Primary care is the cornerstone of our NHS

There is discriminatory bias against general practice within UK medical schools.1,2

The public purse pays to train doctors to provide an effective and comprehensive NHS. Medical school deans receive substantial remuneration and run the most expensive and prestigious university faculties. They are implicitly tasked with training people to provide a service that deals with a million people every 36 hours and that cares for their own personal feelings and opinions.3,4 But fundamental questions remain unanswered and seemingly unexplored. Where does this denigration occur: at medical school or in hospital trusts, or even in general practice itself? Who is responsible for the denigration: consultants, junior doctors, or our healthcare professional colleagues? Why does it occur: is it harmless banter to relieve the stress of the work or is it deeply ingrained prejudice based on a lack of awareness of the GP profession? At what stage does it occur: as medical students, as foundational doctors, at the specialty or GP trainee level? And, most crucially of all, does the ‘banter’ influence the eventual career choice of potential GPs at the trainee stage, student stage, or even the pre-student stage?5

The time has come to end the bashing (Badmouthing, Attitudes, and Stigmatisation in Healthcare). Urgent research exploring the phenomenon and strategies to confront it must be invested in. Primary care is foundational to the NHS, and at the same time as billions of pounds are spent on investing in general practice, we surely need to invest in preventing one of the potential causes of its demise.

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**Bullying and banter**

I couldn’t help noticing the possibly unfortunate juxtaposition of these two editorials in your latest issue. While accepting that both childhood bullying and derogatory banter regarding general practice and psychiatry (the latter having existed for generations) are unacceptable, I can only guess the response from some of the more ‘aggressive’ secondary care specialties to these concurrent calls to right wrongs. In either circumstance, only strength from the aggrieved will be respected: victimhood will not win the day!

In respect of childhood bullying, any GP will of course respond appropriately to patient distress, but to make an expectation of GPs on this subject broadens their remit, yet further increases demands on them, and sets them up to fail; not what is needed in the current environment of low morale.

In respect of our secondary care colleagues’ ‘banter’, an invitation to spend 2–3 days of annual study leave shadowing a GP trainer in their practice should do the trick! A consultant gynaecological oncologist advised me some years ago that he was in awe of how GPs manage such diversity of demand. A specialist can, with justification, claim professional ignorance outside their specialty; a GP has no such luxury!

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**Colchicine in overdose**

Would colleagues please be aware of the devastating consequences of a significant colchicine overdose, particularly when prescribing for patients with previous history of low mood. It is deadly; there is no antidote. Our recent emergency department governance meeting featured a case: the young patient died. Please also note its use as a remedy for ‘pericarditis’ is not currently supported by the British National Formulary.

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**Cruse Bereavement Care**

I read with interest McDonnell and colleagues’ article about dealing with parents bereaved by suicide,1 and Hamilton’s article in the same issue.2 I wonder why GPs do not make better use of Cruse? Cruse Bereavement Care is a national charity that offers help to anyone who has been bereaved, including ‘complicated bereavements’ and ‘complicated grief’, such as by suicide or sudden traumatic death. The bereavement volunteers undergo intensive initial selection and training, and continue to have ongoing training and supervision, to a highly professional level. They can offer help to clients either one-to-one or in groups. The clients’ evaluations show that they feel their mental and physical health improve as a result of this contact. Clients refer themselves, but are often advised by their GPs to do so; in our area half say they have been advised by their GP to contact us.

With the difficulties GPs are experiencing with such pressure on their time, and also the lack of confidence in dealing with these issues, it would seem logical for CCGs to be working with Cruse to provide the service the bereaved deserve and need.

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