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

GPFV: a new charter for general practice?

A partner absorbs years of emotional exploitation and neglect at the whim of a callous spouse. When at the very edge of their capacity to cope, the spouse declares, through an intermediary, that they have learned the error of their ways, will do better, will buy a variety of peace-making gifts, and will 'make amends'.[1] The partner is confused and distressed; they want to believe but the promises seem hollow, none of the offers consistently match the problems experienced, and, more conspicuous than anything else, there is no direct apology and no convincing demonstration that there is an assumption of responsibility for the abuse. The partner confides in their trusted GP and asks if they should forgive and forget?

Howard Skinner,
GP Principal, the Tutbury Practice, Staffordshire.
E-mail: hdskinner@doctors.org.uk

REFERENCE

1. Mathers N. General Practice Forward View: a new charter for general practice? *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687121. http://bjgp.org/content/66/651/500.

DOI: 10.3399/bjgp16X688057

Primary care is the cornerstone of our NHS

There is discriminatory bias against general practice within UK medical schools.[1,2]

The public purse pays to train doctors to provide an effective and comprehensive NHS. Medical school deans receive substantial remuneration and run the most expensive and prestigious university faculties. They are implicitly tasked with training people to provide a service that deals with a million people every 36 hours and that cares for vulnerable populations. However, many deans appear to prioritise their performance in the Research Excellence Framework and the production of clinical academics over training doctors who can survive the rigours of modern medicine and so sustain their personal commitment to long-term, safe, patient-centred practice.

Producing socially aware clinicians who will remain in and support the NHS, and the patients it cares for, should be the key priority for medical school educators. Medical school leaders need to reflect and exemplify this commitment. Surely 'dissing' a career in general practice is a reflection of systemic problems within the medical hierarchy.

George Lewith,
Professor of Health Research, Centre for Resilience, University of Westminster.
E-mail: GL3@soton.ac.uk

David Peters,
Director, Centre for Resilience, University of Westminster.

Chris Manning,
Convenor, Action for NHS Wellbeing.

REFERENCES

1. Baker M, Wessely S, Openshaw D. Not such friendly banter? GPs and psychiatrists against the systematic denigration of their specialties. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687169. http://bjgp.org/content/66/651/508.
2. Ajaz A, David R, Brown D, *et al.* BASH: badmouthing, attitudes and stigmatisation in healthcare as experienced by medical students. *BJPsych Bull* 2016; **40(2):** 97–102.

DOI: 10.3399/bjgp16X688069

Confronting the bashing: fundamental questions remain

We would like to wholeheartedly echo the call by Baker and colleagues[1] in their editorial to end the systematic denigration of both general practice and psychiatry, and at the same time to highlight the paucity of evidence and research in this area that we and others are attempting to re-address. No one appears to doubt the existence of denigration,[2] and even medical students themselves have been compelled to put pen to paper and express their own personal feelings and opinions.[3,4] But fundamental questions remain unanswered and seemingly unexplored. Where does this denigration occur: at medical school or in hospital trusts, or even in general practice itself? Who is responsible for the denigration: consultants, junior doctors, or our healthcare professional colleagues? Why does it occur: is it harmless banter to relieve the stress of the work or is it deeply ingrained prejudice based on a lack of awareness of the GP profession? At what stage does it occur: as medical students, as foundational doctors, or at the specialty or GP trainee level? And, most crucially of all, does the 'banter' influence the eventual career choice of potential GPs at the trainee stage, student stage, or even the pre-student stage?[5]

The time has come to end the bashing (Badmouthing, Attitudes, and Stigmatisation in Healthcare). Urgent research exploring the phenomenon and strategies to confront it must be invested in. Primary care is foundational to the NHS, and at the same time as billions of pounds are spent on investing in general practice, we surely need to invest in preventing one of the potential causes of its demise.

Hugh Alberti,
GP and Subdean for Primary Care, Newcastle University.
E-mail: hugh.alberti@newcastle.ac.uk

Kymberlee Merritt,
GP Trainee and Educational ITP, Newcastle University.

REFERENCES

1. Baker M, Wessely S, Openshaw D. Not such friendly banter? GPs and psychiatrists against the systematic denigration of their specialties. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687169. http://bjgp.org/content/66/651/508.
2. Brooks JV. Hostility during training: historical roots of primary care disparagement. *Ann Fam Med* 2016; **14(5):** 446–452.
3. Glasspool J. GP recruitment and retention. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X683881. http://bjgp.org/content/65/632/116.2.
4. King DA. Encouraging medical students to pursue general practice. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687265. http://bjgp.org/content/66/651/512.1.
5. McDonald P, Jackson B, Alberti H, Rosenthal J. How can medical schools encourage students to choose general practice as a career? *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16x685297. http://bjgp.org/content/66/647/292.

DOI: 10.3399/bjgp16X688081

Bullying and banter

I couldn't help noticing the possibly unfortunate juxtaposition of these two editorials in your latest issue. While accepting that both childhood bullying and derogatory banter regarding general practice and psychiatry (the latter having existed for generations) are unacceptable, I can only guess the response from some of the more 'aggressive' secondary care specialties to these concurrent calls to right wrongs. In either circumstance, only strength from the aggrieved will be respected: victimhood will not win the day!

