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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.

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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

understood through the conceptual framework of complexity science³ which tells us that what is crucial is the coherence of the community of stakeholders in terms of these high-order values as 'rules' for action. That is where our efforts should be focused.

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A new approach to patients with lower urinary tract symptoms

In their otherwise excellent editorial on lower urinary tract symptoms (LUTS), Blanker *et al* made two surprising assertions.¹ They recommend rectal examination, especially when patients fear prostate cancer, but state that its objective value is limited. I presume they mean by this that rectal examination is poor at discriminating between benign and malignant prostatic disease. I agree.

Therefore, to follow this by saying rectal examination will often meet the expectation of the patients, and (if negative) patients can be reassured that prostate cancer is not the cause of their symptoms, but one cannot state categorically that such patients do not have cancer. This sounds rather doubtful medicine; reassuring patients on an imperfect test, when there is a superior one: the prostate specific antigen (PSA).

Blanker *et al* reject the use of PSA in patients with LUTS by equating it with screening. This is an error; screening is systematic investigation of asymptomatic individuals, not investigation of symptomatic

patients. The difference between these populations is twofold.

First, the prevalence of disease is almost certainly higher in the symptomatic population than the asymptomatic one. Most LUTS have positive predictive values for prostate cancer of around 3%, whereas the yield of cancers in asymptomatic screening is lower.² Second, if treatment is being considered, it is likely to be different for a malignant as opposed to a benign prostate.

I wholly agree with the authors that we must inform patients about the pros and cons of PSA testing when they present with LUTS, but we must be careful to use the right information in doing so. I have no desire to have my PSA done while I'm asymptomatic, but may well ask for it once symptoms are bad enough to see my doctor about them.

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Telling the truth: why disclosure matters in chronic kidney disease

Abdi *et al*'s editorial¹ raises some important issues. Many patients with chronic kidney disease (CKD) are asymptomatic, but this differs from say, hypertension, in that end-organ damage has already occurred. Once disclosure has been made to a patient, as it should be, most would need to be guided through a risk assessment by their GP. The apposite appearance, in the same issue, of a paper on communicating risk to patients² highlights the potential difficulties of this. It is problematic with the familiar, such as cardiovascular disease (CVD), and I suspect many GPs would find the process even more complex with CKD. The highlighted

statement caught my eye, that 'Patients should be educated on preventative strategies, including ... temporary cessation of medications such as renin-angiotensin blocking agents during periods of acute illness'.¹ I was reminded of an incident with a patient of mine, many years ago, when angiotensin converting enzyme (ACE) inhibitors were in their infancy in general practice. He had been prescribed an ACE inhibitor for congestive cardiac failure by his cardiologist. His renal picture fulfilled the criteria for referral to a nephrologist, confirmed at a lecture that I had recently attended. On my recommendation, my patient agreed to the referral. He was shortly after admitted to hospital with acute congestive cardiac failure, following the summary cessation of his ACE inhibitor by the nephrologist. His ACE inhibitor was restarted to beneficial effect, but he never quite regained his previous level of wellbeing. I was copied in to the subsequent animated correspondence between hospital specialists. It was my introduction to clinical compartmentalisation.

Given that CKD is a known risk factor for CVD, each GP is likely to have a number of patients who would be within the remit of this recommendation. Clearly, my anecdote does not give an evidential basis to a contrary argument, but does raise a clinical concern. I was surprised, therefore, to find that the recommendation was not supported by references. I would need more than just an authoritative statement to change my clinical practice. Is this merely an accidental error of omission, or is it a case of Dawkins' triad and we are in at the beginning of a new tradition?³

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