### Mental health

Your last issue focused on mental health including the mental health of doctors.1 As a response to severe mental health problems suffered by colleagues, we approached the Scottish Poetry Library with the idea of producing a little book of poetry to act as a companion and comfort to new doctors when they begin their work.

The result was Tools of the Trade, a book of short, accessible poems that all relate in some way to the experience of being a new doctor, which is given to all new Scottish doctors at graduation.2 The poems are divided into sections, ‘Looking after yourself’, ‘Looking after others’, ‘Beginnings’, ‘Being with illness’, and ‘Endings’.

The book has been well received and we are now exploring ways of expanding the project and encouraging more young doctors to use poetry as a way of connecting with their creativity and compassion.

More information about Tools of the Trade is available on the Scottish Poetry Library website [http://www.scottishpoetrylibrary.org.uk/](http://www.scottishpoetrylibrary.org.uk/) and in an article in the journal Education for Primary Care,3 and we will be sharing our experiences of the book at the RCGP conference in October.

Lesley Morrison,
GP, Peebles, Tweeddale, Scotland.
E-mail: lesley.j.morrison3@gmail.com

John Gillies,
Deputy Director, Scottish School of Primary Care, and Honorary Professor of General Practice, University of Edinburgh, Old Medical School, Edinburgh.

### 2014 NICE cholesterol guidelines

Ueda and colleagues address the 2014 National Institute for Health and Care Excellence (NICE) guidelines based on QRISK2 in commendable fashion.1 It would be interesting to ask them for their opinion on an article very recently published in the *Pharmaceutical Journal* entitled The cholesterol and calorie hypotheses are both dead — it is time to focus on the real culprit: insulin resistance,2 which would appear to undermine the very foundations on which QRISK and the NICE guidelines totter.

Not only is there an issue of whether the patient in the consulting room meets the inclusion criteria of the studies that went towards the formulation of any guideline, but also the semantics involved in the word ‘guideline’, which is fundamentally different from ‘code’ [must do]. [Definition of CODE: a collection or compendium of laws. A complete system of positive law, scientifically arranged, and promulgated by legislative authority].

What is a poor jobbing GP to do in a 10-minute consultation? When the patient sitting opposite is still worrying about what their cholesterol level is, and the GP is grappling with the far more important QRISK2 odds concept, while empirical science puts cholesterol in the dustbin alongside the multitude of historical medical fashions that in their time were cutting-edge ‘must do’s’?

‘Primum non nocere’ would suggest sitting on one’s hands as one of the safest of options while prescribing a statin among the most dangerous!

In conversation with our local community geriatrician it became evident that the scientific evidence and data were not within their grasp to offer a cogent response.

Will the BJGP step up to the mark with its plethora of professorial wisdom and knowledge to enlighten us on this matter, please?

Andrew Sikorski,
NHS GP, Wadhurst, East Sussex.
E-mail: andrew.sikorski@doctors.org.uk

### Time to revive the GP-focused clinical examination

We read with interest Block and Easton’s plea that we should claim the focused examination as a specialist GP skill that we can be proud of.1

GP teachers who provide clinical placements for Keele’s undergraduate medical students report informally that students sometimes question their practice of performing focused rather than full, systematic ‘PACES-style’ examinations, and as a consequence they lack confidence in teaching examination skills. Conversely, students often question the need to examine patients when so much imaging is available, and is requested, in hospitals.

We have begun to try to address these problems. We have developed a workshop entitled ‘Learning and Teaching the Skills of Evidence Based Physical Examination (EBPE)’ for clinical teachers. This provides participants the opportunity to consider the evidence for the use of focused examinations in their day-to-day work, as well as the practical aspects of teaching evidence-based physical examination.2 We have delivered this locally to our GP teachers and to a multidisciplinary audience at the 7th International Clinical Skills Conference in Prato, 2017. Informal feedback has suggested that the workshop has increased participants’ confidence in their examinations in their clinical practice, and in their teaching.

Alongside this, Keele’s Year 4 students have a 4-week general practice-based course on clinical reasoning that promotes focused examination to test diagnostic hypotheses, which they are taught to generate consciously during history taking.3,4 We hope that our graduates will build on this learning and become confident that their examinations accurately inform the decisions they need to make for individual patients in whatever clinical setting they are working in.

We believe that our work is helping to highlight this important area of practice, teaching, and learning to both students and their GP teachers, and wholeheartedly agree...
with Block and Easton that more work is needed if we are to understand how GPs use clinical examination in practice, and how it can be used even better.

Sarah Smithson, 
Clinical Lecturer in Medical Education, Keele Medical School. 
E-mail: s.e.smithson@keele.ac.uk

Maggie Bartlett, 
Senior Lecturer in Medical Education, Keele Medical School.

David Blanchard, 
Clinical Lecturer in Medical Education, Keele Medical School.

Matthew Webb, 
Clinical Lecturer in Medical Education, Keele Medical School.

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Explaining the role of pharmacists in multidisciplinary care

I would like to address the author’s concern about multidisciplinary care.1 As stated, his article is not meant to be disparaging towards pharmacists. However, the message delivered is potentially misleading, as it suggests delegating jobs to other professionals could cause patients harm. I would like to clarify the role of pharmacists because it is often misunderstood.

Community pharmacists are here to make an initial assessment and care plan rather than an official diagnosis. If patients return with unresolved symptoms, pharmacists would suggest that the patients see their doctors. Once doctors establish the diagnosis and management plan, pharmacists monitor patients’ therapies in the community, and report drug therapy problems to doctors. It appears that the author is not satisfied with pharmacists’ diagnosis of dark stool. However, making a diagnosis of gastric ulcer probably requires full abdominal examination, digital rectal examination, and endoscopy, which are beyond the scope of practice of many pharmacists.

Anybody is prone to make the wrong initial assessment, because making the right diagnosis requires a lot of clinical experience that aids pattern recognition.2 Making the right diagnosis also depends on the amount of time spent with patients and choice of investigations ordered. One of pharmacists’ roles is to identify symptoms possibly...