# An NHS personal trainer for everyone?

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*I had dinner with Charles soon after the Government announced a White Paper which included regular health checks for everyone as well as the provision of a personal trainer for everyone or at least for those perceived to be unhealthy. I thought this might anger Charles, but before I had time to raise the matter he started.*

**'You know Coe, I have been thinking a little more about the implications of what we christened the *commoveamus* effect and they may be serious!'**

*Charles had recently proposed the* commoveamus *effect, a non-specific adverse response to medical interventions, as the antithesis of the placebo effect.*[1] *As this was relevant to my thoughts about the White Paper I encouraged him to continue.* 'What are you getting at Charles?'

**'The full implications of the placebo and *commoveamus* effects are not similar.'**

'Why?' *I asked.*

**'In contrast to the placebo effect when the drug works as intended, the *commoveamus* effect has the opposite sign to the observed effect which is the specific benefit of the drug. If the *commoveamus* effect outweighs the beneficial effect, the medicine, then there will be overall harm!'**

'But surely controlled trials will show this?' *I responded. My second thoughts, however, were too late.*

**'Quite the contrary, Coe!'** *he replied.* **'The controls will be subject to the same *commoveamus* effect as the actively treated. If the intervention is specifically beneficial, the trials will be just as "positive" when the net effect on the whole population is adverse as when it is beneficial or, for that matter, neutral.'**

'Are you suggesting that some interventions may do more harm than good?'

**'More or less,'** *he replied.* **'Harm as opposed to benefit to the whole population, though possible, might be unlikely. Nevertheless, in low-risk groups, overestimating the global benefit is certainly a potential problem and many individuals might suffer. This should be taken seriously in cost-benefit analyses and the planning of services.'**

'That might be easier if you could prove your point and measure it.'

**'I could not agree more!'** *he replied.* **'The problem is that it if it were ever possible it would take too long but now it is too late. The only way it could have been done would have been to compare the group participating in the controlled trials with an unprejudiced population using distant primary outcome measures, eg survival. I am afraid that all one can do is to accept the possibility, apply some lateral thinking and look out for groups where the coercion is similar but uptake of primary prevention is disparate.'**

'You did just that in comparing men and women when you developed the idea! But talking of coercion, what about the recent White Paper offering everyone regular health checks?' *I replied.* 'I am sure it is not your cup of tea?'

*Rather to my surprise he replied,* **'That depends on the approach! Much as I dislike the nanny state there might be something in it provided they concentrate on health promotion rather than be dazzled by the prospect of disease prevention. Don't forget the false hopes of 1948 that the NHS would become cheaper if not redundant as prevention and treatment of disease improved. In contrast to simple prevention or early cure which awaits the next illness, real health promotion can be cost-effective in the context of saving resources that can be used elsewhere. It makes the potential patient healthier and so more able to cope with the next illness and less demanding of time and money. Besides, and more importantly, it actually makes the subject feel better all of the time.'**

'What are the practical implications?'

**'Let the personal trainer be just that! Advise and observe accordingly, making only directly relevant measurements by which progress can be followed, such as waist circumference, exhaled CO and exercise tolerance.'**

'Would you not measure other risk factors?'

**'Why?'** *he asked.* **'If the minister is to be believed this is a demand-led exercise and not a clinical trial! The interventions are beneficial whatever the**

**numbers and may modify them favourably without the cost of the individual being labelled a patient.'**

'What about the risks of unaccustomed exercise; surely the trainer as well as the subject must be protected?'

**'Life is hazardous and some risks have to be accepted! Is there a scenario where the hazard is great and the positive predictive value of simple investigation high? If, as he should, the trainer has established current exercise tolerance and its limiting factor, what conditions fit the bill?'**

*I thought for a moment and replied,* 'Unrecognised malignant arrhythmias or primary pulmonary hypertension. An ECG would have a good chance of picking them up.'

**'But it might also show other changes of uncertain relevance?'**

'Yes,' *I replied.* 'It might well show non-specific changes. I am sure you would feel such findings would be counterproductive at this stage whether or not they reflected mild coronary disease?'

**'Yes,'** *he replied.* **'But I am sure it would be possible to program a machine to respond only when it detected the relevant changes. Specific investigation might then be justified without compromising the general approach.'**

'Would you ever do any further tests?' *I ventured.*

**'It would be the job of the trainer to get to know his trainees and gain their confidence,'** *he replied.* **'If progress were slower than expected despite good cooperation then relevant investigations should be instigated.'**

'Of course,' *I responded, but I did not quite anticipate what he said next.*

**'As mutual confidence grows, the trainer should get to understand the subject's personality and his likely response to aberrant findings or the suggestion of lifelong medication. He might assess if and when the time has come for him to go to his GP and ask whether, in the light of the other risk factors, these tests should be done. If medication were necessary the new patient might be in a better frame of mind to accept it than if it followed uninvited screening.'**

'Yes, I remember you once saying that the initial management of an innocent diagnosis is critical in avoiding the production of thick notes. The clinician must distinguish between the patient who is reassured by one normal investigation, and the one who feels that any investigation must indicate uncertainty and therefore demands yet another. Are you suggesting that this presents a similar opportunity to sort out those more likely to show the *commoveamus* effect and so reduce its incidence as well as the proportion of abnormal tests?'

**'Yes,'** *he said.* **'Perhaps one might say another example of dual effect in two senses; accepting a short-term risk for long-term benefit, and achieving a double whammy!'**

*I am sure that there is a lot to be said for Charles' approach, particular in the context of the non-attending male who is conventionally regarded as ignoring his health. He would accept that his expectations of the ability of trainers might be unrealistic but no more so than the expectations of the minister so far as recruitment and cost are concerned. Charles would claim to win on the latter.*

*Coemgenus*

## Reference

1 *Coemgenus.* Everyone a patient? Beware the *Commoveamus* effect! *Clin Med* 2005;6:665–6.