Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to **jhowlett@rcgp.org.uk**, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

A big issue?

The October 2005 edition of the *BJGP* arrived as I was chomping into my breakfast pastry last week. As I brushed the crumbs away, I espied the article 'The impact of obesity on drug prescribing in primary care' authored by the delightfully titled Counterweight Project Team (they must have had a blast coming up with that team title!).[1]

The study concludes that obesity more that doubled prescribing in most drug categories in general practice. Hmm — not exactly the Third Secret of Fatima but still, a worthy and practical piece of research, and certainly relevant to general practice.

Then I saw the competing interests. Sponsored by Roche Products Ltd.

I think that this study is worthy of comment, not because of any groundbreaking insights into obesity, but because it raises very important questions about sponsorship, ethics and possible conflicts of interest when doctors undertake research under the sponsorship of a pharmaceutical company.

Did anybody really expect that a study on obesity, funded by an 'unrestricted educational grant' from the company that manufactures Xenical, would have been submitted had the results shown anything other than those favourable to aggressive treatment of obesity? The authors themselves acknowledge the possibility of bias in that some of the practices involved are involved in an obesity audit. Unfortunately, acknowledging possible bias does not make the bias disappear.

While we gratefully acknowledge the support of pharmaceutical companies for our research, continuing medical education and so on, I wonder if this study would ever have seen the light of day if the results had been perhaps less emphatically in favour of aggressive treatment of obesity.

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Repeat prescriptions at Highfield Surgery

Your November issue has a poem concerning repeat prescriptions[1] — the poor overworked GP reported that they were rather impenetrable.

As a result of this poem, my own practice prescription clerk has written a poem in return (see below).

Hopefully it can be seen that clinical indications makes light work of this sometimes lengthy chore. I have just been awarded the BUPA Communications Award for 2005 for my work on clinical indications.

The prescriptions before me as always each day,
I look through the pile I have 'urgent for today'.
I need the 'blue spray', 'the brown pill doctor gave me last week',
'I'm not doing well', 'feeling funny', 'feeling weak'.

I take a deep breath; let's get the job done,
Thank goodness for Nigel, the awards he has won.
For clinical indications on every repeat,
For blood pressure, heart, water retention, your feet.
For your asthma, for hayfever, for hyperthyroidism,
To strengthen your bones, or for your heart's natural rhythm.
We have cream that will cure that annoying itch,
And something also to help with that twitch!

So whatever your needs don't ever despair,
At Highfield Surgery you will receive special care.
You will know why you're taking every capsule, spray, cream or pill,
We are here to look after you should you ever fall ill.

By Rita Liddiard, prescription clerk at the Highfield Surgery, High Wycombe.

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Low carbohydrate diets and diabetes control

Dr Morrison, in her letter, promotes the benefit of low carbohydrate diets for people with diabetes.[1] However, there is no clear consensus of evidence for this.[2,3] There is no defined low carbohydrate diet. The studies are predominantly in type 2 diabetes (a different disease and population than type 1). There is the confounding factor of weight loss, which is of established benefit in glycaemic control. Unfortunately, the studies reviewed in

the articles referenced by Dr Morrison have only a short follow-up period. One review concentrates on using these diets in the short to medium term for weight loss.[2] There are concerns about the possible adverse effects of these diets in terms of cardiovascular risk (dyslipidaemias), renal function, cardiomyopathy and osteoporosis.[3,4] Most of these studies have the confounding factor of increased input and support, which are likely to be of benefit to people with any chronic disease.

In the absence of conclusive evidence of benefit and lack of harm, we would propose a pragmatic solution: achieving and maintaining an appropriate weight, physical activity and a conventionally healthy balanced diet. People with type 1 diabetes can inject the insulin they lack as appropriate for the carbohydrate load and their activity level.

In our (non-expert) opinion, it is better to enable people with diabetes to live a normal life with good control than to promote a difficult-to-achieve, restrictive, expensive and potentially stigmatising diet, which has unclear long-term benefits. This is especially true for young people and adolescents.

We accept that a low carbohydrate diet may be of benefit in certain circumstances. We would welcome further research to clarify these issues in type 1 diabetes, type 2 diabetes and obesity separately. We would be happy to be proved wrong. However, there is a trade off between normal life (and quality of life) and glycaemic control. Health has wider dimensions than HbA1c.

Competing interests

LG is a GP, and is married to WW (who is a Public Health SpR and has type 1 diabetes). This letter reflects our personal opinion and may not reflect the views of our employers.

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Trial and error

Fahey *et al* should be congratulated for trying to work out how GPs can best manage hypertension in primary care.[1] However, I feel that their systematic review has overlooked a number of points when it comes to the selection, analysis and summation of trials that relate to educational interventions for patients and doctors. In their discussion, they state that, ‘Education alone, directed either to patients or health professionals appears unlikely to influence control of blood pressure as a single intervention, as results were highly heterogeneous ...’

What the reviewers have failed to appreciate is that educational interventions cannot be treated as ‘single interventions’. Unlike a tablet, educational interventions are, by their very nature, complex interventions, as they involve teachers/tutors, learners and the context in which they learn. Thus, they are not as amenable to more traditional forms of systematic review or meta-analysis.[2] Furthermore, by only including randomised controlled trials in their review, they have left out a potential goldmine of studies that might have told us more about the value of this type of complex intervention.[3]

In order to further our understanding of educational interventions, what we need is not a summation of data to tell us if it works, but a more theory-driven understanding of why it works, for whom, in what circumstances and to what extent.[4,5] Only then will we be able to harness the power of education for the benefit of our patients and ourselves.

Competing interests

None.

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The idea of medicine

‘What are the Back Pages for?’ Well, for me at least, they are the reason I read the *BJGP* (and thereby chance upon some of the other useful stuff).

November’s offerings were particularly good. They remind me in their different ways that all our history and culture is more about ideas than evidence, and that goes for medicine as much as anything. This is perhaps something of what people mean when they say that medicine is more of an art than a science (although, like David Jewell, the point to me is that it is actually a craft).

But the art/science dichotomy is as true and false at the same time as all our other dichotomies. Ever since we came to think and communicate by way of symbols, ideas have been humanity’s lifeblood. Long may they flourish.

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