



**DOCTOR**  
FOR **HIRE**

WORKING AS A GP LOCUM





## Welcome to your **GPst**

WELCOME to the first edition of *GPST* - a journal dedicated to GP trainees. We hope this will be a useful resource to help you progress through your training in general practice.

*GPST* will focus on a variety of issues, from practical guidance to medico-legal advice to general interest features about life on the frontline of patient care.

Facing your first patient consultations as a GP trainee is never easy. It can be extremely daunting in the first couple of weeks dealing with afternoon surgeries and housecalls, so I've given a few helpful hints on how to handle consultations in my article on [page 4](#).

MDDUS medico-legal adviser Dr Susan Gibson-Smith takes a different perspective on consultations on [page 12](#) when she offers some useful advice on the challenges of dealing with aggressive patients.

The compulsory MRCGP exams

will loom large on the horizon for most GP trainees, so on [page 10](#), MRCGP examiner Dr Mei Ling Denney provides an insight into how to tackle the exams.

There are many opportunities open to doctors in the field of general practice. On [page 8](#), Dr Ian Thompson talks about his experiences as a locum GP, while on [page 5](#) Dr David Hogg describes what life is like for a rural GP.

MDDUS medico-legal adviser Dr Anthea Martin discusses how to treat the sick child on [page 6](#) while on [page 7](#) fellow MDDUS medico-legal adviser Dr Barry Parker highlights the legal implications for GPs when dealing with advance directives and end-of-life care. And the case study on [page 14](#) follows the delayed treatment of a child with meningitis.

• **Dr Peter Livingstone**  
Editor

PHOTO: PAUL GRAHAM

## MDDUS GP trainee education grant

MDDUS is offering GP trainee members the chance to secure £1,000 professional development grants.

We are committed to promoting good practice within the medical profession and in the professional development of our members. But financial pressures can often be a barrier for trainee GPs who are interested in pursuing some of the varied educational opportunities available.

So we are offering two £1,000

awards to successful applicants from GP practices where both the trainee (who began training in August 2010) and trainer are MDDUS members. The grant can be used for any form of educational training, including attendance at courses, conferences and seminars, practice training and the purchase of textbooks.

We are inviting applications for the funding in writing - more details on how to apply can be found on the back cover.

## Doctors' beliefs influence end-of-life care



**DOCTORS** who have no strong religious beliefs are almost twice as likely to hasten the death of a very sick patient, according to new research.

The report in the *Journal of Medical Ethics* found doctors with a strong faith are less likely to discuss this type of treatment with a patient.

Almost 4000 UK doctors from a range of specialties responded to a survey asking what influence their religious belief - or lack of it - had on end-of-life care decisions. It found that religious beliefs did influence decisions taken by doctors caring for patients approaching the end of their lives.

Of the GPs who responded, 14 per cent said they were very or extremely religious while 68 per cent said they were either not religious or only mildly so. Compared to a group of palliative care specialists who responded, GPs were four times more likely to have taken a decision that they knew would hasten a patient's death, and four times more likely to back a change in the law on assisted dying.

Professor Clive Seale, professor of medical sociology at Queen Mary, University of London, commented in the BMJ: "You would expect that GPs respond to clinical factors but their own values come into play in quite a big way. If I were a patient approaching the end of my life, I would want a discussion about religious views with my GP"



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## MRCGP exam changes unveiled

A NUMBER of changes will be made to the MRCGP exam from September.

The Royal College of General Practitioners unveiled its plans to revamp the Clinical Skills Assessment (CSA) and Applied Knowledge Test (AKT) components following a "rigorous review" of the exam process. The College said the changes would make the exam more relevant to "everyday working life".

The move means candidates applying for membership of the College will be graded on more cases in the CSA. The CSA pass mark will be set using the borderline group method - where each case will have its own pass mark - rather than the current system which requires passing eight out of 12 cases.

RCGP examiners will also now mark all the cases on the circuit, so candidates will be evaluated on 13 cases instead of the current 12. The cases will continue to be marked using the current three domains but candidates will receive a total score for all 13 cases instead of individual marks for each case. The pass mark will be set by the combined judgements of examiners for that day.

The RCGP said the borderline group method of marking will allow them to deal with the variability in difficulty of cases. Feedback statements have also been changed as part of the review, and take into account comments from associates in training and CSA examiners. Candidates will then be given more information and advice on how to improve performance.

The latest format of the computer-based AKT will pilot new questions, including free text answers where the candidate types in the answer rather than selecting from a list of options.

They will be able to use short video or sound clips and so-called Hot Spots, where the candidate clicks on a graphic to indicate the site of a clinical sign. The changes have been made in line with suggestions from the Postgraduate Medical Education and Training Board, which is now part of the General Medical Council.

Dr Sue Rendel, RCGP chief examiner, said: "Candidates should not notice any difference in their experience of the exam or the way in which they prepare for it."

## CALL TO ENGAGE WITH REFORM WHITE PAPER

A FIRST "position statement" from the GP Committee of the BMA outlines what it believes should be the fundamental principles underlying the development of GP commissioning as set out in the Government White Paper on reform of the NHS in England.

Among the principles outlined, the GPC believes that it should be made explicit that GPs must not personally profit from commissioning budgets and that freed-up resources be reinvested in patient care. It also states that "a contract held by a GP should never be allowed to conflict with their professional responsibilities in providing care for patients".

In regard to the proposed GP consortia, the GPC said there should be assurances that, wherever possible, NHS providers are the providers of choice and that public and patient involvement should

be integral to the work of consortia. A stated commitment should be the reduction of healthcare inequality, wherever possible, and commissioning consortium must be democratically accountable to participating practices and should also "act with integrity and leadership when considering the accountability of practices".

BMA chair Dr Hamish Meldrum has called the White Paper a "curate's egg" - "good in parts, bad in parts, unclear in parts and even internally inconsistent in parts." But he believes doctors must "critically engage" with the consultation.

"I believe that it is vital that we rise to the challenge and, together, try to ensure that we mould these proposals into a set of solutions that can benefit our patients and the working lives of doctors."

