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Do primary care chaplains need training in mental health issues?

I read with interest Dr Macdonald's article, which showed that talking therapy by chaplains resulted in an equivalent improvement in patient wellbeing as antidepressants.[1]

Leavey *et al*[2] in an interview study concluded that clergy tend to explain mental health problems in terms of social factors with spiritual influences and for them the meaning of mental distress assumes more social and moral significance. Pennybaker *et al*[3] have suggested there is a need to provide chaplains with training in psychiatric illness and to more clearly define their role in mental health care.

Dr Macdonald suggests primary care chaplaincy could be considered as an alternative to cognitive behavioural therapy but before adopting this strategy more widely it would be useful to obtain the views of chaplains on what talking therapy means to them and what training they would need to provide it.

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Incorporating cancer risk information into general practice: a qualitative study using focus groups with health professionals

Usher-Smith *et al* report a useful study in the potential utility of cancer risk assessment tools in general practice.[1] Readers may be interested to know that the www.qcancer.org tool, which calculates risk of a current but as yet undiagnosed cancer, was integrated into EMISWeb in 2016; the most popular GP computer system, used by over 55% of all GPs in the UK.

Also there is a new tool that predicts 10-year risk of different types of cancer, taking account of family history and lifestyle as well as other risk factors that are readily available.[2] There is an online calculator for women (http://qcancer.org/10yr/female/) and one for men (http://qcancer.org/10yr/male/).

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Competing interests

Julia Hippisley-Cox is Professor of Clinical Epidemiology at the University of Nottingham and co-director of QResearch®, a not-for-profit organisation that is a joint partnership between the University of Nottingham and Egton Medical Information Systems (leading commercial supplier of IT for 60% of general practices in the UK). Julia Hippisley-Cox is also a paid director of ClinRisk Ltd, which produces open- and closed-source software to ensure the reliable and updatable implementation of clinical risk algorithms within clinical computer systems to help improve patient care.

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The wrong paradigm may be driving drug glucose control in the face of the evidence

Boussageon *et al* are the latest to highlight the apparent contradiction in our current thinking.[1]

On the one hand, the epidemiological evidence shows a strong link between chronic hyperglycaemia (HbA1c) and adverse patient-important outcomes. On the other hand, the evidence from randomised controlled trial shows that lowering HbA1c by drug treatment is ineffective or harmful to patient outcomes.

This contradiction is because we are using the wrong paradigm.

The current paradigm is that HbA1c has a causal relationship with adverse outcomes and that lowering HbA1c by *any means* must improve patient-important outcomes.

The alternative paradigm is that chronic hyperglycaemia is partly causal, but is only a late and easily measurable part of a more fundamental problem.

Our culturally 'normal' diet, based on carbohydrate, is biologically different from the diet the human species evolved to thrive on. A large proportion of people cannot tolerate a carbohydrate-based diet over years, even 'healthy whole grains'. Eating starch is eating glucose, which requires a corresponding insulin response. An insulin response with every snack and meal for years can, in genetically vulnerable people, cause insulin resistance with variable expression among people and among different body tissues. The Hyperinsulinaemia and Insulin Resistance (HAIR) is the underlying problem driving disorders of glucose and lipid metabolism, characterised by pathological fat deposition as central and visceral obesity, metabolic syndrome, and, when