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Multidisciplinary care

'Mate I'm getting seriously black poo – definitely getting my iron intake, lol!'

I received the above text message from a friend and, unsurprisingly, it raised a few alarm bells. And not just because a grown man had written 'lol' in a text message.

'I spoke to the pharmacist, he said nothing to worry about, it's all the vitamins I'm taking.'

And herein lies my concerns about the ways in which GP work is increasingly being shifted to other healthcare professionals.¹

In the case of my friend, although I'm not his doctor, I know his medical history well. I knew he suffers from indigestion. I knew he recently had a tooth removed. I knew he likes a few beers after football and that he smokes five cigarettes a day.

It emerged he had been taking high doses of ibuprofen to control his toothache. The multivitamin he was taking contained just 14 mg of iron. He went straight to A&E, and by the following morning had been diagnosed with a gastric ulcer. Thankfully, he is now on the road to recovery.

This is in no way meant to be disparaging towards pharmacists, colleagues whom I respect immensely. But it does concern me. The RCGP's *The 2022 GP* talks about working in federated organisations, with patients receiving routine care from a variety of healthcare professions.² But who will take overall responsibility for patients' care?

I fear that in our need to alleviate pressure, we run the risk of going too far in asking other professionals to take on some of our duties. With this we not only lose part of what makes our job the one we chose, but also risk doing our patients harm.

As GPs we have a unique and privileged role. We get to know our patients well. We take on all aspects of their clinical care, and have the breadth of training to enable us to do so, safely and effectively. Although multidisciplinary teams are no doubt effective, we must remember to ensure that someone is looking at the wider picture.

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Bad Medicine: Defensiveness

Dr Spence makes some very pertinent points about our current NHS.¹ There are long waits for GP appointments, for referrals, for scans, for test results. He suggests less prescribing, fewer referrals, fewer investigations. As a patient who has sustained brain damage due to benzodiazepine withdrawal after 40 years' consumption, I am deeply dismayed by my recent experience of the NHS. I have suffered beyond imagination for 4 years, tortured by my brain and body, and am physically and cognitively disabled as a consequence. My doctors seem totally incapable of grasping the extent of my suffering; instead, they translate my symptoms into something more palatable. I have been given several misleading and inaccurate diagnoses. This has now become a deliberate defensive strategy. I am compelled to seek further opinions, thereby wasting further NHS resources. I am part of a large and growing online community populated by the many other patients harmed by mind-altering prescription drugs, mainly benzodiazepines and antidepressants. We share our similar experiences of being dismissed by our doctors, misdiagnosed, and referred inappropriately.

We are shocked as the prescribing of antidepressants increases year on year despite mounting evidence of their lack of effectiveness and the possibilities of significant harm, including permanent damage to the central nervous system. We discuss the ways our withdrawal symptoms are dismissed as signs of mental illness and how we are misdiagnosed with a variety of diagnostic labels such as

depression, anxiety, CFS/ME, neurological functional impairment, somatic disorders, and medically unexplained symptoms. We wonder why we are offered inappropriate help or no help at all. We wonder why there are no appropriate services for patients who have become unwittingly dependent on prescription drugs. We wonder how a medical profession can get things so very wrong (benzodiazepines) and how they can repeat the same mistakes (antidepressants).

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Gluten-free food prescriptions for children with coeliac disease: should families have to pay?

The Department of Health consulted (until 22 June)¹ on withdrawing gluten-free food (GFF) prescriptions for patients with coeliac disease (CD), aiming to save £25 million. Many CCGs have already stopped or restricted prescribing, stating that families should buy their own GFF instead.

CD affects 1% of the population, putting them at risk of long-term consequences (including subfertility, osteoporosis, lymphoma, and poor growth), and the only treatment is a strict GF diet. Children are entitled to free NHS prescriptions, and dietary staples (bread, flour, pasta) have been available within regulated limits since the 1960s.² Since 'gluten intolerance' (functional symptoms exacerbated by gluten intake) emerged in the 1980s, GFF is more evident in supermarkets but remains costly. Availability is poor in convenience and budget stores, where low-income families and those without transport shop more frequently.³ One patient questionnaire found that 28%

struggled to locate stores with GFF, and 27% reported difficulties identifying GFF.⁴

In some CCG consultations, low-quality information reflects press reports claiming '... thousands of prescriptions ... for custard creams, doughnuts, and pizzas'. Anything that prejudices adherence to a strict GF diet has negative implications for long-term health and NHS resources, and NICE recommends access to GFF prescriptions.⁵ Natural alternatives, such as rice, are less nutritious, with 90% less iron and 82% less calcium than bread.⁶ In an era of rising health inequalities, protecting access to GFF on prescription at no cost to the family should remain a fundamental principle of care for children with CD. Innovative models for providing GFF and a national NHS procurement process could better reduce costs.

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Increased survival means increasing roles for primary care after cancer diagnosis

Morgan *et al* point out that cancer survival rates in the UK are improving.¹ It is timely to consider the roles that GPs play following a cancer diagnosis. We would like to report highlights from a workshop (Cancer in Primary Care International Network [Ca-PRi] annual scientific meeting, Edinburgh, 2017), which explored the roles of GPs following a cancer diagnosis in the Netherlands, Canada, the UK, and Australia, and showcased current improvement initiatives and research.

Internationally, the roles that GPs play in cancer care are expanding,² but GP input during treatment and survivorship phases is highly variable within and between countries.³ In the UK, a formal cancer care review is remunerated under the current GP contract, but there is evidence that the review is often unstructured, and is perceived to be of limited use.⁴ Lack of standardised approaches in primary care following a cancer diagnosis are problematic not only because of the dramatic increase in cancer prevalence, but also because of the increasingly chronic nature of the disease and the high prevalence of comorbid diseases. Consequently, more cancer patients and their partners consult their GPs more frequently over longer periods of time.⁵ There is a political and professional will to provide comprehensive, cost-effective care following a cancer diagnosis, and a sense that primary care is uniquely placed to contribute to this.

Indicators include improving patient-professional communication, shared decision making, and continuity of primary care after a cancer diagnosis;⁶ developing guidelines to standardise survivorship care (and promoting adherence to existing guidelines); developing specific primary-care-based behavioural and lifestyle interventions to improve outcomes in cancer survivors; improving primary/secondary care communication; and developing digital systems to support clinical information exchange, patient self-management, for example, the 'OncoKompas',⁷ and to improve recurrence detection, for example, the ASSICA melanoma intervention.⁸

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