# Letters

All letters are subject to editing and may be shortened. General letters can be sent to **bjgpdisc@rcgp.org.uk** (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication.
For submission instructions visit: **bjgp.org/letters**

## Editor's choice

## General complaint

My usual approach to journals is to peruse them over breakfast during the week so I can consign them to the bin on Saturday, having noted a learning point for my ePortfolio.

I am increasingly unable to do that with the *BJGP*.

The January edition took a disproportional amount of time to read:[1] too many useful articles, conclusions to studies that were thought provoking and resonated with my experience or suggestions to improve exercise alongside efficiency of clinical time ('Consultations start in the waiting room'). All the Life & Times pieces were pertinent and challenging. Clinical Intelligence illuminated my non-consideration of myelopathy in cervical pain and I will now have to examine lower limbs as well … Finally 'Corneal ulcers' resulted in a late departure for the surgery and was immediately helpful before the morning was out.

Even this letter has taken a good 50 minutes of my first morning of annual leave in order to finally direct the journal (minus relevant torn-out pages) to recycling as I have had to re-read several of the articles and reinforced the take-home points.

And now I have the February one to process.

Nicky Miller,
*Crossfell Health Centre, Middlesbrough.*
*E-mail: nmiller4@nhs.net*

### REFERENCE

1. Jones R. How far to Babylon? *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp17X693941.

DOI: https://doi.org/10.3399/bjgp18X694937

## The GP consultant

In describing the workforce challenge, Pauline Nelson *et al* conclude that *'skill-mix change is recommended … in general practice,* [but] *it may not always achieve the intended aims'*.[1] As a 5000-patient GP surgery in the East Midlands, an area significantly under-populated by GPs, we changed our practice skill-mix in 2016 with incredible outcomes. We now work as 'GP consultants' — not just as GPs — a term we believe is essential for the future of general practice, to improve our morale and to inspire our future workforce to choose general practice. We supervise our excellent team of nurse practitioners, paramedics, pharmacists, nurses, medical students, and HCAs while they see the patients, update medication, and deal with routine enquires. Because of the skill-mix change, as GPs we can now oversee every patient contact that needs our high-level skills, spend more time with complicated patients, and at the end of most days have spare appointments that are not used and we leave the practice on time.

We are true specialists as GPs and it is time that this was recognised. As our secondary care colleagues have a team who work with them, so should we. The time for isolation in primary care is over. Think of yourself as a 'GP consultant' and create an effective and highly skilled team around you where each person works to their own unique skill-mix, leaving the 'consultant' to supervise, inspire, educate and nurture those around them. I would encourage other GPs to look at our model of care.

Gail M Allsopp,
*GP, West Hallam Medical Centre, Derbyshire, University of Nottingham.*
*E-mail: gma@doctors.org.uk*

James Burns,
*GP, West Hallam Medical Centre, Derbyshire.*

Richard Page,
*Managing Partner, West Hallam Medical Centre, Derbyshire.*

### REFERENCE

1. Nelson P, Martindale A-M, McBride A, *et al.* Skill-mix change and the general practice workforce challenge. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X694469.

DOI: https://doi.org/10.3399/bjgp18X694949

## Organ donation in Wales

The editorials on organ donation in the February issue do not mention the Welsh experience.[1,2] As of 1 December 2015, the Human Transplantation (Wales) Act came into full effect, introducing a presumed consent system, in which every person ordinarily living in Wales voluntarily for longer than 12 months, aged 18 or over, and who has the required mental capacity is deemed to have given their consent to organ donation, unless they have specifically registered a decision either on the Organ Donation Register or verbally told family or friends. A formal evaluation, commissioned by the Welsh Government in 2014,[3] has now reported, with the following main findings:

- awareness of and support for the soft opt-out system of organ donation in Wales is high among the general public and NHS staff, although there has been a recent drop in awareness levels among the general public, suggesting that publicity of the law needs to be maintained;
- more clarity around the role of the family in the organ donation process is required;
- NHS staff working within organ donation may also benefit from further training, particularly around the organ donation conversation with the family;
- analysis of routine data does not show any consistent change in deceased organ donations in Wales, or more widely from Welsh residents; and
- analysis of consent data shows an increase in the percentage of families giving approval for donation. However, this is not reflected in a rise in donors overall, perhaps because the rules about which families could be approached were tightened at the same time as the law was introduced.

Roy A Carr-Hill,
*Researcher, Institute of Education, Professor of Research in Education in Developing Countries, UCL Institute of Education, University College London, London; Honorary Professor, Centre for Health Economics, University of York, York.*
*E-mail: roy.carr_hill@yahoo.com*

**Competing interests**
Roy A Carr-Hill was one of the researchers working on the evaluation of the Welsh opt-out system.

**REFERENCES**
1. Misselbrook D. Organ donation: a national consultation. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X694433.
2. Rudge CJ. Organ donation: opting in or opting out? *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X694445.
3. Young V, McHugh S, Glendinning R, Carr-Hill R. *Evaluation of the Human Transplantation (Wales) Act: impact evaluation report.* 71/2017. Cardiff: Welsh Government, 2017.

