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.

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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.

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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[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.

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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