All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: <http://www.rcgp.org.uk/bjgp-discuss>

Primary excision of cutaneous melanoma

It seemed almost inevitable that there would be a secondary care backlash towards GPs being 'let loose' with a scalpel ('Primary excision of cutaneous melanoma').¹⁻⁴

Any GP practising regular minor surgery sessions over many years will surely unwittingly excise the very occasional malignant skin lesion. I have no doubt that dermatologists occasionally mistakenly excise a benign one!

Are we not in danger of over reacting here? Perhaps GPs should not treat patients with a heart condition. Now that really is serious isn't it?

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Working with non-medical prescribers

Courtenay *et al* highlight the expansion of non-medical prescribing in the UK and argue that it offers 'a strategic innovative solution to address capacity, quality, efficiency, and effectiveness'.¹ They believe that doctors' anxieties about non-medical prescribing should be allayed by the available evidence, although they are concerned about 'the lack of awareness and understanding by

doctors about this literature'.¹

However, some of the categorical statements made in the editorial are supported by references that suggest, rather than clearly demonstrate, the benefits of non-medical prescribing.

For example, one reference that is used (solely) to support six different statements relating to such matters as GPs' confidence in nurse prescribing, the 'freeing up' of GPs' time by nurse prescribing, and non-medical prescribers staying within their area of competence, is a study involving interviews with just five GPs and seven hospital doctors working with nurse prescribers in dermatology.² Indeed, the authors of this study noted that 'generalization of the findings is limited by the small sample size'.²

Furthermore, the supporting reference for the assertion that nurse prescribing 'is safe' is an Irish report³ that looked at the educational preparation for nurse and midwife prescribing, and the perceptions of patients and healthcare professionals. An audit was also conducted which found that the 'vast majority' of prescriptions and consultations were appropriate and safe; however, this was based on a review of 25 nurse and midwife prescribers.

I have worked closely with several hard-working and professional nurse-prescribers and understand the potential benefits to patients and GPs of these extended roles. However, it appears that claims about the benefits and safety of non-medical prescribing, based on some of the evidence referenced in the editorial, should be treated as probable rather than proven.

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Please see the *BJGP* Discussion Forum for the authors' response:

<http://www.rcgp.org.uk/bjgp-discuss>

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How to protect general practice from child protection

Mike Fitzpatrick is clearly struggling with child protection and probably finds resonance with other GPs who feel the same.¹ Careless words cost lives, and I believe Mike and the editors of the Journal should remember this.

As a medical student I was drawn to general practice by the *The Journal of the Royal College of General Practitioners* and the RCGP focus on the physical, psychological, and social components of the consultation. I was very fortunate to have trained in practice with the late Dr Eric Gambrell, where this spirit of working together with other professionals in challenging cases was promoted with enthusiasm. It is sad to see the Journal potentially helping to erect barriers to safeguarding children. As a GP and a Named Doctor for Safeguarding Children, may I suggest the following:

- Don't give up on safeguarding children. Read the PreVAil report showing the continuum of abuse and neglect in infancy to conditions in later life, including academic failure, substance misuse, mental health disorder, maltreatment of one's own offspring, and chronic disease including heart disease and cancer.²
- Read the article 'Beyond the specific child' that highlights the fact that child protection cases in general practice so often present through parental issues and concerns, and suggests a refocus.³
- Continue to voice concerns about excessive child safeguarding guidance, (strident or not), and at the same time call for better resources for the complex tasks in primary care. Bearing in mind the PreVAil report, this may be more worth while than ticking boxes for QoF points.

- Consider the Common Assessment Framework (CAF) as a friend. It is the best tool we have for analytical assessment of complex cases not unlike the landmark RCGP trial I mentioned above.⁴
- Look at the RCGP/National Society for Prevention of Cruelty to Children Toolkit for Safeguarding Children and Young People (section on Child Protection Conferences, page 36).⁵ You will note that it highlights the three main headings of the CAF: child's developmental needs, parenting capacity, and family and environmental factors. The Toolkit goes on to consider key points to include from a GP perspective. Perhaps use this to set up your own template.

If we manage to contribute to make even one or two children's lives better per GP per year through safeguarding, we may be rewarded by seeing their health and wellbeing improved and may even be thanked by future GPs who have one or two adults less scarred forever by child abuse and neglect.

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Busy doing different things

I have worked in practices serving both affluent and deprived patient populations. Therefore, I have no hesitation in stating that GPs across the board are busy. However, it strikes me that we are often busy doing different things.

I recognise the challenges associated with caring for relatively affluent older patients¹ and those with good health-literacy skills.¹ I also have no doubt that 'Deep End' practitioners² aspire to the core values of general practice, namely; to be excellent medical generalists who provide whole person medicine and patient advocacy.³ However, Deep End GPs are often constrained by limited resources in the context of deprivation, making consistent attainment of such values hard to achieve.

GPs serving more affluent populations arguably face a heavy workload but in a very different social context, that, albeit a potential challenge to the delivery of health care, is less likely to lead to detrimental health outcomes. The latest 'report card' on health inequalities in Scotland serves to emphasise this reality, when compared to the most affluent quintile: healthy life expectancy for males in the most deprived quintile is 18.8 years lower, and those aged 45–74 years are 4.7 times more likely to die from coronary heart disease, 9.2 times more likely to die from an alcohol-related disease, and are twice as likely to die of cancer.⁴ The Deep End project serves to remind us that these practices are battling against the odds in the face of real and significant health needs. Such statistics cannot be ignored and a focus on 'workload,' with practitioners assessing how busy they are compared to their peers, risks obscuring these harsh facts.

Health inequalities cannot be solved by the NHS alone. However, the delivery of health care in Scotland, where a flat-line distribution of resources persists despite differential health needs, is clearly not best serving the population. The recent report on the quality of primary care in England⁵ suggested that before quality can start to improve, GPs and their teams will need to look beyond their surgery walls. Addressing health inequalities is another context where we need to consider the 'bigger picture'. Arguably to date, we have failed as a professional group to rise to this challenge.⁶

We must fully appreciate the extent of the problem and be under no illusions that while we may feel that 'we're all in at the deep end paddling hard to keep afloat',¹ the statistics tell a different story.

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GP commissioning can unlock the full potential of research within the NHS

Jonathan Graffy's editorial on research for commissioners is very welcome.¹ He is right to identify GP commissioners' potential role around research governance and how they may benefit from collaboration with researchers to develop and evaluate their services. There is, however, good reason to consider, whatever their eventual form, that the birth of these new commissioning organisations is a once-in-a-generation opportunity to integrate a comprehensive culture of research within the NHS.

GP commissioners are in a position to routinely specify, in contracts, that their providers deliver research-responsive services ensuring that recruiting people to research studies is core and becomes everyday practice. Currently, whether or not a service provider gives patients access