Letters

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General practice at the frontline of preventing suicide

We welcome the important study by Alothman *et al* whose findings highlight the central role of general practice in supporting people who are at risk of suicide.[1] The findings however pose a key question for general practice: How should clinicians manage escalating requests of care in patients experiencing mental illness and self-harm? Two key areas to consider are the patient's wider mental health and support needs, and the continuity of care provided.

The latest National Institute for Health and Care Excellence (NICE) self-harm guidance provides new recommendations for GPs, which include treating coexisting mental health problems.[2] In practice this may vary considerably depending on context. For example, up to three-quarters of people with a diagnosis of personality disorder seek help for self-harm,[3] yet many are unable to access specialist care.[4] Long waiting lists can also preclude access to prompt intervention from mental health services.[2] Accessing support from voluntary, community, and social enterprise (VCSE) organisations can be an important adjunct to clinician support.[5] When managing patients in distress and who more frequently present, considering access to both clinical and non-clinical support is beneficial.

Regular GP appointments to review self-harm for patients managed in primary care is recommended.[2] As Alothman *et al* identified, increased frequency of clinician contact — one or more consultations per month — may point to deterioration of mental health and increased suicide risk. Frequent consultation patterns can, however, offer opportunities. Regular appointments, with the same clinician where possible, can help build trust and provide feelings of safety.[6] Patients and clinicians value continuity of care and the stability it offers during periods of experiencing distress.[6] Continuity of general practice clinician care is an important area for future research in the maturing field of suicide prevention in primary care.

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Competing interests

Faraz Mughal was a member of the Guideline Committee for the NICE 2022 self-harm guideline. Sarah Steeg is funded by the National Institute for Health and Care Research (NIHR) (Fellowship award number: MHF009) as part of the Three NIHR Research Schools Mental Health Programme. Faraz Mughal, Doctoral Fellow, is funded by the NIHR (reference: 300957). The views in this article are those of the authors, and not necessarily those of the NIHR, NHS, or the Department for Health and Social Care.

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DOI: https://doi.org/10.3399/bjgp24X738825

A tale of two doctors: a response

'A tale of two doctors: casualties of an inverse education law?'[1] in the June 2024 *BJGP* reminded me of my own experiences of the 'educational' and appraisal system that I experienced as a GP. As a white, Caucasian male brought up and taught medicine in the UK system, I did not have the additional pressures that Mabel experienced. However, I found the whole system of continued assessment of my ability and suitability to practice extremely and unnecessarily onerous, so much so that it actually impeded my own personally led development. I made a point of ensuring that I was up to date with advances by regular reading of the academic journals, with particular attention to my areas of clinical responsibility including diabetes, palliative care, and occupational health. I sat on the local Diabetes Advisory Group for many years and, when confronted with a new clinical area that needed additional expertise, I undertook relevant diplomas (palliative care and occupational health). I also enjoyed helping out with our local St John's Ambulance section in my early years. However, as the GP workload increased and the need to demonstrate overtly one's professional development, this squeezed out these less formal but more important self-led initiatives. Indeed, I would suggest that the appraisal system is an example of the Heisenberg effect. Heisenberg was an eminent German scientist who discovered that, by measuring a process in physics, the outcome was inherently affected. This applies to many other aspects of life, and no less to the personal and professional development of GPs. The appraisal system has managed to impede the process that it is trying to measure and has been a major factor in the timing of my own and many of my colleagues' retirement.

It is easy to complain about a system rather than provide answers and alternatives. Accepting that there must be some standard criteria for allowing