

insurance is currently curtailed due to major national, even international, financial crises.

The introduction of a co-payment system would simply maximise inequity, burdening especially those who already pay as a proportion of their income, the most for their health care, often for the management of chronic conditions. Raising co-payments in proportion with people's income (in three or more levels) could be a sensible choice, but there is the risk that many 'rich' and also 'not-so-rich' people will not use the NHS, choosing instead some 'low cost' (that is almost the same of co-payment or little more) private poli-specialistic services, as the ones now growing in Italy.

Francesco Carelli,

Professor of Family Medicine, EURACT
Council Director of Communications.
E-mail: carfra@tin.it

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Substance misuse of gabapentin

Neuropathic pain affects up to 8% of the population,¹ causing significant distress and morbidity. Good evidence-based treatment is available,² so early diagnosis is important. Recent publicity and guidelines, and increasing prevalences of age-related causes of neuropathic pain (including postherpetic neuralgia and diabetic neuropathy), have led to increasing rates of diagnosis and treatment in primary care. Gabapentin is one of the recommended mainstays of evidence-based treatment.³

Unfortunately, our clinical experience suggests that gabapentin is now prevalent as a drug of abuse. The drug's effects vary with the user, dosage, past experience, psychiatric history, and expectations. Individuals describe varying experiences with gabapentin abuse, including: euphoria, improved sociability, a marijuana-like 'high', relaxation, and sense of calm, although not all reports are positive (for example, 'zombie-like' effects). In primary care, an increasing number and urgency of prescription requests cannot necessarily be explained by the increased number of cases of neuropathic pain. In the substance

misuse service, the numbers admitting to using gabapentin (local street name: 'gabbies', approx £1 per 300 mg) are also growing.

Prescribing data from the Tayside region of Scotland show a rise in the number of patients receiving gabapentin, and an exponential rise in the total number of prescriptions issued, particularly since it was licenced for postherpetic neuralgia in 2002 (Figure). In the substance misuse services in Tayside in 2009, we found that of those who had been attending for at least 4 years ($n=251$), 5.2% were currently receiving gabapentin on prescription, with a mean dose of 1343 mg, and were >3 times more likely to admit to non-medical use of analgesics ($P=0.006$). Meanwhile, of 1400 postmortem examinations in Central, Tayside, and Fife regions of Scotland in 2011, 48 included gabapentin in their toxicology report, with 36 also including morphine and/or methadone, indicating recent possible opioid dependence. Gabapentin is easily prescribed without restriction, and escalating doses are recommended.^{3,4} It is therefore easy to facilitate any misuse and addiction potential, and to stock the black market. A recent police report indicates the increasing tendency to use gabapentin as a 'cutting agent' in street heroin (and to recover gabapentin on the street and in prisons),

further adding to the abuse and danger potential.⁵ Like opiates, gabapentin is fatal in overdose; unlike opiates, there is no antidote and the long half-life instils the need for prolonged, intensive management of overdose.

The epidemiology of gabapentin misuse needs further detailed and urgent assessment, including cross-linking data from Police, NHS, and other sources. We should consider introducing routine gabapentin testing in urine drug screens. This will inform clinical and political approaches to this possible new and dangerous type of substance misuse, as well as safe management of the distress caused by neuropathic pain.

Blair H Smith,

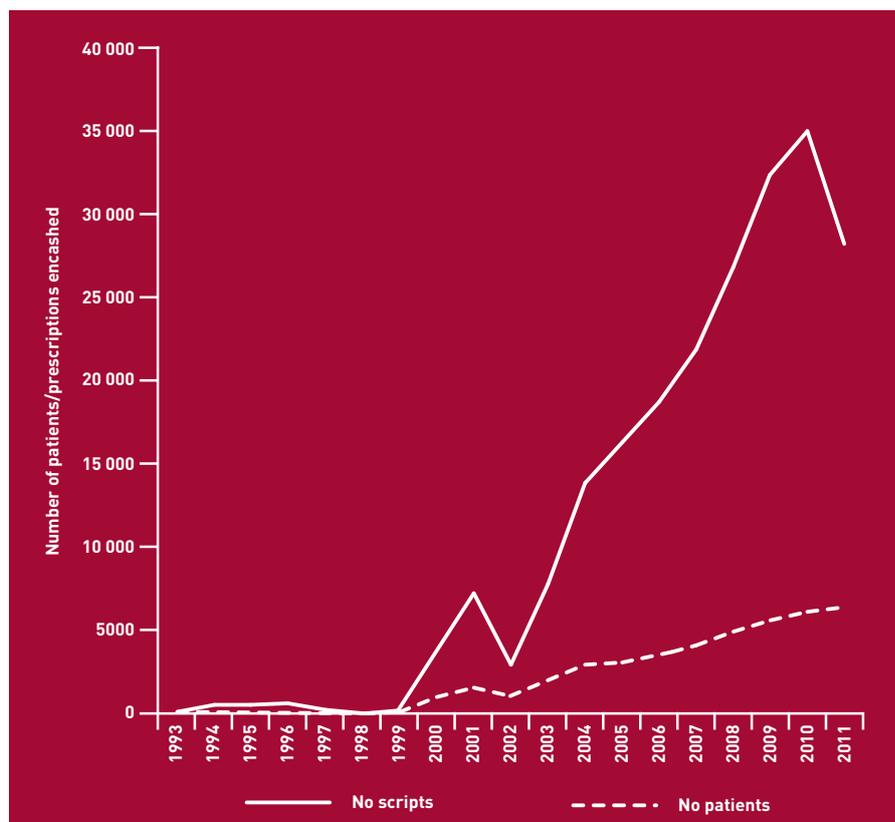
Professor of Population Science, University of Dundee; GP, Peterhead Medical Practice, Aberdeenshire.
E-mail: b.z.smith@dundee.ac.uk

Cassie Higgins,

Research Fellow, Department of Psychiatry, University of Dundee.