## Study highlights early cancer predictors

EIGHT clinical features predictive of cancer in more than 5 per cent of cases have been identified by researchers writing in the *British Journal of General Practice* (BJGP).

Dr Mark Shapley and colleagues from Keele University identified eight symptoms or findings which predict cancer with sufficient accuracy to suggest urgent investigation in specific age and sex groups. These are: rectal bleeding, iron deficiency anaemia, rectal examination suggestive of malignancy, haematuria, haemoptysis, a breast lump, post-menopausal bleeding and dysphagia. The research was a meta-analysis of 25 existing studies from the US and Europe.

These symptoms, signs and test results have the potential to improve the early diagnosis of some cancers in primary care. The authors are calling for more research within the primary care setting to provide GPs with robust methods to help them diagnose and refer cancers much earlier.

Dr Shapley said: "GPs should audit their management and reflect upon these cases as part of their appraisal to improve quality of care. There should be more open public debate on the level of risk that triggers a recommendation for referral by a GP"

## Risk of adverse reactions in CAM use

GPs should ask patients about complementary medicine use in order to reduce the risk of adverse drug interactions.

New research has shown almost half of people in England have used complementary therapies and alternative medicines (CAM). Researchers from the Peninsular Medical School at the University of Exeter analysed more than 7,600 responses to the Health Survey for England 2005, a national household survey that included questions on CAM.

Nearly half (44 per cent) of respondents had used CAM, with a quarter saying they had used it in the last 12 months. Massage, aromatherapy

and acupuncture were among the most commonly used therapies. Just under 30 per cent of respondents who were taking prescription medicines had also used CAM in the last year.

Dr Katherine Hunt, research fellow at the Peninsular Medical School, said the survey was a "valuable reminder" to GPs to routinely ask patients about their CAM use.

"Herb-drug interactions have not been extensively investigated, a situation which is concerning given that the data suggests that more than a quarter of those taking medications in England were using CAM in the same 12-month period."



# LISTEN OR YOU'LL MISS THE DIAGNOSIS...

Good communication skills are crucial to a successful consultation – both what's spoken and unspoken. *GPST* editor **Dr Peter Livingstone** offers a perspective

**A**S WE START out in general practice training, one key element that is constantly emphasised is the importance of good communication skills in consultations.

These skills are crucial in our role as a doctor in building relationships with both patients and with work colleagues. And having good communication skills can make a big difference when it comes to successfully tackling your first patient consultations as a trainee GP.

Effective communication skills are important for many reasons. They have been shown to improve patient satisfaction, concordance and physiological outcomes. I remember seeing a type 2 diabetic whose blood glucose control had been poor despite lifestyle intervention and pharmacology. I spoke to her at length over a few consultations regarding her diabetes, making sure she understood everything, and after three months there was a significant improvement. Simply taking the time to talk things through with a patient can have very positive results.

## Unspoken messages

But talking to patients is not all there is to good communication. It is also worth considering what other 'messages' we are sending out when we communicate – both verbally and non-verbally. I remember seeing a patient who asked me for a prescription for tranquillisers. And while I didn't say as much, she could sense that I was uneasy with her request. This in turn made her feel uneasy as she thought I was going to refuse. While I did eventually prescribe the medication, she never came back to see me again. Consciously or unconsciously, the way we communicate conveys messages about our attitudes, feelings, beliefs, assumptions and prejudices.

It's also important to bear in mind what medical consultations are like for the patient. They can often be emotional and frightening experiences for them. I remember seeing a middle-aged smoker with weight loss and dyspnoea. I had to call him back to the surgery

to inform him of a shadow on the lung which required further investigation. I was extremely nervous about what to say, so I first warned him there was problem and then told him the findings. He immediately broke down in tears and asked: "Could it be cancer?" I agreed that it was a possibility but I also explained it could be chronic lung changes and the only way to find out was by doing further tests. I felt he left the consultation with some hope. I think it is always best to be honest with a patient if they mention the worst-case scenario but I always try to remain positive when speaking to them.

## Listening is a skill

Remember that while a doctor brings medical expertise to a consultation, the patient also has invaluable insight and knowledge about their own health status. Perhaps the greatest single problem in clinical interviewing is the failure to let patients tell their story at the start of the consultation. If the patient does not have an opportunity at this early stage to raise their concerns, the consultation can easily be spent on less significant matters.

For example, a gentleman came to me ostensibly to discuss smoking cessation. I quickly interrupted him, offering advice on what would be best for him. It was only later toward the end of the consultation that the real concern – his impotence – was raised and this required an extension of the consulting time.

Make sure you don't block communication with a patient during a consultation – avoid:

- Checking the clock
- Turning away from the patient to read the notes or computer
- Ignoring or cutting off the patient to ask a question
- Using closed or leading questions.

## Structure

It is vitally important to have a structure to consultations and there are many models out

there. At the start of my GP year I kept a copy of the Silverman et al<sup>1</sup> consultation model so that I wouldn't forget important and valuable areas such as checking the patient understands or safety netting. In reality these are not discrete stages but all interlinked. The Silverman model describes:

### Initiating the session

- Establishing the initial rapport
- Identifying the reasons for the consultation

### Gathering information

- Exploring the problems
- Understanding the patient's perspective
- Providing structure to the consultation

### Building the relationship

- Developing rapport
- Involving the patient

### Explanation and planning

- Providing correct amount and type of information
- Aiding accurate recall and understanding
- Achieving a shared understanding and incorporating the patient's perspective
- Planned: shared decision making
- Options in explanation and planning

### Closing the session

- Check patient understanding
- Health and lifestyle advice

Finally, we have to ask ourselves: do we convey positive regard and a respectful interest and curiosity about the other person, or do we convey impatience, superiority or a judgemental attitude? These latter characteristics are all barriers to getting the full story in a consultation.

