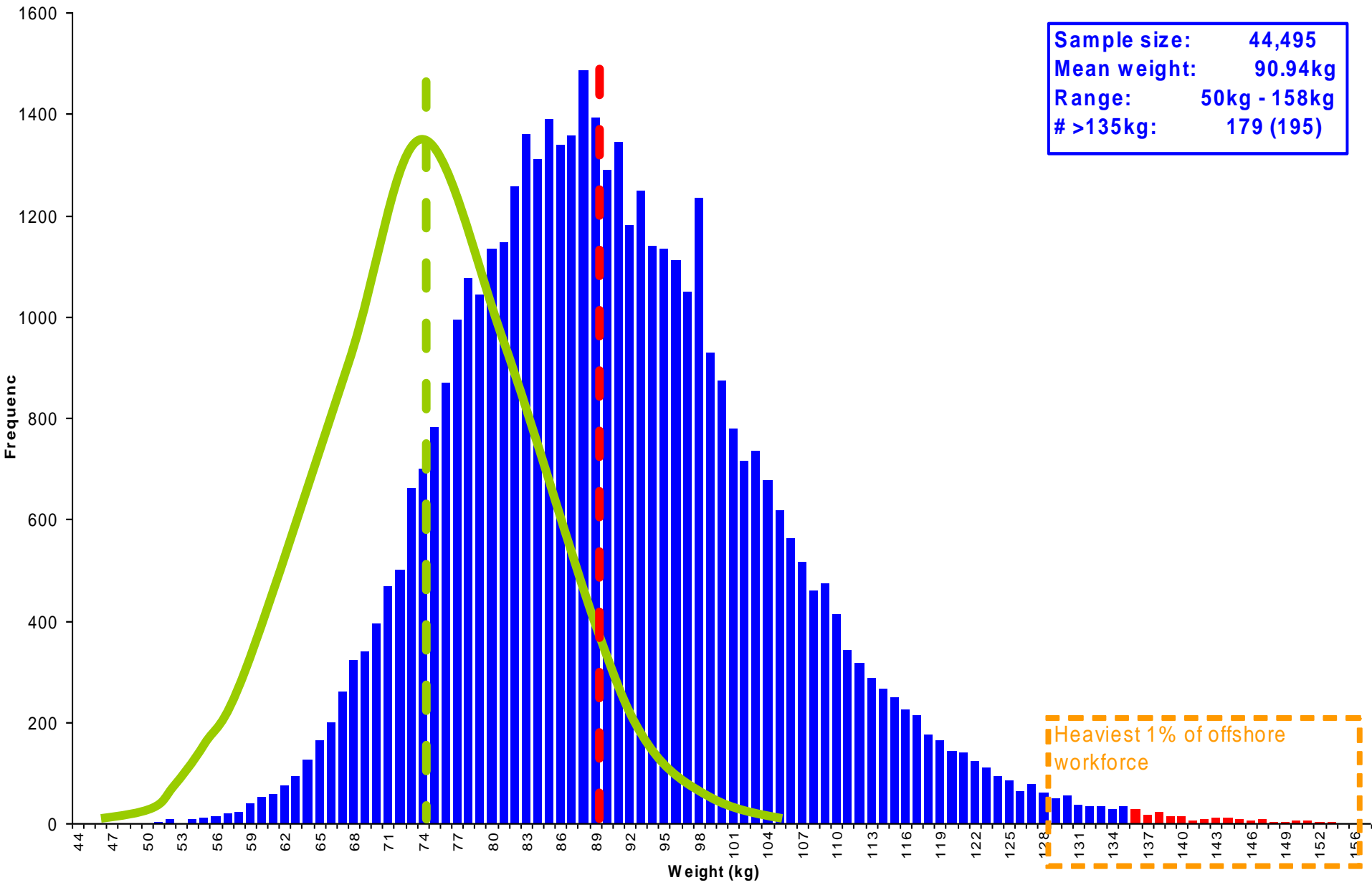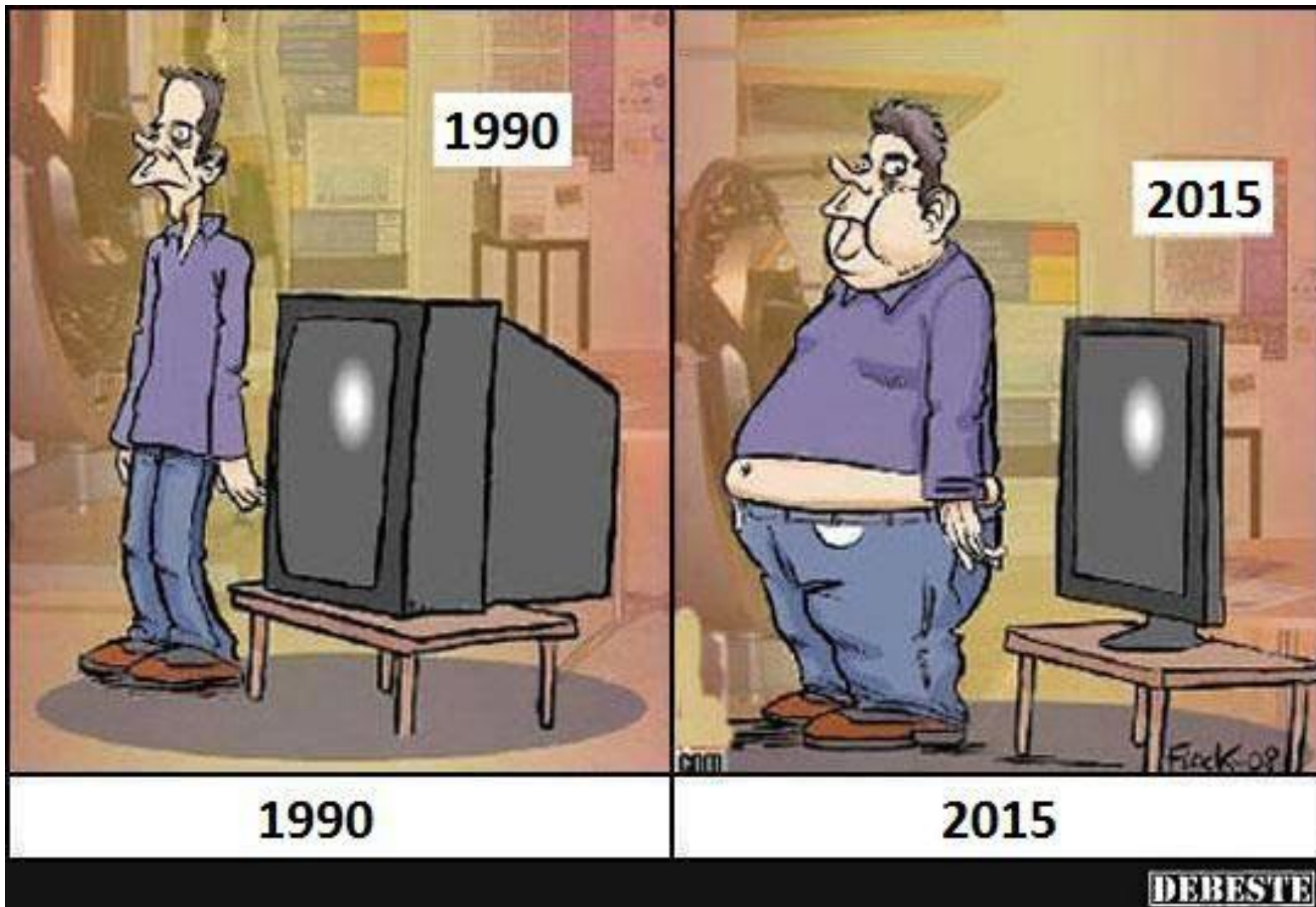
THE NEW (AB)NORMAL

Portion sizes have been growing. So have we. The average restaurant meal today is more than four times larger than in the 1950s. And adults are, on average, 26 pounds heavier. If we want to eat healthy, there are things we can do for ourselves and our community: Order the smaller meals on the menu, split a meal with a friend, or, eat half and take the rest home. We can also ask the managers at our favorite restaurants to offer smaller meals.

40 oz

30 oz

20 oz

10 oz

42 oz

SODA

12 oz

6.7 oz

HAMBURGER

FRENCH FRIES

7 oz

3.9 oz

2.4 oz

1950s

NOW

CDC
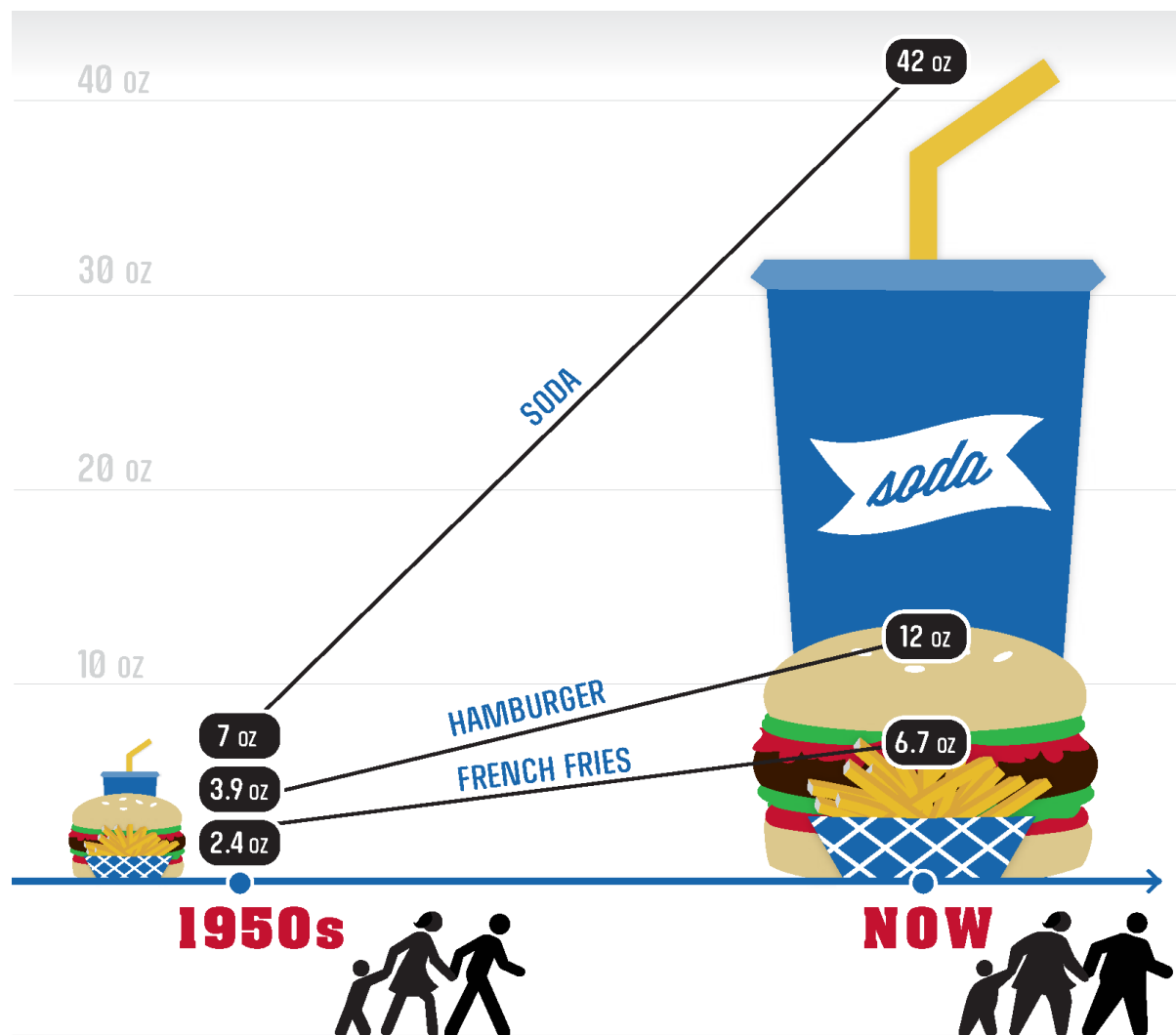
PORTION DISTORTION

Over the past 20 years, portion sizes of some foods in the UK have increased significantly. At the same time, the number of people who are overweight or obese has also increased. Eating more than we need can lead to weight gain, which is a risk factor for several common cancers, including bowel and breast cancer. Choosing to eat smaller portions, avoiding processed foods and basing your diet on mostly plant foods can help you stay a healthy weight.

INCREASES IN PORTION SIZES

1993 ▶ NOW

	STEAK AND KIDNEY PIE (short crust, individual)	SLICE OF WHITE BREAD (large loaf, medium thickness)	CHICKEN CURRY WITH RICE (frozen)
1993	Weight: 160g Calories: 425kcal	Weight: 36g Calories: 85kcal	Weight: 260g Calories: 305kcal
NOW	Weight: 240g Calories: 640kcal	Weight: 40g Calories: 95kcal	Weight: 395g Calories: 460kcal
	50% INCREASE	**11% INCREASE**	**52% INCREASE**

FROM THE BREAD ALONE, HAVING A SANDWICH FOR LUNCH EVERY DAY IS EQUAL TO **7,300 CALORIES A YEAR MORE NOW THAN IN 1993**

North America and Oceania wastes most food per capita

Food produced per capita each year (kg)

◆ Wasted   ◆ Not Wasted

Region	Wasted %
North America, Oceania	32.4%
Europe incl. Russia	31.4%
Japan, Korea, China	33.4%
Latin America	33.7%
N-Africa, W-Asia C-Asia	35.9%
Subsahara Africa	35.6%
S&SE Asia	28.1%

0   250   500   750
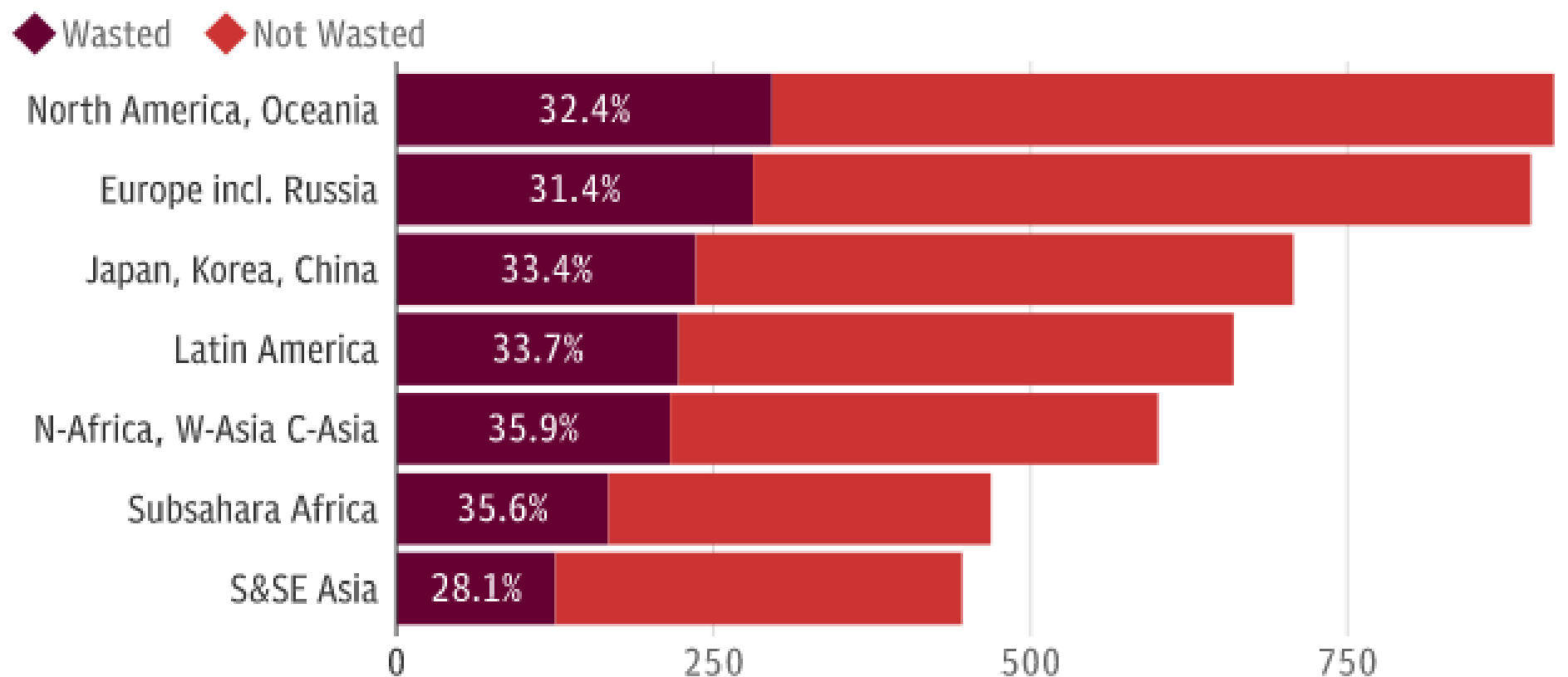
DATA: FAO

big. beefy. bliss.

Double Quarter Pounder** with Cheese

Big Mac*

Angus Deluxe Third Pounder**

i'm lov

Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes

A Randomized Clinical Trial

Zirui Song, MD, PhD[1]; Katherine Baicker, PhD[2,3]

Author Affiliations

Importance Employers have increasingly invested in workplace wellness programs to improve employee health and decrease health care costs. However, there is little experimental evidence on the effects of these programs.

Objective To evaluate a multicomponent workplace wellness program resembling programs offered by US employers.

Design, Setting, and Participants This clustered randomized trial was implemented at 160 worksites from January 2015 through June 2016. Administrative claims and employment data were gathered continuously through June 30, 2016; data from surveys and biometrics were collected from July 1, 2016, through August 31, 2016.

Interventions There were 20 randomly selected treatment worksites (4037 employees) and 140 randomly selected control worksites (28 937 employees, including 20 primary control worksites [4106 employees]). Control worksites received no wellness programming. The program comprised 8 modules focused on nutrition, physical activity, stress reduction, and related topics implemented by registered dietitians at the treatment worksites.

Main Outcomes and Measures Four outcome domains were assessed. Self-reported health and behaviors via surveys (29 outcomes) and clinical measures of health via screenings (10 outcomes) were compared among 20 intervention and 20 primary control sites; health care spending and utilization (38 outcomes) and employment outcomes (3 outcomes) from administrative data were compared among 20 intervention and 140 control sites.

Results Among 32 974 employees (mean [SD] age, 38.6 [15.2] years; 15 272 [45.9%] women), the mean participation rate in surveys and screenings at intervention sites was 36.2% to 44.6% (n = 4037 employees) and at primary control sites was 34.4% to 43.0% (n = 4106 employees) (mean of 1.3 program modules completed). After 18 months, the rates for 2 self-reported outcomes were higher in the intervention group than in the control group: for engaging in regular exercise (69.8% vs 61.9%; adjusted difference, 8.3 percentage points [95% CI, 3.9-12.8]; adjusted P = .03) and for actively managing weight (69.2% vs 54.7%; adjusted difference, 13.6 percentage points [95% CI, 7.1-20.2]; adjusted P = .02). The program had no significant effects on other prespecified outcomes: 27 self-reported health outcomes and behaviors (including self-reported health, sleep quality, and food choices), 10 clinical markers of health (including cholesterol, blood pressure, and body mass index), 38 medical and pharmaceutical spending and utilization measures, and 3 employment outcomes (absenteeism, job tenure, and job performance).
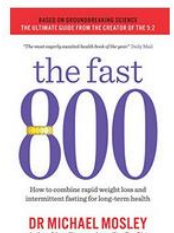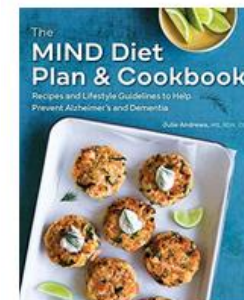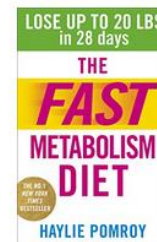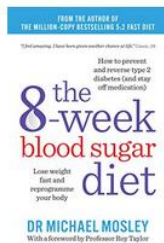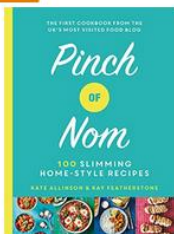
Results Among 32 974 employees (mean [SD] age, 38.6 [15.2] years; 15 272 [45.9%] women), the mean participation rate in surveys and screenings at intervention sites was 36.2% to 44.6% (n = 4037 employees) and at primary control sites was 34.4% to 43.0% (n = 4106 employees) (mean of 1.3 program modules completed). After 18 months, the rates for 2 self-reported outcomes were higher in the intervention group than in the control group: for engaging in regular exercise (69.8% vs 61.9%; adjusted difference, 8.3 percentage points [95% CI, 3.9-12.8]; adjusted P = .03) and for actively managing weight (69.2% vs 54.7%; adjusted difference, 13.6 percentage points [95% CI, 7.1-20.2]; adjusted P = .02). The program had no significant effects on other prespecified outcomes: 27 self-reported health outcomes and behaviors (including self-reported health, sleep quality, and food choices), 10 clinical markers of health (including cholesterol, blood pressure, and body mass index), 38 medical and pharmaceutical spending and utilization measures, and 3 employment outcomes (absenteeism, job tenure, and job performance).

A few more people said they took more exercise and 'managed' their weight, but the workplace programmes made no objective difference to health
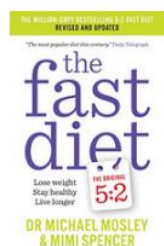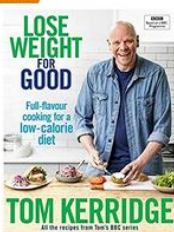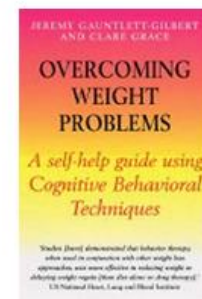
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YOUR FAVOURITES ALL PLANTS — BISH BASH BOSH! — HENRY FIRTH & IAN THEASBY

JEREMY GAUNTLETT-GILBERT AND CLARE GRACE — OVERCOMING WEIGHT PROBLEMS — A self-help guide using Cognitive Behavioral Techniques
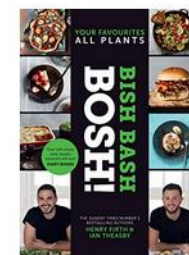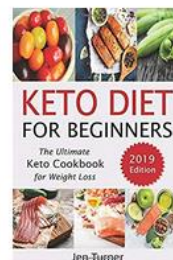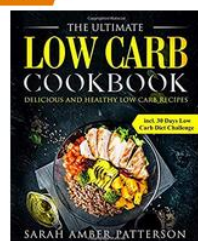
Weight-Loss Outcomes: A Systematic Review and Meta-Analysis of Weight-Loss Clinical Trials with a Minimum 1-Year Follow-Up

MARION J. FRANZ, MS, RD; JEFFREY J. VanWORMER, MS; A. LAUREN CRAIN, PhD; JACKIE L. BOUCHER, MS, RD; TRINA HISTON, PhD; WILLIAM CAPLAN, MD; JILL D. BOWMAN; NICOLAS P. PRONK, PhD
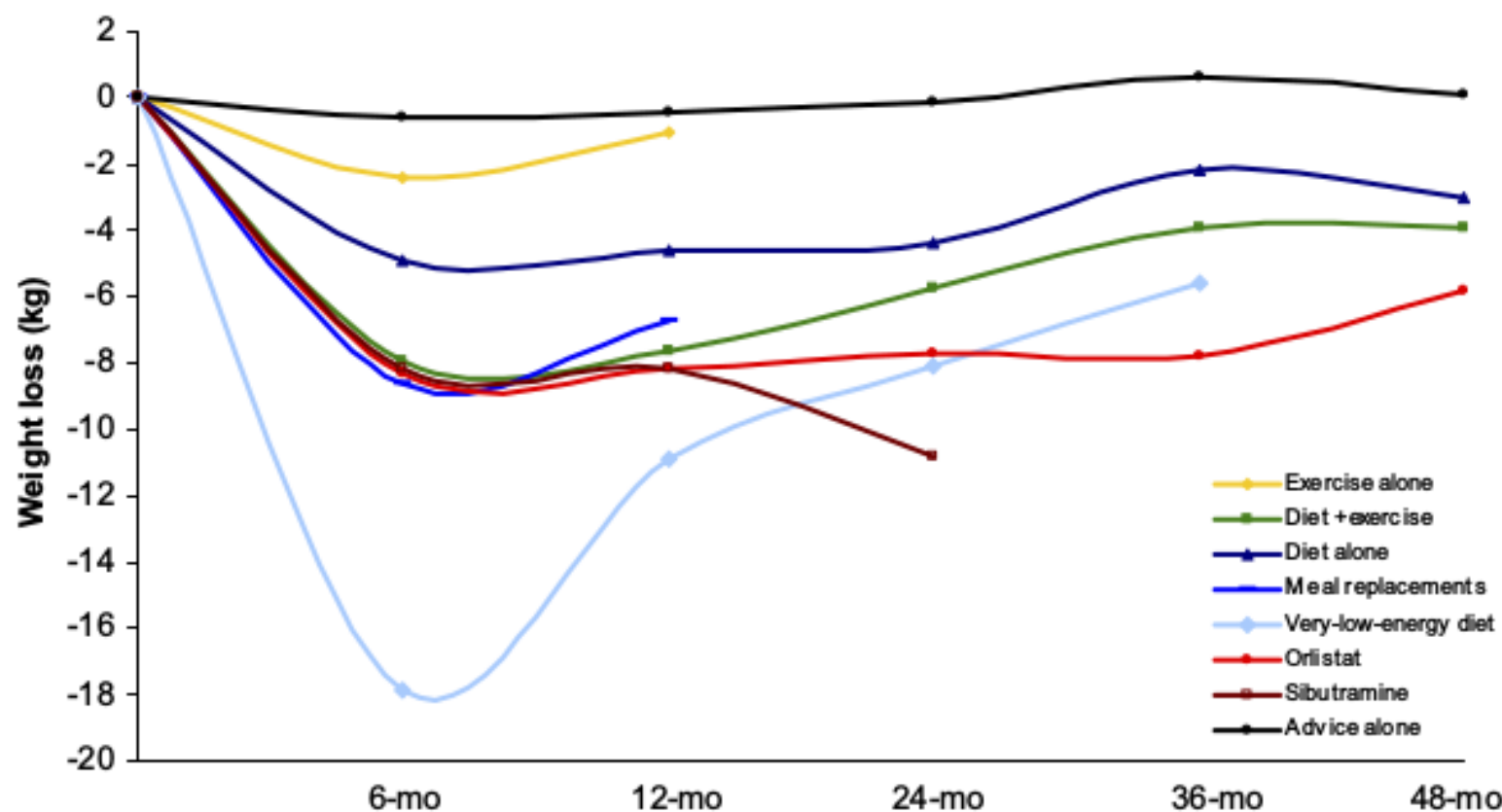
Figure 1. Average weight loss of subjects completing a minimum 1-year weight-management intervention; based on review of 80 studies (N=26,455; 18,199 completers [69%]).

Probability of an Obese Person Attaining Normal Body Weight: Cohort Study Using Electronic Health Records

Alison Fildes, PhD, Judith Charlton, MSc, Caroline Rudisill, PhD, Peter Littlejohns, MD, A. Toby Prevost, PhD, and Martin C. Gulliford, FFPH, MA

Overweight and obesity are growing global health concerns.[1] Strategies to control obesity emphasize obesity management and weight reduction as well as obesity prevention. In the United Kingdom, a national strategy report recommends that the management of obesity be an integral part of clinical practice.[2] This envisages that patients may transition from obesity to a more healthy body weight. A target of 5% body weight loss is often recommended for obese individuals who intend to lose weight.[3] However, access to weight management interventions may be limited,[4] and weight management interventions have only small and poorly maintained effects on body weight.[5,6] To understand the frequency with which reductions in body mass index (BMI, defined as weight in kilograms divided by the square of height in meters) may occur in a large population, we estimated the probability of an obese individual attaining normal body weight or a reduction of 5% in body weight.

METHODS

We conducted a population-based cohort study using primary care electronic health records from family practices in the United Kingdom. We selected a cohort of adults aged 20 years and older from the UK Clinical Practice Research Datalink (CPRD), an anonymized database of longitudinal patient electronic medical records from primary care. The CPRD is the world's largest primary care database and contains more than 7% of the UK population, with nearly 700 general practices contributing data that meets quality standards for research.[7] The CPRD data are considered to be broadly representative of the UK population in terms of patient demographic characteristics and the size and distribution of practices.[7] Our research was part of a larger study to evaluate the use of bariatric surgery. We aimed to estimate body weight transitions in the absence of bariatric surgery; therefore, we excluded participants who received bariatric surgery.

Objectives. We examined the probability of an obese person attaining normal body weight.

Methods. We drew a sample of individuals aged 20 years and older from the United Kingdom's Clinical Practice Research Datalink from 2004 to 2014. We analyzed data for 76 704 obese men and 99 791 obese women. We excluded participants who received bariatric surgery. We estimated the probability of attaining normal weight or 5% reduction in body weight.

Results. During a maximum of 9 years' follow-up, 1283 men and 2245 women attained normal body weight. In simple obesity (body mass index = 30.0–34.9 kg/m^2), the annual probability of attaining normal weight was 1 in 210 for men and 1 in 124 for women, increasing to 1 in 1290 for men and 1 in 677 for women with morbid obesity (body mass index = 40.0–44.9 kg/m^2). The annual probability of achieving a 5% weight reduction was 1 in 8 for men and 1 in 7 for women with morbid obesity.
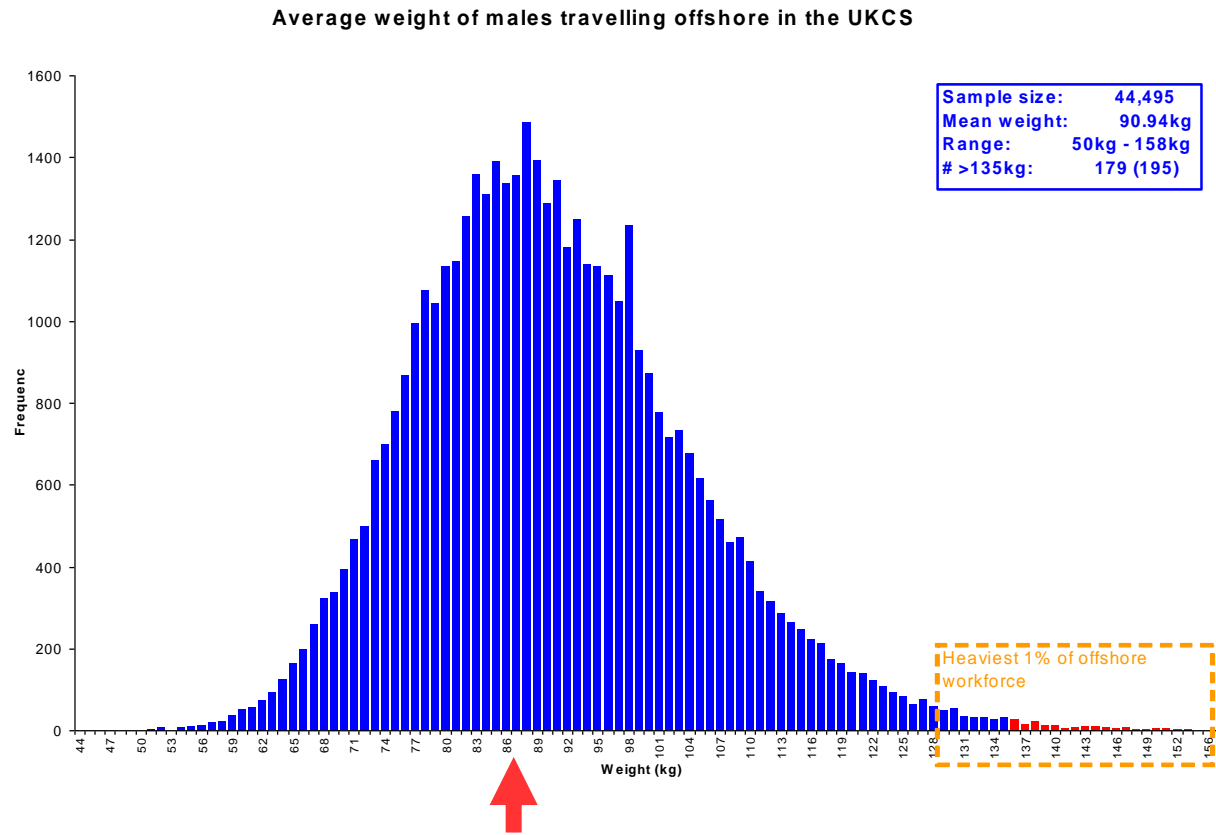
Conclusions. The probability of attaining normal weight or maintaining weight loss is low. Obesity treatment frameworks grounded in community-based weight management programs may be ineffective. (*Am J Public Health.* 2015;105: e54–e59. doi:10.2105/AJPH.2015.302773)

Sample Selection

There were 2 006 296 patients registered in the CPRD between November 1, 2004, and October 31, 2014, who were aged 20 years or older and had 3 or more BMI records. A minimum of 3 BMI records per patient was required to estimate weight changes, including weight regain following weight loss. The annual count of the CPRD registered population aged 20 years and older peaked at 3.7 million during this period, with a total of 7.1 million participants aged 20 years or older registered at any time during the period.

We classified participants according to the BMI value of their first record into 6 categories: 18.5 to 24.9 (normal weight), 25.0 to 29.9 (overweight), 30.0 to 34.9 (simple obesity), 35.0 to 35.9 (severe obesity), 40.0 to 44.9 (morbid obesity), and 45.0 or greater (superobesity) kilograms per meters squared. We selected a random sample of up to 30 000 participants, using the sample command in Stata version 13 (StataCorp LP, College Station, TX), from each category of BMI and gender, resulting in 314 477 participants. There were fewer than 30 000 women with a BMI of 45 or greater

kilograms per meters squared and fewer than 30 000 men with a BMI of either 40 to 45 or 45 or greater kilograms per meters squared.

We then extracted full CPRD records for this sample. We analyzed data for research quality records for each participant. The start was the latest of November 1, 2004, the participant registration date, or the general practice CPRD start date. The end date was the earliest of October 31, 2014, the date death or end of registration, or the last data collection date for the general practice. We excluded the 2738 (1%) participants who had bariatric surgery and the 32 757 (10%) participants who had fewer than 3 BMI values recorded between November 1, 2004 and October 31, 2014; this left 278 982 participants for further analysis.

Analysis

We conducted a longitudinal analysis of BMI records. The start date for each participant was the later of November 1, 2004 or the beginning of the patient's CPRD record. The end date was the earlier of October 31, 2014 or the end of the patient's CPRD record. We used the first BMI record after the participant start date

Objectives. We examined the probability of an obese person attaining normal body weight.

Methods. We drew a sample of individuals aged 20 years and older from the United Kingdom's Clinical Practice Research Datalink from 2004 to 2014. We analyzed data for 76 704 obese men and 99 791 obese women. We excluded participants who received bariatric surgery. We estimated the probability of attaining normal weight or 5% reduction in body weight.

Results. During a maximum of 9 years' follow-up, 1283 men and 2245 women attained normal body weight. In simple obesity (body mass index $= 30.0$–34.9 kg/m^2), the annual probability of attaining normal weight was 1 in 210 for men and 1 in 124 for women, increasing to 1 in 1290 for men and 1 in 677 for women with morbid obesity (body mass index $= 40.0$–44.9 kg/m^2). The annual probability of achieving a 5% weight reduction was 1 in 8 for men and 1 in 7 for women with morbid obesity.

Conclusions. The probability of attaining normal weight or maintaining weight loss is low. Obesity treatment frameworks grounded in community-based weight management programs may be ineffective. (*Am J Public Health.* 2015;105: e54–e59. doi:10.2105/AJPH.2015.302773)

Any kg to 5% less = ~1 in 10

BMI 30-35 to normal weight = ~1 in 100

BMI 40-45 to normal weight = ~1 in 1000

Average UK male = 1.75 m tall

Average weight of males travelling offshore in the UKCS

Sample size:	44,495
Mean weight:	90.94kg
Range:	50kg - 158kg
# >135kg:	179 (195)

Heaviest 1% of offshore workforce

Frequenc

Weight (kg)

Average weight offshore worker 90kg; BMI = 29

Average UK male = 1.75 m tall

Average weight of males travelling offshore in the UKCS

Sample size: 44,495
Mean weight: 90.94kg
Range: 50kg - 158kg
>135kg: 179 (195)

Heaviest 1% of offshore workforce
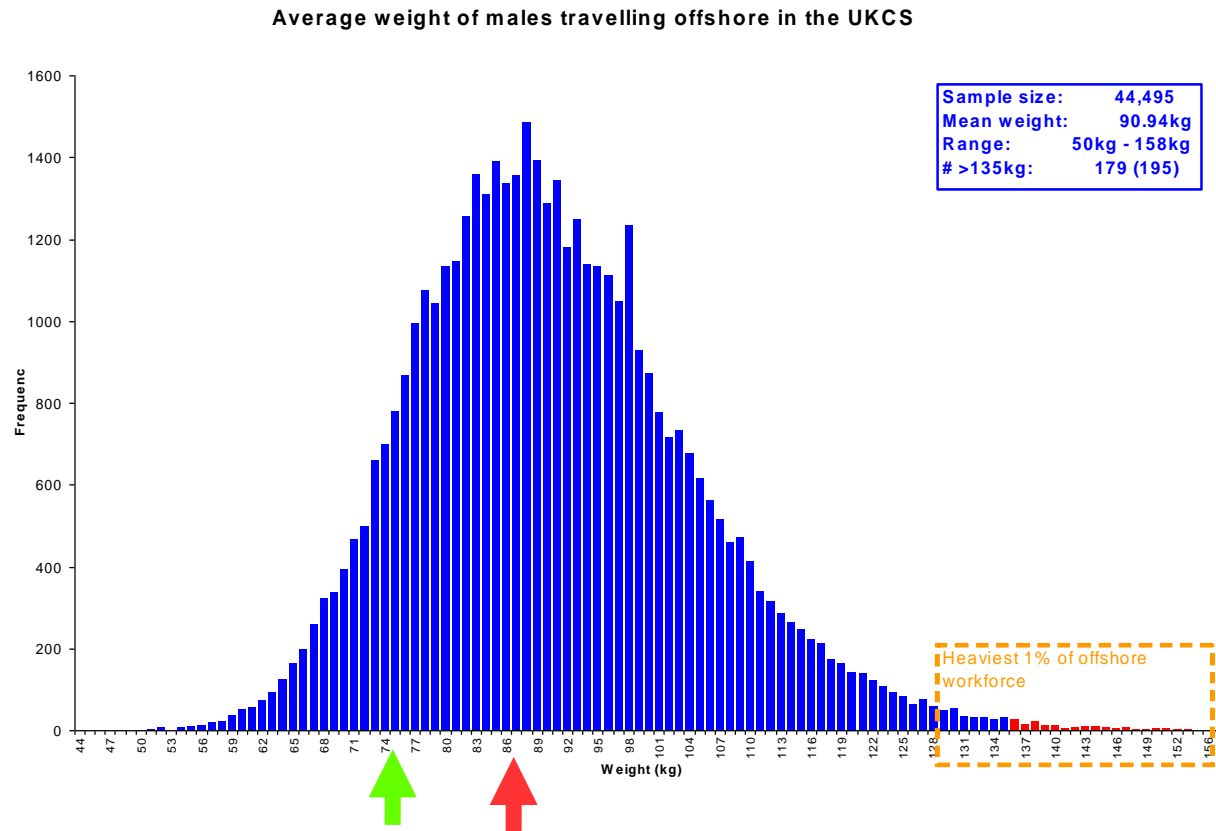
Weight (kg)

Average weight offshore worker 90kg; BMI = 29

Normal BMI = 25 = 76kg (15% weight loss required)

Average weight of males travelling offshore in the UKCS

Sample size: 44,495
Mean weight: 90.94kg
Range: 50kg - 158kg
>135kg: 179 (195)

Heaviest 1% of offshore workforce

Weight (kg)

Frequenc
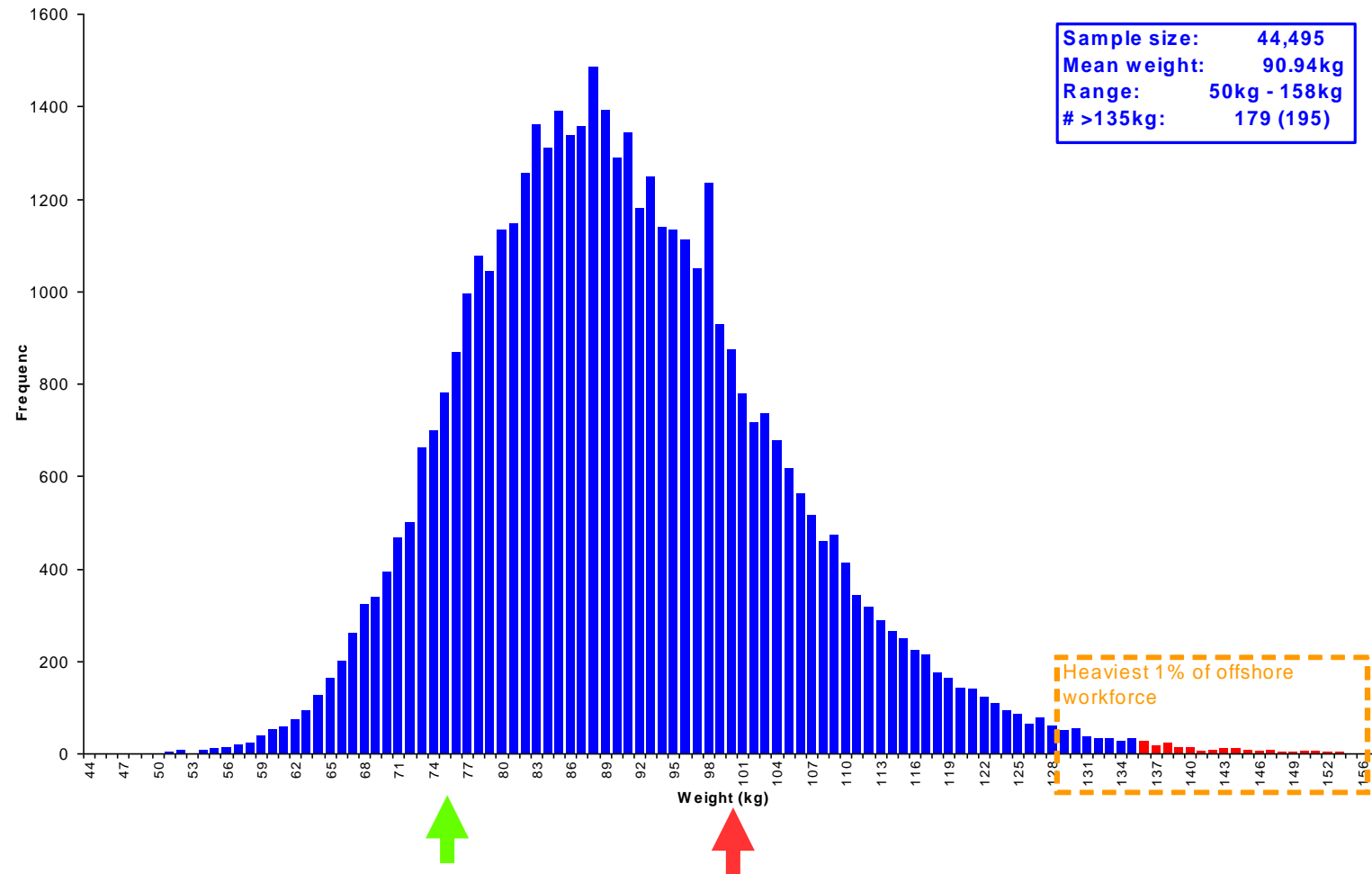
100kg offshore worker = BMI 33

Average weight of males travelling offshore in the UKCS

Sample size: 44,495
Mean weight: 90.94kg
Range: 50kg - 158kg
>135kg: 179 (195)

Heaviest 1% of offshore workforce

Frequenc
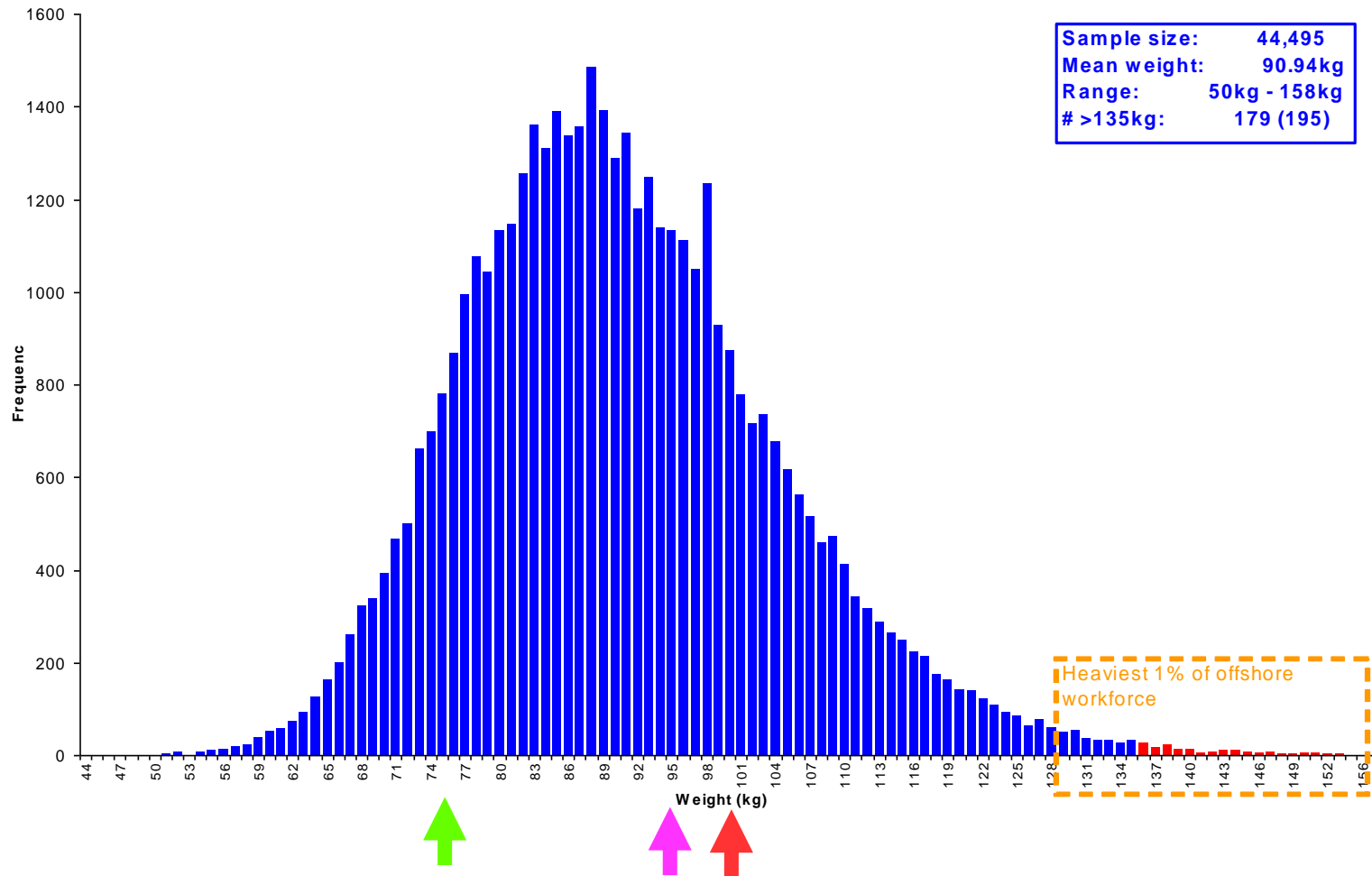
Weight (kg)

