Letters

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Four research papers ... prescribing antidepressants

Stevie Lewis's article 'Four research papers'[1] expresses what so many patients have experienced. GPs have been reluctant to engage with patients who have been trying to tell them about the serious (apparently unrecognised and/or significantly underplayed) problems with antidepressants.[2-3] Now mid-2021, GPs are absolutely overwhelmed, as detailed by Clare Gerada in her 'Stop skinning the cat' article where she says, *'I have never seen things so bad.'*[4]

We are sounding the alarm that antidepressant problems are actually a definite contributor to 'where we are' and that initial decisions to prescribe antidepressants warrant urgent attention ... as well as how to address the longer-term dependence issues that are clearly now evident.

Ed White's article indicates what is occurring[5] and concludes, *'Ultimately, the members of these groups want to know their GP will acknowledge, understand, and support them if difficulties occur, and have the knowledge to help them avoid painful and sometimes debilitating withdrawal symptoms.'*

The 14th edition of *The Maudsley Prescribing Guidelines for Psychiatry* includes new information about antidepressant prescribing and 'discontinuation' order (maudsley-prescribing-guidelines.co.uk). The new Maudsley 'deprescribing' section apparently reflects, for psychiatrists, the Royal College of Psychiatrists' (RCPsych) *Stopping Antidepressants* information for patients, the latter of which is freely publicly available.[6] I encourage GPs to read this concise new RCPsych publication, which is endorsed by the Royal College of General Practitioners, the Royal Pharmaceutical Society, and the National Institute for Health and Care Excellence.

Professor Wendy Burn wrote a blog for the October 2020 *BMJ Opinion* ('Medical community must ensure that those needing support to come off antidepressants can get it')[7] and she also spoke with James Moore about the patient experience in a podcast stream by the RCPsych 'Stopping antidepressants: exploring the patient's experience'.[8]

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General practice in crisis — stop skinning the cat!

Professor Clare Gerada correctly points out that the ideas brought to this editorial are not new.[1] Nonetheless she encapsulates the reasons behind the current crisis most succinctly. Is it not time to move away from the early divergence of GP and general medical trainees and make training more collaborative from the start? The Medical Act[2] may need revisiting but there would be the potential to achieve the following objectives:

1. Skills largely dormant in medical trainees (uncertainty, shared management plans, and so on) would become ingrained while GP trainees would develop more confidence in general medicine;
2. Those trainees destined to become GPs would have enhanced clinical skills and decision making;
3. Some trainees may have the motivation and sufficient skills to take dual qualifications;
4. Mutual respect (currently at a low ebb) would be restored. Each would understand the role of the other and frustrations such as the 'inordinate expansion of the GP role' referred to by Professor Gerada would be less likely;
5. Creation of intermediate teams would be facilitated; and
6. Such flexibility may even encourage recruitment.

Professor Gerada correctly points out that GP training is too short and that exposure to general practice by hospital doctors is long overdue.[1] I would argue that the latter should be integrated into the training programme and not viewed by the medical trainees as a 'box to be ticked'. The concept of generalism is seen as important by the Royal College of Physicians too but addressing this need does not appear to be joined up with the Royal College of General Practitioners.[3] The current model utilises GPs in extended roles working within secondary care.[4] However, these roles are often bespoke and usually lack a formal training structure.

Since evolution seems to have ground to a halt, is it time for revolution?

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What is needed for Universal Basic Income?

We read with great interest Blake's[1] compelling case for Universal Basic Income (UBI) to decrease the trauma-inducing nature of the current socioeconomic system. As Euan Lawson correctly points out,[2] the very concept of UBI — regular payments to all citizens regardless of circumstance — is not new. Around the world, numerous local experiments show benefits in health and socioeconomic outcomes.[3] In rural Kenya, a large-scale UBI experiment during the COVID-19 pandemic improved food security, wellbeing, and rates of illness.[4] In Canada, a 4-year experiment that ran until 1979 saw an 8.5% decline in hospitalisations and a reduction in GP visits.[5] Other UBI experiments are equally promising.

However, Blake stops short of acknowledging the conditions required to implement UBI including political will, public demand, and the ability to supply UBI.[6] The latter, an understandably pragmatic objection, is a key factor mediating public and political will. Proponents suggest UBI could be generated through taxation of income, corporations, wealth, or the abolishment of tax reliefs. UBI could replace alternative welfare systems, and potentially save money overall through improvements in health and wellbeing.[7]

Under a meritocratic socioeconomic system, the concept of UBI may have also found more public acceptance through the furlough scheme, which, while engendering the spirit of UBI, is not UBI. The scheme affirmed how changes in personal economic circumstances are often beyond an individual's control and may have pushed UBI into the Overton window — the frame of acceptable political discourse. Meanwhile, criticisms of UBI, suggesting it fails to tackle the root causes of poverty and discourages work and societal participation,[3] are increasingly unfounded.[8] As general practice experiences increasing pressures related to service delivery, there is ever-less capacity to impact the upstream determinants of health. With growing evidence supporting the financial and social case for UBI, and rising public acceptability, advocating to our politicians for a fairer socioeconomic system with UBI could be one means of fulfilling the doctor's role as envisioned by Virchow: *'natural attorneys for the poor'*.

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Competing interests

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Interpreting negative tests when assessing cancer risk

I would like to thank the authors for a concise article, highlighting the importance of safety netting and symptom assessment along a cancer diagnostic journey.[1]

There is a complementary aspect to this learning — interpreting a positive test result when assessing cancer risk. One of the authors has highlighted elsewhere[2] that *'Of women with CA125 levels above the current abnormal cut-off, 10.1% were diagnosed with ovarian cancer and a further 12.3% with another form of cancer.'*

Thus, pre-test probability probably needs to be considered in a wider context, at different points of establishing a diagnosis. The paper by Funston *et al* is a very helpful addition to this editorial, especially in a teaching context for trainers and trainees.

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