Remember, as Sir William Osler once said:

**"Listen to the patient, he is telling you the diagnosis."**

*Peter Livingstone is an ST3 at Govan Health Centre in Glasgow and editor of GPST*

<sup>1</sup> Silverman J, Kurtz S, Draper J. *Skills for communicating with patients*. 1998, Oxford: Radcliffe Medical Press Ltd

# SPLENDID ISOLATION

Being a rural GP offers some unique rewards and challenges. Here **Dr David Hogg** talks about how he set up a useful online forum for rural practitioners and about his new job on the Isle of Arran

**D**AVID HOGG was still in training as a GP when he set up the RuralGP blog ([www.ruralgp.org.uk](http://www.ruralgp.org.uk)) in April 2009. The blog intends to be a resource for remote and rural GPs, GP trainees and nurses, and aims to provide up-to-date information about key events, discussions and initiatives in the UK rural health agenda.

David is originally from Edinburgh but trained in Glasgow, graduating in 2005. He progressed directly from FY2 into GP training in Ayrshire and completed his GP registrar year in Kilmarnock in August.

His rural interests were kindled by a student module in 2005 when he studied the provision of diabetes care on the Isle of Lewis. Since then he has maintained an interest in rural practice and will be spending the next year as a GP Rural Fellow on Arran.

"If I wasn't doing medicine, I'd be an outdoor activities instructor," says David. "But I get a lot of enjoyment from my job and wouldn't swap my current position for anything else."

## How did the idea for the RuralGP blog come about?

I was at a meeting in London of the RCGP Rural Forum, and we were discussing how we could provide an easily accessible resource for rural GPs. We agreed to trial a blog for six months, using a variety of podcasts, presentations and stories. Most feedback has been positive, and we've decided to keep it running.

## What is the purpose?

There's a huge amount of information on the internet that is very relevant to rural and remote GPs, however without adequate signposting it can be difficult to know where to look for this. The RuralGP blog aims to highlight some of the important stories and useful links, as well as foster some degree of community amongst rural GPs.

## How would you like to see it develop?

I think the internet has far more potential for rural practitioners than it is currently used for. Rural GPs have more difficulty in attending meetings, accessing peer support and going to courses, and there are ways of breaking those barriers with tools like Skype, webcasting, podcasting and email groups. The RuralGP blog is starting to assimilate some of these tools, as well as highlighting good examples



PHOTO: JENNI TURNBULL

of where this has been achieved already. The associated RuralGPNetwork is an email group of more than 150 rural GPs - it's free to join and is currently hosting some very stimulating discussion between colleagues.

Whilst access to broadband in rural areas remains difficult for some, I think this will become less of an issue over the next few years.

## What are the main challenges to being a rural GP?

I've only been in rural practice for a few weeks now, so I don't claim to be an expert! However, living in a close community, as well as being "on call" for most of the time, can bring reward as well as occasional frustration. Rural GPs need to be generalists - last week I treated a chap with SVT, sutured some minor injuries and incised and drained an abscess. That's on top of the usual GP presentations seen in any practice. It's a stimulating career choice.

## Are there any special skills needed?

Extended skills in all domains of general practice are useful - such as minor surgery, palliative care, emergency medicine, dermatology and general medicine. You may also find yourself attending a road accident, doing a ward round or applying a plaster cast. If you are new to the job, more experienced colleagues are usually happy to help you learn these skills, and there are going to be some exciting GP training programmes specifically for rural practice soon.

## What qualities make for a good rural GP?

The cliché "every day is different" applies, so

*"There's always a risk of supermarket aisle consultations, but the majority of patients respect your time off"*

flexibility and resourcefulness come in handy. Referring someone to hospital can require a wait for the ferry, or a helicopter transfer... until that happens you are responsible for that person so it's important to have some confidence in dealing with sick patients, including children. Being able to quickly integrate yourself into the community is important, as people are naturally curious about your background, and it's important to be interested in people's lives, not just the medicine.

## What's attracted you to pursuing rural general practice?

I love the outdoors, and my daily commute is second to none. Being able to offer a more personal service to patients is a major attraction. I became quite disillusioned with the many protocols, referral pathways and systems which are endemic - and perhaps necessary - in larger healthcare settings, and found it difficult to maintain continuity of care with my patients. Here on Arran, if I admit a patient to the hospital, it's me who will oversee their admission and I hope that this will be conducive to a more effective recovery. I think there's more accountability - which increases patient safety - and this also allows a far greater level of holistic care. The nursing staff here offer a fantastic level of care - they often know the patient personally - and we all take our turns in dropping bloods off at the ferry terminal and delivering the occasional prescription en route to something else.

## Are there drawbacks?

There's always a risk of "supermarket aisle" consultations, but the majority of patients respect your time off and offer a great level of support to health professionals. There's ongoing interdependency - I'm as reliant on the service provided by the ferry, petrol station, baker or bank, as they are on me for medical services. Being on an island may give a sense of isolation too, but I manage to return to Glasgow on a regular basis whilst doing the Fellowship year here and participating fully in the on-call rota.

## Other advice?

If any students or trainees want to know more about rural practice, I'm happy to be contacted ([david.hogg@nhs.net](mailto:david.hogg@nhs.net)).

*Interview by Jim Killgore, MDDUS editor*



## THE SICK CHILD

Sound practice principles are important not only for your young patients but also for you, says medico-legal adviser **Dr Anthea Martin**

**F**OR SOME GP trainees, paediatrics will form part of their training scheme and many will have experience of it from their foundation training. But for others, their only experience of treating children will have been learned in medical school.

Whatever your level of experience, it is important to remember that the principles of caring for children in general practice are straightforward and based on the basic principles of good medical practice.

### History and examination

Taking a good history is the very cornerstone of every consultation and it's no different when the consultation involves a child. Children and young people are individuals with rights and it is important to involve them in a consultation and to listen to what they have to say.

Clearly where a child is too young to communicate effectively you must rely on their parents. Always listen to parents and take on board their concerns - it can be all too easy to dismiss them as being over-anxious. Many of the complaints that we see at MDDUS concerning children are raised by parents who believe their concerns have not been taken seriously or that they have not been listened to.