100kg offshore worker = BMI 33

5% weight loss = 95kg = BMI 31

Average weight of males travelling offshore in the UKCS

Sample size:	44,495
Mean weight:	90.94kg
Range:	50kg - 158kg
# >135kg:	179 (195)

Heaviest 1% of offshore workforce

Frequenc (y-axis), **Weight (kg)** (x-axis)
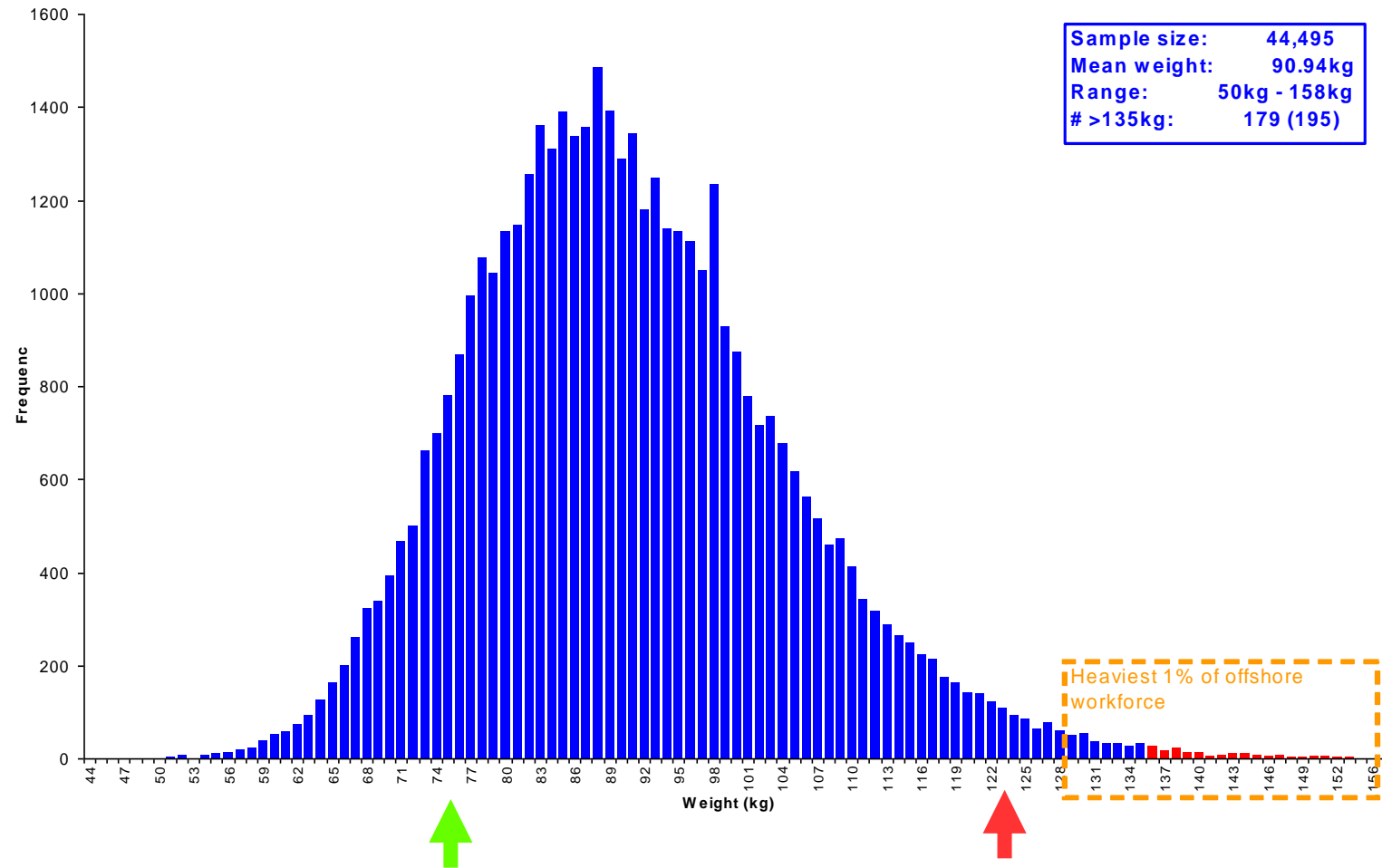
123kg offshore worker = BMI 40

Average weight of males travelling offshore in the UKCS

Sample size:	44,495
Mean weight:	90.94kg
Range:	50kg - 158kg
# >135kg:	179 (195)

Heaviest 1% of offshore workforce
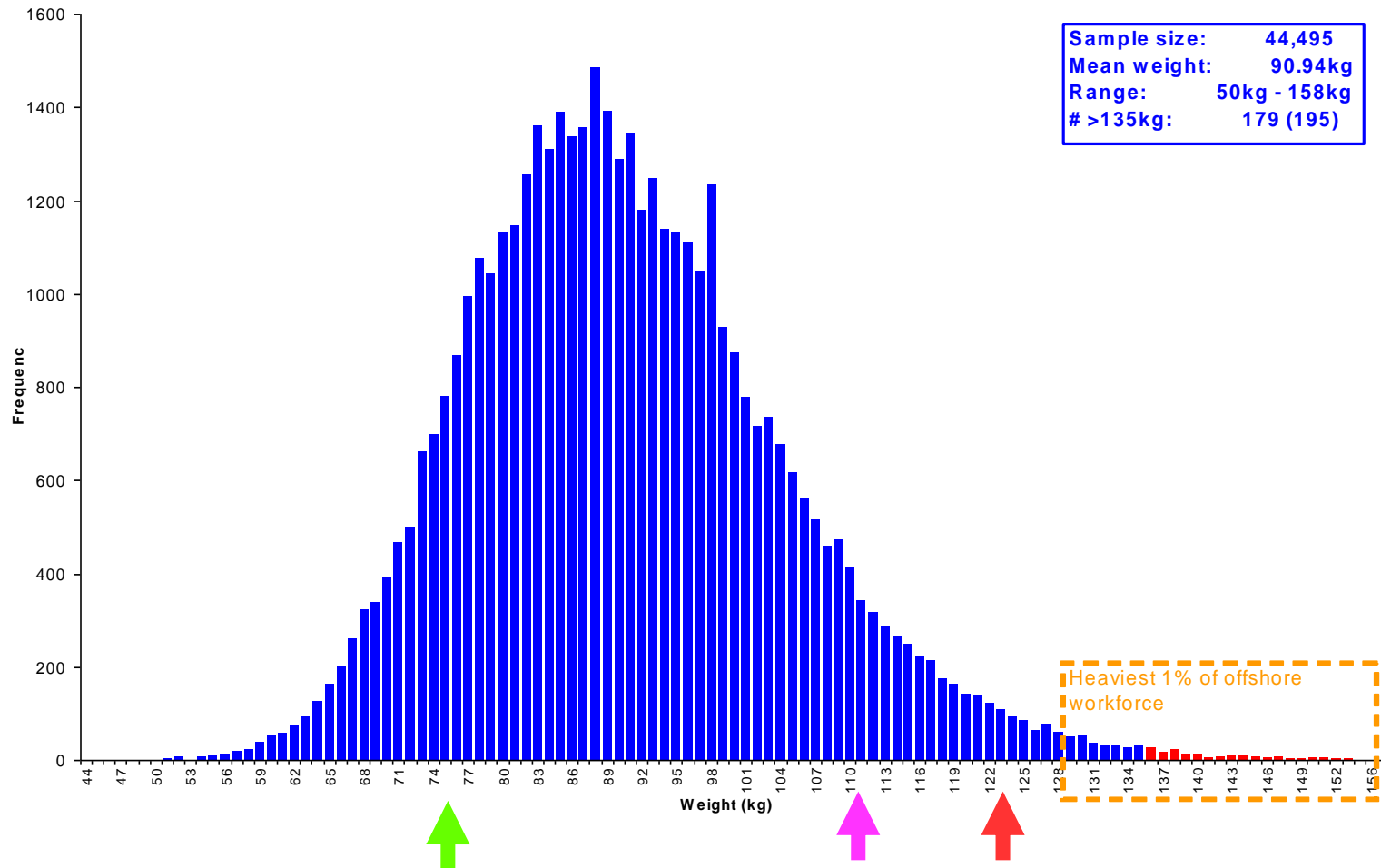
123kg offshore worker = BMI 40

10% weight loss = 111kg = BMI 36

Conclusions

Losing weight is difficult

Helping people to lose weight is difficult

'Externalities' adversely affect efforts

Questions to consider:

Does threatening job loss result in sustained weight loss?

Where do we 'draw the line'?
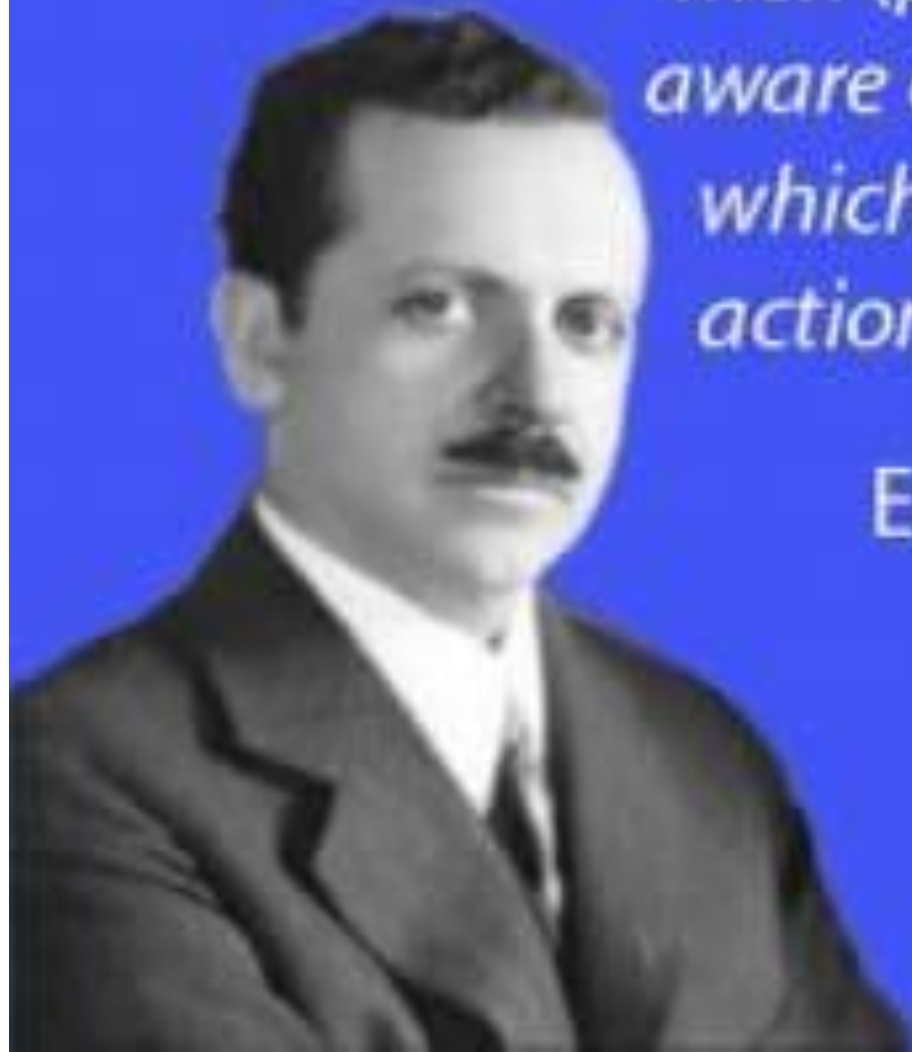
"Men (people) are rarely aware of the real reasons which motivate their actions."
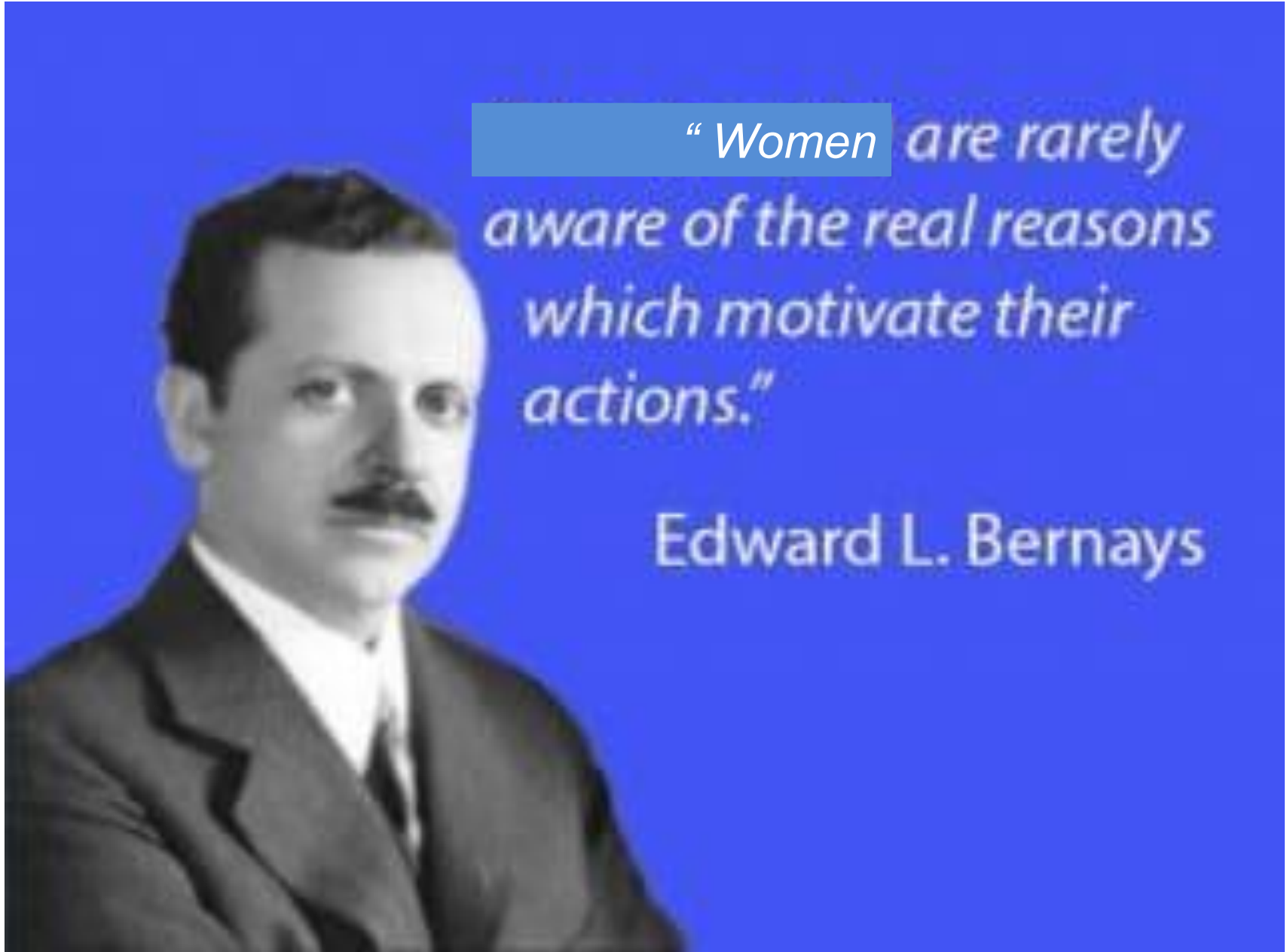
Edward L. Bernays

" *Women* are rarely aware of the real reasons which motivate their actions."

Edward L. Bernays

Age-standardised prevalence of smoking: males, 15 years and over, 2015 (WHO)
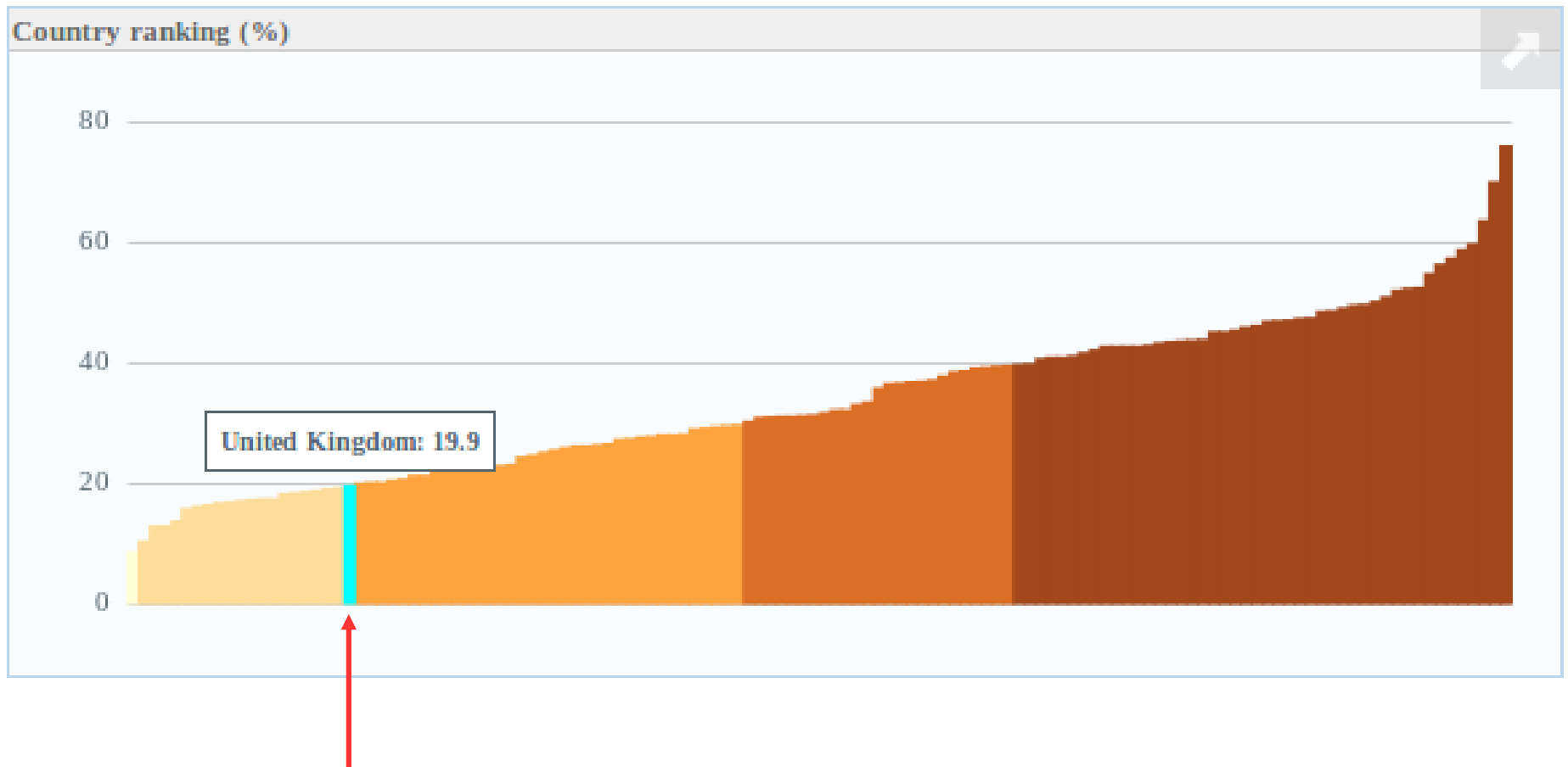
Adult smoking habits in the UK: 2015 (ONS, March 2017)

Proportion (%) of those who smoke or have quit

2015: Ban on smoking in cars with people under the age of 18 present.

1982: The proportion of "quitters" overtakes the proportion of current smokers, largely due to mounting anti-smoking evidence and campaigning which took off in the early 70s.

2006/2007: Ban on smoking in the workplace and enclosed public places. Also becomes illegal for those below 18 to purchase tobacco.

80s and 90s: Growing evidence that smoking is linked to poor health outcomes e.g., heart disease.

Increasing popularity of e-cigarettes as an aid to quit smoking.

—— Current smokers   —— Smokers who have quit

1974 1978 1982 1986 1990 1994 1998 2001 2003 2005 2007 2009 2011 2013 2015

BRITISH AMERICAN TOBACCO

About us   **Our products**   **How we work**

Our history – a timeline

We were founded in 1902 – find out what's happened in the past 116 years.

1902

When the UK's Imperial Tobacco Company and the American Tobacco Company of the United States form a joint venture, the British American Tobacco Company. James 'Buck' Duke becomes the company's first chairman. His strategy is to devise a superior product, hire the best people to make it, price it as low as possible, and mechanise production.

1910

Our cigarettes sales now exceed 10 billion per year.

1960

Global sales exceed 280 billion cigarettes with trading profits of more than £58 million.

1981

Trading profits from the tobacco operations triple over the previous decade to more than £463 million.

2015

We complete a number of investments and strategic partnerships focused on future growth. The Group acquires TDR in Croatia, the leading independent cigarette manufacturer in Central Europe. We also acquire the remaining shares in our Brazilian subsidiary, Souza Cruz, that we don't already own.

Highlighting our commitment to lead in Next Generation Products, we acquire CHIC Group, a market-leading Vapour Product (e-cigarette) business in Poland. We continue to develop Vype with new products and expansion into new markets, and we launch our first Tobacco Heating Product, glo iFuse, in Romania.

Cochrane Library

Electronic cigarettes for smoking cessation (Review)

Hartmann-Boyce J, McRobbie H, Bullen C, Begh R, Stead LF, Hajek P

There is evidence from two trials that ECs help smokers to stop smoking in the long term compared with placebo ECs. However, the small number of trials, low event rates and wide confidence intervals around the estimates mean that our confidence in the result is rated 'low' by GRADE standards. The lack of difference between the effect of ECs compared with nicotine patches found in one trial is uncertain for similar reasons. None of the included studies (short- to mid-term, up to two years) detected serious adverse events considered possibly related to EC use. The most commonly reported adverse effects were irritation of the mouth and throat. The long-term safety of ECs is unknown. In this update, we found a further 15 ongoing RCTs which appear eligible for this review.

This is an update of a previous review. The first review was published in 2014 and included 13 studies. For this update, we searched for studies published up to January 2016 and found 11 new studies. Only two of the included studies are randomized controlled trials and followed participants for at least six months. These provide the best evidence. The remaining 22 studies either did not follow participants for very long or did not put people into treatment groups so could not directly compare ECs with something else. These

Legislative smoking bans for reducing harms from secondhand smoke exposure, smoking prevalence and tobacco consumption (Review)

Frazer K, Callinan JE, McHugh J, van Baarsel S, Clarke A, Doherty K, Kelleher C

Since the first version of this review was published, the current evidence provides more robust support for the previous conclusions that the introduction of a legislative smoking ban does lead to improved health outcomes through reduction in SHS for countries and their populations. The clearest evidence is observed in reduced admissions for acute coronary syndrome. There is evidence of reduced mortality from smoking-related illnesses at a national level. There is inconsistent evidence of an impact on respiratory and perinatal health outcomes, and on smoking prevalence and tobacco consumption.

Effect of workplace smoking ban

Hurt et al, Arch Int Med Oct 29, 2012

Myocardial Infarction and Sudden Cardiac Death in Olmsted County, Minnesota, Before and After Smoke-Free Workplace Laws

Olmsted County, Minnesota, USA

2002 – smoking ban in restaurants
2007 – smoking ban in all workplaces

Compare 18 months before 2002 ban with 18 months after 2007 ban

How many heart attacks and sudden cardiac deaths?

	Before	After	Reduction
MI	150.8	100.7	33%
Sudden Death	109.1	92.0	17%

(per 100,000 population)

Effect of smoking ban

Pell et al, NEJM July 2008

Smoke-free legislation and hospitalisation for acute coronary syndromes

Scotland, UK

March 2006 – smoking ban all public places

Compare 10 months before March 2006 with
10 months before March 2007

How many heart attacks and sudden cardiac
deaths?

	Before	After	Reduction
admissions	3235	2684	17%
England (no smoking ban)			3%

Lancet study Nov 2013 (Bullen et al, NZ)
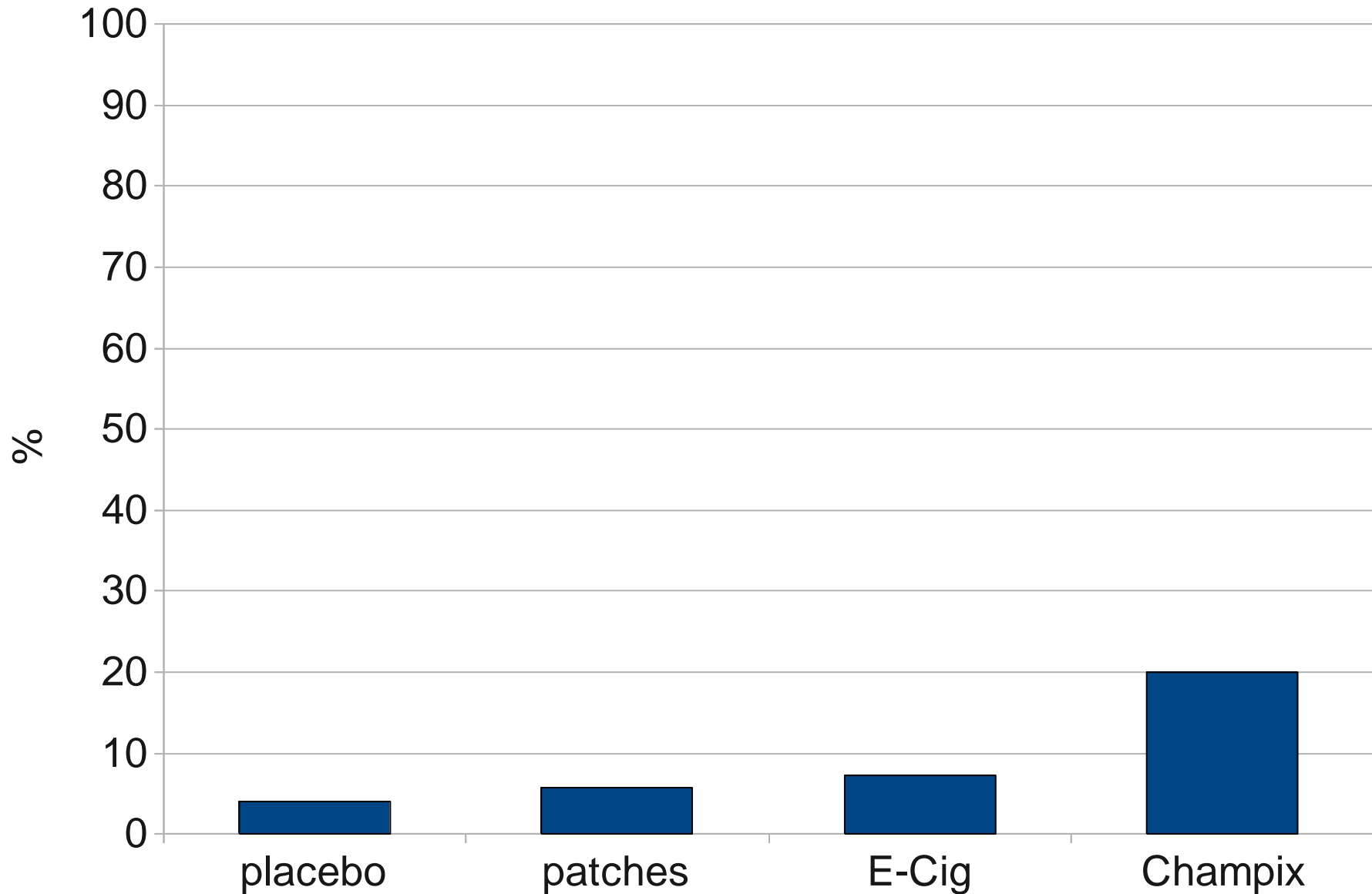
More favourable to manufacturers

Tobacco promotions; enthusiasm for vapourisers;
NRT ignored; medication feared

Tobacco banned; caution with vapourisers;
NRT and/or medication easily available

More favourable to 'stoppers'

Legal status of cannabis (for non-medical, 'recreational' use)

