Letters

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Beyond relational continuity

We thank Dr Burch[1] for his interest in our article and agree that the distinction between longitudinal and relational continuity is important.

We are pleased that he too thinks that *'relational continuity for patients* [in] *primary care … should be maximised wherever possible'*. He is correct that others have included information and management continuity in the broad concept of continuity of GP care. However, we prefer to separate these and believe that informational continuity is essentially good record-keeping, and management continuity good practice and care plans. Of course, both of these are desirable but our article concerned 'relational continuity'.

The patients' perception of having a deep (trusting) relationship with their GP has been reported by Ridd *et al*[2] linked to the number of consultations had with that GP. It shows a linear increase in the depth of the relationship up to eight consultations when there is a 50% probability of patients thinking they have a 'deep' relationship with the GP concerned. We continue to think relational continuity is by far the most important part of continuity and is the main mechanism generating the important outcomes.[3] It needs further study in a randomised controlled trial of an intervention to improve continuity.

We do not follow his point about general practice *'as it is, rather than how we would like it to be'*, as we very much study general practice as it is. Our earlier report,[4] in 2019, reported the measured continuity in a group general practice with 9000 patients over 2 years that was actually received by patients; 65% of all appointments made by patients aged 65 or over were with their personal GP despite all the GPs being part-time.

Since then, we have learned of other practices where measured continuity of GP care is higher, and we have recently reported how it is also high in two other European countries.[5]

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Gadolinium use and risks: an update for colleagues in primary care

Gadolinium-based contrast agents (GBCA) are widely used in magnetic resonance imaging (MRI) to improve image quality, particularly in angiography and oncologic imaging.[1] Gadolinium (Gd) is a naturally occurring heavy metal. In its elemental form, gadolinium is toxic, but, when bound to chelating agents, it is safe for use in humans. GBCA are usually injected intravenously at the start of the MR scan. The extent of gadolinium use in imaging is ubiquitous. In 2018, it was estimated that, since approval in 1988, over 460 million dosages of gadolinium had been administered worldwide.[2]

Acute allergic reactions to gadolinium are rare. Nephrogenic systemic fibrosis (NSF), a systemic disorder linked to GBCA administration in patients with impaired renal function,[3] has decreased in incidence with the use of newer GBCAs and a more cautious approach to administration.

The phenomenon of gadolinium deposition in the brain was first described in 2014 on MRI images.[4] Subsequent studies have confirmed that these signal changes in the brain correspond to gadolinium deposition; this phenomenon occurs in patients with normal renal function. There is no definite evidence linking gadolinium deposition in the brain with any adverse patient outcome.

Despite the lack of causation of a disease state, the action of regulators in the US and Europe has been remarkable. In the US, the Food and Drug Administration took the step of requiring imaging centres to distribute patient Medication Guides to better apprise patients of GBCA-associated risks before administration. The European Medicines Agency went further by restricting the use of certain GBCAs, while concluding that *'there is currently no evidence that gadolinium deposition in the brain has caused any harm to patients'*.[5]

We raise this clinical and regulatory conundrum for the information of colleagues in primary care as, with more direct requesting of a wider range of imaging investigations by GPs, it is likely that questions on this topic will be posed by patients. Colleagues in primary care would be advised to seek up-to-date advice from the radiology department of their local hospital or imaging services provider, as the regulatory position on this topic will undoubtedly alter as new evidence emerges.

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There's a lot to learn from Neighbour

I read with interest regarding transparent questioning in a consultation.[1] Benfield argues that transparent consulting allows patients to understand why the questions are asked. Neighbour[2] describes that explaining why you need the information makes it easier to get it. He also gives us several techniques in the handing-over process: 'think aloud' (that is, letting the patient in on your thought processes) and 'fly some kites' (that is, speculating out loud on some of the available options).[2] I believe that these help transparent consulting: you can clarify your intent, thought process, and concern. It is a reminder that we still have a lot to learn from Neighbour.

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Structured medication reviews for frail, older people should be done by GPs or experienced nurse practitioners

A good medication review is a review of a person and of all the conditions for which we are prescribing medication. Of course, I agree with the editorial's authors[1] that such a review can sometimes reduce polypharmacy and avoidable hospital admissions. But this is true especially in frail older people with multiple comorbidities, a group where relational continuity is particularly important. Shared decision making about medication often involves relatives and other carers, and agreeing to reduce dosages or stop medications invariably requires more than one conversation. As well as covering the standard medication-specific agenda, the conversation involves inviting the patient and their family to discuss the everyday burden of taking medication, and it needs to establish the patient's goals for their health care, particularly where medications are being taken to reduce the likelihood of future harm, rather than to mitigate or ward off symptoms.

The clinician needs not only to be competent to interpret evidence-based guidance, but also confident enough to disregard it where they and the patient agree that following it does not serve the patient's agenda. They also need a trusting relationship with the patient and their family, ideally a pre-existing relationship and necessarily one that can be continued into the future, because stopping one's usual medication is frightening. So, I think that, at least for frail older people, 'medication reviews' are one element of GP work that should not be systematically delegated to a clinical pharmacist, and certainly not to a newly qualified one, however well they have done during their '18 months of training'. Perhaps one good use of proactive frailty identification[2] could be to ensure that those identified are offered a review consultation with a GP or an experienced nurse practitioner involved in the patient's ongoing care. The DES should be amended to cover 'a minimum consultation duration of 30 minutes' with this senior clinician, as well as at least one follow-up appointment.

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Corrections

In the article by Bailey SER, *et al*, Clinical relevance of thrombocytosis in primary care: a prospective cohort study of cancer incidence using English electronic medical records and cancer registry data, *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X691109, due to a coding error, Figure 2 graphs showed all-time cancer incidence, rather than 1-year cancer incidence. The graphs have been corrected in the online version. These changes do not impact on the main findings or conclusions of this study.

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In the Analysis article by Irving G, Neves AL, What next for COVID Oximetry and virtual ward? *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X717041, one of the authors' names had been omitted; the correct name is Ana Luisa Neves.

DOI: https://doi.org/10.3399/bjgp21X717185

In the article by Oldenhof E, *et al*, Role of the prescriber in supporting patients to discontinue benzodiazepines: a qualitative study, *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/BJGP.2020.1062, reference 51 and two concluding paragraphs were cut in error during editorial production; these have now been reinstated in the online version.

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