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Ten things I wish I had known about academic primary care

As an academic GP trainee I read Wanat *et al*'s article with interest.¹ I was surprised that there was no mention of the inherent administrative bureaucracy and red tape that is rife within academia, and which I certainly wish I had had a greater understanding of prior to commencing my academic journey. I seem to have had more meetings about future meetings, and spend more time filling in paperwork and amendments, than actually doing any productive research. Brexit appears to have made this worse, particularly for projects that require the use of technology where data controllers exist outside of the UK. Legal requirements differ now that we are no longer part of the European Union; trying to get paperwork filled in that fulfils the requirements of all countries involved while satisfying the legal requirements of each is exceptionally difficult. Additionally, some research bodies are pushing for paperless projects – arguably a step in the right direction, until, of course, the technology doesn't work. Cue further amendments that need to be penned, internally approved, signed by multiple staff members, and then submitted for further ethical approval in order to simply allow one to use an emergency scribble pad because HIVE or EMIS is down.

While quality assurance and patient protection is paramount of course, I can't help but feel that paper (or paperless ...) pushing is killing research productivity. There appears to be much duplication of form-filling effort in the name of keeping bureaucrats at the top of a 'top-down' system happy. The focus on honest research output and practical, commonsensical patient care is becoming lost; the system itself is too prohibitive so as to be successful – particularly for those with smaller grants and fewer dedicated staff members. I think that this is a really important point to make to new, young, and enthusiastic academics to avoid early disillusion and burnout.

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The role of the GP in maximising school attendance

The article '*The role of the GP in maximising school attendance*' suggests that GPs should be doing everything they can to get children into school.¹ It suggests that children who suffer anxiety about school just need a bit of encouraging. It suggests that giving in to parents is taking the easy option. I am a former assistant headteacher and now one of many thousands of parents who have been forced to home educate our children because of failings in the education and health systems.

I am the parent of an autistic child who suffered burnout and school trauma after 10 weeks of attending secondary school. We were very lucky that our GP understood autism and wrote to the school to say that my son would not be able to attend for the remainder of the term. Without this letter we would have been subjected to daily phone calls and weekly visits from school, and the threat of a fine.

The article fails to recognise that for many neurodivergent children school is the cause of their anxiety and that being forced to return to an unsuitable environment will result in them becoming ill. Children could be put at further risk of experiencing burnout and school trauma if they are forced to keep going to school when what they need is rest, low pressure, a plan for reasonable adjustments to be made, or an Education and Health Care Plan (EHCP) to provide a different education pathway.

I fully understand the sentiment of the article. We all have a duty to safeguard young people but it is important that we don't generalise and put other young

people at risk in the process. There are many other pathways through education and without the support and understanding of GPs many children will be denied the pathways that would best suit them.

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Multimorbidity: a problem in the body, or a problem of the system?

In their timely critical analysis of 'complex multimorbidity', Pati *et al*¹ highlight that multimorbidity is the norm rather than the exception in care. Moving beyond single-disease-based treatments is therefore vital. However, they question the value of measuring 'complex multimorbidity' for clinical practice as definitions encompass varied phenomena and patient experiences.

We concur with the concerns expressed by Pati *et al* and would go even further in questioning the value of current efforts in quantifying multimorbidity. Insights into the needs of patients are hard to quantify, and often ultimately a matter best judged in the specifics of each clinical encounter. Targeting efforts and resources towards managing multimorbidity through seeking more precise definitions and metrics may miss the mark.

The *conceptual* value of multimorbidity resides precisely in its capacity to prompt a shift beyond single-disease-based understandings of illness. The 'problem' of multimorbidity emerges specifically in a context of care systems that have, over the past century, become increasingly specialised, standardised, and incentivised around single-disease-based approaches.

This leads to high treatment burdens and polypharmacy for patients with multimorbidity. Multimorbidity requires a generalist understanding of illness, recognition of the role of social adversity, and the treatment of illness as a unified experience.

We propose a novel understanding of multimorbidity. Instead of focusing on measuring and defining multimorbidity as a problem inside patients' bodies, we argue it is more fruitful to embrace multimorbidity as a concept that highlights problems in care systems. The key challenge of multimorbidity lies in the increasing difficulties contemporary care systems encounter in coping with complexity.^{2,3} Multimorbidity is an experience that manifests through the discrepancy between medical policy and life-as-lived, brought to the fore by people's attempts to bridge fissured care systems.⁴

The difficulties experienced by patients (and arguably clinicians) as they grapple

with multimorbidity serve as a motivation to advocate for increased funding for general practice, improved continuity of care, and heightened attention to issues of overtreatment and polypharmacy.⁵ We suggest that these steps – more than refined definitions – are what really matter when it comes to improving the care of patients 'with multimorbidity'.

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