🟦	Legal
🟧	Illegal but decriminalized
🟥	Illegal but often unenforced
🟥	Illegal
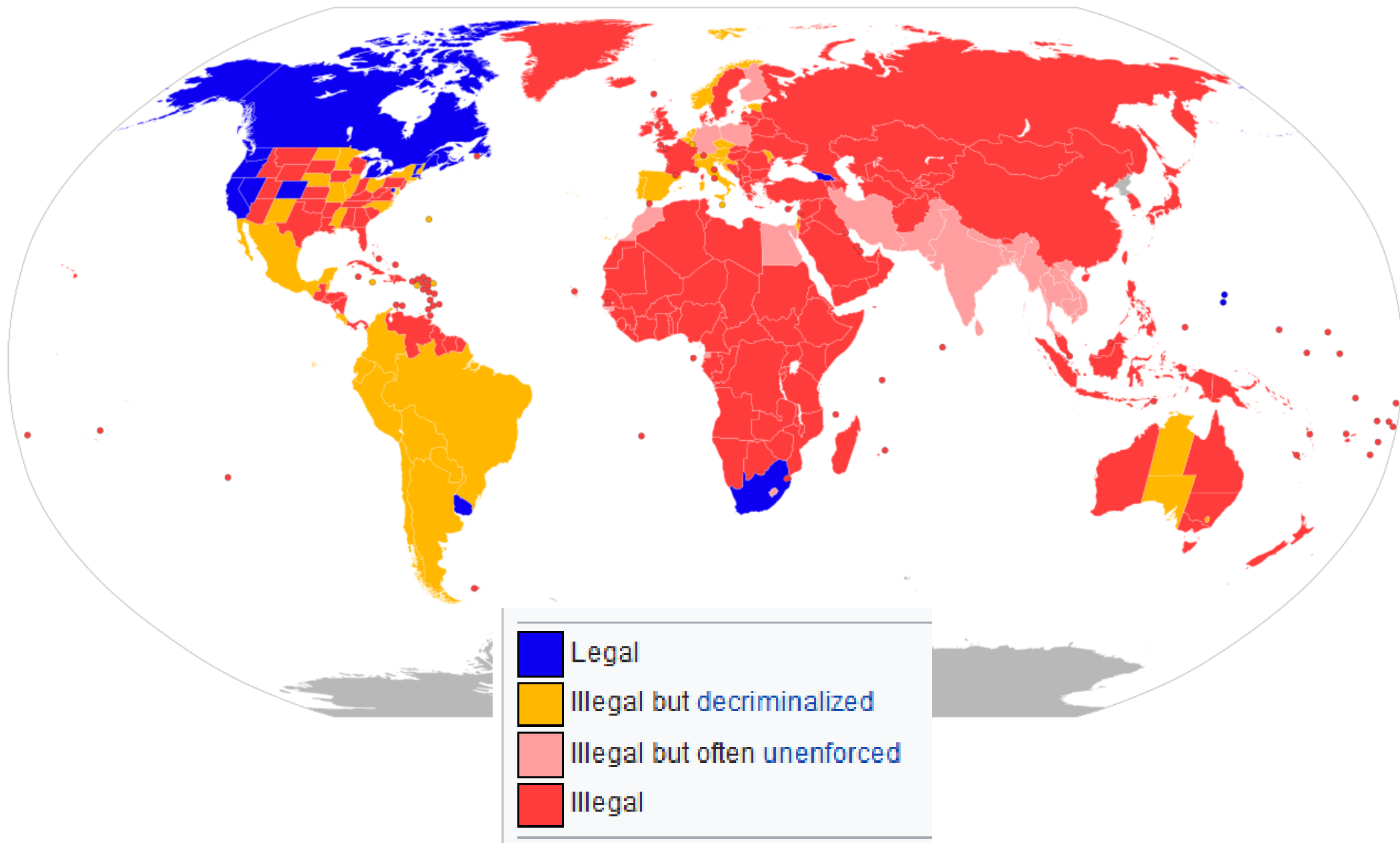
MOST LUCRATIVE
$value per square kilometre

Grapes
$625,000

Beans
$30,000

Rapeseed
$60,000

Maize
$79,000

Soybeans
$72,000

Wheat
$56,000

Rice
$140,000

Sugar Cane
$262,000

Sugar Beet
$270,000

Palm
$145,000

Coca (cocaine)
$37,700,000

Cannabis
$47,660,000
per km²

Barley
$36,000

Tomatoes
$1,415,000

Cassava
$153,000

Potatoes
$365,000

Opium Poppy
$6,000,000

Tea
$178,000

Coffee
$107,000

Vegetables (minor)
$305,000

Tobacco
$277,000
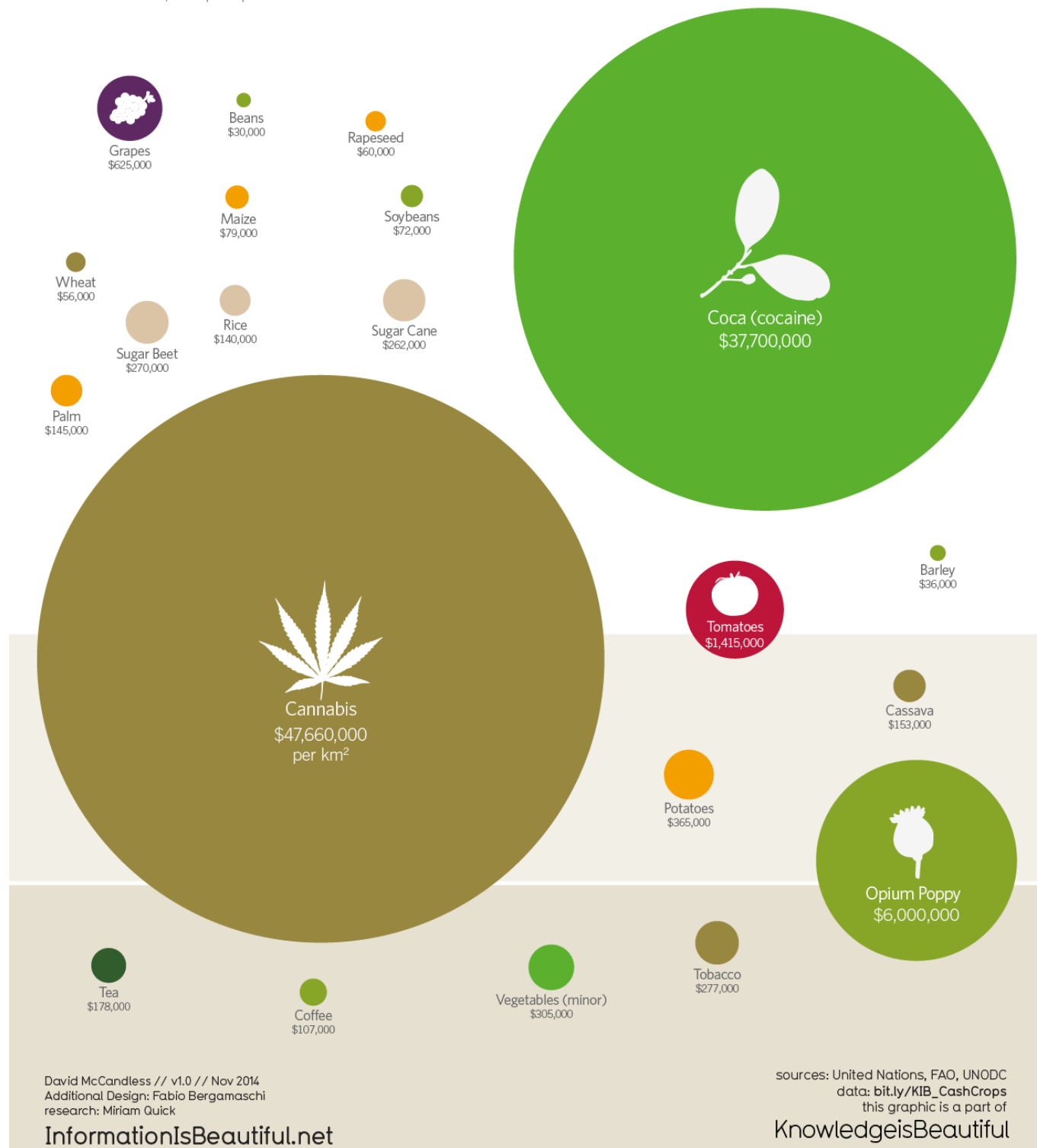
David McCandless // v1.0 // Nov 2014
Additional Design: Fabio Bergamaschi
research: Miriam Quick

InformationIsBeautiful.net

sources: United Nations, FAO, UNODC
data: bit.ly/KIB_CashCrops
this graphic is a part of

KnowledgeisBeautiful

EASY TO QUIT

Medical Marijuana Electric Cigarette

Cannabis E-Cigarette

The e-cig designed to administer THC in the form of medicinal marijuana oil concentrate is now available to the public.

The new device known as the **ECO-SAFE** is expected to be the most ground breaking advance in this controversial treatment field since the legalization of pharmaceutical marijuana itself.

The powerhouse behind the Eco-Safe is its specially designed coil that can withstand aggressive use and lasts 5 times longer than comparable coils.

Conclusions

There are BIG vested interests involved

Population health is NOT the priority

We already know what works

"Super-duper" for dinner or supper! This jelly omelet with VELVEETA goodness all through it

A KRAFT PRODUCT
VELVEETA

A smile doesn't cost much when you make a Raisin Pudding Pie.

jamiegenevieve ✔ Follow

1,214 posts **1.2m** followers **877** following

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Scottish Makeup Artist, Weekly Vlogger & YouTuber 👋
Twitter: @jamie_genevieve
Business: jamiegenevieve@hotmail.com
www.youtube.com/user/jamiegenevieve

⊞ **POSTS**   👤 **TAGGED**

Newsbeat

James Charles loses a million subscribers after YouTube row

By Nesta McGregor
Newsbeat reporter

12 May 2019   f   ⊙   y   ✉   ⌣ Share

GETTY IMAGES

James Charles has lost more than one million subscribers amid a row with fellow YouTube star Tati Westbrook.

He now has 14.2m subscribers - previously the figure was 16m, according to the website Social Blade.

Platforms owned by Facebook

Facebook
2.3B monthly
active users

WhatsApp
1.6B

Messenger
1.3B

Instagram
1.0B

Platforms owned by others

YouTube
1.9B monthly
active users

WeChat
1.1B

TikTok
500M

Reddit
330M

LinkedIn
303M

Twitter
330M

Snapchat
287M

Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care

Boys

Age band (years)
— 10-12   - - - 13-16   -·-·- 17-19

Incidence (per 10 000 patients)

Girls

Incidence (per 10 000 patients)

Year

Boys

Age band (years)
— 10-12   - - - 13-16   -·-·- 17-19

Girls
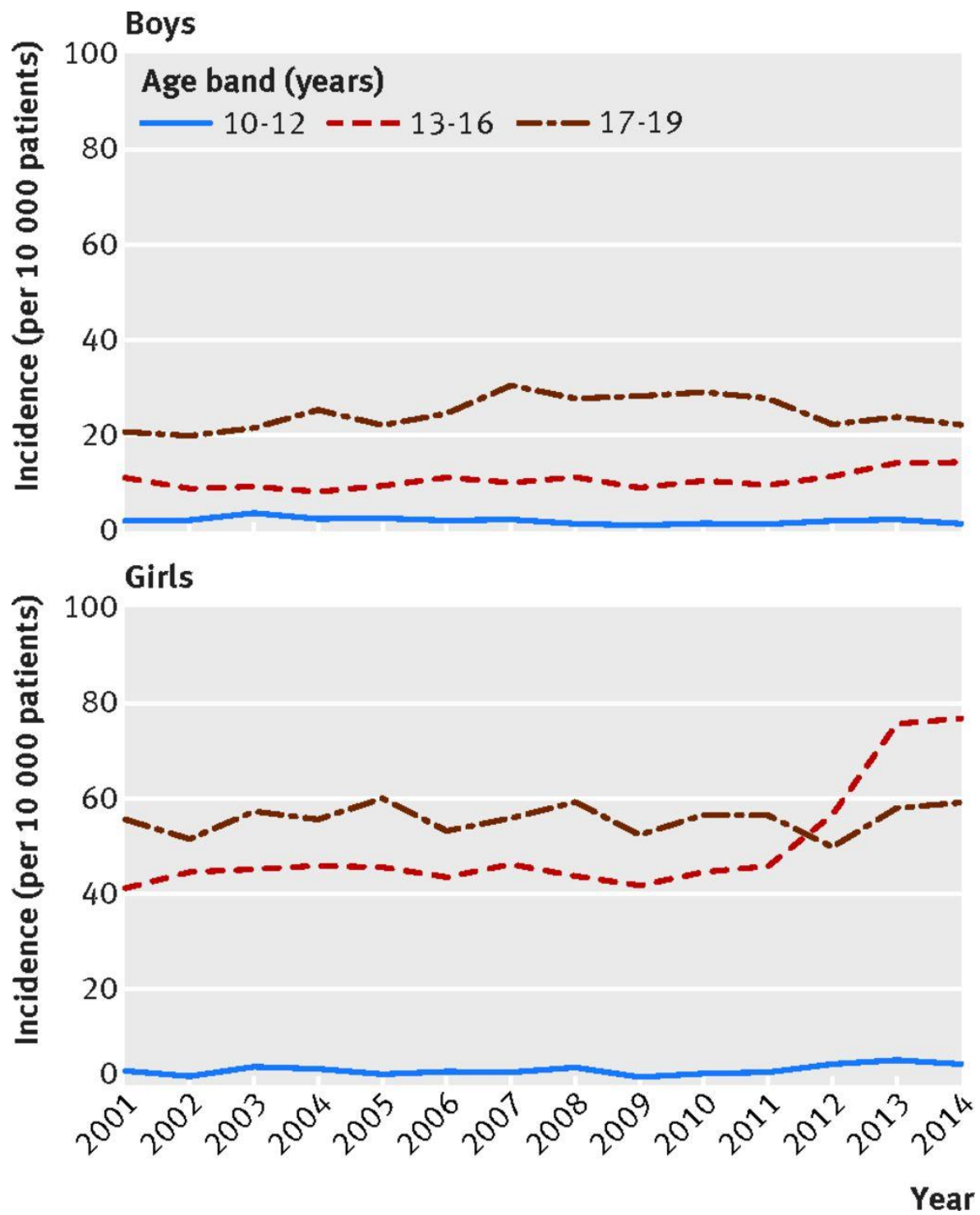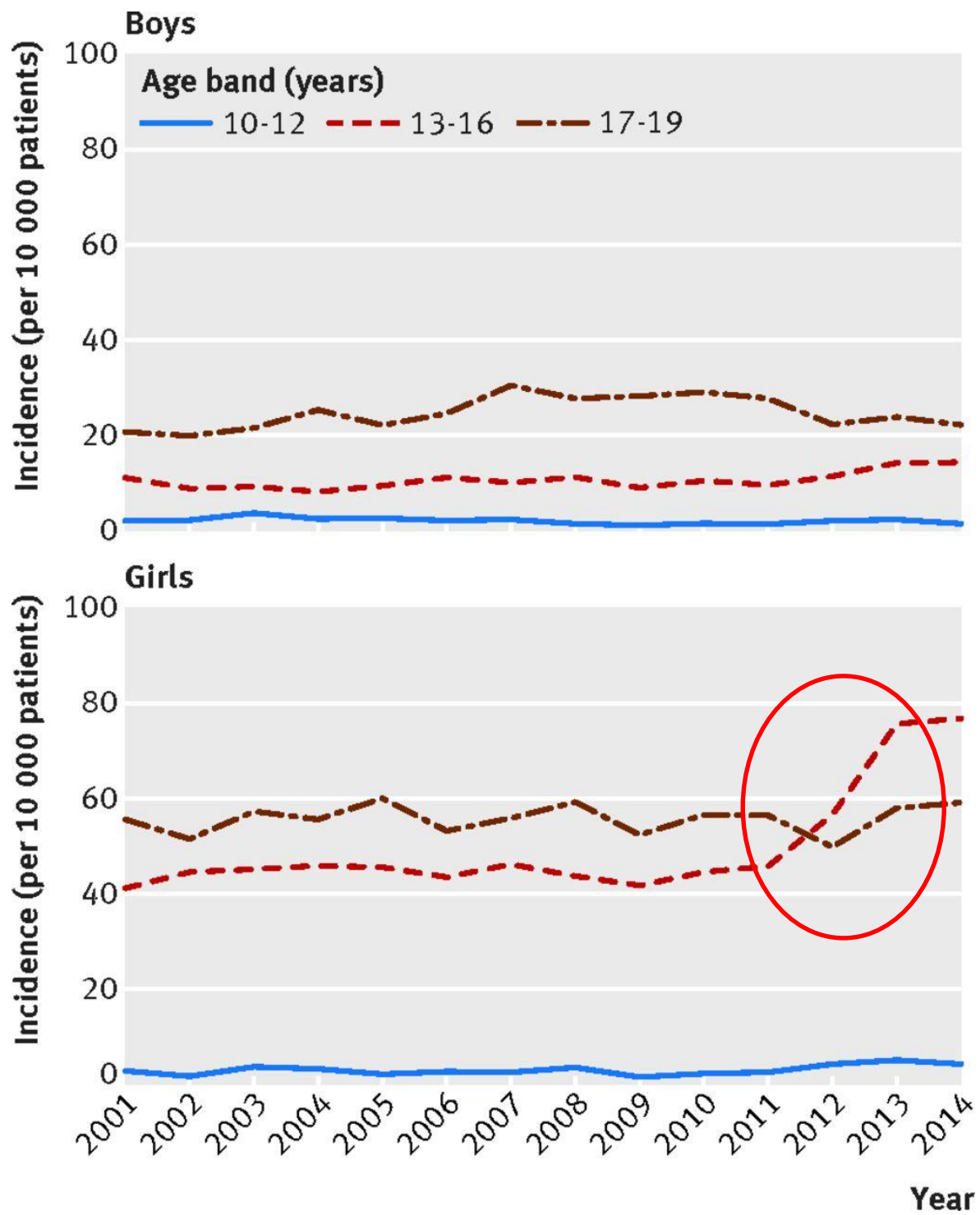
Figure 7: Age-specific suicide rates by broad age groups, females, UK, registered between 1981 and 2016

