# From the editor

## Three (or four?) scourges of modern medicine

Opioid dependence is of course a widely recognised problem in most countries, with major medical, legal and societal consequences. There is an increasing awareness of the misuse of prescription opioids, in addition to the long-standing problem of addiction to non-prescribed opioids. The gabapentinoids (gabapentin and pregabalin) were initially licensed to treat epilepsy, but can be effective in, and are now widely used for, neuropathic pain. Given the prevalence of chronic pain, and the (correct) need to reduce the use of strong opioids, doctors are increasingly turning to gabapentinoids. Sometimes the prescription is appropriate, but, as Morrison and colleagues discuss in this issue, gabapentinoids are being used increasingly to treat nociceptive chronic pain, for which there is no evidence of efficacy. Indeed in the UK, perhaps two-thirds of prescriptions are for 'off licence' use. Following an all-too-familiar path, gabapentinoids were initially considered as relatively 'safe' and to have no potential for dependence.

Obesity is a growing problem in both 'developed' and 'developing' nations, and has been labelled a pandemic. In the developed world, the poor are disproportionally affected. There are of course many ways of reducing obesity at the level of society, but what should the clinician do when faced with an obese individual? Traditionally many of us have taken a rather condescending or even hectoring line: 'Don't you realise the difficulties you are bringing on yourself and storing up for the future? Eat more healthily and get more exercise!' While lifestyle changes (and, to a limited extent, drugs) can reduce obesity, Cordero and colleagues argue that we should be making much wider use of bariatric surgery to treat obesity and its attendant comorbidities.

Another scourge of modern medicine is over-investigation. This often begins with ordering too many 'simple' blood tests. Meidani and colleagues describe a successful intervention to reduce the ordering of simple tests by junior hospital doctors. Another effective approach might be to require the clinician requesting the tests to collect the samples themselves. When I was required to do phlebotomy on my own outpatients in my first consultant post, I certainly curtailed by ordering blood tests: an unintentional intervention that has had a persisting influence on my practice!

And the fourth scourge? As a medical student and junior doctor, one of my 'bosses' was the late David Sackett, an early evangelist for evidence-based medicine (EBM). He would stride along the corridors of the John Radcliffe Hospital carrying an A4 binder, bulging with clinical data (in those days of yore we had no hand-held computers). At the same time, and I think in part driven by EBM, clinical guidelines started to appear and very rapidly proliferated, resulting in what one might term GBM (guideline-based medicine). Do read Toft's counterblast.

I would like to thank all our reviewers (listed on the Journal's website), and wish all readers a fulfilling and healthy New Year.

**Martyn Bracewell**
*Editor-in-Chief*


# The College Journal Prize

A prize of £250 will be awarded to the first-named author of a paper on a clinical topic (except for reviews), deemed by a panel of judges to be the best paper by a doctor in a training grade published in the *Journal of the Royal College of Physicians of Edinburgh* in issue 4, 2017 and issues 1, 2 and 3, 2018.

The prize-winner will be invited to give a short oral presentation based on their paper at the Medical Trainees' Conference 2019.

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