

as drug' has long been recognised and it is in this encounter that the healing process begins. Thus, it remains common for patients — in response to a professional, sensitive, unhurried ear — to state: 'I feel better already, Doctor ...'

A further benefit of the therapeutic history is that it promotes 'well-judged' clinical restraint, that is, self-care, incremental management, and the option not to intervene at all.<sup>3</sup> The digital algorithm, by contrast, fuels expectations, anxiety, and workload by concluding 'needs bloods/ecg/cxr then see GP'. Many of these tests will prove unnecessary, not least because about a half of presentations in general practice lack an overarching diagnosis to guide management.

The holy grail of the 'digital front door' must not be to divert or delay as many contacts with the GP as possible. The experienced receptionist remains central to ensuring that patients receive appropriate initial management, particularly vulnerable patient groups. Digital triage risks undermining the receptionist's art of helping to tease apart unprepared presentations and recognising that certain patients simply need 'to speak to the GP, before going any further'.

Trainees choose general practice because they enjoy talking to patients. Digital triage risks putting the technological cart before the discursive horse. It also endangers the art of the 'therapeutic history'. Anxiety famously makes children of us all<sup>4</sup> and its best remedy in early illness is to 'speak to a GP'. Digital triage is not a 'one size fits all' solution for a battered GP profession and a public who have increasingly lost the ability to judge degrees of urgency. Preserving the art of the consultation as the bedrock of general practice is critical for patients, sustainable use of resources, and to ensuring recruitment of tomorrow's GPs.

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DOI: <https://doi.org/10.3399/bjgp24X736797>

## Prednisolone in COPD: the overlooked harm

Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in the world, with the mainstay of treatment instigated in primary care.<sup>1</sup>

Prednisolone is used in the management of COPD exacerbations. The use of steroids is associated with a higher risk of bone fractures and osteoporosis-related events.<sup>2,3</sup> While the aetiology of bone loss in this context is multifactorial, it is recognised that corticosteroid use is a significant contributing factor.<sup>3</sup>

National guidelines advocate for the risk assessment of osteoporosis in post-menopausal women and men >50 years of age with prolonged steroid use, with recommendations that subsequent bone protection should be offered to those deemed high risk. High-dose steroid regimens are considered >5 mg oral prednisolone daily for prolonged duration of use >3 months.<sup>4,5</sup> Cumulative doses are easily surpassed by COPD patients receiving three acute prescriptions of steroids for exacerbations.

In our single urban GP practice, we conducted a retrospective case note analysis from 2018–2023 involving 131 patients. Alarming, only 12.5% had undergone osteoporotic risk assessment, despite significant steroid burden with doses ranging from 600–4000 mg annually.

Is such significant risk worth the reward? A 2023 European meta-analysis suggests it is not: treatment is ineffective, and clinicians accept significant harm for a marginal benefit, at best.<sup>6</sup>

Our clinicians are becoming immune to the risks of prednisolone prescriptions and are misaligned with national guidance. Prednisolone prescribing is becoming a habit rather than critical thought. We fear that we are not alone and urge clinicians to remain vigilant to the harms

associated with steroid burden in some of our most vulnerable patients.

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## Corrections

Low-value pharmaceutical care among Dutch GPs: a retrospective cohort study. Joris IJM Müskens, Simone A van Dulmen, Tjerk Wiersma, et al. *Br J Gen Pract* 2022; **72(718)**: e369. DOI: <https://doi.org/10.3399/bjgp.2021.0625>. In Figure 2 the x-axis was incorrectly presented as 'Patients, n'. It has been corrected to 'Practices, n'. The online figure has been revised accordingly. We apologise for this error.

DOI: <https://doi.org/10.3399/bjgp24X737025>

Lukas BM Koet, Evelien IT de Schepper, Arthur M Bohnen, et al. *Br J Gen Pract* 2022; **72(719)**: e405. DOI: <https://doi.org/10.3399/bjgp.2021.0557>. Anxiety problems in children and adolescents: a population-based cohort study on incidence and management in Dutch primary care. In Table 2 the top row 'Median contacts with GP for anxiety (IQR)' had two transposed values. The columns 'Aged 13–17 years n = 198' is '1 (1–2)' and 'Age categories P-value' is '0.87'. The article has been corrected online. We apologise for this error.

DOI: <https://doi.org/10.3399/bjgp24X737037>