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Steroid treatment cards: patient safety remains at risk

The *British National Formulary* advises that all patients prescribed corticosteroids for more than 3 weeks are issued with a steroid treatment card that they carry on their person at all times.[1] An audit was carried out to determine if these guidelines are being met in patients receiving palliative care at Willow Wood Hospice. A similar survey carried out by Zeppetella in 1998, and published in a letter to this journal, revealed that 43% of patients referred to St Joseph's Hospice, London, did not have a steroid treatment card,[2] and I was interested to determine if practice had now improved.

Seventeen patients were included in my audit; all were prescribed corticosteroids orally, either dexamethasone or prednisolone, which they had been taking for over 3 weeks. Nine patients (53%) did have a card; eight (47%) did not. Out of those with a card, only two (22%) admitted to carrying it at all times.

Steroids are prescribed for many indications in palliative care, including the relief of non-specific symptoms, such as anorexia, fatigue, and cachexia syndrome.[3] However, their long-term usage is associated with serious side effects, such as Cushing's syndrome and an increased susceptibility to infection. Prolonged use may cause suppression of the hypothalamic-pituitary-adrenal axis resulting in adrenal insufficiency with risk of adrenal crisis, cardiovascular collapse, or even death in the event that steroids are stopped suddenly, including during anaesthesia.[4] The steroid treatment card acts as a reminder to patients about the potential side effects and dangers of abrupt cessation, as well as a warning to healthcare professionals about patients' medication status: ultimately it aims to ensure patient safety.

This audit demonstrated that the British National Formulary guidelines are not being met in 2010: almost 50% of patients did not have a steroid treatment card and of those with a card, few always carried it. These findings reflect those of Zeppetella's survey, suggesting that this may be a long-standing, widespread problem. Steroid treatment cards should be distributed to and carried by patients on long-term steroids: this issue needs to be recognised and steps taken to improve clinical practice in this area.

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Patients' perceptions of hypertension management: a concern for healthcare practitioners

Patients' attitudes towards medication have a major impact on disease management, but this is often neglected. A large body of literature has been published from developed nations on the evaluation of non-adherence in chronic disease management and in patients with hypertension in particular.[1–2] However, there is a paucity of data in the context of hypertensive patients' perspective from developing countries, to gather in-depth information towards hypertension management.

In the context of developing nations like Pakistan, health-seeking behaviour always occurs in the context of medical pluralism, where the patient uses different systems of healing. Patients make independent assessments regarding the use of modern medicines. Orthodox medications do not have such dominance over the population as seen in the western world.[3–4] In addition, indigenous healing systems, particularly hikmat (treatment with herbs) and spiritual healing, are quite prominent in these populations. There is no legal or official acknowledgment as far as the spiritual healing is concerned; but it is still the treatment of choice for the majority of the population. Insufficient information and understanding emerges as major barriers associated with all aspects of medicine use. Knowledge about the disease and drugs used for its treatment is apparently poor and in return produces a great impact on patients' adherence to medication. Another issue that lies ahead for health practitioners is that discussions of the advantages and disadvantages of drugs in ways that are relevant for individual patients is rarely seen in practice.

What is needed at this point is a complete revision of the practices that are currently being employed in the healthcare system. Individuals must be educated not only on the risk factors, presenting features, and complications of hypertension, but also about the benefits of medications on treatment outcomes and quality of life. Patients may need to be educated about the differences between curing hypertension and treating it with medications. Efforts to educate the public about lifestyle modifications in the prevention of hypertension and other cardiovascular diseases may also be of great importance. Advancement in

preventive and curative health responses needs to be reconsidered. Development of immediate health strategies, policies, and interventions are the most important of the present day and this development has to move ahead from promises to practices. The gap between healthcare professionals and the patients must be narrowed if optimal results are to be achieved. This may result in the change of perception and the development of trust in medication that will lead to ideal pharmaceutical care.

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Revalidation

In the double speak of Big Brother, Mike Pringle and Steve Field hold the banner of revalidation like Custer at the last stand.

David Edgcumbe has clarified what most hardworking conscientious GPs have known for years. When it comes to revalidation there is little support from College Members and fewer from outside the College.[1] I raised this at Council 2 years ago, but College Council packed with GPs who do not feel the heat of wall-to-wall consultations have no realisation that the Emperor has no clothes.

Quality general practice has no room for performing like a circus clown every 5 years. Despite all the platitudes that it is about professional development, it is about measuring what we cannot measure and removing GPs who do not tick the boxes.

As a UK GP abroad, I see the barriers being erected to prevent UK GPs returning from New Zealand or Australia which will cement the loss of UK doctors. To require GPs, who in my experience are more competent than those in the UK, to jump these hurdles will ensure that they stay abroad.

Let us vote and see if the Emperor really does have clothes.

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New competencies ignored: general practice is in danger in Italy

As The European Academy of Teachers in General Practice and Family Medicine specifies, GP trainees have to be trained in the specific competencies this profession requires. These competencies have been defined on the grounds of the traditional expectations of GPs but are in need of evaluation, revision, and directed development for the immediate future of general practice.

According to Nigel de KareSilver,[1] there are a range of new competencies that require the advocacy of general practice within the medical profession: leadership, representation in society, academic and journalistic writing, teaching of students, trainees, and doctors from other specialties, advising professional bodies, both governmental and scientific, and research.

Currently, in Italy very little is taken in to account of this new skill set when recruiting or training graduates, nor at the undergraduate level where we are only at the first step in creating courses with a core general practice curriculum in a few centres in Milan and Rome. Some big and underfunded changes are on the horizon in the reorganisation of delivery of health care. These would strongly impact on the social role of the GP.[2]

Established GPs are extremely frustrated at being pulled and pushed by politicians and technologists with big and unrealistic decisions in the form of diktat.

In Italy there is a serious danger that GPs, so nationally divided with no effective lobby, would be 'changed' into a new breed of clinician, little more than bureaucratic officers or clerks, becoming a new group in which the holistic relational core competencies will be lost before new ones are learned and applied.[3] In Italy there is no flexible scheme to provide protected time for teaching, research, or leadership. As a consequence, social needs will receive little consideration and GPs will perform only low-level duties, be subservient to local health politicians, and eventually progressively escape from family medicine, resulting in falling GP numbers from the loss of established doctors through retirement that will not be replaced due to the falling number of GP trainees.

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