

Kahneman's central point is that we use two different kinds of thinking. 'System 1' thinking works fast, using intuitive mental short-cuts. 'System 2' thinking is slower, rational, and deliberative. In his very readable book<sup>2</sup> Kahneman demonstrates that System 1 is what people use most of the time, even highly-educated, numerate people like the students who volunteered for his experiments: they were unaware of jumping to conclusions, and shocked when later shown the errors this had led them to make. When given increasingly complex tasks that forced them to switch into using System 2 thinking, they reported that this felt like hard work, and Kahneman observed highly-consistent physiological changes associated with this feeling.

Explaining things to people and helping them make choices is central to our job as GPs. It is high time we stopped acting as if people were likely to respond by engaging in System 2 thinking, or to be comfortable when given tasks that require it. For example, the whole enterprise of communicating risk and facilitating shared decision-making is aimed at an imaginary patient who weighs up the facts and her doctor's advice alongside her individual preferences in order to compute a rational choice. We should acknowledge that this patient is a very rare bird, and begin working out how best to interact with System 1 thinkers, as Gardner *et al* suggest.

While we are about it, our own learning and teaching would be improved by recognising how seldom we use System 2 thinking ourselves, especially within 10-minute consultations. Healthy (consultation) habits are what keep us safe most of the time, but the drawbacks of intuitive short-cuts explain many of our mistakes, mistakes that often seem surprising when examined retrospectively using System 2 thinking. We should all read Kahneman!

Louisa Polak,

*GP and PhD Student, North Hill Medical Group, Colchester, CO1 1DZ.*

*E-mail: louisa.polaki@lshtm.ac.uk*

## REFERENCES

1. Gardner B, Lally P, Wardle J. Making health habitual: the psychology of 'habit-formation' and general practice. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X659466.
2. Kahneman D. *Thinking, fast and slow*. London: Penguin, 2011.

DOI: 10.3399/bjgp13X662966

## Questionnaire survey of the effect of calorie labelling on consumers' cold drink purchases

In their systematic review of the health impacts of neurolinguistic programming (NLP), Sturt and colleagues found no evidence of benefit in 'weight challenged adults'.<sup>1</sup> As GPs know only too well, obesity is a major health problem in the UK. The UK Department of Health recently launched the Responsibility Deal programme in which organisations pledged to provide calorie labelling on their products.<sup>2</sup> In September 2012, for a medical student project, we conducted a confidential questionnaire survey of customers sitting in Eddie Wilson's café at St. George's, University of London, to investigate whether their choices of cold drinks were influenced by calorie labelling.

The response rate was 92% (92/100). The mean age of participants was 25 years (range 18 to 54) and 60% were female. They describe their ethnicity as white 55%, Asian 27%, black 11%, or other ethnic group 7%. On average the 37% (34/92) of responders who said they read the calorie content chose a lower calorie drink than those who didn't: mean (SD) calorie content 62.3 kcal (85.7) versus 103.2 kcal (83.7),  $P = 0.03$ . The 26% (24/92) of people who said they were influenced by the labelling chose even lower calorie options, often diet drinks or water: mean 27.3 kcal (55.3). On average women chose lower calorie drinks than men: 71.5 kcal (83.2) versus 112.8 kcal (85.5),  $P = 0.02$ . However there were no differences between the calorie content of drinks in people with BMI  $\leq 25$  and  $>25$  (based on reported height and weight).

A recent study suggested that in New York, US, a policy of banning super-sized sugar-sweetened drinks ( $>16$  fl oz) in fast-food restaurants could reduce calorie consumption per consumer by 63 kcal (95% CI = 61 to 66).<sup>3</sup> Similarly in England, enforcing a minimum price per unit of alcohol could help to reduce alcohol consumption. Around one-third of responders from our health education institution said they read the calorie labelling and were influenced in selecting a lower calorie drink. In contrast to NLP, where evidence is of limited quantity and quality,<sup>1</sup> it is possible that changes in government policy could contribute towards tackling the obesity epidemic.

Christianne Dominise,

*Medical Student, Population Health Sciences and Education, St George's, University of London, London, SW17 0RE.*  
*E-mail: m0901443@sgul.ac.uk*

Pippa Oakeshott,

*Reader in General Practice, Population Health Sciences and Education, St George's, University of London, London, SW17 0RE.*

## REFERENCES

1. Sturt J, Ali S, Robertson W, *et al*. Neurolinguistic programming: a systematic review of the effects on health outcomes. *Br J Gen Pract* 2012; **62(604)**: 580-581.
2. Dumanovsky T, Huang CY, Nonas CA, *et al*. Changes in energy content of lunchtime purchases from fast food restaurants after introduction of calorie labelling: cross sectional customer surveys. *BMJ* 2011; **343**: d4464.
3. Elbel B, Cantor J, Mijanovich T. Potential Effect of the New York City Policy Regarding Sugared Beverages. *New Engl J Med* 2012; **367(7)**: 680-681.

DOI: 10.3399/bjgp13X662975

## Not just another primary care workforce crisis

It seems that the general practice workforce is being managed by insurance companies.

A colleague, sick with clinical depression following marital breakdown and disruption within her practise, is subject to certain GMC undertakings that limit future practice. She has met their requirements to sit and pass the RCGP clinical examinations and has successfully applied for a supervised GP Registrar post and a place on an Induction and Refresher (I&R) scheme, all supported by her last GP Dean, her future Dean, and the director of the training practise that she will be joining. She can now proceed with her refreshed career, but a place on the PCT performers list is conditional on evidence of professional indemnity.

And here is the rub; the prospective employer has a group indemnity but their insurance company, incorrectly, gave advice that an individual application would have to be made. This was refused, and a complaint was followed by a review 1 month later, and the application was again refused. Two further insurance companies refused cover