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

of evidence quoted in support of my comments about the effectiveness of the Quality and Outcomes Framework (QOF) in improving standards and contributing to a reduction in health inequalities.[1] In particular to the three articles I quoted after the statement 'research has illustrated 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'.

The article quoted by Campbell and others[2] describes the positive changes in quality of care associated with the introduction of the QOF in targeted conditions. In the discussion they quote 'an unanticipated benefit of the scheme has been a reduction in sociodemographic inequalities in health care' citing other work by the same group of researchers.[3] I agree with Treasure that reference to this article would have provided a more direct link to the evidence on the timescale of improvement that he sought.

I make no excuses for quoting the editorial by Asworth[4] as illustration of this point. The piece provides an excellent narrative summary of the QOF story, quoting the evidence again for 'the convergence between achievement in prosperous and deprived communities' and also discussing the improvements in performance for small practices.[5]

The final paper in question is an interesting attempt to link high cardiovascular QOF scores to improved cardiovascular disease (CVD) outcomes (admissions and mortality). The cross-sectional study shows a stronger association in more deprived areas suggesting that improving the quality of primary care through the QOF pay-for-performance scheme reduces the inequalities in CVD outcomes.[6]

There is now a large body of evidence supporting the view that QOF has both improved performance in the targeted clinical domains, and that performance in deprived localities has improved disproportionately. Both these factors will contribute to a reduction in health inequalities.

Sally Hull,
368–374 Commercial Road, City of London, E1 0LS. E-mail: s.a.hull@qmul.ac.uk

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 Engl J Med* 2009; **361(4):** 368–378.
3. Doran T, Fullwood C, Kontopantelin E, Reeves D. Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *Lancet* 2008; **372(9640):** 728–736.
4. Ashworth M, Krodowicz M. Quality and outcomes framework: time to take stock. *Br J Gen Pract* 2010; **60(578):** 637–638.
5. Doran T, Campbell S, Fullwood C, *et al*. Performance of small practices under the UK's Quality and Outcomes Framework. *Br J Gen Pract* 2010; **60(578):** 643–648.
6. 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.

DOI: 10.3399/bjgp11X561357

Confident and competent

As a newly-qualified GP, who has benefited from an extension in training from the standard 3 to 4 years I felt I should reply to the 'Competent but not confident?' article.[1]

Valid arguments were presented, including the need to review the quality of the current 3-year training programmes, and tailoring them to the individual trainee needs. However, the assertion that newly-qualified GPs are 'not as well prepared as they used to be' and an extension of training will 'slow down the conveyor belt' and 'not make for better bangers' is unfounded. Rather than being less prepared than trainees in previous years, it seems more obvious that the level of preparation required to fulfil the increasingly complex clinical and managerial role of a GP has increased, thus leading to calls for an extension in training.[2,3,4]

From my own personal experience the ST3 (registrar) year was very much focused on passing the components of the MRCGP such as the examinations and workplace-based assessments (WBPA). While these do offer an educational benchmark, I felt that they did not fully equip me for the diverse potential role of a GP including areas of research, service development, and commissioning. I, therefore, participated in a voluntary extension of training as an 'Academic ST4', splitting my time between primary care and a university primary care department.[5] The ability to move beyond strategic learning targeted at exams, and developing new skills in research and practice development in a supported environment has been an excellent experience and was certainly not 'always having one's hand held'.

The option to extend training by another 1 to 2 years offering varied programmes developing skills in clinical, teaching, academic, and management settings can only be encouraged. I feel this would lead to more confident GPs with an enhanced portfolio of skills to meet the challenges of the 21st century healthcare environment.

Thomas Round,
GP, Bromley-by-Bow Health Centre, Academic Clinical Fellow, Kings College London.
E-mail: thomas.round@kcl.ac.uk

REFERENCES

1. Edgcumbe D. Competent but not confident? *Br J Gen Pract* 2010; **60(581):** 933.
2. Tooke J. *Recommendation 45. Aspiring to excellence: final report of the independent inquiry into modernising medical careers.* London: MMC, 2008.
3. Hibble A. The GP curriculum: three years, five years or life? *Educ Prim Care* 2009; **20(2):** 83–86.
4. Royal College of General Practitioners. *The business case for the extension of GP training.* London: RCGP, 2010. http://www.rcgp.org.uk/pdf/Business_Case_for_the_Extension_of_GP_Training.pdf (accessed 9 Feb 2011).
5. Allen A, Whiteford A. Extended general practice training. *BMJ Careers* 2010; **24 Nov:** http://careers.bmj.com/careers/advice/view-article.html?id=20001664 (accessed 9 Feb 2011).

DOI: 10.3399/bjgp11X561366

Chronic daily headache: Authors' response

We thank Hamilton and Roobottom for their recent correspondence regarding our research.[1] Our conclusion that direct access CT is now the preferred choice for patients with chronic daily headache in primary care was not based upon our identification of abnormal findings or economic analysis, as suggested by Hamilton and Roobottom, but simply a reflection of the questionnaire information that was returned to us by GPs using this service.

Hamilton and Roobottom identify that we found a higher rate of imaging abnormalities in an asymptomatic