for prescribers in prisons in drug-using patients. These include mirtazapine, clonazepam, tramadol, and gabapentin, as well as other opioids and benzodiazepines. RCGP SEG calls on community prescribers to be cautious in prescribing these medicines in patients who have a history of addiction problems. RCGP SEG calls for research into the prescribing of pregabalin in prisons and in the community, with particular consideration to age differentials, addiction histories, and the indication for the prescription.

Unexplained deaths in custody are an important issue. RCGP SEG calls for detailed toxicology reporting in such cases as well as full consideration by coroners of all prescribed and non-prescribed drugs in these tragic cases.

Marcus Bicknell,
Chair of RCGP's Secure Environments Group.
E-mail: marcus.bicknell@gp-c84704.nhs.uk
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Use of PHQ-9 scores to guide treatment decisions in primary care

Shaw and colleagues stated no changes in depression management were seen in studies they reviewed of using patient health questionnaire (PHQ-9) scores to guide primary care treatment.1 This statement is an inaccurate reflection of the literature they reviewed and cannot go unchallenged.

The observational study conducted in Southampton practices, in the year following the introduction of the DEP3 QOF indicator rewarding the use of symptom questionnaires at follow-up of depressed patients between 5 and 12 weeks, showed that follow-up scores appeared to influence decisions to change treatment significantly.2 After controlling for confounders, patients who showed an inadequate response in questionnaire-score change at follow-up were nearly five times more likely to experience a subsequent change in treatment, compared to those with an adequate response (odds ratio 4.72, 95% CI = 2.83 to 7.86).3

Shaw and colleagues downplayed the evidence of the quasi-randomised trial from the US which found that feeding back

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PHQ-9 scores to primary care physicians at diagnosis and follow-up led to significantly increased rates of remission and response, clearly showing benefit to patients. They failed to point out that changes in management in the intervention arm of the trial were actually more numerous too. More patients received antidepressant treatment at baseline, and antidepressant regimen changes over the following 6 months among partial or non-responders might have been expected if feedback of PHQ-9 scores was influencing treatment, suggesting the trial was under-powered to detect small but clinically significant differences in care in those cases where treatment changes were indicated.

Research in specialist practice, specifically excluded from Shaw and colleagues’ review, has even more convincingly demonstrated the benefits of monitoring depression treatment with symptom questionnaires. Systematic reviews and meta-analyses in specialist psychological and psychiatric care have shown that outcomes can be improved with an effect size of between 0.1–0.3 standard deviations, being most beneficial in those cases where treatment changes were indicated. Although these differences in treatment changes were not statistically significant, they were all in the direction expected if feedback of PHQ-9 scores was influencing treatment, suggesting the trial was under-powered to detect small but clinically significant differences in care in those cases where treatment changes were indicated.

In the September 2012 article: Sheron N, Moore M, Ansett S, et al. Developing a ‘traffic light’ test with potential for rational early diagnosis of liver fibrosis and cirrhosis in the community. Br J Gen Pract 2012; DOI: 10.3399/bjgp12X649151, the algorithm “predicted probability (p) = exp(HA * 0.015 + P3NP * 0.447 + (PLT * -0.005) – 0.661)" should have stated “predicted probability (p) = exp(HA * 0.015 + P3NP * 0.447 + (PLT * -0.005) – 0.661)" should have stated “predicted probability (p) = exp(HA * 0.015 + P3NP * 0.447 + (PLT * -0.005) – 0.661)"

Correction

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I’m a GP in Hawick, and was a colleague and friend of Dr Pat Manson, GP trainer of 23 young doctors, who tragically died last April. I have thought for some time that it would be useful and valuable to produce a little book of poetry for new doctors at the beginning of their emotionally demanding work. It would fit easily into their pockets and be a source of comfort and support. When they are often at risk of being overwhelmed by the vast amount of protocols and clinical data, this little book would serve to nourish their humanity.

I had discussed this idea with Pat and, as was his way, he was positive and encouraging about it. He was creative and loved poetry. He was passionate about teaching and motivating young doctors and he cared deeply about his patients but, as his BMJ obituary said, The wellbeing and care of his patients was the cornerstone of his professional life and he gave his time unstintingly, often to his own personal detriment ... Ultimately he was overwhelmed by his own exacting standards and sadly took his own life.

When he died, Lesley, Pat’s widow, and I felt that the booklet would be a fitting tribute to him and I approached the Scottish Poetry Library. They are keen to help produce it and we hope to give it to every new Scottish graduate this and next year. As a charity, they are contributing their experience and knowledge of poetry. Estimated production costs are £5000 for 1 year’s graduates and £8000 for 2 years.

Would you like to be part of his project and help produce a poetry booklet dedicated to Pat and to the work that he loved and which he did so very kindly and well?

You can donate via this justgiving site: http://www.justgiving.com/Scottish-Poetry-Library-Poetry-for-New-Doctors, or by sending a cheque payable to Scottish Poetry Library: Poetry for New Doctors, 5 Crichton’s Close, Canongate, Edinburgh, EH8 8DT.

Lesley Morrison, E-mail: leslie@ljmorrison.fsnet.co.uk

DOI: 10.3399/bjgp13X670633

Poetry for new doctors: in memory of Dr Pat Manson

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