Reviewer's report

Title: General Practitioner initiated lifestyle advice for overweight and hypertension

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Reviewer: Tim Holt

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I am a UK based GP and have worked briefly in the past in general practice in Australia. I was a little concerned by the overall message of this report, which appears to criticise Australian GPs for missing clear opportunities to influence the health of the population. I expect that Australian GPs are similar to the GPs involved in the focus group study cited in this paper (reference 20), which found that they regard a multi-agency, centrally co-ordinated approach (i.e. not confined to primary care) to be most appropriate to tackle the problem of lifestyle change at a population level in the primary prevention situation. This does not mean that they regard lifestyle advice as unimportant, only that they perceive their own role as limited.

Despite the authors' claims, there is in fact a shortage of evidence that simple lifestyle advice delivered purely in a consultation environment affects important outcomes significantly. For instance, the main reference cited by the authors that such GP interventions are effective (reference 7) was a trial of an intervention that also involved at least three motivational telephone contacts (lasting 10-20 minutes) delivered by exercise specialists based at the local sports foundation over a three month time period.

General practitioners do have one thing to offer over such exercise specialists and other agents potentially involved in the modification of cardiovascular risk: they are prescribers of drug therapy. This provides them with a probably underused opportunity to provide something that other agents cannot. Whilst drug therapy is only one part of cardiovascular disease prevention, it is one that is decidedly evidence based, one that general practitioners are in a fairly unique position to deliver, and also one for which they are legitimately criticised for failing to deliver sufficiently. To do so requires time protection in itself, if all of the prescribing issues are to be covered adequately (clarification of dose frequency, potential side effects, need for monitoring and follow up, etc....)

So I am not at all surprised to learn that Australian GPs feel other issues (including the issues brought to the consultation by the patient as new problems which the patients themselves regard as of first importance) take priority over opportunistic, poorly-evidence based advice interventions that are probably ineffective on a large proportion of occasions. I was in fact impressed that the proportion of patients receiving advice on salt restriction was as high as this study reports.
This article includes a number of limitations (including self reporting of key data) but these are recognised and discussed openly. The analysis seems to be appropriate.

The main conclusion seems to be that Australian GP’s should be using more of their finite consultation time on lifestyle advice. We are not told how long a typical Australian primary care consultation lasts, nor what proportion of consultations are pre-scheduled reviews of hypertension, obesity or other CVD risk factors (during which omission of lifestyle advice would be less excusable), and what proportion are spontaneously requested by patients to discuss other problems.

However, the paper reports original data in an important area that are of publishable quality and I would support acceptance in a revised form. But I would prefer to see the message changed to that of an appeal for the development of more effective lifestyle advice interventions, given the opportunities (demonstrated in this paper) that GPs have through their contacts with patients on an annual basis to deliver such interventions.

If the authors have evidence that the remaining time in general practice consultations (after the patient initiated problems have been dealt with) would be better used on lifestyle advice (that could be provided at least as well by a non-prescriber) than on pharmacological control of cardiovascular risk factors then I am very receptive to it. The current draft does not convey this evidence.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests