5. Carelli F. Persisent vegetative state. *Br J Gen Pract* 2012; **60(571):** 132.

DOI: 10.3399/bjgp13X662939

Tools

For the last decade or two general practice, indeed medicine in general, has been manufacturing 'tools' as if a 21st century industrial revolution was under way. Am I alone in my distaste and negative reactions, feeling that in most cases the word 'tool' is now used in a most ignorant and inappropriate way? Most patients know exactly what tools are, and use them to good effect in the real world. (I once used a tendon hammer, before I retired: a valued tool).

Surely there are many more infinitely preferable words in the English language from which to choose, if concepts such as a scheme, plan, protocol, syllabus, or resource is really what is meant, for something intangible but intended to be teachable (if not necessarily memorable).

While ruminating on why these etymological reflections have kept bothering me continually over the years, and as several dictionaries seemed to support me, I turned to the December *BJGP* to see if it was as ubiquitous as I thought. On the contents page, I read the very first entry: 'page 621: European Antibiotic Awareness Day 2012: TARGET antibiotics through guidance, education, and ... TOOLS' (my capitals).[1]

The last word triggered something in me — this local etymological mishap had now achieved a European, if not global, dimension. I even read the article, and found this four-lettered t-word not only appeared at the end of Table 1 ('tools to use with patients'), but it had even secreted itself in the acronym 'TARGET' as well as in 'toolkit' (fortunately the acronym was suitably and considerately elaborated for those who can't keep up with them).

I looked back at the contents pages: 'page 661: Writing therapy: a new tool for general practice?'[2] This saw me reaching instinctively for my pen, to share these thoughts with the Editor. (Very therapeutic!).

At this point I read on in the Journal, and was fascinated to find Neville Goodman's 'Familiarity breeds: clichés in article titles'; and barely surprised to find the errant word quoted in his last sentence.[3] This monosyllabic t-word, although just a word, not a phrase, surely also has all the characteristics of a cliché, by his definition. It not only appears in article titles, but in the very fabric of our current medical literature, and it is time we called a tool a spade, or at least classed it with coalfaces as reprehensible management-speak.

Hugh Dinwoodie,

75 East Trinity Road, Edinburgh.
E-mail: hugh.dinwoodie1@btinternet.com

REFERENCES

1. Moore M, McNulty C. European Antibiotic Awareness Day 2012: TARGET antibiotics through guidance, education, and tools. *Br J Gen Pract* 2012; **62(605):** 621–622.
2. Mugerwa S, Holden JD. Writing therapy: a new tool for general practice? *Br J Gen Pract* 2012; **62(605):** 661–663.
3. Goodman N. Familiarity breeds: clichés in article titles. *Br J Gen Pract* 2012; **62(605):** 656–657.

DOI: 10.3399/bjgp13X662948

The 2022 GP: our profession, our patients, our future

The comments made by Clare Gerada and Ben Riley in the November issue of the *BJGP*[1] resonate well with my own views.

Together with fellow GPs in Cape Town, South Africa from 1995–2000, we set up a pilot model of delivering primary care under the auspices of the Health Development Institute a community-based research non-governmental organisation (NGO).[2] This pilot entailed GPs reaching out to the community through participatory workshops involving the community and other professionals (priests, lawyers, social workers, teachers, clinical psychologists, and sociologists) in an effort to seek a shared definition, and possible intervention, regarding preventable health problems.

The following workshops were held:

- On domestic violence, identifying the pitfalls in the implementation of legal provisions like magisterial interdict, as well as how powerful denial is among the women to actually admit that they have an abusive partner, and need help.
- A workshop involving many teachers in three communities who were subjects of a teacher depression epidemic in the Western Cape, a consequence of the rapid social change in South Africa in 1994 from apartheid to democratic rule. The workshop was able to identify support systems that teachers could tap into.
- On unwanted babies for which the government had opted for a technical intervention (legalised abortion) as opposed to social interventions like churches setting up and expanding the adoption services to provide for unwanted babies.
- An AIDS/HIV workshop to find out the community perception of the AIDS epidemic, to what extent do communities feel in a state of helplessness, and what support systems could be set up to empower communities to help themselves; to find out to what extent men saw the need for protected sex using condoms, and the cultural constraints from using condoms.
- Concerning diseases of lifestyle, to find out what the community members perceived as the causes of hypertension, diabetes, heart attacks, and obesity, as well as what public health/political interventions could help to reduce the prevalence of these conditions.

What we noticed afterwards was that the attitudes of the community began to shift from being only consumers of health care to instead being participatory and owning the fight against the community burden of these conditions.

EM Mankazana,

Freelance GP.
E-mail: mxomankl@doctors.net.uk

REFERENCES

1. Gerada C, Riley B. The 2022 GP: our profession, our patients, our future. *Br J Gen Pract* 2012; **62(604):** 566–567.
2. Mankazana EM. *From exile to exile. Autobiography of a South African Black professional in South Africa before, during and after apartheid.* New York: Authorhouse, 2011.

DOI: 10.3399/bjgp13X662957

Making health habitual

I was delighted to find that Gardner's useful article on promoting healthy habits[1] referred to Kahneman's Nobel prize-winning findings about how people think.