In respect of childhood bullying, any GP will of course respond appropriately to patient distress, but to make an expectation of GPs on this subject broadens their remit, yet further increases demands on them, and sets them up to fail; not what is needed in the current environment of low morale.

In respect of our secondary care colleagues' 'banter', an invitation to spend 2–3 days of annual study leave shadowing a GP trainer in their practice should do the trick! A consultant gynaecological oncologist advised me some years ago that he was in awe of how GPs manage such diversity of demand. A specialist can, with justification, claim professional ignorance outside their speciality; a GP has no such luxury!

Vernon Needham,

Retired GP, Andover.
E-mail: vernonneedham@nhs.net

REFERENCES

1. Scott EJ, Dale J. Childhood bullying: implications for general practice. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687145. http://bjgp.org/content/66/651/504.
2. Baker M, Wessely S, Openshaw D. Not such friendly banter? GPs and psychiatrists against the systematic denigration of their specialties. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687169. http://bjgp.org/content/66/651/508.

DOI: 10.3399/bjgp16X688093

Colchicine in overdose

Would colleagues please be aware of the devastating consequences of a significant colchicine overdose, particularly when prescribing for patients with previous history of low mood. It is deadly; there is no antidote. Our recent emergency department governance meeting featured a case: the young patient died. Please also note its use as a remedy for 'pericarditis' is not currently supported by the *British National Formulary*.

Gavin Lloyd,

Consultant Emergency Physician and ED Patient Champion, Royal Devon & Exeter NHS Foundation Trust
E-mail: gavin.lloyd@nhs.net

REFERENCE

1. Sinnige J, Korevaar JC, van Lieshout J, *et al*. Medication management strategy for older people with polypharmacy in general practice: a qualitative study on prescribing behaviour in primary care. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685681. http://bjgp.org/content/66/649/e540.

DOI: 10.3399/bjgp16X688333

Child health training and the College

Although it is not in the College's gift to remove approval from training programmes, we do share the concerns expressed by Dr Sharvill in his letter.[1] The College is aware that general practice training is not long enough and that it is difficult to fit all of the necessary training experiences and placements into a 3-year envelope. The time spent in general practice has been extended from 12 to 18 months, which provides trainees with a greater opportunity to experience a full range of different clinical specialisms within the general practice context. We also regularly review our curriculum, and have enhanced child health in the MRCGP assessments.

In addition, we have published a joint position statement with the Royal College of Paediatrics and Child Health entitled *Learning Together to Improve Child Health*, which advocates the importance of interprofessional training.[2] We are also undertaking a joint survey of the number of training placements in paediatrics to better understand the scale of the problem and how it might best be addressed.

This is an issue of great importance to the College and we want to ensure that all GP trainees have access to the paediatric and child health training and experience that they need to be both competent and confident in this important area.

Kamila Hawthorne,

Vice Chair (Professional Development), Royal College of General Practitioners.
E-mail: kamila.hawthorne@rcgp.org.uk

REFERENCES

1. Sharvill NJ. Child health training: why does the College not act? [Letter]. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X685801. http://bjgp.org/content/66/648/350.1.
2. Royal College of General Practitioners, Royal College of Paediatrics and Child Health. *Learning together to improve child health*. London: RCPCH, 2016. www.rcpch.ac.uk/news/learning-together-improve-child-health (accessed 7 Nov 2016).

DOI: 10.3399/bjgp16X688105

Cruse Bereavement Care

I read with interest McDonnell and colleagues' article about dealing with parents bereaved by suicide,[1] and Hamilton's article in the same issue.[2] I wonder why GPs do not make better use of Cruse? Cruse Bereavement Care is a national charity that offers help to anyone who has been bereaved, including 'complicated bereavements' and 'complicated grief', such as by suicide or sudden traumatic death. The bereavement volunteers undergo intensive initial selection and training, and continue to have ongoing training and supervision, to a highly professional level. They can offer help to clients either one-to-one or in groups. The clients' evaluations show that they feel their mental and physical health improve as a result of this contact. Clients refer themselves, but are often advised by their GPs to do so: in our area half say they have been advised by their GP to contact us.

With the difficulties GPs are experiencing with such pressure on their time, and also the lack of confidence in dealing with these issues, it would seem logical for CCGs to be working with Cruse to provide the service the bereaved deserve and need.

Mary Davis,

Retired GP, Godalming; Chair, Southwest Surrey Cruse Bereavement Care.
E-mail: drmaryeld@aol.com

REFERENCES

1. Foggin E, McDonnell S, Cordingley L, *et al*. GPs' experiences of dealing with parents bereaved by suicide: a qualitative study. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X686605. http://bjgp.org/content/66/651/e737.
2. Hamilton IJ. Understanding grief and bereavement. *Br J Gen Pract* 2016; DOI: 10.3399/bjgp16X687325. http://bjgp.org/content/66/651/523.

DOI: 10.3399/bjgp16X688117