Letters

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Pharmacists' perceptions of their emerging general practice roles in UK primary care: a qualitative interview study

We welcome the publication of the research by Butterworth *et al* exploring pharmacists' perceptions of their potential roles in general practice as a valuable contribution to the literature about this topic.[1]

A timeline of reports or policies that have supported the emergence of pharmacists in general practice was presented in Table 1. We note the omission of pharmacist prescribing and suggest that this table should also include the Crown Report of 1999.[2] This report led to the legislation that permitted adequately trained pharmacists in the UK to be supplementary prescribers from 2003 and then independent prescribers from 2006.[3] Pharmacist prescribing in general practice is acceptable to patients[4] and effective, showing beneficial outcomes in chronic conditions.[3] The ability of pharmacists to undertake prescribing tasks that would otherwise be conducted by medical doctors has made pharmacists in general practice an option to address the issue of a shortage of GPs in the UK.

A section of the discussion focuses on the acceptability to patients of a pharmacist consultation in general practice. The authors refer to UK research of audiorecorded pharmacist interactions with patients in general practice which concluded that pharmacists responded supportively to patients' emotional cues and concerns.[1] We believe that the reference for this study should be attributed to Riley *et al*[5] and not the reference cited.[6]

Louise S Deeks,

Pharmacist Researcher, Discipline of Pharmacy, University of Canberra, Australia.
E-mail: louise.deeks@canberra.edu.au

Mark Naunton,

Pharmacist Researcher, Discipline of Pharmacy, University of Canberra, Australia.

Sam Kosari,

Pharmacist Researcher, Discipline of Pharmacy, University of Canberra, Australia.

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Clinical relevance of thrombocytosis in primary care

One thing jumped out at me from this paper that the authors didn't comment on.[1] The risk of developing cancer within 1 year in a male aged >40 years with a platelet count of <400 is 4.1%, which is above the cut-off at which NICE suggests investigating for malignancy.

What does this mean for GPs? That if we consider taking a full blood count in an older male (for any reason) we should really be asking ourselves, 'Could this be cancer?'

George Melling,

GP ST1, Musgrove Park Hospital, Taunton.
E-mail: georgemelling@gmail.com

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Authors' response

Thank you for your letter, which discusses the 1-year cancer incidence of 4.1% in males aged >40 years with a normal platelet count.[1] We were surprised at this too.

You raise an interesting point and one that we are currently investigating. The 4.1% risk found in the males with a normal platelet count in the present cohort probably reflects the increased likelihood of something being wrong with a patient who has a blood test, regardless of the test result. Investigation for malignancy would not be recommended based on the findings in this study:[2] in effect, all men with a full blood count would be considered for cancer. Rather, we expect the GP would investigate on the symptoms or signs that prompted the blood test; this would also focus any investigation.

It is likely the higher risk for cancer is clustered at the high end of the normal platelet count and we have recently been awarded funding to investigate this possibility in a fresh cohort of patients.

Sarah ER Bailey,

Research Fellow, University of Exeter Medical School.
E-mail: s.e.r.bailey@exeter.ac.uk

Emily J Ankus,

MD Candidate, USF Morsani College of Medicine.

Willie Hamilton,

Professor of Primary Care, University of Exeter.

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Child not brought to appointment

French *et al*'s paper highlighted that non-attendances at hospital paediatric clinics is associated with greater social deprivation and likelihood of a child protection alert in their hospital notes.[1] We would like to make two suggestions. First, we feel that it is probably no longer appropriate to use the term 'Did Not Attend' (DNA) when describing a child's non-attendance at clinic. Because it is not a child's responsibility to attend clinic (it is their parent's responsibility to take them), it would be more appropriate to say that the child was not brought to appointment. The Nottingham Safeguarding Children Board has developed a video to get this point across.[2] This is not a new idea, but was proposed by Powell *et al* in 2012.[3] Although it is a subtle difference, by coding non-attendance of children as 'Child not brought to appointment' (SystmOne: Xab0Q; EMIS: 9Nz1) we are emphasising potential failure on the part of those responsible for the child's welfare.

