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

REFERENCES

1. Drinkwater S. *Improving mental health liaison in primary care. An evaluation of a pilot project*. Luton: Luton HAZ, 2003.
2. Gilbody S, Bower P, Fletcher J, *et al*. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med* 2006; **166(21):** 2314–2321.
3. Von Korff M, Katon W, Bush T, *et al*. Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. *Psychosom Med* 1998; **60(2):** 143–149.

DOI: 10.3399/bjgp11X561294

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

REFERENCES

1. Courtenay M, Gerada C, Haywood J. Working with non-medical prescribers. *Br J Gen Pract* 2011; **61(583):** 85–86.
2. Drennan J, Naughton C, Deirdre Allen D, *et al*. *National independent evaluation of nurse and midwife prescribing initiative*. Dublin: University College Dublin, 2009.

DOI: 10.3399/bjgp11X561302

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.

REFERENCES

1. Fitzpatrick M. Mad men take over the coalition. *Br J Gen Pract* 2011; **61(582):** 71.
2. WHO. *Global health risks: mortality and burden of disease attributable to selected major risks*. Geneva: World Health Organization, 2009.
3. Glasgow R, Kleges L, Dzewaltowski D, *et al*. The future of health behaviour change research: what is needed to improve translation of research into health promotion practice? *Ann Behav Med* 2004; **27(1):** 3–12.
4. Dolan P, Hallsworth M, Halpern D, *et al*. *MINDSPACE: influencing behaviour through public policy*. London: Cabinet Office, 2010.
5. Sunstein C, Thaler R. Libertarian paternalism is not an oxymoron. *Univ Chicago Law* 2003; **70(4):** 1159–1202.

DOI: 10.3399/bjgp11X561311

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

others for whom these are non-existent or marginal issues. We do face challenging problems in rheumatology, endocrinology, neurology, psychiatry, and cancers (notably of the breast and prostate), and many more that are little influenced by behavioural factors. I am greatly encouraged that over the two decades I have been in practice, thanks in part to better medical diagnosis and treatment, and despite what the fellows and professors of Imperial would regard as disgustingly unhealthy lifestyles, our patients are living longer and healthier lives.

Of course, I have some patients whose health has been adversely affected by smoking and alcohol, and others who suffer from car accidents, violence, and sports injuries. My job as a doctor is to help them with their medical problems, however they have arisen, not to tell them how to live their lives. I am not 'in the business of influencing behaviour': that is a legitimate activity for parents and teachers in relation to children, or circus trainers in relation to performing animals, and perhaps for clergyman, and probation officers. In my experience, patients are well aware that smoking and excessive drinking are not good for their health. Taking advantage of a medical consultation in an attempt to change these habits is impertinent, obtrusive, and implicitly authoritarian. (I do not, by the way, consider having a vaccination or a screening test as 'behaviour', a concept that implies a customary or habitual activity.)

Doctors' moralistic interventions are also likely to be counterproductive as they are corrosive of moral autonomy.[1] They also give the impression that doctors have some expertise in the sphere of righteous living — which they have not — and that novel psychological techniques can enable them to achieve the desired outcomes — that, notwithstanding the extravagant claims of behavioural economics, remains to be seen. It is disturbing that the elitist ideology of nudge, that reflects such a paternalistic and disrespectful approach towards patients, is enjoying a growing influence over health policy.

Michael Fitzpatrick,
6 Ridge Road, London, N8 9LG.
E-mail: fitz@easynet.co.uk

REFERENCE

1. Furedi F. *Defending moral autonomy against an army of nudgers*. Spiked-Online, 20 January 2011. http://www.spiked-online.com/index.php/site/article/10102/ (accessed 9 Feb 2011).

DOI: 10.3399/bjgp11X561320

The symptom iceberg

The paper by McAteer *et al* in the January edition of the *BJGP*[1] provides data on symptom prevalence from a postal survey with a low response rate and including only those of working age. However, the title is misleading because there was no information about whether the symptoms were below the waterline of medical consultation, as described by the editorial.

The symptom iceberg was identified by Last[2] and operationally defined by Hannay,[3] as the prevalence of significant symptoms in the community that were not referred for professional advice. This latter study included all age groups and was based on personal interviews with a high response rate from those visited.

David Hannay,
Kirkdale, Carsluith, DG8 7EA.
E-Mail: drhannay@googlemail.com

REFERENCES

1. McAteer A, Elliot AM, Hannaford PC. Ascertaining the size of the symptom iceberg in a UK-wide community based survey. *Br J Gen Pract* 2011; **61(582):** 12–17.
2. Last JM. The iceberg 'completing the clinical picture' in general practice. *Lancet* 1963; **282(7297):** 28–31.
3. Hannay DR. *The symptom iceberg*. London: Routledge & Kegan Paul, 1979.

DOI: 10.3399/bjgp11X561339

Health inequalities

I was struck by some statements in two of the leaders in the December Journal so I looked up the references.

One leader[1] reported that 'practices in deprived localities improved performance to the level of their peers in the least deprived areas over a period of only 3 years' and referenced three papers. The first of these papers[2] didn't seem to me to compare deprived areas with other areas. The second[3] was a review article that supported its comments about deprivation by referencing a leader rather than a research paper — I didn't pursue that line of enquiry. And the third[4] was a cross-sectional study that didn't seem to report change over time.

The other leader reported that 'The DASH diet ... is associated with a lower incidence of heart failure, all-cause mortality, and stroke'[5] and referenced two papers. The first[6] demonstrated a reduction in Framingham 10-year coronary heart disease risk score rather than in outcomes; and the second[7] was a review article, the abstract of which (I couldn't access the full article) referred to evidence of risk factor reduction rather than event reduction.

My interpretation of these papers doesn't seem the same as the leader writers' and I'd welcome some clarification.

Wilfrid Treasure,
Muirhouse Medical Group, Edinburgh.
E-mail: wtreasure@gmail.com

REFERENCES

1. Hull S. Health inequalities affect the health of all. *Br J Gen Pract* 2010; **60(581):** 877–878.
2. Campbell SM, Reeves D, Kontopantelis E, *et al*. Effects of pay for performance on the quality of primary care in England. *N Eng J Med* 2009; **361(4):** 368–378.
3. Ashworth M, Kordowicz M. Quality and Outcomes Framework: time to take stock. *Br J Gen Pract* 2010; **60(578):** 637–638.
4. Kiran T, Hutchings A, Dhalla IA, *et al*. The association between quality of primary care, deprivation and cardiovascular outcomes: a cross-sectional study using data from the UK Quality and Outcomes Framework. *J Epidemiol Community Health* 2010; **64(10):** 927–934.
5. Nicoll R, Henein MY. Hypertension and lifestyle modification: how useful are the guidelines? *Br J Gen Pract* 2010; **60(581):** 879–880.
6. Chen ST, Maruthur NM, Appel LJ. The effect of dietary patterns on estimated coronary heart disease risk: results from the Dietary Approaches to Stop Hypertension (DASH) trial. *Circ Cardiovasc Qual Outcomes* 2010; **3(5):** 484–489.
7. Craddick SR, Elmer PJ, Obarzanek E, *et al*. The DASH diet and blood pressure. *Curr Atheroscler Rep* 2003; **5(6):** 484–491.

DOI: 10.3399/bjgp11X561348

Author's response

It is reassuring to have evidence that readers of the *BJGP* assess the robustness of statements in the leader articles by reviewing the quoted papers. Improving precision of the evidence cited can only be for the good.

Treasure takes exception to the quality