

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.

REFERENCES

1. Morrison K. Low carbohydrate diets for diabetes control [Letter]. *Br J Gen Pract* 2005; 55: 884.
2. Kennedy RL, Chokkalingham K, Farschi HR. Nutrition in patients with type 2 diabetes: are low-carbohydrate diets effective, safe or desirable? *Diabet Med* 2005; 22(7): 821–832.
3. Arora SK, McFarlane SI. The case for low carbohydrate diets in diabetes management. *Nutr Metab (Lond)*. 2005; 2: 16.
4. Crowe TC. Safety of low-carbohydrate diets. *Obes Rev* 2005; 6(3): 235–245.

A Lindsay Gibb

GP

William Welfare

Public Health SpR, Flat 24, Catherine House, 96–98 Upper Parliament Street, Liverpool L8 7LQ.
E-mail: willandlindsay@yahoo.com

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.

Geoff Wong

GP principal
Daleham Gardens Surgery,
5 Daleham Gardens,
London NW3 5BY
E-mail: geoffrey.wong@nhs.net

REFERENCES

1. Fahey T, Schroeder K, Ebrahim S. Educational and organisational interventions used to improve the management of hypertension in primary care: a systematic review. *Br J Gen Pract* 2005; 55: 875–882.
2. Farrow R, Norman G. The effectiveness of PBL: the debate continues. Is meta-analysis helpful? *Med Educ* 2003; 37(12): 1131–1132.
3. Norman G. RCT = results confounded and trivial: the perils of grand educational experiments. *Med Educ* 2003; 37(7): 582–584.
4. Dolmans D, De Grave W, Wolfhagen I, van der Vleuten C. Problem-based learning: future challenges for educational practice and research. *Med Educ* 2005; 39: 732–741.
5. Pawson R, Greenhalgh T, Harvey G, Walshe K. *Realist Synthesis: an introduction*. Manchester: ESRC Research Methods Programme, 2004. <http://www.ccsr.ac.uk/methods/publications/documents/RMPmethods2.pdf> (accessed 2 Dec 2005).

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.

Jeremy Meadows

GP Principal, Chessel Practice,
4 Chessel Avenue, Southampton
SO19 4AA.
E-mail: jeremymeadows@onetel.com