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Vitamin D testing: three important issues

In Liverpool we are auditing vitamin D testing and prescribing in primary care, following guidelines issued to GPs in early 2012 to encourage evidenced based testing and prescribing.¹ Our data indicates that some GPs are testing in an increasingly non-targeted way. GPs in Liverpool ordered over £100 000 worth of vitamin D tests in 2012, over 10 times the amount spent in 2007. Though more people were identified as deficient, the proportion of deficient results identified decreased significantly. We feel guidance from NICE is needed for detection and treatment of vitamin D deficiency in primary care.

We also feel it is high time for universal vitamin D supplementation of pregnant and postnatal women and young children as recommended by Chief Medical Officers.² With our increasingly diverse population in the UK we are very aware that currently some groups are missing out on prevention, and Healthy Start vitamin uptake is very low. In Liverpool we are rolling out universal supplementation out this spring. This should lead to a decrease in vitamin D deficiency, decrease in rickets and decrease in need for testing and high dose prescribing.

Thirdly and very importantly the authors wonder why the use of licensed preparations is so low in primary care. This is because there are no high-dose licensed preparations available for us to prescribe. I have been working with vitamin D deficient patients for the past 10 years. My experience, as well as that of GP colleagues up and down the country, is that compliance is a big problem with low dose preparations particularly in certain population groups at risk of deficiency. Liverpool has a substantial Somali population with deficiency identified in around 80% of individuals.³ Our experience is that to ensure compliance with treatment in our Somali population we need to give a high loading dose of vitamin D over a short period of time. There is also no high-dose licensed liquid preparation for children. I note the authors appear to have had some connections with various pharmaceutical companies involved in vitamin D manufacture. It would be excellent to see

some high dose preparations licensed for use in the UK.

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DOI: 10.3399/bjgp14X677400

Proceed with caution: authors' response

In the December issue Iliffe¹ assured us that our article 'anticipatory care of older patients represented the triumph of hope over experience'.² We find this a bewildering claim in view of the extensive research evidence to the contrary. No less than six controlled trials between 1979 and 1993 showed that a programme of care, tailored to the special needs of those in advanced old age, reduced the time spent in institutional care (hospitals and nursing homes). They are referenced in our book.³ In addition Beswick in 2008, a much more recent meta-analysis than that cited by Iliffe,⁴ has made a thorough appraisal of nearly all the research work done in this field. From 89 studies he showed that interventions reduced the risk of not living at home, of nursing-home and hospital admissions and falls. However death rates were not reduced.

Iliffe completely ignores these objectives in pursuit of his opposing views which may not be comparing like with like and he appears to be suggesting that our claims were exaggerated. In fact our claims are exceedingly modest but very important to vulnerable old people. The object of our proposed anticipatory care models is to target vulnerable and frail subjects. They are then offered more time, care and support from the primary care team and trained volunteers. The aim is to enable them to enjoy the best life possible in each case and to remain active and independent for longer. We think the best measure of improved outcomes is the reduced time spent in institutional care and hospital as bed days. Iliffe admits that there is research evidence in support here, together with improved patient morale and (in some papers) reduced mortality. However his negative view of preventive care of vulnerable older patients defies the main body of research findings. They are also overturned by the findings of a recent Care Quality Commission Survey. On 21 November they reported⁵ that, in the past year, no less than 530 000 people aged ≥65 years required an emergency admission to hospital for conditions which were preventable. Had the GPs involved run an anticipatory care programme the saving to the Exchequer would have been great. Without appropriate action by government, the RCGP and other medical, social and voluntary organisations, there remains a major cause for concern for the welfare of frail older people within the UK.

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DOI: 10.3399/bjgp14X677419

We need another word for 'chronic'

Is it time to stop using the word 'chronic' and talking about chronic disease? The *BJGP* in December has the reference to chronic in the title of four of its articles.^{1–4} Language changes with time and with usage. For example, the phrase 'terminal care' has made a transition to the more positive-sounding 'palliative care', not least because we are far more open in our discussions with patients than we were a generation or two ago and need to be sensitive to their interpretation of our terminology. Similarly, doctors may understand the term chronic in its primary dictionary sense of 'persisting for a long time or constantly recurring' and so may the some of the public.⁵ But others are more likely to hear its secondary, informal meaning 'of a very poor quality' and be offended, frightened, or bemused by this label being attached to their disease or, worse still, to their general health?

As we revise our curriculum at Nottingham we hope to incorporate further student experience that is community based with patients who have single morbidity or multiple comorbidities. Our debate is not over the urgent need for such education with population demographics changing to an increasingly older population, but what we call it, rather than chronic disease. Could it be: long-term conditions; integration of care in complex disease; integrated care; managing complex conditions; community-based disease; advanced primary care; living with long-term illness, or another new entity? Whatever term is adopted, it should be more optimistic and evolve from a discussion between disciplines and with patient participation groups.

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DOI: 10.3399/bjgp14X677428

Primary care patients' reasons for choosing emergency department services in Jordan

Over-use of emergency departments (EDs) by patients with primary care problems is a matter of concern. I studied patients and carers of children attending the family medicine clinics in the ED of Al-Bashir Hospital in Amman, Jordan¹ from May to July 2011, during office hours (Sunday to Thursday, 8:00–16:00) to determine their main reason for choosing this service rather than a GP or medical centre.

A total of 1310 patients attended: 747 (57%) were adults, 563 (43%) were children accompanied by carers and 778 (59%) were female and 532 (41%) male. Reasons for attending were: 374 (29%) self-assessed urgency, 301 (23%) convenience (accessible and less waiting time), 231 (18%) self-assessed seriousness, 143 (11%) took treatment but still not well, 122 (9%) referred from other facilities, 97 (7%) needed a second opinion, and 42 (3%) were related to sick leave.

Siminski *et al*'s survey in Australia² suggested three important reasons: urgency, being able to see the doctor and have tests or X-rays done in the same place, and the seriousness or complexity of the health problem.¹ The EMPATH study in the US³ identified five factors characterising patient's principal reasons for seeking ED care, with medical necessity the most frequent,

followed by ED preference, convenience, affordability, and limitations of insurance.

There is an important distinction between clinically-assessed triage categories and self-assessed urgency and complexity. Patients can only be expected to act on their own judgement.² Use of the ED is for most people an affirmative choice over other providers, rather than a last resort, and it is often a choice driven by lack of access or dissatisfaction with other providers.³

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DOI: 10.3399/bjgp14X677437

Self management: what happens to people with long-term conditions in between NHS appointments?

The NHS is grasping the nettle of activity promoting self-management as part of the long-term conditions (LTC) QIPP programme, but clinicians are slow to engage and consultations with individual patients are often few and far between. Is this really going to be enough to keep patients motivated to self-manage their condition? Less discussed, and even less understood is the role of voluntary and community organisations in promoting self-management. Organisations based in the community are well placed to engage, support, signpost and deliver activities to increase self-care, self-management, and levels of activation for people with LTCs.

The Think Ahead: Stroke Information Service in Wigan has developed a Self-