Communication is vital in terms of obtaining consent for examination. Where a child is capable of giving consent or agreeing to an examination then you should involve the child in that decision, explaining what will happen in a way that they can understand. Where the child does not have capacity to consent, you should involve the parent. In one case from MDDUS' files, the mother of a young boy complained because a doctor examined her child's testicles. She felt it was completely unnecessary and had not consented to the examination, but in fact it was a perfectly reasonable examination for the doctor to do in the circumstances. He apologised for not explaining to the mother why he wanted to examine the child's testicles and for not obtaining her explicit permission to do so. The mother accepted his apology and the complaint was resolved.

### Investigation and treatment

MDDUS advisers are sometimes asked if a doctor can treat a child who attends the surgery without a parent or other adult. Doctors can see children and young people on their own and treatment can be provided with their consent if they are capable of understanding the nature, purpose and possible consequences of investigations or treatment.

The capacity to understand will vary and depend on the maturity of the child, the treatment proposed and the complexity of decision to be made. Doctors have the same duty of confidentiality to children as they do to adult patients. Information can be shared with their parents if the child agrees, where the child lacks capacity, where it is in the child's best interest to share the information or where there is an overriding public interest.

### Documentation

The GMC advises doctors to keep clear, accurate, contemporaneous and legible medical records that report the relevant findings. It is advisable to consider documenting relevant negative findings as well as positive ones. For example, in the case of a febrile child - where a child has been examined to determine if there is a non-blanching petechial rash present - it would be equally important to record its absence as well as its presence.

MDDUS has dealt with several claims where there is an alleged delay in diagnosis of meningitis. This is notoriously difficult to diagnose in the early stages, where the early symptoms and signs may be quite non-specific (see case study on page 14). The recording of the absence of such a rash demonstrates that the doctor has considered this diagnosis and examined the child, checking for appropriate signs of the illness. This helps greatly in the event of a complaint or claim raised at a later date that a diagnosis of meningitis was missed.

### Prescribing

When prescribing for children you should be familiar with and refer to guidance published in the *British National Formulary*. And if in doubt...ask!

In all aspects of their work doctors must recognise and work within the limits of their competence. If you require advice about treating children, seek assistance from your trainer or a senior colleague. Full guidance concerning the treatment of 0-18 year olds is available from the GMC.

*Dr Anthea Martin is a medico-legal adviser at MDDUS*



# ADVANCE DIRECTIVES

**E**ND-OF-LIFE issues are never far from the news these days with the continuing debate on assisted suicide and what constitutes dignity in death. This increased awareness is no doubt at least partly behind the growing number of patients having advance directives prepared, setting out what they want in the way of medical intervention should they become ill in the future and lose capacity to state their preferences.

GPs do not have to be legal experts to deal appropriately with advance directives but they do require a basic appreciation of the underlying principles in order to discuss important considerations with patients.

In Scotland there is no clear precedent to indicate how courts would view advance directives, but case law in England appears to support them as legally binding in certain circumstances. Similarly, there is no basis in statute for advance directives in Scotland, while in England they are recognised in the Mental Capacity Act 2005.

There are several key points that are worth remembering when discussing advance directives with a patient:

- Firstly, advance directives may specify treatments of any kind that a patient wants or does not want in the future, and they may be verbal or written. However, any advance directive refusing life-saving or life-prolonging treatment must be written, signed and dated by the patient and witnessed and signed by a third party.
- A patient must have the mental capacity to complete the directive and must not do so under duress from others.
- At the time when the directive is being enacted, it must be clear that there has been no significant change of heart on the part of the patient since the directive was first completed.
- The situation or illness faced by the patient must be the same as that described in the directive for it to be applicable.
- Only advance refusals of treatment may be legally binding (England and Wales): advance requests for specific active treatment can certainly be made, but doctors cannot be forced in this way to agree to provide treatment in the future against their better judgment.
- For them to be of value as legal documents, advance directives must not be too specific or too general in their terms.



Considering these points it can be seen how problems might arise, and these are best illustrated by some examples drawn from real-life situations.

## Case 1

Mr A, a 65-year-old physically disabled patient with learning difficulties, presents you with an advance refusal of treatment directive, but later his friend informs you that she has concerns about the care being provided to the patient by his family, who have been heard to say that they are fed up having to look after him. The friend has heard about the directive and is aware that the patient was taken along to a solicitor by his daughter to have it completed.

Here the issue of mental capacity arises and it would therefore be important to discuss the terms of the directive to make sure that the patient understands its implications clearly and has capacity to agree to it. There may also be issues of duress from a family member, and it may be worth clarifying with the patient his own feelings about his situation and his reasons for agreeing the directive.

## Case 2

Miss B completes an advance directive stating that as a Jehovah's Witness she does not want a blood transfusion, even if her life is at risk. She is subsequently admitted several years later gravely ill due to heart disease and requiring a life-saving blood transfusion. Her husband points out that she left the Jehovah's faith when she met him and her views have changed.

There is significant evidence of a change of opinion which requires consideration. This was the basis of a real-life case which was heard in an English court. Weighing up the evidence it was agreed that the patient's views were likely

to have changed, and the blood transfusion was sanctioned.

## Case 3

Mr C, a patient with a malignant brain tumour currently in remission, completes an advance directive refusing life-prolonging treatment if the tumour recurs and he loses consciousness. Unfortunately, he suffers a haemorrhagic stroke as a consequence of other treatment, and becomes comatose with no prospect of recovery.

The advance directive indicates that this patient would not wish life-prolonging treatments if these appeared futile, but because it relates specifically to brain tumours, it is not relevant to his current situation. It may still be used as evidence when considering his best interests, but would not be legally binding.

In summary, it is increasingly likely that at some point in your career you will be asked to take note of an advance directive and you must be aware of the limitations and complexities that exist. Any significant uncertainty about the validity of an advance directive should be addressed by seeking legal advice, as contentious cases may well require settlement in court. Whilst awaiting a decision, it is of course important in disputed situations to continue immediately necessary treatment to protect the patient until a decision is reached.

The GMC has produced useful guidance on advance directives and other end-of-life issues in the booklet *Treatment and care towards the end of life: good practice in decision making* (2010) and this can be accessed at [www.gmc-uk.org](http://www.gmc-uk.org)

*Dr Barry Parker is a medico-legal adviser at MDDUS*

# DOCTOR FOR HIRE

Being a GP locum promises flexibility and variety with the chance to choose where and when you work. **Dr Ian Thompson** offers an insight into the job

**W**HEN you finish your GP training, there are various career options to consider, from the commitment of a practice partnership to perhaps working for the armed forces. One career option that may not immediately spring to mind is locum GP work. While this role might not suit everyone, it is certainly worth considering.

