Sugar sweetened drinks should carry obesity warnings

California has had the right idea in considering health warnings on sugary drinks, writes **Simon Capewell**

The California Senate Appropriations Committee is deliberating a bill that would require drinks manufacturers to place the following warning label on all sweetened non-alcoholic drinks: "STATE OF CALIFORNIA SAFETY WARNING: Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth decay."[1]

Under the Sugar Sweetened Beverages Safety Warning Act (the first of its kind in the United States) these labels would apply to any such drink that "has added caloric sweeteners and contains 75 calories or more per 12 fluid ounces." It would also require vending machines to bear warning labels and would allow for fines of $50 (£30; €37) to $500 for failed inspections.

Many other potentially harmful products already carry effective health warnings. The effectiveness of tobacco warnings and plain packaging is now accepted by almost everyone not linked to the industry.[2] These successes in tobacco control highlight the importance of targeting the "three As"—affordability, availability, and acceptability.[3] Warning labels clearly target acceptability.

Public support for warnings about added sugar seems high, suggesting that such labelling is politically feasible. In a recent field poll almost 75% of 1002 bipartisan Californian voters supported the proposed bill.[1] And in March 2014 the US Food and Drug Administration suggested adding a separate line on labels to alert consumers to the amount of "added sugars."

Sugar is being progressively demonised: in the UK, a recent Populus public opinion poll commissioned by the BBC found that about 60% of 1000 adults would support health warnings on food packaging similar to those on cigarette packets. Still more supported banning sugary drinks in schools or limiting the amount of sugar allowed in certain foods. Furthermore, almost half (45%) would support a tax on sugary drinks.[5]

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Sugary calories consumed as liquids simply do not provide the same signals of satiety, or fullness, generated by equal calories from solid foods.[6]

Such sugar sweetened beverages offer an obvious target for policy makers, particularly if similar policies have succeeded elsewhere. Sugary drinks account for as much as 10% of a UK child's energy intake.[7] In one study from several European countries, adults who drank more than one can of sugary soda a day had a 22% higher risk of developing type 2 diabetes than those who drank less than one can a month.[8] And because the absolute risk of type 2 diabetes is known to be high, this relative increase in risk is important.

But UK and US policies are failing to reverse trends in obesity. Most obesity treatments currently offered to people, such as advice or preventive medicines, are weak and poorly sustained.[11] More effective policies are therefore urgently needed.

Might "calorie control" strategies profit from previous successful lessons in tobacco and alcohol control? [2] Halving UK and US children's sugar sweetened beverage consumption could mean a 50-100 kcal (209-418 kJ) reduction in energy intake a day, perhaps arresting or even reversing the current increases in obesity.

In Europe the food and beverage industry recently spent more than €1bn (£813m; $1.37bn) in vociferous attempts to delay, dilute, and demolish food labelling.[13] The industry would not do this unless its future profits were threatened (what the pressure group Action on Smoking and Health calls the "squeal factor").

We might expect the industry to oppose warning labels on sugary drinks with a barrage of opposing arguments, reminiscent of previous opposition to standardised tobacco packaging. Indeed, the big food and soda manufacturers have traditionally used the "SLEAZE" denialism tactics developed by tobacco and alcohol producers.[13 14] But most industry arguments will be flawed: threats to pass additional costs on to consumers, predictions of dire reductions in profits or huge job losses, concerns about consumer resistance to change, and so on. In truth, thousands of food and drink products are reformulated and relabelled every year as brands are "refreshed."

In 2013 the financial services company Credit Suisse published *Sugar Consumption at a Crossroads*, a report that sent a loud warning to the markets.[15] This March, Moody's credit rating agency lowered its outlook for the global beverage industry from "positive" to "stable," citing the Mexican government's soda tax.

And recently the campaigning group Action on Sugar persuaded the Tesco supermarket chain to write to all of its suppliers asking them to remove all added sugars from children's soft drinks (Tesco anticipates that most suppliers will cooperate).[16] Meanwhile, Co-op stores plan to slash added sugar from their products, and ASDA has agreed that the innovation of healthy new products is "fundamental."[16]

Of course, cynics may ask whether, as with tobacco, these industry moves might be preemptive—an attempt to preserve profits, wrong-foot competitors, and deflate pressure for more effective regulations. Conversely, less progressive segments of the industry have denounced the health proposals or have exaggerated the (minimal) reformulation efforts already achieved.[16]

Warning labels for refined sugars hidden in sweetened drinks and processed foods represent an interesting natural experiment. They may offer an effective new strategy for complementing existing, potentially powerful interventions, such as duties on sugary drinks or banning marketing to children.[17]

These proposals may also herald a tipping point in public attitudes and political feasibilities. Investors, industrialists, and international health groups will all be watching closely.

