needed to ratify the utility of adopting a collaborative care approach to depression and bipolar II disorder in the NHS.

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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

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 autonomy⁵ — is, in our view, something worthy of fuller consideration.

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COMPETING INTERESTS
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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
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 clergymen, and probation officers. In my experience, patients are well informed about smoking and excessive drinking and 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. 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.

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REFERENCE

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The symptom iceberg

The paper by McAteer et al in the January edition of the BJGP 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 and operationally defined by Hannay, 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.

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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 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 didn’t seem to me to compare deprived areas with other areas. The second 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 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’ and referenced two papers. The first demonstrated a reduction in Framingham 10-year coronary heart disease risk score rather than in outcomes; and the second 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.

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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...