DOI: https://doi.org/10.3399/bjgp18X694961

# A squash and a squeeze

Your excellent editorial[1] and figures reported by the BBC recently that as many as 1 in 11 adults are prescribed an addictive medication[2] suggest that we are in the midst of a sea change in our thinking about chronic pain. For years we have been steadily climbing the defunct WHO analgesic ladder, inexorably gaining more and more medications and their inevitable side effects. It is time for a change.

I am reminded of the wonderful children's book by Julia Donaldson, *A Squash and a Squeeze*. In it a woman living in an idyllic rural location is frustrated by her lack of space. She calls a wise old man to help. One by one he introduces more and more animals into her house — first a hen, then a goat, a pig, and finally a dairy cow. Chaos ensues, and the house feels ever smaller and the woman more and more alarmed until she throws her arms into the air, *'I'm tearing my hair out, I'm down on my knees.'* Yet the wise old man has a plan, for one by one he withdraws the animals ... the chaos lifts and the woman is struck by the newly appreciated space in her house.

So I urge you to take off the fentanyl patch ... stop the gabapentin ... and tramadol ... and dihydrocodeine ... and codeine. ... and see if the fog and chaos lifts. These painkillers are a squash and a squeeze, and it is time for us to act like the wise old man or woman that our patients expect.

Peter A Churn,

*GP Partner, Educational Supervisor, and ST1 Course Organiser, Harbours Medical Practice, Cockenzie and Port Seton.*
*E-mail: petechurn@doctors.org.uk*

**REFERENCES**
1. Quinlan J, Alam F, Knox K. Opioid analgesic dependence: where do we go from here? *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X690065.
2. Roberts M. 'Growing problem' of addiction to prescription drugs probed. *BBC News* 2018; **24 Jan:** http://www.bbc.co.uk/news/health-42787958 (accessed 6 Feb 2018).

DOI: https://doi.org/10.3399/bjgp18X694973

# Requirement for retinal screening in patients taking hydroxychloroquine and chloroquine

We read the article by McGill and Ambrose on lupus in young people with interest.[1] They reiterate that patients should receive retinal screening after 5 years of exposure to hydroxychloroquine.[1] It is estimated that there may be up to 161 000 users of hydroxychloroquine in the UK. The prevalence of hydroxychloroquine retinopathy is around 7.5% after 5 years of hydroxychloroquine therapy (increasing to 20–50% after 20 years).[2] The Royal College of Ophthalmologists has made a collaborative recommendation for systematic retinal screening in users of hydroxychloroquine and chloroquine in the UK.[3] GPs and other prescribers of hydroxychloroquine, who take responsibility for drug monitoring requirements, should be aware of the key details of the recommendations:

- all patients expected to remain on hydroxychloroquine for more than 5 years should be referred to the hospital eye service for baseline evaluation within 12 months of starting treatment;[3]
- patients should be referred to the hospital eye service for annual screening after 5 years of treatment;
- patients with additional risk factors (chloroquine use, impaired renal function (eGFR <50 ml/min/1.73 m2), daily dose of hydroxychloroquine greater than 5 mg/kg/day, and patients concurrently taking tamoxifen)[4] should be screened annually after 1 year of treatment; and
- prescribers should note that the risk of retinal toxicity can be reduced by ensuring the daily dose of hydroxychloroquine is <5 mg/kg/day.

A patient information leaflet has been developed by the Macular Society and should be distributed to all patients taking hydroxychloroquine.[4] A referral form is included with the recommendations to assist in the timely referral of patients to the hospital eye service for baseline evaluation and screening. The patient, GP, and hospital specialist (if relevant) will be notified in writing of the outcome of each screening visit.

Andrew J Lotery,

*Professor of Ophthalmology, Department of Ophthalmology, University of Southampton NHS Foundation Trust, Southampton.*
*E-mail: A.J.Lotery@soton.ac.uk*

Imran H Yusuf,

*Ophthalmologist, The Oxford Eye Hospital, John Radcliffe Hospital, Oxford.*

**REFERENCES**
1. McGill G, Ambrose N. The management of lupus in young people. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X694805.
2. Melles RB, Marmor MF. The risk of toxic retinopathy in patients on long-term hydroxychloroquine therapy. *JAMA Ophthalmol* 2014; **132(12):** 1453–1460. [Erratum appears in *JAMA Ophthalmol* 2014; **132(12):** 1493.]
3. Royal College of Ophthalmologists. *Hydroxychloroquine and chloroquine retinopathy: recommendations on screening — membership consultation.* London: RCOphth, 2018.
4. Macular Society. *Eye screening for patients taking hydroxychloroquine (Plaquenil®).* Andover: Macular Society, 2017.

DOI: https://doi.org/10.3399/bjgp18X694985