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NO HOLDS BARRED Margaret McCartney

Overprescribing antidepressants: where's the evidence?

Is the United Kingdom in the grip of an antidepressants epidemic? We are certainly gripped by an epidemic of the media writing about them. The past few months have seen reports of more antidepressants being used during the financial crisis,[1] stories of how many people seem to be taking them,[2] and an article in the *Guardian* by Peter Gøtzsche—a member of the newly formed Council for Evidence Based Psychiatry, which aims "To reduce psychiatric harm by communicating the latest evidence."[3]

"It's hard to believe that so many people have become mentally disturbed and that these prescription increases reflect a genuine need," said Gøtzsche. He blamed overdiagnosis, conflicts of interest among the writers of the *Diagnostic and Statistical Manual of Mental Disorders*, and the illegal marketing of psychiatric drugs. He concluded, "Another report said that, amongst people over 65, antidepressants are believed to kill one out of every 28 people treated for one year, because they lead to falls and fractures."

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Is this true? The paper he referred to was a population based cohort study, capable of finding association but not causation.[4] And the council said that antidepressant use had increased by 92% in England since 2003[5]; however, it cited the Health and Social Information Centre, which records prescription items rather than prescription amounts.[6]

Over the past decade GPs have been told to prescribe tablets monthly rather than, as previously, an amount that would last 2-3 months.[7] The number of items dispensed is likely to have increased as a result—but it is uncertain, from the data cited by the Council for Evidence Based Psychiatry, whether this means that more people are taking them.

Similarly, a report by the Health Foundation and the Nuffield Trust, which found an increase in antidepressant use during the recession, analysed prescription cost data.[8] But it concluded, "We cannot determine whether these trends are based on the same people receiving more medication, or whether they reflect an increase in the number of people receiving antidepressants." And a study published in 2009 found that the proportion of antidepressant prescriptions given to people with a new diagnosis of depression was constant from 1993 to 2005—making it unlikely that more people with symptoms of depression were treated with antidepressants during that timeframe.[9]

I have little doubt that overdiagnosis occurs. And I have no illusions about the effectiveness of antidepressants in mild to moderate depression. But big data can mean big problems, and this can pose more questions than it answers. Failing to pay attention to uncertainties and caveats means that we can overshoot the evidence, and this can cause harm through the under-recognition and undertreatment of mental illness.

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BMJ BLOG OF THE WEEK William Cayley

When it's awkward

"I just hate this sort of thing." When I overheard that at a recent funeral, as we waited in line to greet the bereaved family, I thought to myself, "How sad . . . and how true." Sad, because times of grief are when others need us most, but also true, because most of us find talking with the grieving awkward, and we don't like it.

Before entering medicine, I trained as a hospital chaplain. One of my wise teachers impressed on me the principle that—when talking with patients—if something difficult, challenging, or awkward about the situation crosses your mind then the patient is probably already aware of it.

For example, if you think a patient may be concerned about cancer, they probably already are, and broaching the topic may actually be more of a source of comfort that someone is actually listening, rather than a distressing introduction of a new worry.

Right now, I know two people facing imminently terminal cancer. While driving home recently, I thought about making a quick phone call to one of them for a check-in, then my next thought was how tired I was, and that I may not be ready for a potentially emotional phone call. In the end, I did call and was glad I did, but I realised later that had I hesitated and not called, my feeling of awkwardness over the hard situation my friend faces could have robbed him of whatever small comfort my conversation may have offered.

As medical professionals, we are called (I was going to say "trained" but maybe our training for this is not the best) not simply to care for our patients, but to help them deal with the tough stuff.

We should be able to discuss risks, benefits, evidence, and numbers needed to treat, but also be there to journey with our patients through the awkward patches. And this applies whether those awkward patches are of the patient's making; are seemingly random "bad luck" events (a cancer diagnosis, death of a family member); or even awkward moments of our own making (a missed diagnosis, a procedure gone badly, an expensive medication misprescribed).

It's important to keep our emotional perceptions tuned in to when we feel the most awkward. Is it the angry patient? Is it the mistaken diagnosis? Is it the bereaved spouse?

Listening to our own inner sense of discomfort can be a decent indicator as to when a patient is in particular need of comfort or support. When it's awkward, that's when they need us most.

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