Alex Baldacchino,

Senior Lecturer in Psychiatry, University of



Dundee; Consultant Psychiatrist, Fife NHS Addiction Services.

Brian Kidd,

Senior Lecturer in Psychiatry, University of Dundee; Consultant Psychiatrist, Substance Misuse Service, NHS Tayside.

Jonathan Bannister,

Senior Lecturer in Anaesthetics, University of Dundee; Consultant Pain Specialist, Pain Clinic, Ninewells Hospital, Dundee.

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The GP's role in improving the uptake of healthy start vitamins

We were interested to read the editorial by Saxena *et al.*¹ We agree that GPs are in an ideal position to support expectant mothers through their pregnancy and the postnatal period. An important aspect of any GP's role is of course health promotion and recently efforts have been made by local health authorities to encourage expectant mothers to consider vitamin D supplementation.

Symptomatic cases of vitamin D deficiency are on the rise in the UK and are especially common in young children from a South Asian, Middle Eastern, or African background. The Healthy Start programme

entitles all pregnant women, new mothers, and young children from low income families to receive vouchers that can be exchanged for free vitamins. It is often believed that cultural, social, or language differences may explain the poor uptake of vitamin D supplementation in the above communities.

Between February–March 2012, we distributed a questionnaire to all mothers attending a health visitor clinic at a general practice in Glasgow to identify whether mothers with an adequate knowledge of English were aware of the Healthy Start programme and whether they administered vitamin supplements to their children. Out of 37 mothers approached, 34(92%) questionnaires were returned. Most mothers ($n=33$, 97%) were of white, Scottish ethnic origin with English as their native language. The median age of the infant attending the clinic was 4 months (range 1–4). During the pregnancy, none of the mothers took Healthy Start vitamins, despite being eligible in terms of family income. Ten mothers (29%) paid for over-the-counter vitamins for pregnancy. Only three mothers (8%) could recall receiving written information about vitamin supplementation in infants and eight mothers (24%) recalled receiving verbal information. Of the 14 infants who were eligible for Healthy Start vitamins, four (29%) were taking vitamin supplements and only one of these was taking Healthy Start vitamins.

This audit highlights that there is poor uptake of the Healthy Start programme, even in groups whose native language is English. It is clear that new mothers are not sufficiently well informed of the availability of vitamin D supplementation during pregnancy and infancy. By improving awareness of vitamin supplementation, GPs could make a clear difference to the health of the mother and the young child.

Angela Lucas-Herald,

FY2 in Paediatrics, Department of Child Health, Royal Hospital for Sick Children, Dalnair Street, Glasgow.
E-mail: angelalhi@doctors.org.uk

Katherine Grosset,

GP, Cairns Practice, Old Shettleston Road, Glasgow.

Morag Robertson,

Health Visitor, Cairns Practice, Old Shettleston Road, Glasgow.

Syed Faisal Ahmed,

Professor, Paediatric Endocrinology Consultant, Department of Child Health, Royal Hospital for Sick Children, Dalnair Street, Glasgow.

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Whose compass for morality?

The world is full of contradiction, and so it is among the pages of the *BJGP*! Take the article from Andrew Moscrop on clinical leadership¹ and set it alongside the paper from Andrew Lee *et al* on commissioning.² Both impact directly on the need for a moral compass in clinical commissioning. Lee *et al* have no doubts about their morality. For them (as with NICE) utilitarianism is the moral philosophy to apply in clinical commissioning: 'the greatest benefit for the greatest number', but without specifying what constitutes 'benefit'. At least Bentham (founder of utilitarianism) was more specific with 'happiness' as the magnetic North of the moral compass. If only life were so simple! In what reads like special pleading on behalf of public health specialists Lee *et al* argue both for the pre-eminence of population over the individual and, curiously, the balancing of competing voices. In contrast, Moscrop embraces complexity in his impassioned plea for a 'moral compass' in leadership. He makes a strong case for the central role of values but advocates 'uncovering and perhaps challenging well-established assumptions, behaviours, values, and beliefs' (perhaps including utilitarianism?). Crucially, he proposes a 'shared morality' though he leaves this idea hanging in the air.

I suggest Moscrop's argument could be developed using the notion of distributed leadership originating from education.³ Here both the determination of what is good and the bearing of responsibility are shared among a wide community of stakeholders, though accountability usually remains with a designated leader. The moral compass consists in a few high-order shared values pertaining to what it takes for humans and the environment to flourish. This is best