

the body's compensatory mechanisms fail, type 2 diabetes mellitus (T2DM). The whole problem is the cause of the patient-important outcomes, not just the hyperglycaemia.

It is now easy to see: if drugs lower HbA1c by raising insulin and worsening HAIR, this can be ineffective or harmful to patient outcomes.

The standard treatment of T2DM, endorsed by the drug industry, is to base every meal on carbohydrate, which may worsen the underlying insulin response and HAIR, rapidly followed by multiple chronic drug prescriptions, which may be ineffective or harmful even while temporarily improving HbA1c.

A low carbohydrate, high healthy fat 'real food' diet can reverse the underlying dietary cause, offload the pressure on glucose and lipid metabolism, and allow the HAIR and T2DM to gradually recover.

Craig A McArthur,  
GP Partner, NHS Highland.  
E-mail: [craig.mcarthur@nhs.net](mailto:craig.mcarthur@nhs.net)

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## Medically unexplained symptoms

Hard evidence regarding diagnosis, care, and management of this area of practice is, unsurprisingly, hard to come by. It is disappointing that the article by Chew-Graham *et al* does not specifically mention the importance of personal continuity of care in these cases, and the desirable development of trust of a patient with a clinician.<sup>1</sup> Fragmented care at best makes management of patients with these conditions difficult. Without trust, satisfactory explanation, and understanding, a positive impact is much less likely. At its worst, fragmented care can act as a reinforcement rather than a relief of symptoms.

Only with this recognition, and appropriate dedicated review opportunities within the GP appointment system (perhaps into which ONLY the GP is authorised to

book), can desirable continuity be achieved (continuity was given prominence with several articles in *BMJ* 2017; 356).

Vernon H Needham,  
Retired GP, Provost, Wessex Faculty RCGP.  
E-mail: [vernonneedham@nhs.net](mailto:vernonneedham@nhs.net)

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## Giving patients choice of appointment length

I appreciated Natasha Elmore's thoughtful and considered responses to correspondence linked to her recent publication.<sup>1-3</sup>

We previously carried out work on giving patients the choice of appointment length,<sup>4</sup> and found (contrary to GPs' expectation) that patients were accurate at estimating appointment length required. Having chosen a specific appointment length, patients also gave careful thought as to how they may manage their own consultation, based on consult duration preference.

Rod Sampson,  
GP, Cairn Medical Practice, Inverness.  
E-mail: [rod.sampson@nhs.net](mailto:rod.sampson@nhs.net)

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## Bad medicine: red drugs

I am grateful to Des Spence for highlighting the issue of drug diversion in his recent piece.<sup>1</sup> The redirection of legally acquired medications into illicit channels undoubtedly perpetuates drug culture in society and causes significant harm to the individual: emotional, physical, financial, and otherwise.

However, I feel he is misguided in suggesting that this issue is driven by the widely held idea that 'pain is what the patient says it is', or more specifically by prescription practices based on this tenet. Though he rejects it as 'unscientific and false', to me this simple statement neatly conveys the notion that pain is a nebulous phenomenon, occurring without the tangible anatomical or biochemical substrate that might allow it to be measured objectively.

The corollary of Spence's view is then surely that pain is not always what the patient says it is; but it is hard to see how this stance would be useful, or indeed workable, in clinical practice. It implies a need for doctors to distinguish the genuine from the fraudulent. Not only is this impossible, given pain is subjective and unquantifiable, but it also welcomes prejudice. How might we identify would-be drug diverters? Do they really look or behave in the stereotyped manner that Spence portrays? I would argue that mispronouncing a drug's name has poor positive predictive value in this respect.

Allowing doctors to become the arbiters of their patients' pain is not a credible solution to the quiet epidemic of drug diversion. Under-treatment of valid pain will beget unnecessary suffering and it is easy to conceive that sufficiently determined patients will contrive increasingly elaborate, disingenuous methods to acquire the prescriptions they seek.

Matthew J Sliney,  
Clinical Medical Student, University of Oxford.  
E-mail: [matthew.sliney@magd.ox.ac.uk](mailto:matthew.sliney@magd.ox.ac.uk)

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