Second, we also feel it is important for GPs to have policies and procedures in place that clarify what they should do if a child is not brought to a GP appointment. Such a non-attendance should not only be coded correctly but also trigger an appropriate response, perhaps a follow-up phone call from a receptionist or GP. Of course, hospitals should also have clear guidance on what action to take if a child is not brought.

Jeremy Gibson,

GP, Southern Derbyshire Clinical Commissioning Group.
E-mail: jeremy.gibson@nhs.net

Jenny Evennett,

Paediatrician, Derby Teaching Hospitals NHS Foundation Trust.

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Improving together: a new quality framework for GP clusters in Scotland

Smith *et al*'s editorial is welcome in that it describes a way forward to promote quality in general practice in Scotland, but many GPs will be disappointed with it because of what it conspicuously fails to address.[1]

The authors ask GPs, among others, for *'patience'*, *'mutual trust, empathy, and lenience in judgement'* in the final paragraph. This is an extraordinarily audacious request on their part, given how long GPs have struggled to cope with the many negative consequences of the GP contract agreed by the BMA in 2004, and the sustained disinvestment imposed by the Scottish government since 2006. The combined impact of their policies contributed to the *'production'* of the *'clinical environment'*, a euphemism for the inadequate and falling capacity, via the haemorrhaging of GPs and failure to attract new recruits.

GPs should be asking the BMA and the Scottish government to use this opportunity of a new contract for a complete overhaul of the way they are funded. A new system is required which ensures that the additional funding apportioned to deal with higher workload and unit costs is not at risk of being diverted away from patient services to personal incomes. They should also be asking the BMA to ensure the financial accountability of GPs, as opposed to the protectionist role that enables the variation in personal income, unrelated to performance.

For their union leaders to represent them legitimately in the future, GPs should demand transparency and access to the relevant documentation rather than the unacceptable secrecy and restricted access that characterises general practice funding to date. The latter may have been deemed essential by the BMA, but it self-evidently has not been in the interests of the majority of GPs, and, by virtue of their essential role, the interest of the NHS more widely.

Helene J Irvine,

Consultant in Public Health Medicine, NHS Greater Glasgow and Clyde.
E-mail: hirvine@nhs.net

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Helpful strategies for GPs seeing patients with MUPS

I read with interest the article by the Norwegian research group.[1] I have only recently become aware of the diagnostic label MUPS, despite suffering from such symptoms for over 40 years.

In 1975 I was prescribed nitrazepam for myoclonic epilepsy, and suffered an adverse reaction to the drug that went unnoticed by doctors. I tried to commit suicide and was referred to psychiatry. I consumed antidepressants for 40 years. I discussed my symptoms *ad nauseam* with countless doctors for four decades. I cannot fault the amount of time that was spent with me at great cost to the NHS. I also suffered from IBS symptoms for 10 years. Exclusion diets and tablets made no difference. I then consulted a chiropractor who resolved my IBS problems in 6 weeks. My spine had been pressing on the nerves leading to the gut.

Six months later I was advised by my GP to stop taking nitrazepam. It very soon became clear that I do not suffer from depression and have not suffered from it for decades. My brain had been suppressed by the drug, resulting in many MUPS. I am now disabled physically and cognitively due to a horrendous withdrawal but am unable to achieve a diagnosis of protracted benzodiazepine withdrawal syndrome or other accurate description of my condition. Other diagnostic labels are preferred that do not implicate the drug. And so most of my adult life has been devastated by prescription drug side effects. My doctors adopted all the strategies suggested over the years. However, what would have helped me most would have been an understanding of the cause of my symptoms so that these could be properly addressed. Perhaps the questions should be 'Why is the label MUPS used at all?' and 'Why is it being discussed and promoted at this particular time?' And why have I been offered four referrals to psychiatry to discuss my current MUPS, which are neurological in nature and directly related to benzodiazepine withdrawal? I would be happy to hold a focus group with GPs that addressed these rather more probing and perhaps contentious questions.

Fiona H French,

Retired.
E-mail: fionahfrench@hotmail.com

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