Department
of Health

From the Chief Medical Officer,
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Professor Sir David Spiegelhalter
President-Elect
Royal Statistical Society
12 Errol Street
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Dear David

Thank you for forwarding me the letter from the Royal Statistical Society to the Secretary of State concerning the recent communications about the new low risk alcohol guidelines that we published on 8 January. I am replying, since we have published the new guidelines as independent scientific advice from us the Chief Medical Officers.

As you acknowledge we have made clear that the focus of the consultation will be to seek views on the clarity, expression, and usability of the guidelines from members of the public, not to seek views on the scientific evidence reviews which have taken place since 2013, or the Sheffield modelling. We would, of course, welcome you formally submitting your views as part of the consultation process.

I would like to clarify with you a couple of the specific issues raised in the letter as below:

1. The suggestion that the guidelines have '*downplayed or even denied benefit*' which '*directly contradicts the estimates published in the ...report*' I would say is contrary to the conclusion of the expert group and is not in line with the actual report. This statement relies on Tables 10 and 11 in the Guideline Development Group's (GDG) report, but this is only one way of looking at the issue (absolute risk) and the GDG also took account of the other way (relative risk). The latter is represented in Figures 12 and 13 on page 17 (and Figures 6 and 7 in the Sheffield report), showing that the benefit to men overall is really very small and non-significant – even more so bearing in mind the flaws in the evidence base on the cardio-protective effect noted by the GDG. It is also important to look at the breakdown by age group – and hard to ignore the point that any overall reduction in mortality does not appear for age groups under 55 (men and women), i.e. for the majority of adults, there is no such reduction, while

there is significant alcohol-related mortality – getting on for half of alcohol-related mortality – for these age groups.

The graphs in the report are, however, quite hard to visualise and it may be helpful to show the detailed tables behind them. I hope that these will be considered by the Guidelines development group when it reconvenes after the consultation, to allow any further confirmation they feel is needed of the statements that should be made. I would be happy for them to be made available to you then and for any further exchange of views to take place that may be helpful.

2. That '*the potential harms for cancer were repeatedly emphasised, even though the modellers concluded that these were outweighed by the reduction in strokes and heart disease for low consumption in both men and women.*' This is a view, probably an overly simple one that the reductions in risk cancel out the increased risks of death from cancer. The GDG's report points out (e.g. para 64) that this is the case only on the particular measure used, which is numbers of deaths increased and prevented. The deaths prevented tend to be deaths that would have taken place in old age, whereas the deaths caused by alcohol are mostly premature deaths (under 65). For deaths caused by alcohol-related cancers, a high proportion, about three quarters, happen under the age of 75. As the GDG's report says:

   'This means that understanding the actual harm from drinking, including the balance of years of life lost due to alcohol (at younger ages) and the ones saved (at older ages) is not adequately described by taking account only of the effect of drinking on numbers of deaths.'

   Or putting it another way the report acknowledges that it is different individuals who experience the harms and the benefits, so it is only right that there is some emphasis on cancer risks. This also takes account of the low level of public understanding of these risks.

   We are commissioning a further analysis of what the guideline level, and different levels of drinking, mean in terms of years of life lost, or gained, not just numbers of deaths, with a view to aiding future risk communications. This will also be available for the Guidelines development group after the consultation. If it is useful, I hope it can be shared with you also.

3. That '*No mention was made of the harms of additional consumption, and that these were higher in women.*' It is true, this was not mentioned in the press release, but the emphasis was rightly on the new low risk guideline. It is not a new fact that risks are higher for women at higher levels of consumption and I fully intend this should be part of future risk communications from the Department of Health and Public Health England.

4. Finally, that '*... the tone of the Department of Health website was very prescriptive, saying men 'should' drink less than 14 units.*' In isolation this single sentence may be seen as such. However I would doubt the suggestion that the overall tone is

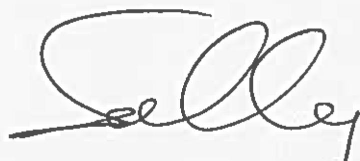
prescriptive. Certainly, I do not wish that to be the case. These are low risk guidelines not prescriptive. This is about giving information.

It is vital to get the balance right in communicating complex scientific issues and I am sure you can help in this. I would also like to take this opportunity to say how grateful I have been for your engagement in the development of the guidelines and around the launch earlier this month. Your expertise and insight have been invaluable.

I have consulted the Guidelines Development Group co-chairs, Mark Petticrew and Sally Macintyre, on this letter.

I am content for my reply to be available to the public on the RSS website.

Yours ever



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