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REFERENCES

1. Costa AF, van der Pol CB, Maralani PJ, *et al*. Gadolinium deposition in the brain: a systematic review of existing guidelines and policy statement issued by the Canadian Association of Radiologists. *Can Assoc Radiol J* 2018; **69(4):** 373–382.
2. McDonald RJ, Levine D, Weinreb J, *et al*. Gadolinium retention: a research roadmap from the 2018 NIH/ACR/RSNA workshop on gadolinium chelates. *Radiology* 2018; **289(2):** 517–534.
3. Boyd AS, Zic JA, Abraham JL. Gadolinium deposition in nephrogenic fibrosing dermopathy. *J Am Acad Dermatol* 2007; **56(1):** 27–30.
4. Kanda T, Ishii K, Kawaguchi H, *et al*. High signal intensity in the dentate nucleus and globus pallidus on unenhanced T1-weighted MR images: relationship with increasing cumulative dose of a gadolinium-based contrast material. *Radiology* 2014; **270(3):** 834–841.
5. Harvey HB, Gowda V, Cheng G. Gadolinium deposition disease: a new risk management threat. *J Am Coll Radiol* 2020; **17(4):** 546–550.

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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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REFERENCES

1. Benfield M. Transparent consulting: defining a consultation tool. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X716705.
2. Neighbour R. *The inner consultation: how to develop an effective and intuitive consulting style*. 2nd edn. London: CRC Press, 2005.

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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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REFERENCES

1. Stewart D, Madden M, Davies P, *et al*. Structured medication reviews: origins, implementation, evidence, and prospects. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X716465.
2. Mulla E, Orton E, Kendrick D. Is proactive frailty identification a good idea? A qualitative interview study. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/BJGP.2020.0178.

DOI: https://doi.org/10.3399/bjgp21X717149

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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