

## Why do men die early and suffer more?

This will be the theme of the 6<sup>th</sup> Biennial World Congress on Men's Health and Gender (9-11 Oct 2009, Vienna, Austria). This timely conference will highlight:

- Lower urinary tract symptoms (LUTS): is BPH the culprit?
- New treatment options for premature ejaculation
- Cardiovascular disease in men and women

This announcement comes less than one month after Cancer Research UK released a report stating that men are 40% more likely to die of cancer than women, and 16% more likely to develop it in the first place. After excluding gender-specific cancers, the difference between men and women was even greater, with men being about 70% more likely to die from cancer than women and over 60% more likely to develop it in the first place. Similar statistics exist for coronary heart disease and other conditions.



Causes of higher mortality and morbidity have complex explanations. At a biological level, men lack the protective effect of oestrogen. At a psychological and sociological level, expectations of traditional masculinity encourage men to adopt attitudes and behaviours which increase the risks not only of developing coronary heart disease and various cancers but also delaying the reporting of symptoms beyond a point at which the condition can be treated effectively. If you are interested in men's health, please look out for more in a future issue of *Good Questions*.

### In this issue:

Why do men die early and suffer more?	1
When is a psychologist not a psychologist?	1
In the news	2
Making the headlines	2
Health awareness – dates for your diary	2
In the journals	3
Britain's got talent – but does it have ethics?	3
Darzi one year on – quality assured?	4
Forthcoming events	4

## When is a psychologist not a psychologist?

From 1<sup>st</sup> July, the Health Professions Council (HPC) takes over the regulation of practitioner psychologists. The entry-level threshold ('doctoral level') recognises the UK government's promise to the British Psychological Society that standards would not drop as a result of the transition from voluntary to statutory regulation. However, it is disappointing that the HPC has decided not to protect the title 'psychologist', which would have been comprehensive and less confusing for the public and other professionals who need to work alongside reputable psychologists.

Instead the HPC protects the terms 'registered psychologist' and 'practitioner psychologist' as well as various specialist terms such as 'health psychologist' and 'clinical psychologist'.



The British Psychological Society

*Chartered Psychologist*

The gold standard of the profession remains the award of CPsychol (Chartered Psychologist), which is a recognisable mark of experience, competence and reputation for anyone looking to learn from, consult or employ a psychologist.

If you are in any doubt about the credentials of so-called 'psychologists', you can check the existing [BPS register](#) or the new [HPC register](#) from 1<sup>st</sup> July.

[adapted from 'HPC heeds advice on entry levels' published in *The Psychologist*, July 2009]

## In the news

### ▪ Drink causes 10% of European deaths

A study from the Centre for Addiction and Mental Health (Toronto, Canada) has found that one in 25 (3.8% of all) deaths worldwide was attributable to alcohol in 2004 (the latest year for which global figures were available). This statistic hides a large gender difference, with 6.3% of men experiencing alcohol related deaths compared to just 1.8% of women. Most deaths involving alcohol were the result of injuries, cancer, heart disease and liver cirrhosis. Furthermore, alcohol accounts for 5% of years lived with disability around the world.

The average global alcohol consumption is around 12 units per person per week. Two units is equivalent to a pint of mild beer or a large glass of wine. Europeans drink almost twice the world average, at 21.5 units per week, while the average person in the US drinks 18 units. The recommended safe limit is 21 units per week for men and no more than 14 units for women.

### ▪ Cervical screening age to remain at 25

Following the death of reality TV star, Jade Goody, there were increased calls to lower the age at which women in England can attend cervical cancer

screening. Campaigners wanted the age to be lowered from 25 years to 20 years. A review conducted by an independent advisory committee on cervical screening decided that there should be no change in the screening age because evidence indicated that earlier screening could do more harm than good, causing too many false positives and increasing the risks of premature births among some women. However, in Scotland, Wales and Northern Ireland, women currently attend screening from the age of 20 years. It was announced that, in England, more guidance will be given to doctors on recognising and treating women with symptoms.

### ▪ Bowel cancer survival rates improve

Nine out of 10 people diagnosed with bowel cancer in its early stages survive, largely due to better surgical techniques. However, early diagnosis is the key and the report (by the National Cancer Intelligence Network and the Northern and Yorkshire Cancer Registry and Information Service) warns that survival may depend on immediate reporting of symptoms followed by prompt checking by a doctor.

The bowel cancer screening programme will distribute home-testing kits across England by the end of 2009.

## Making the headlines

- NICE chief criticises "one size fits all" approach to health promotion
- Medical bills cause most bankruptcies
- Concerns over older mother trend
- Images plus text work best to put people off smoking
- Far More Chinese Have Mental Disorders Than Previously Reported
- Alcohol's Good for You? Some Scientists Doubt It
- Gene clues to schizophrenia risk

## Health Awareness

### - dates for your diary

- National Metabolic Diseases Awareness Week: 28 June – 4 July
- National Transplant Week: 5-12 July
- Twins, Triplets & More Week: 6-12 July
- 24/7 Samaritans Awareness Day: 24 July
- Love Parks Week: 25 July – 2 Aug
- Sickle Cell Awareness Month





## In the Journals

### *Identity and self-efficacy predict eating behaviour*

**1** Identity and self-efficacy theories were used to examine the relationship between healthy-eater identity, self-efficacy for healthy eating and healthy eating as an outcome.

**2** Identity theory states that the self can be organised into multiple parts or identities (e.g. self as mother). Identities have meanings which provide expectations for behaviour (e.g. I am a mother, I should nurture my child). Thus, when people adopt an identity, they are motivated to verify the identity.

**3** Self-efficacy is a social cognition that reflects individuals' beliefs in their abilities to carry out courses of action necessary to lead to an outcome.