I chose to work as a GP locum because I wasn't ready to commit to a partnership at the end of my registrar training. Over the years I've met many different GP locums at various stages in their careers. Many of them are GP registrars who have not yet found a partnership but are keen to do so, while some have made a positive career choice to be a locum GP because they appreciate the flexibility which this work offers.

Others are returning to general practice work following a career break and some have left a partnership because they wanted to change their career plans. There are also retired partners who choose to locum to keep their hand in with clinical work.

## Variety

Work as a GP locum can be very varied and interesting. You can work in a variety of urban and rural practices experiencing a range of different settings of general practice. In the five years I have worked as a full-time locum I have gone from doing long-term regular sessions with a limited number of practices to working in a different part of Scotland and completing ad hoc sessions with more than 40 practices over four health board (PCO) areas in six months.

At other points of my career I have had a succession of long-term maternity locums based in one practice. There are advantages to this in that you can become part of the local practice team (though this depends on the practice) and get some continuity of care with patients.

## Unpredictable

It's hard to know what you'll come up against in a new practice. I have faced some interesting challenges, often because the individual practice units are disorganised. One year I went in to cover a single-handed practice after the Christmas break to find the computers were down, the receptionist did not have any instructions on what to do and the practice manager was unavailable. Fortunately in this



scenario I used my own expertise to get the server running again while waiting for IT support.

Other more rewarding challenges have included stitching up an elderly lady's hand after she cut it filleting fish, saving her a long trip to the local emergency department, and then seeing her a few weeks later with it all nicely healed.

*"It's hard to know what you'll come up against in a new practice."*

## Pros and cons

Locum work has many advantages, including being your own boss and deciding when you want to be available for work. When you do work, you are contracting to provide a service to a practice so it is important to be professional about that and provide the kind of service they want, but in my view the flexibility of having control over when and where you decide to work outweighs any problems.

Also, you don't have to worry about many of the management issues that partners have to deal with. This includes building maintenance, practice staff management and HR issues like poorly performing staff, absenteeism or what additional contracts the practice will agree with the board. You can work in a wide range of practices and choose not to return if you don't like working in one place.

On the down side, unless you get a long-term locum contract you often lose out on the continuity of care that is sometimes regarded as key in general practice. You also have to deal with the variable availability of work so plan for the lean times when it is busy.

On occasions the practices you work in may not be as organised as you'd like, and you are usually unable to influence those systems. Equally, practices often don't





make clear the details of how they operate and local referral processes can be very varied, making it a challenge to know exactly how to manage patients.

Continuing professional development and not having a fixed group of peers can be a challenge as a locum, which is why it is important to be involved with your local sessional GP group. The National Association of Sessional GPs ([www.nasgp.org.uk](http://www.nasgp.org.uk)) keeps a list of local groups, though this can be out-of-date for some areas. In some regions these groups have links with the Local Medical Committee, which is a good way to get your views heard by representatives of local practices.

### Medico-legal challenges

A lot of what you do as a locum is the same as any good GP should be doing - keeping accurate and contemporaneous records. But there are some areas where the lack of continuity potentially puts you at risk. If you decide to refer a patient, how do you make sure you complete the referral? Do you have a system for ensuring that referrals you dictate are completed by the practice? Can you be sure that someone will follow-up on any test that you request?

Often the answers lie in linking with existing systems for the practice you are working in, but making sure that you hand over key tasks at the end of your session is an important part of being a locum GP. I got into the habit of documenting the next step I planned in the notes so that anyone could pick up where I left off.

One of the biggest frustrations for locum GPs in the medico-legal sense is the reluctance of many practices to give you your own login to the clinical system. This is more important these days when nearly all practices rely on the computer system for notes. It is particularly frustrating for locum GPs given that the requirement for unique individual logins was part of the Scottish Information and Management Technology DES a few years ago, as well as being part of general good IT practice and also good