Kahneman's central point is that we use two different kinds of thinking. 'System 1' thinking works fast, using intuitive mental short-cuts. 'System 2' thinking is slower, rational, and deliberative. In his very readable book[2] Kahneman demonstrates that System 1 is what people use most of the time, even highly-educated, numerate people like the students who volunteered for his experiments: they were unaware of jumping to conclusions, and shocked when later shown the errors this had led them to make. When given increasingly complex tasks that forced them to switch into using System 2 thinking, they reported that this felt like hard work, and Kahneman observed highly-consistent physiological changes associated with this feeling.

Explaining things to people and helping them make choices is central to our job as GPs. It is high time we stopped acting as if people were likely to respond by engaging in System 2 thinking, or to be comfortable when given tasks that require it. For example, the whole enterprise of communicating risk and facilitating shared decision-making is aimed at an imaginary patient who weighs up the facts and her doctor's advice alongside her individual preferences in order to compute a rational choice. We should acknowledge that this patient is a very rare bird, and begin working out how best to interact with System 1 thinkers, as Gardner *et al* suggest.

While we are about it, our own learning and teaching would be improved by recognising how seldom we use System 2 thinking ourselves, especially within 10-minute consultations. Healthy (consultation) habits are what keep us safe most of the time, but the drawbacks of intuitive short-cuts explain many of our mistakes, mistakes that often seem surprising when examined retrospectively using System 2 thinking. We should all read Kahneman!

Louisa Polak,

GP and PhD Student, North Hill Medical Group, Colchester, CO1 1DZ.
E-mail: louisa.polak@lshtm.ac.uk

REFERENCES

1. Gardner B, Lally P, Wardle J. Making health habitual: the psychology of 'habit-formation' and general practice. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X659466.
2. Kahneman D. *Thinking, fast and slow.* London: Penguin, 2011.

DOI: 10.3399/bjgp13X662966

Questionnaire survey of the effect of calorie labelling on consumers' cold drink purchases

In their systematic review of the health impacts of neurolinguistic programming (NLP), Sturt and colleagues found no evidence of benefit in 'weight challenged adults'.[1] As GPs know only too well, obesity is a major health problem in the UK. The UK Department of Health recently launched the Responsibility Deal programme in which organisations pledged to provide calorie labelling on their products.[2] In September 2012, for a medical student project, we conducted a confidential questionnaire survey of customers sitting in Eddie Wilson's café at St. George's, University of London, to investigate whether their choices of cold drinks were influenced by calorie labelling.

The response rate was 92% (92/100). The mean age of participants was 25 years (range 18 to 54) and 60% were female. They describe their ethnicity as white 55%, Asian 27%, black 11%, or other ethnic group 7%. On average the 37% (34/92) of responders who said they read the calorie content chose a lower calorie drink than those who didn't: mean (SD) calorie content 62.3 kcal (85.7) versus 103.2 kcal (83.7), P = 0.03. The 26% (24/92) of people who said they were influenced by the labelling chose even lower calorie options, often diet drinks or water: mean 27.3 kcal (55.3). On average women chose lower calorie drinks than men: 71.5 kcal (83.2) versus 112.8 kcal (85.5), P = 0.02. However there were no differences between the calorie content of drinks in people with BMI ≤25 and >25 (based on reported height and weight).

A recent study suggested that in New York, US, a policy of banning super-sized sugar-sweetened drinks (>16 fl oz) in fast-food restaurants could reduce calorie consumption per consumer by 63 kcal (95% CI = 61 to 66).[3] Similarly in England, enforcing a minimum price per unit of alcohol could help to reduce alcohol consumption. Around one-third of responders from our health education institution said they read the calorie labelling and were influenced in selecting a lower calorie drink. In contrast to NLP, where evidence is of limited quantity and quality,[1] it is possible that changes in government policy could contribute towards tackling the obesity epidemic.

Christianne Dominise,

Medical Student, Population Health Sciences and Education, St George's, University of London, London, SW17 ORE.
E-mail: m0901443@sgul.ac.uk

Pippa Oakeshott,

Reader in General Practice, Population Health Sciences and Education, St George's, University of London, London, SW17 ORE.

REFERENCES

1. Sturt J, Ali S, Robertson W, *et al.* Neurolinguistic programming: a systematic review of the effects on health outcomes. *Br J Gen Pract* 2012; **62(604):** 580–581.
2. Dumanovsky T, Huang CY, Nonas CA, *et al.* Changes in energy content of lunchtime purchases from fast food restaurants after introduction of calorie labelling: cross sectional customer surveys. *BMJ* 2011; **343:** d4464.
3. Elbel B, Cantor J, Mijanovich T. Potential Effect of the New York City Policy Regarding Sugared Beverages. *New Engl J Med* 2012; **367(7):** 680–681.

DOI: 10.3399/bjgp13X662975

Not just another primary care workforce crisis

It seems that the general practice workforce is being managed by insurance companies.

A colleague, sick with clinical depression following marital breakdown and disruption within her practise, is subject to certain GMC undertakings that limit future practice. She has met their requirements to sit and pass the RCGP clinical examinations and has successfully applied for a supervised GP Registrar post and a place on an Induction and Refresher (I&R) scheme, all supported by her last GP Dean, her future Dean, and the director of the training practise that she will be joining. She can now proceed with her refreshed career, but a place on the PCT performers list is conditional on evidence of professional indemnity.

And here is the rub; the prospective employer has a group indemnity but their insurance company, incorrectly, gave advice that an individual application would have to be made. This was refused, and a complaint was followed by a review 1 month later, and the application was again refused. Two further insurance companies refused cover