needed to ratify the utility of adopting a collaborative care approach to depression and bipolar II disorder in the NHS.

Vishal Vyas,
School of Clinical Medicine, University of Cambridge, Cambridge.

Mark Agius,
Department of Psychiatry, University of Cambridge, Cambridge.
E-mail: Mark.Aguis@sept.nhs.uk

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Working with non-medical prescribers

Your editorial on non-medical prescribers[1] does not mention the huge problems the grass root GPs face on a daily basis, picking up the pieces after supplementary prescribers and some independent prescribers have decided to prescribe drugs to their patients. GPs are regularly requested to write out and print FP10s for drugs prescribed on paper by palliative care teams, community diabetic care teams, community cardiology teams, community nursing teams, leg ulcer clinics, wound management clinics, podiatry clinics, continence clinics, and the list goes on.[2] They appear in large volumes throughout our day and many times GPs just generate prescriptions and sign them because there is no time to liaise with the relevant health professionals and verify their validity. There is pressure from patients and relatives who have been asked to collect their drugs from the GP and are often waiting in surgery. This is very frustrating and raises doubts about the safety of such prescribing. As the person signing the prescription is ultimately responsible, it is not fair to ask GPs to do this. If we are going to give this duty to other professionals, they should take full responsibility for their actions. GPs could be consulted but should not be left with a pile to process with no other information. This is sadly a routine practice in our area. I wonder what the experience of GPs elsewhere is?

Kavita Pancholi,
GP, Strood, Rochester.
E-mail: kavita.pancholi@nhs.net

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Nudging

We would like to challenge some of the points raised in Dr Fitzpatrick's sceptical take on the 'latest cult' of 'nudging' the behaviour of the British public.[1] In particular, we were surprised at his claim that behaviour contributes only marginally to most health problems. This is not the typical experience of many doctors in the NHS, who spend significant portions of their day dealing with the consequences of behaviours such as smoking, alcohol misuse, and poor diet. Neither is it reflected in morbidity and mortality figures that show the increasing impact of such behaviours on measures of health.[2]

We as doctors — whether we like it or not — are in the business of influencing behaviour. This may be in encouraging some behaviours (vaccination, cancer screening) and discouraging others (smoking, excess alcohol). While we may have developed a nuanced approach to influencing the behaviour of individuals that we have known for some time, it can be more challenging for policy makers seeking to influence the health behaviour of whole populations.

Unfortunately, despite five decades of research on how to influence behaviour, we are still faced with a short supply of effective interventions that can be used to tackle these problems.[3] Insights from behavioural economics and the wider behavioural sciences now provide us with a powerful set of new and refined policy tools to use. Rather than being 'pop psychology' such insights are built on many years of robust and cross disciplinary work — more fully explored in the MINDSPACE report.[4]

We need to recognise that we face an increasing burden of disease related to the decisions we make. Introducing policies that better align behaviour with underlying intentions — while ultimately respecting an individuals autonomy[5] — is, in our view, something worthy of fuller consideration.

Shazid Karim,
GP ST4 and Darzi Fellow, 10th Floor QMQE Building, St Marys Hospital, Praed Street, London, W2 1NY.
Email: s.karim@imperial.ac.uk

Dominic King,
Clinical Research Fellow, Centre for Health Policy, Imperial College London.

Ara Darzi,
Chairman of the Institute for Global Health Innovation, Imperial College London.

Competing interests

DK is a co-author of the MINDSPACE report.

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Author's response

The world of general practice looks very different from the perspective of my surgery in Hackney than it does from the lofty heights of Imperial College. As it happens, I do not spend 'significant portions' of my day dealing with the consequences of smoking, alcohol, and poor diet. Most of my patients are children, older people, and