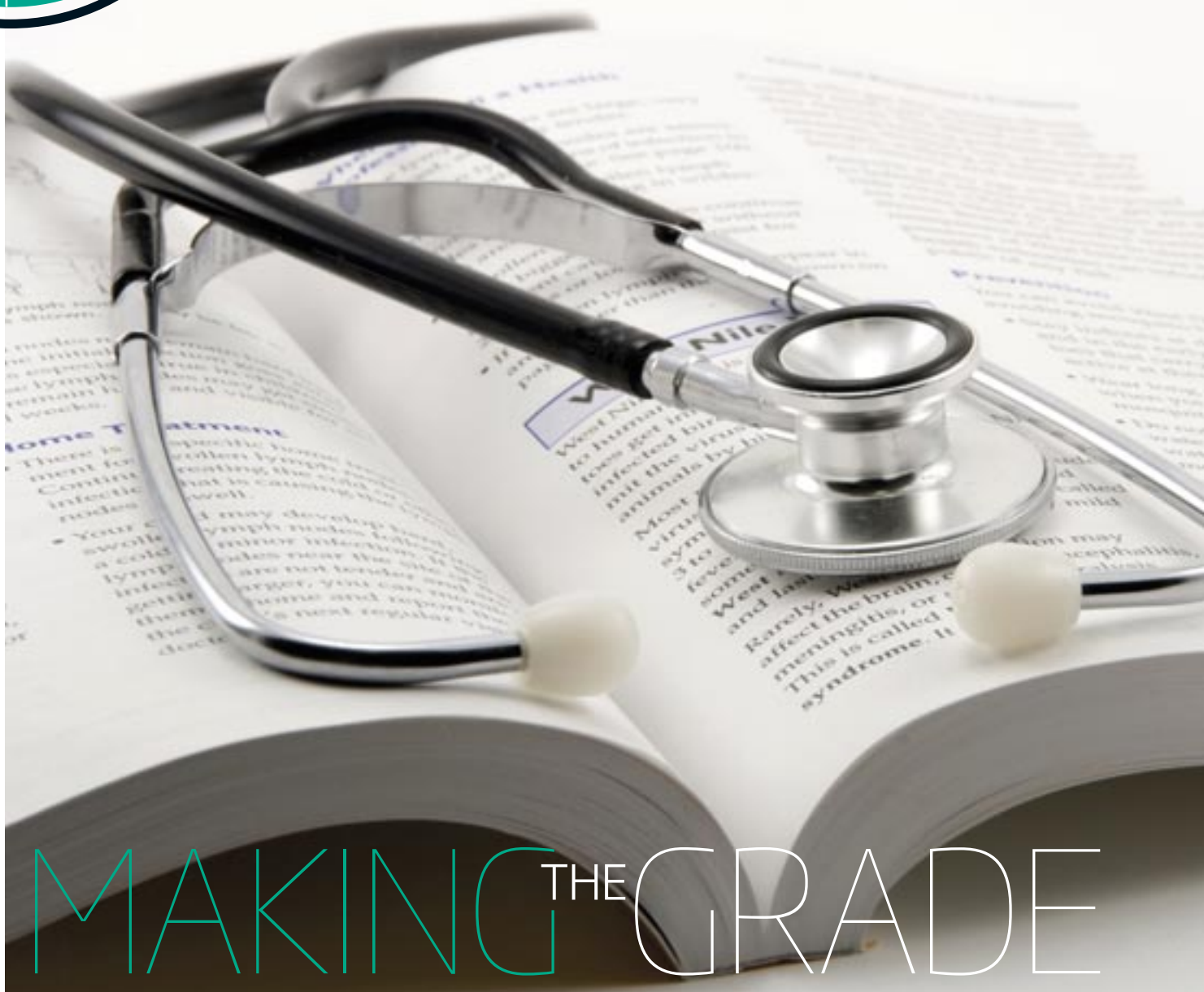
practice from a medico-legal viewpoint. If you are unfortunate enough to be given a generic "locum" login to the clinical systems or, worse still, expected to use the login of a partner then it is important to put either your name or initials at the end of any clinical entry to identify yourself.

### Tips for starting as a GP locum

- Get on the performers' list of your local health board/PCT. Read detailed guidance from the Department of Health at [www.tinyurl.com/2bo8lrd](http://www.tinyurl.com/2bo8lrd).
- Join a local sessional GP group.
- Register as self-employed with HMRC and pay National Insurance contributions within 100 days of starting work or you will be fined.
- Explicitly agree with practices in advance what work is involved for what fee. The BMA are developing example terms and conditions, and some locums have published their own on the internet.
- Keep accurate records of the work you do, mileage and other expenses for your tax return.
- Consider hiring a medical accountant who understands GP locum work.
- Create a system for making invoices, recording where you have worked and what you were paid, your mileage and completing pension forms. You can use standard office software, but also check the (currently free) Locum Organiser at [www.locumorganiser.com](http://www.locumorganiser.com)
- Be polite to practice admin staff. They are usually a mine of information when you are unsure.



*Dr Ian Thompson works as a part-time GP partner and part-time GP locum in south-east Scotland. He formerly represented locum GPs on the BMA's Scottish GP Committee and UK Sessional GPs Subcommittee*



# MAKING THE GRADE

Preparing for the compulsory exams can be a stressful time, but MRCGP examiner **Dr Mei Ling Denney** says timing is key

**M**OST GP trainees will naturally feel a degree of anxiety about the compulsory MRCGP exams. The process can be stressful and expensive, especially as doctors must achieve a pass in order to become certified to practise as a GP.

But if you can get the timing right, understand what the examiners are looking for, and prepare well, you should be able to take them in your stride.

The new MRCGP examination was introduced in 2007 and is compulsory for entry to the General Medical Council's GP register. It comprises three parts: the Applied Knowledge Test (AKT), the Clinical Skills Assessment (CSA) and the Workplace-Based Assessment (WPBA). I will focus on the AKT and CSA and the recent changes that have been introduced to these components of the exam.

## **AKT**

The AKT is a three-hour, 200-item multiple-choice, pass/fail exam which tests application of

knowledge and ability to interpret information. Question writers are MRCGP examiners, who are all practising GPs. They base questions on everyday clinical work, including clinical problems, guidelines and practice management. Although most of the AKT is concerned with GP clinical medicine, a fifth of the questions cover critical appraisal and ethical/legal/organisational issues.

Although candidates often worry most about statistics and critical appraisal questions, in many ways these are the easiest to revise for as the subject area is quite specific and there are many books and e-learning aids available. Make sure you read GP-related articles in the *BMJ* and *BJGP* as many of these come into the questions on evidence-based practice. It's also a good idea to participate fully in any practice team meetings to pick up tips on how to manage non-clinical problems that GPs might face in the surgery.

Questions come in different formats, mainly single best answer with some extended matching questions. Newer question formats

you will receive detailed scores and feedback through your e-portfolio.

### CSA

The CSA tests both clinical and consultation skills in a circuit of 13 cases taken from everyday general practice. All consultations are marked by experienced examiners observing each 10-minute case, whilst trained role-players act as 'patients'. The examiners are testing ability to gather information, apply knowledge of disease processes, demonstrate evidence-based decisions, person-centred care and effective communication with patients and colleagues.

Each case is marked in three domains:

1. Data gathering, examination and clinical assessment skills
2. Clinical management skills
3. Interpersonal skills.

### Domain 1

Here the key to success is focused history-taking, using a hypothetical-deductive approach. Make sure you have a realistic list of differential diagnoses - practise doing this in real life. Read the patient notes and use them appropriately - avoid repeating the facts back to the patient but incorporate relevant ones in the consultation.

You may be given clinical measurements and test results but not every piece of information supplied has the same priority for a given consultation. Target your choice of physical examination to the patient, and remember you are only expected to do what is reasonable in a 10-minute GP consultation. A new RCGP learning resource is available on eGP to guide you in this. Don't do whole systems

sensitively to achieve a desired outcome.

