Letters

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Editor's choice

So why should I go to the RCGP Annual Conference ...?

I can summarise it in three words: enthusiasm, inspiration, and pride.

Having an event that celebrates our diversity of thoughts, ideas, people, and talent is something I think we should be incredibly proud of. I attended workshops about art and wellbeing, greener practice, burnout in the wider team, new models of practice, developing research interests, and consulting with vulnerable patients (to name a few). I came away inspired to make improvements in my own practice.

After the conference my overarching thoughts about my job are those of pride, not negativity. I can be patient because we are moving in a direction where I will have the time. I will be kind to my team, because they are facing the same pressures as me. I am filled with renewed vigour for the profession I love, and the patient care I provide. I came into this profession wanting to build relationships that help people. It's an absolute privilege, and I never want to lose that.

I feel as though we have the potential to change the landscape, systematically and individually, for our patients. If, as our inspirational chair Helen Stokes-Lampard says, we play Lego instead of Jenga, we can build a future where we can provide the level of care we strive for, where we enjoy going to work because we have the headspace to think around the tricky problems, and people surrounding us who help us through the tough times and celebrate the good times with us. Working together and leading each other with kindness, enthusiasm, and pride. All of which were cultivated and celebrated at a hugely enjoyable conference with friends and colleagues. I can't wait for next year.

We have been surviving individually. Now it's time to thrive together.

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Research in the context of the climate emergency

It was a pleasure to read the article 'Planetary health and primary care: what's the emergency?'[1] in this month's *BJGP*. I fully support the content presented but have one addition. As rightly stated in the article, *'we can no longer say we do not know what we are doing'*; however, instead we all too often opt for not saying anything at all.

Even as a genuine threat to our very existence, with impacts already being felt globally, the climate emergency and ecological breakdown are rarely mentioned in the background or acknowledgements of research publications and presentations. When we consider the potential impact of scientific developments that aim to extend the quantity and quality of lives well into future, we must also acknowledge that, given our current trajectory, such a future may not even exist.

As such, I propose a further action that we 'need to do now'. In line with Extinction Rebellion's first demand, we must 'tell the truth': the climate emergency and ecological breakdown should be acknowledged and included as context for interpreting research results, for example, by adding content along the lines of 'the potential impact of this research is only possible if the climate emergency and ecological breakdown is urgently addressed'. Silence has become actively misleading.

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Mitigating climate change: using the physician's tool of the trade

I agree that we should be taking action to mitigate climate change.[1] Switching to a plant-based diet, which can save up to 0.8 tonnes of CO_2 per year, is certainly one of these interventions. But this is not an easy change for everybody to make, and we need to be prepared to lead by example, making our own lifestyle changes alongside those we expect of patients. For example, I do not think we should give up so easily when it comes to cutting down our own emissions from airplane flights: 1 hour of flying is equivalent to around 0.25 tonnes of CO_2 per passenger (www.carbonindependent.org/22.html). Although medics are fortunate enough to have opportunities to attend international conferences, this does not entitle us to write off the option of cutting down on flying to reduce our carbon emissions. There are other options to consider, for example, broadcasting conferences over the internet or holding conferences in places that are easily accessible by rail or other more sustainable forms of transport.

We also need to take care about how to broach the subject of lifestyle change. As with any health promotion message involving lifestyle change, there is a fine line between encouraging and empowering patients and making them feel overwhelmed with an impossible task. An environmentally friendly diet may be easy for some to achieve but very difficult for others if they have limited financial resources or other psychosocial stressors taking up their attention and time. We need to use our best consultation skills and assess the possibility of lifestyle change within each individual's life situation. Discussing more manageable possibilities, for example, having a meatless day as suggested in Storz's article, could be an essential step.[1]

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De rerum natura: is this now just the nature of things, or has it always been so?

In an attempt to escape the never-ending barrage of political news this week, I decided to seek refuge in a podcast or two. Perhaps a comedy programme? Too much satire, I thought. Even the comedians have gone Brexit crazy. What about a science discussion, I mused? No such luck as the topic was the statistics of election polling. I took a deep dive into the archive to find an episode on Lucretian poetry in the first century BCE.[1] Wonderful! I silently exclaimed, 2000 years is just enough distance from contemporary politics to escape.

I was transported to the collapse of the Roman Republic, where Epicurean philosophy was being extolled in poetic verse.

'Leaders seemed more concerned about competing with each other, than uniting for the stability of Rome', explained the presenter.

'During a time of political turbulence, when powerful, wealthy people were willing to create chaos just to achieve their personal ambitions.' Blimey, had I accidentally switched to *The Today Programme*? Oh no, wait, this was still the podcast.

'The elite groups cared little for the ordinary people until it came time to buy their votes with promises to increase the "dole" of grain; just enough to seem generous.'

I gave up and accepted that this clearly is the nature of things, then and now. So, what is the increased 'dole' of grain this election? Surely it is the same as every post-war election: the NHS. This election campaign, however, the medical community seems quieter than usual. Perhaps because the main political parties are offering to increase the budget for the NHS, just enough to seem generous.

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What makes a good-quality GP report for an Initial Child Protection Conference?

This article gives good advice on how to write a report for an ICPC.[1] It identifies a key issue, however, that is not addressed at all: that 'GPs have been poor attenders at ICPCs'.

GPs can have a fundamental reluctance to engage in a process that is perceived as undermining the doctor–patient relationship. The GP is often the only professional at an ICPC who has a therapeutic relationship with the parent(s) as well as with the child. We are very aware that inside every vulnerable adult is likely a child who endured trauma themselves, and comes to us as an adult figure whom they can trust. These are the very patients whose parenting is likely to cause child protection concerns. Being asked to provide information that may protect one child can sometimes feel like an act of betrayal, and even abuse, of the other child within the adult parent. This undoubtedly leads to us under-reporting and carrying a lot of risk.

As a Deep End GP I believe this is one of the reasons why GPs are reluctant to work in disadvantaged areas. We often deal with this dilemma by either not engaging, or by doing a report, but not attending the meeting, because of the sense of being complicit in a perception of judgement and criticism of the parent. This can have the unintended consequence of the parent/patient feeling abandoned by us.

Paradoxically, I have concluded that the best way to protect both the child and the vulnerable adult is to thoroughly engage with the process: to not only be open with the parent about concerns but also explicit that you will walk with them on what can be a harrowing journey. With our knowledge of families we can have a critical input. Our independence allows us to challenge other services. And, finally, we can support and advocate for the vulnerable parent as well as the child, regardless of the outcome.

This is not a comfortable space for GPs, but it is a challenge we need to consider if we are to meet our responsibilities to all our patients.

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Spiritual intervention and the 'LOADS SHARED' mnemonic

I read with interest Dr Macdonald's article on the 'LOADS SHARED' mnemonic[1] and I agree that it would be a useful tool in assessing spiritual needs, especially in patients who neither initially identify as spiritual nor desire spiritual care. GPs are very aware of the modern maladies of loss of wellbeing, obesity, addictive behaviour, depression/anxiety, and social isolation described by Hanlon *et al*[2] and could easily identify the spiritual cues of shame/guilt, health (losses), appearance, relationships, employment, and death/bereavement suggested by Macdonald.[1] Furthermore, chaplains in primary and secondary care might also find 'LOADS SHARED' a useful mnemonic in providing spiritual care to their patients.

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