**4** Measures included healthy-eater identity, perception of healthy eating, nutrition knowledge, self-efficacy for both intake of fruits and vegetables and foods of low nutritional value.

**5** 101 university students and staff completed questionnaires. Two weeks later, participants recalled recent consumption of (a) fruits / vegetables, and (b) foods of low nutritional value.

**6** For both eating outcomes, healthy-eater identity was a significant predictor after controlling for nutrition knowledge. The addition of self-efficacy improved prediction in the case of both eating outcomes.

Strachan SM & Brawley LR (2008) Healthy-eater identity and self-efficacy predict healthy eating behaviour: a prospective view. *Journal of Health Psychology*, 14(5): 684-695.

## Britain's got talent – but does it have ethics?

The ITV1 show, Britain's Got Talent, has taken not only the nation but literally the world by storm. Few people in the UK can be unaware of the unparalleled furore surrounding contestant Susan Boyle following her first audition, and the subsequent unrelenting attention she received from the world's media. Miss Boyle did not go on to win the competition but within 24 hours of the final show, she had been admitted to The Priory following an emotional breakdown. TV bosses have been criticised (*Sunday Times, Daily Mail*) for not providing adequate psychological care or counselling of the contestants, which they have refuted. They have also indicated that the contestants are 'willing volunteers' and suggested that the brevity of the show (3 or 4 appearances) minimised their concerns.

Despite media backlash about ITV1's duty of care to its contestants, there has been little academic commentary on the episode. Fiona Jones (writing in *The Psychologist* July 2009) notes the lack of understanding of the role psychologists can play: 'a little preparation and professional support from psychologists might have gone a long way'. In particular, the brutality of the format and blatant exploitation of human frailty and emotion has also been criticised, relating to the age of children in the competition. Many of us will have had ethically safer research studies rejected by over-zealous ethics committees on the grounds of the potential upset that asking people about their emotions might cause. So, why is it that no-one has fully considered the impact of a sudden (and sometimes short-lived) thrust towards international stardom? Or the potentially devastating impact of the judges' comments, not receiving enough of the public vote, or the sometimes cruel portrayal of contestants in the media?

Reality shows seem to be here to stay but ethical considerations need to be taken seriously and contestants need to be prepared and offered greater psychological support to prevent problems before they occur.



## Darzi one year on – quality assured?

This week, Lord Darzi published his report detailing the progress made in the first year since his reforms were introduced<sup>1</sup>. Five years ago, everyone was talking about ‘payment by results’ but now the buzzword is ‘quality’. The former engendered a culture of quantity, conveyor belt treatments and box ticking. The latter is truly aspirational. On 30<sup>th</sup> April, I was privileged to be able to attend a lecture by Lord Darzi at the Royal Society of Medicine. As you would expect, Lord Darzi is an eloquent speaker but his speech was not simply the rhetoric that many of us come to expect from politicians. His message was clear and heartfelt – the NHS needs to focus on innovation and quality if it is to be a world-class healthcare provider.



Lord Darzi believes that patients need more freedom of choice and a greater voice with which to comment on the care they receive<sup>2</sup>. Surgical teams will be required to publish annual quality reports which record their performance not only in terms of safety and medical outcomes but also in terms of patient satisfaction and other patient-reported outcomes. For this first time, the NHS will, across the board, be taking a systematic account of patients’ perspectives of their treatment. Patient reported outcome measures (PROMs) are being piloted now for other aspects of healthcare, including chronic disease management. This, in particular, acknowledges the importance of the patients’ perspective of living with a long-term condition, which has been established over the past twenty years in a wealth of research conducted by health psychologists and other social scientists.

In his one-year report, Lord Darzi outlines significant progress in all three areas – patient safety, clinical effectiveness and patient experience. Major improvements highlighted in the report include the opening of 50 new GP-led health centres, the introduction of personal care plans for 9.3m patients with long-term conditions and the growth in keyhole surgery. But many more challenges remain. There is still more work to be done in promoting clinical leadership and high standards across the NHS, reducing administrative burden on frontline staff and making clinicians and their teams responsible for their own budgets and outcomes. Proposals for the coming year include:

- **Refining of targets based on evidence** – e.g. removal of the obsolete 13 week outpatient and 26 week inpatient performance targets, reviewing data collections in order to reduce the burden on front line staff.
- **Clinician budget ownership** – allowing clinical teams to manage their budgets will promote entrepreneurship and innovative delivery of services built around the needs of the patient.
- **Peer review accreditation system** – creation of a new voluntary peer review system in which clinicians will judge the standard of their peers in order to drive up quality and achieve a ‘gold standard’ of care.

In the era of Darzi, quality is certainly on the agenda but will it mean an end to postcode lotteries and will PROMs data be used in the clinical setting to help tailor treatments to the patients’ needs and wishes or will it be used simply as yet another monitoring tool. The first year shows a commitment to excellence regardless of expense – time (and a biting recession) will tell whether that can be sustained in the longer term.

### References

1. Darzi AS (2009) *High Quality Care for All: Our Journey so Far*. London: The Stationary Office.
2. Darzi AR (2008) *High Quality Care for All: NHS Next Stage Review*. London: The Stationary Office.

*"For the first time, the NHS will be taking systematic account of patients’ perspectives of their treatment"*

### Forthcoming events

7-8 July 2009

LifePsychol 2009  
Birmingham, UK

17-19 Aug 2009

Measurement, Design and Analysis Methods for Health Outcomes Research  
Harvard School of Public Health, Boston, USA

9-11 Sept 2009

BPS Division of Health Psychology  
Aston University, UK

23-26 Sept 2009

European Health Psychology Society  
Pisa, Italy

9-11 Oct 2009

6<sup>th</sup> Biennial World Congress on Men’s Health and Gender (WCMH)  
Vienna, Austria