well as a better understanding of relationship dynamics as a result.

Despite some health visitors being recently relocated away from GP practices, safeguarding models must include them. This will have to involve general practice championing their cause and testifying to the value they bring, rather than quietly becoming resigned to the fact that they are not around as much as they used to be and subsequently re-writing models of care without their input.

I believe that children will benefit as a result.

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Authors' response

We agree with Dr Meldrum about the critical role of health visitors and his helpful suggestion of using the phrase 'best practice models of primary care safeguarding' to move forward in this area.

Qualitative research with professionals consistently highlights that health visitors are necessary for bringing wider information to GPs, for following-up GP concerns with a home visit and for acting as a conduit of information between children's social care and GPs; see for example our study of GPs, health visitors, and practice nurses in England.[1]

With reduced co-location, one way of bringing together GPs and health visitors for child safeguarding is to have regular meetings to discuss families who have been identified as vulnerable or who raise child protection concerns. These meetings are recommended by the RCGP in their Child Safeguarding Toolkit.[2] However, there is little guidance about how they should best be implemented and there remain many unanswered questions, such as: who should attend? Should social care or education colleagues be invited? How often should meetings take place? Who should be discussed and for what purpose? Who should follow up on the meetings and how? How can the meetings be funded and/or attendance incentivised? Do these meetings help support better child safeguarding practice in primary care, and, crucially, make things better for children and families?

These meetings are of great interest to us and our preliminary research suggests that the potential of the meetings is not yet being realised even when they take place.[3] This is an area of practice that we wish to develop through good-quality evaluative research and in conjunction with primary care teams.

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Response to 'Burnt out or fired up' and 'The Tao of family medicine'

In what is perhaps an example of Jung's 'wounded healer', Alastair Dobbin in his excellent article 'Burnt out or fired up' shows the two-way nature of this relationship.[1] As Gautama Buddha recognised, being a doctor hopefully leads to a deeper understanding of the human condition and, ultimately, leads to the healing of the physician as well as the patient.

Nigel Mathers in his James Mackenzie Lecture 2013 emphasises the importance of the intuitive side of general practice, of experiencing a sense of 'flow', to 'be' rather than 'do'.[2]

But I find that when I have to keep one eye on the patient (who may have four or five pressing problems), one eye on the computer (which has a long list exhorting us to focus on the minutiae irrelevant to the consultation), and possibly my intuitive 'third eye' on the clock, the sense of 'flow' is more akin to being swept along on a raging torrent, trying desperately to prevent oneself being dashed against the rocks.

And it's very hard to 'be' when one is being given increasingly bizarre things to 'do' (unplanned Admissions DES, anyone?), which leaves us no time to 'be' anything at all, with our patients, staff, or even families.

To continue the Eastern theme of these two articles I quote Swami Vivekananda who said, '*it is an insult to a starving man to teach him metaphysics*'.

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Antipsychotics and osteoporosis: current awareness and practice in primary care

As part of health surveillance in mental illness, GPs are increasingly being asked to check prolactin on those taking antipsychotics. Risperidone, amisulpride, and older antipsychotics raise prolactin and this in turn is a cause of osteoporosis.[1,2] The level of awareness and current practice of antipsychotic-induced hyperprolactinaemia in primary care is unknown.

To find answers 28 GP practices were surveyed. In the first survey (13 practices, 59 GPs) we asked, *'Are you aware of any guidelines around the management of hyperprolactinaemia?'* Nineteen (32%) responded and all said no. Most would seek specialist advice and were unaware of its management. In the second survey (15 practices, 54 GPs) we asked, *'Have you been aware of any associations between hyperprolactinaemia and osteoporosis?'* Fifteen (28%) responded and three (20%) were aware.

Neither the National Institute for Health and Care Excellence nor the Royal College of Psychiatrists have published guidelines. There are very few local guidelines but the Maudsley recommendations are widely recognised within secondary care.[3,4] High prolactin is a known cause of premature osteoporosis and high prolactin is common on antipsychotics. Men are probably at risk as much as women are since prolactin is an independent factor.[5] These health risks are clearly important but there is confusion as to who should oversee its surveillance and management. With the ever-increasing demands on primary care there is a view that management of high prolactin from antipsychotics falls outside their remit. Local or national guidelines would at least make it less threatening. As it stands, prolactin monitoring has been done in primary care when asked but its management is seen as a secondary care responsibility. All parties should cooperate to address this gap in health care since a significant proportion of young people with mental illness will generate health and financial burdens of premature osteoporosis.

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IPCR research: any offers?

Some years ago I developed a system that I found to be a most useful consultation tool: