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Bad Medicine: The medical untouchables

Thank you Dr Des Spence for having the courage and moral fortitude to speak where thousands of others remain deafeningly silent. I am polydrugged, having been prescribed Ativan (1985), sertraline (2005), and tramadol (2012). The consensus is that I should come off these. I agree, BUT who, pray, will help me with withdrawal? On my medication it says with a view of

reduction, that is, on the Ativan and tramadol — although not once has there been any suggestion as to how. I turned to 'Dr Google' and a helpline in Bristol — one of only two in the UK. It has taken 2 painstaking years to withdraw safely from benzodiazepines.

I am a taxpayer and have been for over 40 years. Why, unlike for illegal substances, is there no help, TLC, or rehab facilities for me and thousands like me? A worker, a mother, a friend. I have no respect for the doctors who are either ignorant about this or wilfully silent. Honesty is needed from the profession in order to restore a semblance of trust.

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A new spin on old methods

I recall my GP trainer sharing with me his preferred distraction techniques to ease the examination of young children, particularly those distressed with intercurrent illness. Over the last 25 years I've added my own methods, the latest of which, an accidental discovery, puts a new spin on clinical examination techniques.¹ Recently, a 5-year-old with distressing otalgia picked up the fidget spinner on my desk and was so engrossed he barely noticed me examine him. I must add that the fidget spinner was a gift, but this experience perhaps gives colleagues an excuse to buy one as a justifiable practice expense. Happy spinning!

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Mental health

Your last issue focused on mental health including the mental health of doctors.¹

As a response to severe mental health problems suffered by colleagues, we approached the Scottish Poetry Library with the idea of producing a little book of poetry to act as a companion and comfort to new doctors when they begin their work.

The result was *Tools of the Trade*, a book of short, accessible poems that all relate in some way to the experience of being a new doctor, which is given to all new Scottish doctors at graduation.² The poems are divided into sections, 'Looking after yourself', 'Looking after others', 'Beginnings', 'Being with illness', and 'Endings'.

The book has been well received and we are now exploring ways of expanding the project and encouraging more young doctors to use poetry as a way of connecting with their creativity and compassion.

More information about *Tools of the Trade* is available on the Scottish Poetry Library website (<http://www.scottishpoetrylibrary.org.uk/>) and in an article in the journal *Education for Primary Care*,³ and we will be sharing our experiences of the book at the RCGP conference in October.

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2014 NICE cholesterol guidelines

Ueda and colleagues address the 2014 National Institute for Health and Care Excellence (NICE) guidelines based on QRISK2 in commendable fashion.¹ It would be interesting to ask them for their opinion on an article very recently published in the *Pharmaceutical Journal* entitled 'The cholesterol and calorie hypotheses are both dead — it is time to focus on the real culprit: insulin resistance',² which would appear to undermine the very foundations on which QRISK and the NICE guidelines totter.

Not only is there an issue of whether the patient in the consulting room meets the inclusion criteria of the studies that went towards the formulation of any guideline, but also the semantics involved in the word 'guideline', which is fundamentally different from 'code' (must do). [Definition of CODE: a collection or compendium of laws. A complete system of positive law, scientifically arranged, and promulgated by legislative authority].

What is a poor jobbing GP to do in a 10-minute consultation? When the patient sitting opposite is still worrying about what their cholesterol level is, and the GP is grappling with the far more important QRISK2 odds concept, while empirical science puts cholesterol in the dustbin alongside the multitude of historical medical fashions that in their time were cutting-edge 'must do's'?

'*Primum non nocere*' would suggest sitting on one's hands as one of the safest of options while prescribing a statin among the most dangerous!

In conversation with our local community geriatrician it became evident that the scientific evidence and data were not within their grasp to offer a cogent response.

Will the *BJGP* step up to the mark with its plethora of professorial wisdom and knowledge to enlighten us on this matter, please?

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Time to revive the GP-focused clinical examination

We read with interest Block and Easton's plea that we should claim the focused examination as a specialist GP skill that we can be proud of.¹

GP teachers who provide clinical placements for Keele's undergraduate medical students report informally that students sometimes question their practice of performing focused rather than full, systematic 'PACES-style' examinations, and as a consequence they lack confidence in teaching examination skills. Conversely, students often question the need to examine patients when so much imaging is available, and is requested, in hospitals.

We have begun to try to address these problems. We have developed a workshop entitled 'Learning and Teaching the Skills of Evidence Based Physical Examination (EBPE)' for clinical teachers. This provides participants the opportunity to consider the evidence for the use of focused examinations in their day-to-day work, as well as the practical aspects of teaching evidence-based physical examination.² We have delivered this locally to our GP teachers and to a multidisciplinary audience at the 7th International Clinical Skills Conference in Prato, 2017. Informal feedback has suggested that the workshop has increased participants' confidence in their examinations in their clinical practice, and in their teaching.

Alongside this, Keele's Year 4 students have a 4-week general practice-based course on clinical reasoning that promotes focused examination to test diagnostic hypotheses, which they are taught to generate consciously during history taking.^{3,4} We hope that our graduates will build on this learning and become confident that their examinations accurately inform the decisions they need to make for individual patients in whatever clinical setting they are working in.

We believe that our work is helping to highlight this important area of practice, teaching, and learning to both students and their GP teachers, and wholeheartedly agree