

caused by drugs, and aid doctors' differential diagnoses. Pharmacists tend to be excited whenever they identify possible drug therapy problems, because this is their opportunity to shine. However, their enthusiasm can result in criticism and denial by others, as evidenced in a recent study.³

If doctors are concerned about pharmacists' assessments, doctors can offer interprofessional teaching. Alternatively, doctors can request to see every patient with dark stools who concurrently take iron tablets, but I doubt whether our busy general practice and A&E colleagues would appreciate this approach. Similarly, I myself am grateful to other professionals helping with venipuncture and intravenous cannulation on the wards, and escalating when needed.

To conclude, I acknowledge the author's concern about potential patient harm, but only if pharmacists are expected to fulfil the entire role of doctors. It would be equally unsafe to expect doctors to perform all of pharmacists' duties.

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Competing interests

Eugene YH Yeung has received salaries from working as a medical doctor and a pharmacist, but neither has paid him to write this letter.

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Patient use of blood pressure self-screening in general practice waiting rooms: authors' response

We thank Prof. Smith for his comments.¹ We are unaware of any published literature regarding the use of self-screened blood pressure measurements in repeat

prescription requests for combined oral contraceptive pill (COCP), although we are currently undertaking some further research exploring the demographics of service users that would show if women of reproductive age are using blood pressure self-screening.

Self-screening systems are available that link a blood pressure monitor and weighing scales to a touch screen that can administer simple questionnaires such as smoking status and potentially ask about COCP side effects and use. These systems integrate the data into the patient's electronic medical record and alert practice staff to any readings or responses that require follow-up. In theory, the annual review required for the ongoing prescription of COCP could be administered via such a system. However, whether conducting 'pill checks' in this manner is desirable or acceptable to women would require careful consideration.

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Competing interests

Richard McManus has received BP monitoring equipment for research purposes from Omron and Lloyds Pharmacies, and has received honoraria and travel expenses from the Japanese Society of Hypertension and American Society of Nephrology.

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Long-term benzodiazepine and Z-drugs: are we committing the denominator fallacy?

In a US population of patients co-prescribed benzodiazepines with antidepressants, only 12% went on to long-term use.¹ Yet, in this UK study, '35% of all users of BZD are taking these drugs long term'.² How can we reconcile these two findings? One

possibility is that UK prescribing is more liberal than in the US. Another is that the UK study looked at BZDs (benzodiazepines and Z drugs), whereas the US study looked at benzodiazepines alone.

Another explanation is the difference between individual risk and prevalence. In a survey of 1 year's BZD prescriptions, you are likely to include those patients who started in previous years and are still receiving a BZD prescription, but omit shorter-term users from previous years. This increases your numerator (longer-term users) but omits short-term users from the denominator (all users), inflating the percentage of longer-term users. In fact, it is not clear how they calculate 'that 35% of all users of BZD are taking these drugs long term'. If, for example, the search strategy was 'all patients prescribed BZD in 2014 or 2015', then longer-term users who started in 2013 or earlier would be captured, but shorter-term users would not. It may therefore be valid to say that 'over the time period studied, 35% of patients prescribed a BZD are taking these drugs long term'. This does not, however, equate to the risk to an individual of their BZD use becoming long term (which Bushnell *et al* estimate at 12%, albeit in a different population).¹

We are in danger of committing the prosecutor's fallacy, assuming $P(A|B) = P(B|A)$; that is, probability of *A* given *B* = probability of *B* given *A*. The 'denominator fallacy',³ failing to identify the denominator correctly, which has been previously described in medicine and beyond, is also relevant here. I would suggest that patients are more interested in individual risks than in population statistics. Doctors of course need to be aware of prevalence, not least when designing services. But with a patient in front of us, it's important we don't confuse the two.

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