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The God Delusion

What an idea to advocate putting *The God Delusion* under Christmas trees.[1]

If Dawkins is to be taken respectfully then don't insult him with Christmas. Alternatively, reject Dawkins and enjoy our festival.

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Conflicts of interest
Committed Christian, Ironic sense of humour

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The book review of Richard Dawkins book *The God Delusion* by Simon Curtis in your December 2006 issue was most disappointing.[1] With such a controversial book which has such major flaws in it's arguments it is a pity that the *BJGP*, which I am sure has a readership that includes many people from a variety of faiths, did not balance this review with an alternative, more informed, viewpoint. Simon Curtis has clearly been swept along by Mr Dawkins populist atheism without stopping to ask important critical questions.

Alister McGrath, Professor of Historical Theology at Oxford University and a former atheist himself, has written extensively on atheism, particularly the ideas of Richard Dawkins. He describes '*The God Delusion*' as 'perhaps his [Dawkins'] weakest book to date, marred by its excessive reliance on bold assertion and rhetorical flourish, where the issues so clearly demand careful reflection and painstaking analysis, based on the best evidence available. Attractive precisely because it is simplistic, Dawkins demands the eradication of religion'.[2]

This simplistic opinion of Dawkins, that the elimination of religion would be a solution to the world's ills, is an unhelpful stance for the *BJGP* to support without balance. McGrath goes on: 'The question of the future role of religion is far too important to leave to the fanatics, or to atheist fundamentalists. There is a real need to deal with the ultimate causes of social division and exclusion. Religion's in there, along with a myriad of other factors … But it also has the capacity to transform, creating a deep sense of personal identity and value, and bringing social cohesion. Let's skip the rhetoric, and cut to the reality. It's much less simple — but it might actually help us address the real social issue that we face in modern Britain'.[2]

There are a great many well-read and clear-thinking doctors and scientists who do not accept the views of Richard Dawkins. Many would say that, given the evidence, to be an atheist requires a greater leap of faith than to be a believer. Their views cannot be simply dismissed when the ills of society are at stake.

I therefore recommend that you balance your published review with a further comment from someone who has really grappled with the issues. I would also suggest that you review Alister McGrath's book *The Dawkins Delusion* when it is published in February 2007.

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Carpal tunnel syndrome

As a clinical neurophysiologist, I deal daily with referrals to investigate carpal tunnel syndrome (CTS). Bongers *et al*'s study of CTS in general practice[1] concerned me on a number of points.

Firstly, in 70% of patients, the clinical diagnosis of CTS was not confirmed by investigation. In our experience in Cardiff, both GPs and hand surgeons only get the diagnosis of median nerve entrapment and resulting CTS correct two-thirds of the time. As a result, we regularly see those who have undergone bilateral carpal tunnel decompression, but are still symptomatic, as their symptoms originate from undiagnosed cervical radiculopathies.

I am also concerned that the basis on which the diagnosis has been made is unstable. A meta-analysis by D'Arcy and McGee[2] demonstrated that the following were of little or no value in diagnosing CTS: age, bilateral or nocturnal symptoms thenar atrophy, sensory abnormalities, Tinel sign, Phalen sign, pressure provocation test, and the tourniquet test.

Finally the assertion that there is no gold standard investigation for CTS is incorrect. Although not perfect, nerve conduction studies have been shown to have a specificity of 99% and a sensitivity of 89% in diagnosing CTS.[3]

I would also like to suggest that a possible reason for women being affected by CTS more than men is that common causes include endocrinological and rheumatological disease, both of which are more common in women. There is also a distribution of fat in the arms which is also sex specific.

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Peer review

Dr Welsby's belief that GPs are the only people capable of assessing general

practitioners is quite correct. For several years in South Africa we in the Cape Town private sector have operated a voluntary and much less labour intensive peer review system with a view to negotiating higher consultation fees in return for reduced costs. Because about 50% of the medical funds' expenditure goes on pharmaceuticals, and because prescribing habits are easy to monitor, we have concentrated on drug costs.

Dr Welsby suggests that his proposed system would have detected much earlier the unprofessional habits of the late unlamented Harold Shipman. I would suggest that the current systems should have exposed him much sooner.
I understand that Shipman was murdering his patients using heroin — which he was presumably getting from the local pharmacist or wholesaler. Why did the supplier of the heroin, and the NHS clerk who paid the accounts, not realise that Shipman was using more heroin than all the other area doctors combined?

Some years ago while doing the peer review at one of our emergency departments I spotted a previously unrecognised pethidine addict by the simple process of looking at the dangerous drugs register. He was prescribing more pethidine in a day than the other doctors in a month.

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Z-drugs

The two papers in the December issue of the *BJGP* on benzodiazepines and Z drugs are a timely reminder of the continuing (and, in my view, unacceptable) disparity between evidence and practice in primary care across the UK.[1,2] That such attitudes towards these drugs persist is quite astonishing.

Concern over the use of these drugs was highlighted by the Committee on the Review of Medicines as far back as 1980.[3] This concern led to the production of guidance on the use of benzodiazepines by the Committee on Safety of Medicines in January 1988,[4] advice that was backed at the time by the RCGP and the Royal College of Psychiatrists. There is every reason to believe that this guidance should be extended to cover the Z drugs.[5]

There is now very real concern that chronic benzodiazepine use may result in permanent cognitive impairment.[6] This, of course, may have legal as well as clinical implications for primary care physicians.

GPs in the UK pride themselves on their independent status within the NHS but this status cannot, and should not, be used as an excuse to continue to practice in the face of overwhelming evidence to the contrary. Failure to address these quality disparities really does bring our profession into disrepute.

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An overstated case?

Siriwardena *et al*[1] in their article move from their initial assertion of a 'lack of evidence distinguishing short-acting benzodiazepines and the newer Z-drug hypnotics' in their introduction; to an implied assertion in the title of their article and in the paragraph 'how this fits in' that there is evidence that there is no difference. A lack of evidence is not the same as evidence of no difference.

Indeed the NICE appraisal[2] of this subject pointed to a need for research in this area, and also highlighted the reality that it was unlikely to occur.

In pharmacology training doctors are taught about half-lives, this was the argument put forward in the past for using less of, for example, nitrazepam as hypnotics. Z-drugs have significantly shorter half lives than short-acting benzodiazepines, it is not surprising then that GPs believe that Z-drugs cause less 'daytime sleepiness/sedation'. In situations where evidence is lacking doctors will be influenced by guidelines, by their own experience, by their understanding of pharmacology, and, yes, by those who seek to influence their prescribing.

While it is true that the trend in hypnotic prescribing is not evidence based, it is not true that it goes against the evidence. The evidence is simply not there. This is an important axiom in evidence-based medicine.

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