### Domain 3

This domain also includes professional attitudes and ethical behaviours. Being patient-centred is very important but this does not mean automatically giving the patient what they want, and not all consultations require patient-centredness. You should try to really understand the patient's illness experience and health beliefs and take these into account. It is essential to develop a rapport, demonstrate active listening skills, and share ideas and concerns. Show respect for others - examiners want to know that you can interact with staff and colleagues courteously and effectively.

It is important for you not to consult differently during the exam, as this may result in an artificial consulting style. Instead, focus on the nub of the case, using good consultation skills to add structure and manage time efficiently.

### The new marking system

For the CSA, the pass mark will be set using the borderline group method, where each case will have its own pass mark, rather than the previous system of needing to pass eight cases out of 12. Examiners will mark all three domains and give a final global score. Before, only the global score actually counted but now the domain grades will count towards the candidate's final mark, and the overall case grade will not.

Each candidate will end up with a numerical score for each case and these are added up to create their total CSA exam mark. The pass mark will be set every day by the new method to reflect the varying difficulty of cases, which makes it fairer to candidates. In a similar way to the AKT, you will be informed of your

*"Learning for the exams should be no different from learning to be a good GP"*

such as video clips, and questions requiring "free text" responses will be introduced once they have been trialled.

The secret to success is good preparation and time management during the exam. Practise the different question formats by going through up-to-date AKT books. During the exam, check frequently that you are on track to cover all the questions in time. Don't waste time agonising over difficult questions - these can always be electronically highlighted and returned to later.

After you have registered with the RCGP to sit the AKT, you must book a test at one of the invigilated centres (also used for driving test theory exams) - act quickly to make sure you get allocated to a centre of your choice. You can take the AKT up to three times a year, but it now cannot be taken before your ST3 stage of training. AKT passes are no longer valid for only three years - essentially there is now no limit. A maximum number of four attempts are allowed and the best timing for it is usually at the end of ST2 or early ST3. After the exam,

examinations, and handle instruments correctly to avoid hurting the patient.

### Domain 2

Clinical management and how a patient is involved in the decision-making are areas where many candidates fall down. Examiners look for the recognition and management of common medical conditions in primary care. You should be able to deal with patients with multiple complaints, appropriately prioritising items on both your and the patient's agenda. Management plans should be realistic, reflecting appropriate knowledge of evidence-based medicine.

You must be aware of the wide scope of the curriculum, and try to actively seek experience to cover areas of weakness and ones where you have less exposure. This might include patients from different ethnic, cultural or social backgrounds, physically or mentally handicapped patients, and angry or upset patients. Health promotion, though important, may only be a priority in some of the consultations - do this

overall score alongside the pass mark for the CSA on that day.

Changes that apply to AKT passes obtained after August 1, 2010 also apply to the CSA, in that a CSA pass will no longer be subject to a three-year validity limit. You can now take the CSA a maximum number of four times, and only when you have achieved at least ST3 stage of training. If you started your GP training before August 2009, transition arrangements apply - details are on the RCGP website.

In summary, the exams are really quite straightforward and are very much focused on general practice. Make use of your trainer as much as possible to give you feedback on your progress and whether you are at the right stage to take the exams. Learning for the exams should be no different from learning to be a good GP, and should not be too stressful if you have done your homework!

*Dr Mei Ling Denney is an MRCGP examiner, and is currently Deputy Chief Examiner/ R&D lead for the MRCGP assessment*



# ANGER MANAGEMENT

IT CAME out of the blue. He stood up and pushed his chair over and declared: "I am not leaving this room until you give me my prescription."

He was blocking my exit to the door and suddenly I felt very vulnerable. How did I get myself into this situation, and more importantly how could I get myself out?

This scenario will be familiar to many of the UK's GPs. A BMA survey of 3,000 doctors in 2003 found violence at work was a problem for more than half of respondents, with more than a third having experienced workplace violence in the last year. This applied to hospital doctors and GPs, with the majority of GP incidents taking place in the consulting room or waiting area and involving either a patient known to them or a member of the patient's family.

## Managing Mr Angry

One of the most enjoyable and challenging aspects of general practice is the variety of people and medical problems that come through your door. As a new GP, you will be developing your clinical knowledge and communication skills in order to manage each new scenario that presents itself. It is vital to take time early in your training to consider your strategy for managing Mr or Mrs Angry who, if not skilfully handled, can transform into Mr or Mrs Violent.

Understanding the anger/assault cycle is a good place to start. Professor Glynis Breakwell identifies five phases in the transition from anger to violence in her 1997 book *Coping with Aggressive Behaviour*:

Trigger → Escalation → Crisis → Recovery → Post crisis depression

Patients' anger can be triggered by a variety of events and in most cases these triggers are completely unrelated to the individual doctor. Triggers include:

- **Problems with the surgery:** a delay in getting an appointment or a prescription; not being able to see the GP of their choice or a long wait.
- **Perceived medical failings:** a belief that their illness or concerns have not been taken seriously or they have not received the treatment they feel entitled to.
- **Guilt:** feelings arising from actions or behaviour, or with regard to a sick relative.

- **Grief:** patients may be grieving either due to bereavement or perhaps they have been given a significant diagnosis.
- **Problems at home:** financial worries, social or psychological problems and relationship difficulties.
- **Underlying medical conditions** can predispose patients to a short fuse, anxiety or a psychiatric illness, or drug or alcohol dependence.
- **Poor communication skills:** a doctor appearing uninterested and dismissive, being abrupt and rude.

Rule number one is - do not react to the anger personally. The patient may express their dissatisfaction to you verbally (for example: "I have been waiting for 20 minutes to see you") or non-verbally through their body language: arms folded, pursed lips, facial expressions. Understanding what can trigger a patient's anger will help you react better.

## Escalation

How you choose to respond can determine whether the anger escalates or is defused. So first of all, recognise that the patient is upset. A good response to the remark above would be: "I'm really sorry to have kept you waiting; 20 minutes is a long time." This acknowledges that the patient is upset and that 20 minutes is a long time to wait, as well as offering an apology.

