Yonder

Yonder: a diverse selection of primary care relevant research stories from beyond the mainstream biomedical literature

District nursing, deprescribing, psychotropic drugs, and reasonableness

District nursing. Throughout the world, policymakers are (belatedly) recognising the value of non-hospital care and shifting their focus to community services. Although the training of sufficient numbers of primary care physicians is one obvious priority, there is also a parallel need to sustain and develop clinicians from a variety of other disciplines. In the UK, there is a long tradition of nurses visiting patients at home to provide care, although national reports show decline in numbers and low morale in this district nursing workforce. A recent study of UK district nurses highlighted that major healthcare reorganisations and significant financial pressures have both had a big impact on services.[1] In particular, it alluded to challenges with recruitment and retention, a changing case-mix of patients, the growth of specialist nursing services and their impact on generalist nursing, the capacity of services to meet growing demand, and the influence of the short-term service commissioning process on the need for long-term workforce development. It's clear that there is a significant paradox between health policies championing home care and the worrying decline in district nursing services.

Deprescribing. In people with life-limiting diseases, discontinuation of inappropriate medications can reduce the drug burden, decrease the number of drug interactions, and potentially improve quality of life. In a recent systematic review, a Belgian research team sought to identify the enablers and barriers to deprescribing in these individuals.[2] Prominent enablers were involvement of multidisciplinary teams in medication reviews, as well as the patient and family. Important barriers were shortages in staff and the perceived difficulty or resistance of patients and their families. The authors suggest that the harms of polypharmacy should be emphasised prominently to healthcare professionals during training, and that organisations should encourage clinicians to discuss care goals and treatment targets routinely with patients and family members.

Psychotropic drugs. Although psychotropic drugs clearly have benefits for certain patients with clear-cut diagnoses, they are widely used in primary care for individuals with more complex needs, often with an entanglement of medical and socioeconomic problems. Despite the problems with side effects, dependency, and abuse, GPs often find themselves turning to them in the absence of better options. In a recent Swedish study, questionnaires about these drugs were sent to 199 GP surgeries, and responses were received from 516 individual GPs.[3] Unsurprisingly, a majority of GPs stated that they found it easier to start psychotropic drugs than to stop them, and most GPs admitted that psychotherapy was often a more suitable treatment option. There was also some reluctance to alter other GPs' prescriptions. Overall, the GPs in this study were content with their levels of antipsychotic prescribing, which the authors suggest *'may indicate both self-delusion and/or a supreme insight into the patients' circumstances'*.

Reasonableness. When is it reasonable to go to the emergency department? With many UK hospitals on 'black alert' all year around, this is a hotly debated issue in the NHS, and presumably in other countries with stretched healthcare systems and overcrowded hospitals. The question is ultimately one that is explored during the triage admission interview in the emergency department, which was recently the topic of a Romanian sociological study.[4] Although previous studies on gatekeeping in emergency departments have emphasised the assessment of individuals in terms of legitimacy and deservingness, the concept of 'reasonableness' presented in this study is more nuanced, and is concerned with the possibility of the visit to have been avoided. Individuals who put on a favourable presentation of themselves, and who had a narrative of 'reasonableness' in their medical and social circumstances, were more likely to be exempted from blame from triage clinicians. Might a similar model apply to gatekeeping practices in primary care?

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