Age 13-16
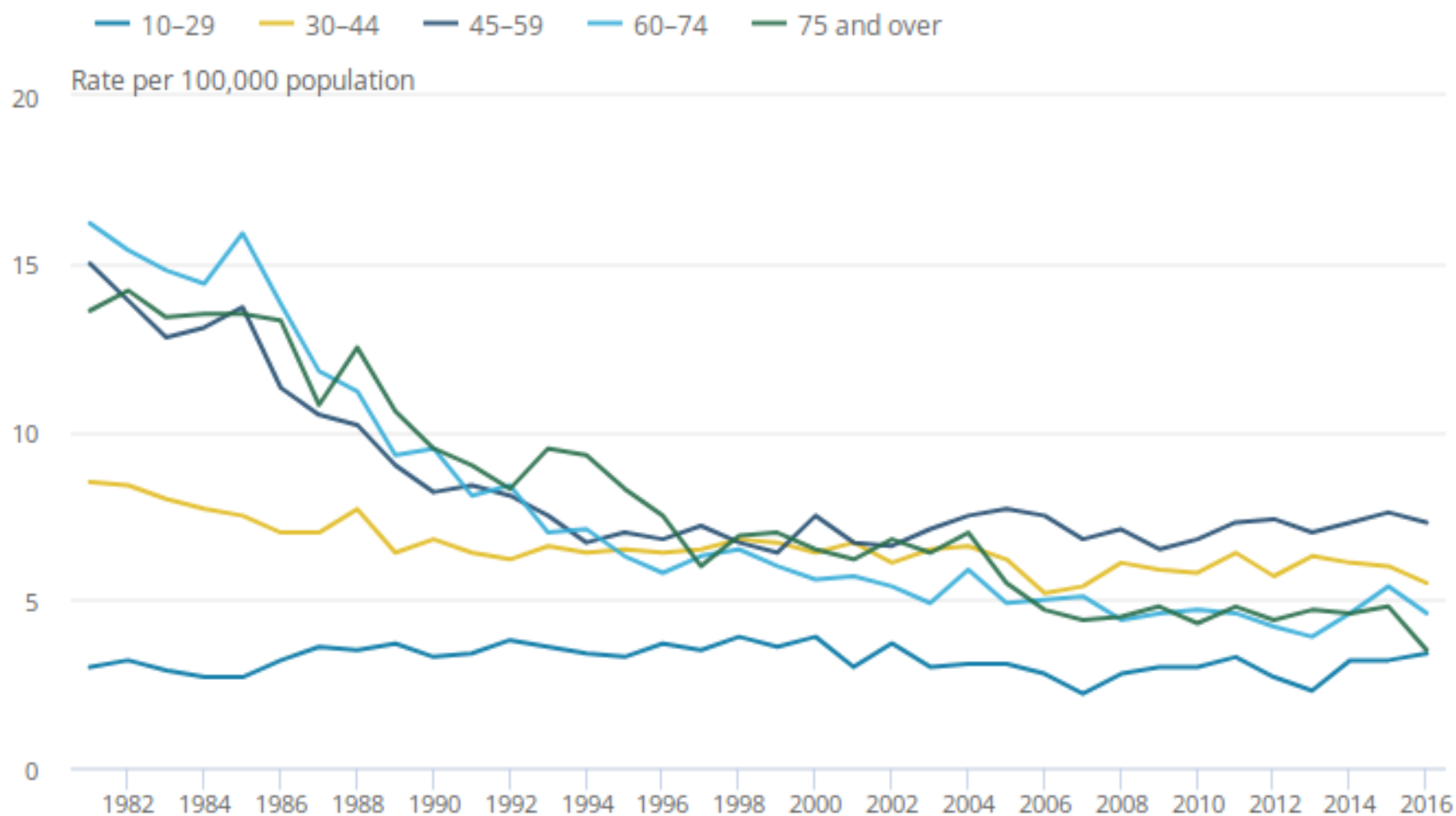
Figure 5.5: Correlation between activities and general happiness, 8th and 10th graders, Monitoring the Future, 2013-2016 (controlled for race, gender, SES, and grade level)

Activity	
Sleep	
Sports or exercise	
In-person social interaction	
Volunteer work	
Going to movies	
Religious services	
TV news	
Print media	
Radio news	
Music concert	
Video arcade	
Homework	
Working	
TV	
Internet news	
Talking on cell	
Video chat	
Texting	
Leisure time alone	
Social media	
Computer games	
Internet	
Listening to music	

-0.25 -0.2 -0.15 -0.1 -0.05 0 0.05 0.1 0.15 0.2 0.25

■ nonphone activities
■ phone activities

Agenda

Occupational Health & Hygiene Technical Group

Oil & Gas UK Aberdeen Office
14.00 – 17.00; Chair – Audrey Laing, Darrin Hawkes

	Lead	Time
1. Introductions		
a. Safety Brief & Competition Policy, Introductions & AOAB	Katherine Meffen	
2. OCA / RGU Study results		14.05 – 14.20
Summary of the OCA sponsored review of 3/3 rotas and mental health and wellbeing	Katherine Meffen	
3. Sleep, Fatigue and Mental Health		14.20 – 14.50
	Dr Olga Runcie	
3. Mental Health First-Aiders		14.50 – 15.10
	TBC	
4. Sharing Good Practice		15.30 – 16.00
Prostate Cancer awareness – campaigns, information	All	
4. Legislative / Group Updates		16.00 – 16.20
a. ECHA Benzene OEL / STEL proposals		
b. Energy Institute		

Prostate Cancer Early Detection

by PSA testing and palpation of the prostate gland

Numbers are for men aged 50 years and older, not participating vs. participating in early detection for 11 years

1000 men without early detection:
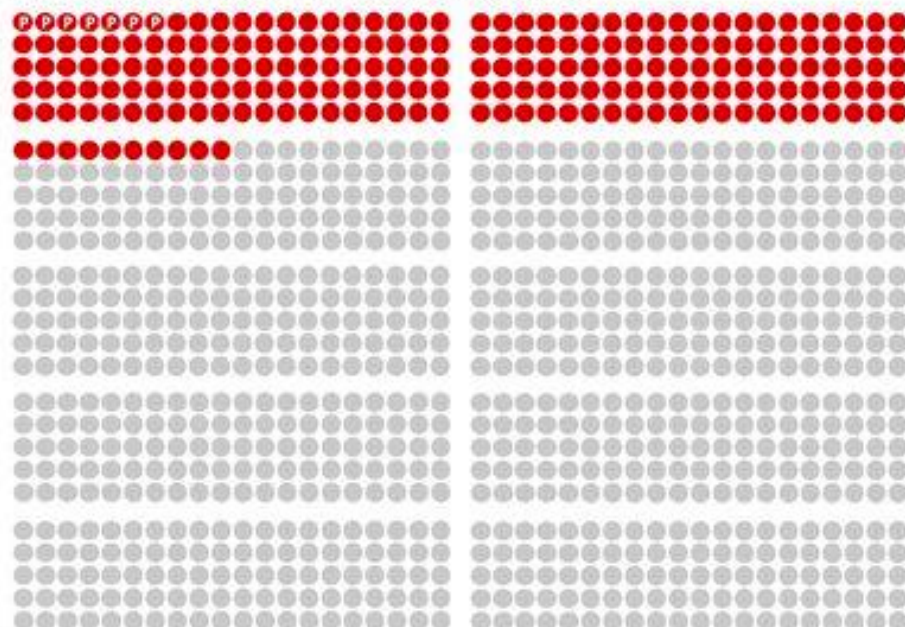
1000 men with early detection:
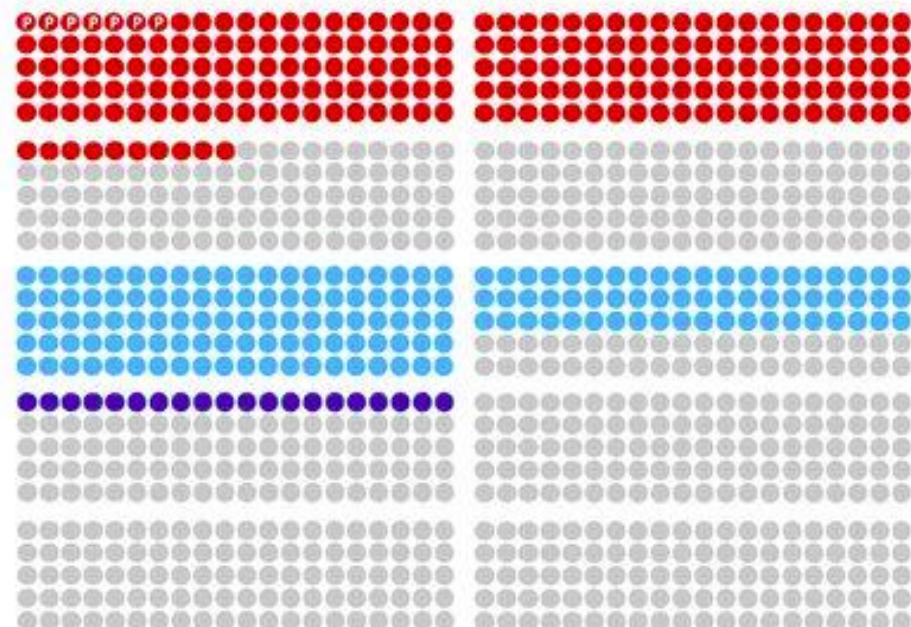
		without	with
🅿	Men who died from prostate cancer:	7	7
●	Men who died from any cause:	210	210
●	Men who experienced a biopsy and a false alarm:	–	160
●	Men who were diagnosed and treated for prostate cancer unnecessarily:	–	20
●	Remaining men:	790	610

Source:
Ilic et al. (2013) *Cochrane Database of Systematic Reviews*, Art. No.:CD004720.

A Medical 'Specification'

Health Questionnaire
Physical Examination
Functional Capacity Checklist (not specified)
Height & Weight
Body Mass
Body Mass Index
Hip/Waist ratio
Blood pressure (taken twice at not less than 10-20 min interval)
Pulse rate
Visual Acuity
Depth/Colour vision

A Medical 'Specification'

Red cell count	Fasting glucose	Total cholesterol
Heamatocrit	HbA1c	HDL
Heamoglobin		LDL
White cell count		Triglycerides
Neutrophils	Urea	
Eosinophils	Creatinine	
Basophils		Hep B and C markers
Lymphocytes		(pre-employment)
Monocytes	GGT	
Platelets	SGOT	Blood Group (if not
ESR	SGPT	known)

A Medical 'Specification'

PSA – if indicated and appropriate on all men 50 and older

Quantiferon gold TB test (not if previous positive)

Stool – microscopy for parasites
Faecal occult blood test

Audiometry

Spirometry

Resting ECG
Stress ECG – above 50 if indicated

CXR
Lumbar XR – for all offshore positions at pre-employment or as clinically indicated

4.27   Screening may be offered by employers as part of a remuneration package, to help moderate health insurance costs or to complement other health promotion activities. However, once taken up, it is an activity for the sole benefit of the individual worker. It must be differentiated from health surveillance which is an activity undertaken as part of a hazard control programme or to ensure continuing fitness to work where there are specific health criteria. Health screening programmes should be evidence-based and, to be ethically acceptable, should satisfy established criteria such as those published by the UK National Screening Committee.[70] Those criteria are a development of the ones developed by Wilson and Jungner[71] in 1968 and may be summarised as:

4.28   Screening is a voluntary activity and while occupational health professionals may encourage and promote participation, they must avoid being complicit in programmes that use compulsion. Where

Long-Term Effect of Population Screening for Diabetes on Cardiovascular Morbidity, Self-Rated Health, and Health Behavior

Justin B. Echouffo-Tcheugui, PhD[1]

Rebecca K. Simmons, PhD[1]

A. Toby Prevost, PhD[2]

Kate M. Williams, PhD[3]

Ann-Louise Kinmonth, MD[3]

Nicholas J. Wareham, PhD[1]

Simon J. Griffin, DM[1,3]

[1]MRC Epidemiology Unit, University of Cambridge School of Clinical Medicine, Cambridge, United Kingdom

[2]Department of Primary Care and Public Health Sciences, School of Medicine, King's College London, London, United Kingdom

[3]The Primary Care Unit, Cambridge Institute of Public Health, Cambridge, United Kingdom

ABSTRACT

PURPOSE There is limited trial evidence concerning the long-term effects of screening for type 2 diabetes on population morbidity. We examined the effect of a population-based diabetes screening program on cardiovascular morbidity, self-rated health, and health-related behaviors.

METHODS We conducted a pragmatic, parallel-group, cluster-randomized controlled trial of diabetes screening (the ADDITION-Cambridge study) including 18,875 individuals aged 40 to 69 years at high risk of diabetes in 32 general practices in eastern England (27 practices randomly allocated to screening, 5 to no-screening for control). Of those eligible for screening, 466 (2.9%) were diagnosed with diabetes. Seven years after randomization, a random sample of patients was sent a postal questionnaire: 15% from the screening group (including diabetes screening visit attenders and non-attenders) and 40% from the no-screening control group. Self-reported cardiovascular morbidity, self-rated health (using the SF-8 Health Survey and EQ-5D instrument), and health behaviors were compared between trial groups using an intention-to-screen analysis.

RESULTS Of the 3,286 questionnaires mailed out, 1,995 (61%) were returned, with 1,945 included in the analysis (screening: 1,373; control: 572). At 7 years, there were no significant differences between the screening and control groups in the proportion of participants reporting heart attack or stroke (OR = 0.90, 95% CI, 0.71-1.15); SF-8 physical health summary score as an indicator of self-rated health status (β −0.33, 95% CI, −1.80 to 1.14); EQ-5D visual analogue score (β: 0.80, 95% CI, −1.28 to 2.87); total physical activity (β 0.50, 95% CI, −4.08 to 5.07); current smoking (OR 0.97, 95% CI, 0.72 to 1.32); and alcohol consumption (β 0.14, 95% CI, −1.07 to 1.35).

CONCLUSIONS Invitation to screening for type 2 diabetes appears to have limited impact on population levels of cardiovascular morbidity, self-rated health status, and health behavior after 7 years.

Efficacy and effectiveness of screen and treat policies in prevention of type 2 diabetes: systematic review and meta-analysis of screening tests and interventions

Eleanor Barry,[1] Samantha Roberts,[1] Jason Oke,[1] Shanti Vijayaraghavan,[2] Rebecca Normansell,[3] Trisha Greenhalgh[1]

[1]Nuffield Department of Primary Care Health Sciences, Radcliffe Primary Care Building, Radcliffe Observatory Quarter, University of Oxford, Oxford OX2 6GG, UK

[2]Department of Diabetes, Newham University Hospital, Barts Health NHS Trust, London, UK

[3]Population Health Research Institute, St George's University of London, London SW17 0RE, UK

Correspondence to: E Barry Eleanor.barry@phc.ox.ac.uk

Additional material is published online only. To view please visit the journal online.

