medical practice, possibly more common these days with so many potent and interacting drugs with some unfortunate side effects.

The urge for euthanasia is surely utilitarian. It saves time for doctors and relatives, and avoids the experience of failure when we can’t cure. It may be that GP training needs to concentrate more on the value of life, and even the mysterious value of suffering. I well remember a patient with severe pain from gastric cancer, who refused all pain relief, as he wanted to ‘be brave’. He was an agnostic and I doubt if he understood the value a Christian attaches to suffering, But he was an example to all who cared for him.

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REFERENCE

Low carbohydrate diets for diabetes control
Fleming, Cross and Barley1 are right to be concerned about the growing prevalence of type 2 diabetes in General Practice.

Despite the growing incidence of type 1 and 2 diabetes and the accelerating cost of the resources needed to monitor and treat these patients, we are obviously not succeeding in reducing either the number of people affected or the severity of the complications of these conditions.

Yet there is a simple, effective, low-cost strategy that is proven to work with diabetes: reduce the amount of sugar and starch in the diet.

This is backed up by rigorous scientific research and I have included a few of the more recent reviews concerning this subject below.2–4

On a more personal note, my son became diabetic 18 months ago. His HbA1C is 5.1 and his insulin requirements have not increased since stabilisation after diagnosis. His blood sugars are rarely out of the 4–7.8 range even after meals on a restricted carbohydrate diet. He rarely experiences hypoglycaemia and has had no severe events.

I have also encouraged my diabetic patients to try this way of eating for themselves. It is usual for patients with type 2 diabetes to experience a 2–3% drop in HbA1C after 3 months on a low carb diet. The impact on reducing complications and associated drug costs can be imagined.

The lower the carbohydrate consumed the less insulin is needed for type 1 diabetics and the less hard the pancreas has to work for type 2 diabetics. For example, insulin dependent diabetics can expect to half or third their insulin requirements. Less insulin injected results in more predictable blood sugars and less hypoglycaemia.

The medical establishment has been less than enthusiastic about adopting low carb diets. All of the usual gripes have been thoroughly debunked or can be dealt with by modifications to the diet. It is time to stop feeding patients a diet of junk science and start feeding them food that makes them well instead of sick.

You would think that Diabetes UK would be interested in promoting a diet that does all of these:

• prolongs honeymoon phase in type 1 diabetics;
• prolongs pancreatic function in type two diabetics;
• promotes a healthy weight;
• reduces need for insulin;
• reduces need for oral hypoglycaemic drugs;
• promotes high HDL and low triglycerides;
• reduces hypoglycaemia;
• reduces glucose intolerance to type two diabetes;
• optimises glycaemic control including post prandial blood sugars.

Sadly, Diabetes UK does not.

If health professionals or patients want to learn more about this I can recommend Dr Bernstein’s Diabetes solution.5 Dr Richard Bernstein became an insulin-dependent diabetic when he was 12 years old and continues to practice as a physician dedicated to diabetes management at the age of 67. He was the first patient to use a portable blood sugar monitor, and through careful self experimentation he managed to reverse most of his diabetic complications. He has developed a comprehensive educational course that turns normal patients into highly competent self carers with truly normal blood sugars round the clock.

How long can we as a profession afford to keep our heads in the sand regarding the benefits of low carb diets for diabetics?

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Breakdown in communication
While I feel that Mike Fitzpatrick does set out to be deliberately provocative I cannot let his September offering on communication skills go without comment. I cannot claim to write for all the communication skills educators throughout the world but the negative tenor of this article certainly dismisses part of what I do for a living.

Certainly we know that there are still problems with the way that doctors communicate with patients. The fact that communication training is being extended into the postgraduate years is a good thing and does not provide evidence that undergraduate communication skills experience is failing to meet its objectives. However Dr Fitzpatrick cannot have it both ways: that doctors’ communication is not
improving and that communication is best learnt through observation in clinical situations.

If the role models that medical students and junior doctors are observing are poor communicators how do we expect these learners to improve? I agree that observation and reflection is an important part of the experiential learning process, as is practising skills. But we know that in clinical situation learners vary rarely receive feedback to help them reflect and improve. Therefore communication needs to be introduced before the students first talk to real patients (theoretical knowledge plus work with simulated patients) and followed up by observation with debriefing so that they can begin to distinguish the good from the poor.

The other problem is that senior medical students and junior doctors rarely discuss management plans with patients; when the latter do they are rarely observed and they learn this important process through trial and error, as well as the memory of how their senior colleagues have performed. The apprenticeship model is all well and good if the tutor is all of the following: a fine communicator, an excellent clinician and a good teacher.

Modern experiential communication skills training does not degrade what is profound in medical practice. It must be continued into clinical settings and refined with practice. Dr Fitzpatrick writes that doctor-patient communication relies on ‘establishing a degree of empathy and trust’, yet he has previously disparaged the concept of the ‘expert patient’ and the idea of the ‘meeting between experts’ that is an important part of the doctor-patient relationship. However, this may also have been written in his role as devil’s advocate.

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REFERENCE

Your publication of an article entitled Communication Skills by Mike Fitzpatrick has made us uncertain as to the purpose of the Back Pages of your journal. If they exist to offer provocative opinion to your readers, you have succeeded. If they are intended to be based on and knowledgeably informed by the full breadth of current literature, then your success is more questionable in this instance and may mislead your readers.

There is ample evidence that clinical communication can be both taught and learnt.1 We are not aware of any evidence of the benefits of apprenticeship learning of communication, indeed the reverse has been suggested.2 To propose that the teaching of communication is in any way ‘comic book’ does not reflect our experience of current undergraduate and postgraduate teaching at this university and elsewhere. On the contrary, learners and teachers take the task extremely seriously and we have evidence, from course evaluation, of learners’ improving skills.

Where Fitzpatrick is appropriately provocative is in his discussion of teaching the on-going doctor-patient relationship, which he describes as heavily influenced by previous mutual interactions. We in no way underestimate the difficulty of such teaching at either undergraduate or Foundation levels, but argue that training has to begin somewhere, in the same way that a cyclist must first learn to balance and steer before attempting to travel any distance.

In our communication teaching with undergraduates, we have not used a Breaking Bad News video for nearly a decade, as we have found live demonstrations and experiential training in small groups using simulated patients much more effective. May we, through your columns, extend a cordial invitation to Mike Fitzpatrick to attend some of these current evidence based courses for medical students. We hope that such an experience will both rekindle his faith in the future competence of our profession and knowledgeably inform further discussion in the Back Pages of your journal.

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The Back Pages exists to publish articles on all aspects of general practice, and allow writers to express more extreme and more personal views, which would not survive peer review. They recognise our view that there is much more to general practice than questions that can be answered by means of formal research. More than anything else they share with the rest of the Journal the duty to inform, to encourage debate, to provoke, and if we can, to entertain. Having two serious letters challenging Mike Fitzpatrick suggests something’s working right — and attacks on editorial policy are especially welcome if they reveal that the BJGP is being read and taken seriously. Ed.

Continuity of care versus speed of access

General practice is facing a period of uncertainty, with the Government seemingly intent on using its forthcoming White Paper to shake up the core elements of a system that has served the NHS so well over generations. Whatever the outcome of ministers’ high-profile ‘listening exercise’, it is already clear that increasing fragmentation of general practice will be an inevitable consequence of the Government’s determination to give private providers a central role in primary care and to expand massively the network of NHS walk-in centres and commuter clinics.

Against this background, Mike Fitzpatrick’s comments on the trade-off between continuity of care and speed of access to a GP are a welcome contribution to the debate.