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## Ramadan and women's health

Ramadan is a widely observed practice of Muslim communities across the world. In April 2022, millions of people will undergo a month of radical change, withholding from all food and drink during daylight hours and giving more in charity and reflection. Ramadan can be challenging to those with chronic health conditions. Islamic law places an emphasis on the preservation of life: those who are likely to come to harm through fasting are religiously exempt.

Nonetheless, the desire to fast is strong for many, not least due to the strong communal experience that Ramadan brings; patients often persist despite medical advice to the contrary.<sup>1</sup> Appointments and work schedules are rearranged outside the month to maximise the Ramadan experience, including women who are due for their smear tests and mammograms.

Muslim women have a mandatory religious exemption from fasting during the menstruation or lochial phase. Women who are pregnant/breastfeeding may not fast if they fear harm to them or their child. The change in routine during Ramadan may cause erratic menstrual cycles, particularly with longer fasts and significantly altered sleep/food intake. Some women may wish to control their periods with medication to allow for more (predictable) days of fasting in Ramadan. Pregnant and breastfeeding women may also wish to fast if they feel able to and should be supported where it is safe to do so through practical guidance that is published around this and for chronic diseases.<sup>1,2</sup>

Fasting for consecutive days in Ramadan is not the only option that Muslim patients may take. Alternate-day fasting or fasting for a portion of the month is also possible, with options to make up fasting straight after Ramadan or in the winter months where shorter days and cooler weather help those who may find it intolerable otherwise.<sup>3</sup>

Patient-centred shared decision making is the hallmark of general practice and empowering patients is the key to productive clinician-patient relationships.<sup>1</sup> Muslim women have one of the poorest patient satisfaction experiences and outcomes,

especially around maternal health.<sup>4</sup> Through greater awareness of issues such as Ramadan, we can redress the lack of equity and move to improve these health inequalities.

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## Locums and antibiotic prescribing

Borek *et al*'s quantitative study of locum GPs' prescribing of antibiotics compared with other prescribers in general practice, published over 6 years after the events studied, is seriously flawed both in the design of the study and in the authors' interpretation of the outcome.<sup>1</sup>

The retrospective study design is flawed because there can be no randomisation of patients to either locum or non-locum consultation. The implied premise is that patients who attend locums and emerge with a particular diagnosis are exactly comparable with those attending others with the same diagnosis, and that the proportion of patients for whom antibiotics are appropriate is the same for both groups.

Patients often exercise choice in their booking of appointments. Many elect for continuity and seek an appointment with their regular doctor. Those whose symptoms are most severe may settle for an appointment with whoever is available soonest, which may be more likely to be a locum. It is therefore inappropriate to assume that the severity of the illness, the patients' level of risk, the exact nature of the illness in patients with the same diagnostic label, or its likelihood of responding to an antibiotic is equivalent in both groups.

The authors then go on to muddle statistical significance with clinical significance. I believe that the same prescriber (me, for instance) with similar patients actually prescribes in a statistically different way on a Monday morning and a Friday evening for patients with the same diagnostic label ... and probably differently again the next Monday. A 4% difference is no difference at all in the context of complex human behaviours of this kind. The conclusion should surely be that 6-7 years ago GPs, prescribing nurses, and locum GPs all prescribed antibiotics similarly.

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### Author response

We thank Dr Zermansky for their engagement with our paper. The qualitative

part of this *mixed-methods* study explored influences on antibiotic prescribing and potential reasons for any differences in patterns of prescribing; so, we agree with Dr Zermansky regarding the complexity of antibiotic prescribing decisions and the many different factors affecting decisions.

The purpose of the quantitative analysis was to describe *patterns* of prescribing for which the retrospective design is appropriate. It does not focus on mechanisms underlying the observed patterns, such as differences in patient-mix. As highlighted in our article, the quantitative analysis focused on patients without relevant comorbidities, and excluded recurrent, chronic, and complicated (for example, bilateral otitis media) presentations, but this does not guarantee that some of the (absence of) differences are explained by other differences in case-mix seen by nurse prescribers, locums, and other GPs.

We did not explore patterns of prescribing across different days of the week, but previous analyses have shown little difference (see Supplementary Tables S1–S2 in Pouwels *et al.*).<sup>1</sup> We accept that our study analysed prescribing data up to 2015 (the dataset that we had access to at the time of the analysis), which we acknowledge as a limitation in the paper.

We disagree with Dr Zermansky's suggestion that the conclusion should be that all prescribers '*prescribed antibiotics similarly*'. We found a 4% difference between locums' and other GPs' antibiotic prescribing. We did not claim this difference to be statistically significant but rather a difference that is potentially clinically significant. To put this 4% in perspective, the 2015/2016 Quality Premium aimed for a reduction in the total number of antibiotics prescribed in primary care by 1% (or greater) from each clinical commissioning group's 2013/2014 value.<sup>2</sup>

Overall, we emphasise that our study does not 'blame' locums for high prescribing but rather highlights the complex contextual influences on antibiotic prescribing in general practice. Thus, optimising antibiotic prescribing will require changes at the individual, practice, and system levels.

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## Astonishing results

Peezy was developed in response to patient feedback to address the hygiene and dignity issues complained of by patients. Evidence of reduced contamination of urine samples was found later.

Our UK and US customers have found reduced contamination, and savings in reduced retesting, overall expenditure, and antibiotic prescribing due to improved accuracy of diagnosis. Device failure is almost unknown. A recent anecdotal report from a US distributor states: '*Some lab employees and the supervisor stated they had previously taken Peezy home for personal use. The lab supervisor felt Peezy was "indestructible", and she was unable to get it to fail.*'

Had we experienced the massive 25% device failure rate quoted, we would never have launched the product. We provide training for staff issuing Peezy. In turn, first-time users are correctly instructed in its use. Other than device supply, we were excluded from any involvement in the study, so this was not possible.

We wrote to the principal author asking to clarify if Peezy patients were asked to ensure a full bladder before sampling but this specific question was not answered. We cannot verify that Peezy was used correctly. The authors admit that the Peezy failure rate may have affected the analysis. *About a quarter of Peezy UCDS [urinary collection devices] failed, and this may have impacted the intention-to-treat analysis.*<sup>1</sup>

As a small to medium-sized enterprise we are unable to fund large clinical trials and rely on smaller independent studies. However, a reduction in contamination rates has been widely reported.<sup>2–7</sup>

Llor comments: '*We certainly do not know how patients collect the urine samples despite being instructed to perform midstream urine sample collection.*'<sup>8</sup> Peezy standardises urine sampling. The National Institute for Health and Care Excellence says of Peezy: '*The device is the only urine collection method that meets Public Health England's UK Standards for Microbiology Investigations: Investigation of urine.*'<sup>9</sup>

The astonishing failure rate is unprecedented, and points to inadequate instruction. The absence of sample contamination reduction contradicts the evidence given to us. We do not accept the results of this study, which is at odds with the clear satisfaction of our customers and their end users.

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## Competing interests

Vincent Forte is inventor of the Peezy and a Founder Director of Forte Medical Ltd.

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