ABSTRACT

OBJECTIVES
To assess diagnostic accuracy of screening tests for pre-diabetes and efficacy of interventions (lifestyle or metformin) in preventing onset of type 2 diabetes in people with pre-diabetes.

DESIGN
Systematic review and meta-analysis.

DATA SOURCES AND METHOD
Medline, PreMedline, and Embase. Study protocols and seminal papers were citation-tracked in Google Scholar to identify definitive trials and additional publications. Data on study design, methods, and findings were extracted onto Excel spreadsheets; a 20% sample was checked by a second researcher. Data extracted for screening tests included diagnostic accuracy and population prevalence. Two meta-analyses were performed, one summarising accuracy of screening tests (with the oral glucose tolerance test as the standard) for identification of pre-diabetes, and the other assessing relative risk of progression to type 2 diabetes after either lifestyle intervention or treatment with metformin.

ELIGIBILITY CRITERIA
Empirical studies evaluating accuracy of tests for identification of pre-diabetes. Interventions (randomised trials and interventional studies) with a control group in people identified through screening. No language restrictions.

RESULTS
2874 titles were scanned and 148 papers (covering 138 studies) reviewed in full. The final analysis included 49 studies of screening tests (five of which were prevalence studies) and 50 intervention trials. HbA_{1c} had a mean sensitivity of 0.49 (95% confidence interval 0.40 to 0.58) and specificity of 0.79 (0.73 to 0.84), for identification of pre-diabetes, though different studies used different cut-off values. Fasting plasma glucose had a mean sensitivity of 0.25 (0.19 to 0.32) and specificity of 0.94 (0.92 to 0.96). Different measures of glycaemic abnormality identified different subpopulations (for example, 47% of people with abnormal HbA_{1c} had no other glycaemic abnormality). Lifestyle interventions were associated with a 36% (28% to 43%) reduction in relative risk of type 2 diabetes over six months to six years, attenuating to 20% (8% to 31%) at follow-up in the period after the trials.

CONCLUSIONS
HbA_{1c} is neither sensitive nor specific for detecting pre-diabetes; fasting glucose is specific but not sensitive. Interventions in people classified through screening as having pre-diabetes have some efficacy in preventing or delaying onset of type 2 diabetes in trial populations. As screening is inaccurate, many people will receives an incorrect diagnosis and be referred on for interventions while others will be falsely reassured and not offered the intervention. These findings suggest that "screen and treat" policies alone are unlikely to have substantial impact on the worsening epidemic of type 2 diabetes.

REGISTRATION
PROSPERO (No CRD42016042920).

Introduction

BMJ Open

The NHS Health Check in England: an evaluation of the first 4 years

John Robson,[1] Isabel Dostal,[1] Aziz Sheikh,[2] Sandra Eldridge,[1]
Vichithranie Madurasinghe,[1] Chris Griffiths,[1] Carol Coupland,[3] Julia Hippisley-Cox[3]

ABSTRACT

Objectives: To describe implementation of a new national preventive programme to reduce cardiovascular morbidity.

Design: Observational study over 4 years (April 2009 —March 2013).

Setting: 655 general practices across England from the QResearch database.

Participants: Eligible adults aged 40–74 years including attendees at a National Health Service (NHS) Health Check.

Intervention: NHS Health Check: routine structured cardiovascular check with support for behavioural change and in those at highest risk, treatment of risk factors and newly identified comorbidity.

Results: Of 1.68 million people eligible for an NHS Health Check, 214 295 attended in the period 2009– 12. Attendance quadrupled as the programme progressed; 5.8% in 2010 to 30.1% in 2012. Attendance was relatively higher among older people, of whom 19.6% of those eligible at age 60–74 years attended and 9.0% at age 40–59 years. Attendance by population groups at higher cardiovascular disease (CVD) risk, such as the more socially disadvantaged 14.9%, was higher than that of the more affluent 12.3%. Among attendees 7844 new cases of

Strengths and limitations of this study

- This is the first national study describing implementation of the new National Health Service (NHS) Health Check programme 2009–2012.
- It is based on a large representative sample of 655 general practices in England with 1.68 million people aged 40–74 years eligible for an NHS Health Check of whom 214 295 attended.
- Of those eligible, 70% had ethnic group recorded and 99% socioeconomic group recorded. In attendees, recording of ethnic group and major risk factors was over 90%.
- Non-attendees were younger, more likely to smoke and recording of cardiovascular risk was less complete.
- There is no information available about attendance for support for behavioural change following general practitioner (GP) referral.

the first of its kind, aiming to provide a routine structured clinical assessment and management for adults aged 40–74 years without pre-existing diabetes or CVD. The

CrossMark

[1]Centre for Primary Care and Public Health, Queen Mary University of London, London, UK
[2]Usher Institute of Population Health Sciences and Informatics, The University of

change and in those at highest risk, treatment of risk factors and newly identified comorbidity.

Results: Of 1.68 million people eligible for an NHS Health Check, 214 295 attended in the period 2009–12. Attendance quadrupled as the programme progressed; 5.8% in 2010 to 30.1% in 2012. Attendance was relatively higher among older people, of whom 19.6% of those eligible at age 60–74 years attended and 9.0% at age 40–59 years. Attendance by population groups at higher cardiovascular disease (CVD) risk, such as the more socially disadvantaged 14.9%, was higher than that of the more affluent 12.3%. Among attendees 7844 new cases of hypertension (38/1000 Checks), 1934 new cases of type 2 diabetes (9/1000 Checks) and 807 new cases of chronic kidney disease (4/1000 Checks) were identified. Of the 27 624 people found to be at high CVD risk (20% or more 10-year risk) when attending an NHS Health Check, 19.3% (5325) were newly prescribed statins and 8.8% (2438) were newly prescribed antihypertensive therapy.

Conclusions: NHS Health Check coverage was lower than expected but showed year-on-year improvement. Newly identified comorbidities were an important feature of the NHS Health Checks. Statin treatment at national scale for 1 in 5 attendees at highest CVD risk is likely to have contributed to important reductions in their CVD events.

- Non-attendees were younger, more likely to smoke and recording of cardiovascular risk was less complete.
- There is no information available about attendance for support for behavioural change following general practitioner (GP) referral.

the first of its kind, aiming to provide a routine structured clinical assessment and management for adults aged 40–74 years without pre-existing diabetes or CVD. The NHS Health Check includes review of CVD risks, behavioural change support and treatment of newly identified risk factors or comorbidity through integration with routine clinical provision in general practice. We describe an evaluation of the first 4 years of this national programme.

The NHS Health Check is a 5-year rolling programme which targets one-fifth of the eligible population each year, aiming to invite 3 million people at an annual cost of £165 million.[1–5] The Department of Health report that 2.4 million NHS Health Checks were undertaken in the 2 years (2011–2012).[4] Nationally, uptake is reported at around 50%

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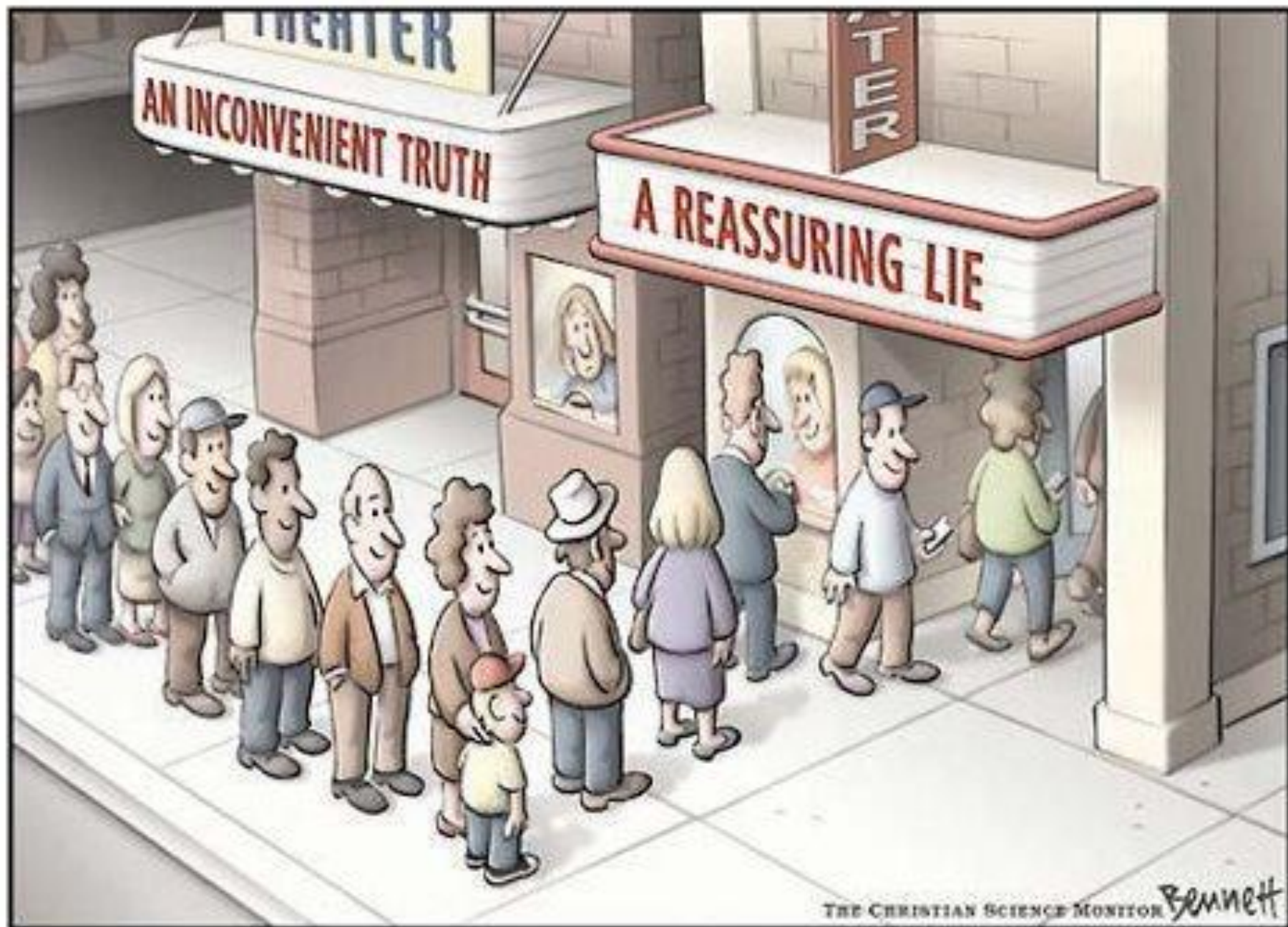
The reassuring lie:

Blood, X-ray, ECG and other tests at industry medicals are harmless interventions of great potential benefit to the employee through early identification of serious illness

The inconvenient truth:

Blood, X-ray, ECG and other tests at industry medicals are:

rarely evidence-based
ethically dubious

but

financially beneficial to some parties

commercially resistant to challenge by medical directors
and/or examining physicians

ORIGINAL ARTICLE

The role of mental health problems and common psychotropic drug treatments in accidental injury at work: a case–control study

Keith T Palmer, Stefania D'Angelo, E Clare Harris, Cathy Linaker, David Coggon

ABSTRACT

Objectives Mental illness and psychotropic drugs have been linked with workplace injury, but few studies have measured exposures and outcomes independently or established their relative timings. To address this shortcoming, we conducted a case–control study nested within a database prospectively recording injury consultations, diagnoses and drug prescriptions.

Methods The Clinical Practice Research Datalink logs primary care data for 6% of the British population, coding all consultations (by the Read system) and drug prescriptions. We identified 1348 patients aged 16–64 years from this database who had consulted a family doctor or hospital over a 20-year period for workplace injury (cases, 479 diagnostic codes) and 6652 age, sex and practice-matched controls with no such consultation. Groups were compared in terms of consultations for mental health problems (1328 codes) and prescription of psychotropic drugs prior to the case's injury consultation using conditional logistic regression.

Results In total, 1846 (23%) subjects had at least one psychiatric consultation before the index date and 1682 (21%) had been prescribed a psychotropic drug. The OR for prior mental health consultation was 1.44 ($p<0.001$) and that for psychotropic drug treatment was 1.57 ($p<0.001$). Risks were significantly elevated for several subclasses of mental health diagnosis (eg, psychosis, neurosis) and for each of the drug classes analysed. Assuming causal relationships, about 9–10% of all workplace injuries leading to medical consultation were attributable to mental illness or psychotropic medication.

Conclusions Mental health problems and psychotropic treatments may account for an important minority of workplace injuries.

What is already known on this subject

Mental illness and psychotropic drugs have been linked with occupational injury in earlier studies, but inability to measure exposures and outcomes independently, or to establish their relative timings, may have led to risks being overestimated.

What this study adds

Using a database that overcame these problems, we focused on events that preceded medical injury consultation. Prior mental health diagnoses and psychotropic drug prescriptions were associated with significantly higher risks of injury consultation. About 9–10% of all workplace injuries leading to medical consultation appeared to be attributable to these factors.

from non-independence in measurement of exposures and outcomes (common instrument bias) and reverse causation. For example, workers who perceive and report more anxiety on a screening questionnaire may more readily recall minor injuries at work, while workplace injury may cause anxiety neurosis (or lead to its diagnosis), rather than being consequent upon it. We found only a few cohort and case–control studies in which these two concerns were overcome by independent assessment of
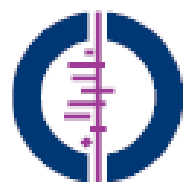
Pharmacological interventions for smoking cessation: an overview and network meta-analysis (Review)

Cahill K, Stevens S, Perera R, Lancaster T

2013:

SAE (serious adverse events) meta-analysis of 14 varenicline trials found no difference between the varenicline and placebo arms (RR 1.06; 95% CI 0.72 to 1.55), and subgroup analyses detected no significant excess of neuropsychiatric events (RR 0.53; 95% CI 0.17 to 1.67), or of cardiac events (RR 1.26; 95% CI 0.62 to 2.56).

On current evidence, none of the treatments appear to have an incidence of adverse events that would mitigate their use.
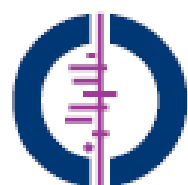
Nicotine receptor partial agonists for smoking cessation (Review)

Cahill K, Lindson-Hawley N, Thomas KH, Fanshawe TR, Lancaster T

2016:

Our analysis of reported serious adverse events occurring during or after active treatment suggests there may be a 25% increase in the chance of SAEs among people using varenicline (RR 1.25; 95% CI 1.04 to 1.49; 29 trials, 15,370 people; high-quality evidence). These events include comorbidities such as infections, cancers and injuries, and most were considered by the trialists to be unrelated to the treatments. There is also evidence of higher losses to follow-up in the control groups compared with the intervention groups, leading to a likely underascertainment of the true rate of SAEs among the controls. Early concerns about a possible association between varenicline and depressed mood, agitation, and suicidal behaviour or ideation led to the addition of a boxed warning to the labelling in 2008. However, subsequent observational cohort studies and meta-analyses have not confirmed these fears, and the findings of the EAGLES trial do not support a causal link between varenicline and neuropsychiatric disorders, including suicidal ideation and suicidal behaviour. The evidence is not conclusive, however, in people with past or current psychiatric disorders. Concerns have also been raised that varenicline may slightly increase cardiovascular events in people already at increased risk of those illnesses. Current evidence neither supports nor refutes such an association, but we await the findings of the CATS trial, which should establish whether or not this is a valid concern.

The most frequently recorded adverse effect of varenicline is nausea, but mostly at mild to moderate levels and tending to subside over time. Early reports of possible links to suicidal ideation and behaviour have not been confirmed by current research.

Sorting the system…..