Acknowledge, agree, apologise: this type of response makes it difficult for the patient to continue to be angry, and effectively disarms them. If the doctor follows this up with some active listening the situation should be resolved.

Similarly, don't ignore aggressive cues in body language. In this scenario the doctor could say: "You seem to be upset about something, is there anything bothering you?" If, however, the doctor ignores the patient's comment and body language, or chooses to respond defensively (for example, by saying: "Well I can't help that; it's not my fault the computer is playing up"), this is more likely to escalate the patient's frustration and anger.

Indications that the patient's anger is escalating can be verbal, with the patient making threatening remarks, repeating themselves, shouting or swearing. Non-verbal signs can be loss of eye contact, sweating, pacing the floor, pointing or adopting an aggressive posture. It is important to





Dealing with aggressive patients is a challenge many GPs will face at some point in their career. MDDUS medico-legal adviser **Dr Susan Gibson-Smith** offers some advice on how to handle these difficult situations

recognise this escalation because there is still an opportunity to defuse the anger at this stage.

Remember: do not react personally. Instead think: "Why is the patient angry and what can I do to help them sort this out?" Acknowledge the behaviour the patient is exhibiting and describe it to them, for example: "I can see from the way you are shouting that you are very upset. Can you tell me what is upsetting you?"

Speak in an even tone and do not shout. Maintain normal eye contact and adopt a non-aggressive pose. Use active listening techniques like nodding and repetition and summarising with paralinguistic phrases 'uh huh' and 'mmmh', all of which convey to the patient that their feelings are important to you and you are taking the concerns seriously. Express empathy, concern and support for how they are feeling and apologise for any upset.

Once the patient is calmer you can discuss how you can help. It is important not to just give the patient whatever they want just because they are upset. Present the patient with realistic achievable options and come to a shared,

should have a protocol for what to do if a doctor presses the panic button, so be familiar with it.

### Recovery phase

Even after the crisis or escalation phase has passed you are still at risk as the patient's anger can quickly spark again, so watch for signs of further escalation. Most people are not quick to calm down. The recovery phase usually lasts around 45 minutes but it can be double that after a serious outburst.

Next is the post-crisis phase which is one of resting and recovering from the high state of arousal that the body has just experienced. The ability to think clearly begins to return and the patient may feel guilty about what has happened, which may lead to feelings of shame and depression.

### A case in point

So let's look again at the opening case of the patient demanding a prescription. This man was promised by one of the GP partners, Dr X, that he would be given a prescription for Viagra following an appointment to discuss the matter. The patient made an appointment but was booked in with the GP trainee, Dr T, without being told. This is the first trigger of his anger.

Once the consultation gets underway, Dr T is not confident that the patient meets the criteria for a prescription on the NHS. He turns his back to the patient to search the internet for guidelines. He doesn't notice the patient's facial expression and body language indicate he is getting annoyed. Dr T finally finds the guidelines and asks some very intimate questions which make the patient uncomfortable. His embarrassment makes him even more angry. Once Dr T is sure of his facts, he tells the patient that he doesn't qualify for an NHS prescription of Viagra. Their discussion becomes heated and the patient shouts repeatedly that Dr X "said I could get it".

Dr T responds by holding up the NHS guidelines on Viagra prescribing to justify his argument. The patient loses his temper and pushes over his chair. Dr T's exit is blocked but he manages to get out and finds another GP who resolves the situation.

If you find yourself in a similarly difficult situation, then bear in mind some of the techniques mentioned above and hopefully your consultation will end on a more positive note.

*Dr Susan Gibson-Smith is a medico-legal adviser at MDDUS*

*"Ensure that in your consulting room you have an uninterrupted pathway to the exit."*

agreed plan. As in all good consultations you should check the patient's understanding of what you have agreed and fulfil your side of the bargain. At the end of this you may feel emotionally exhausted and it is important to recognise this and deal with your emotions before the next patient.

### Crisis

Not all situations can be defused. Sometimes the warning signs are missed and the situation will escalate to crisis. This is when Mr Angry turns into Mr Violent. Rule number two is - get out and get help. Your safety is paramount and it is vital to ensure that in your consulting room you have an uninterrupted pathway to the exit. Make sure there is no furniture blocking the way to the door and, ideally, the patient's seat shouldn't impede your exit. Check the layout of your consulting room in advance with this in mind.

Most consulting rooms have a panic button so check where it is and find out what happens if you press it. The practice

DELAYED REFERRAL

# A NOT SO SIMPLE FEVER

**DAY ONE**

MRS Y brings her six-month-old baby girl to see her GP - Dr H - as the child has been unwell for more than a week. The baby has a cough, runny nose, high temperature, diarrhoea, is lethargic and will take breast milk but no solids. Mrs Y tells Dr H that an out-of-hours doctor had seen the baby when she first became ill several days before and prescribed antibiotics and a liquid paracetamol. Worried that the symptoms seem to be persisting, Mrs Y wants Dr H's opinion. The GP examines the baby's chest, throat and ears but finds no abnormality. The doctor tells Mrs Y to keep the child cool and continue with the paracetamol.



**DAY THREE**

The baby's parents contact a second out-of-hours doctor in the early hours of the morning as the child is still coughing and feverish. They tell the doctor that the baby has also been vomiting and is showing signs of having stomach cramps. He advises them to see their own GP that same day. The parents take the baby back to their practice as soon as it opens that morning and she is seen this time by Dr Q. The doctor notes that the child has an upper respiratory infection and has a fever but the clinical examination is clear. She prescribes a further course of antibiotics and liquid paracetamol. Dr Q makes no record to indicate if the child has been vomiting or showing signs of stomach cramps.



**DAY FOUR**

When the baby's condition fails to improve, Mrs Y again calls an out-of-hours service and speaks to Dr R. She tells the doctor of the baby's history, that she has been vomiting and also has a high-pitched cry. Dr R doesn't examine the baby and advises Mrs Y to keep the child cool and stop administering antibiotics in a bid to stop the vomiting. Several hours later Mrs Y seeks help from another out-of-hours doctor, who refers the baby for a paediatric assessment. Later that day the baby is diagnosed with pneumococcal meningitis and admitted to hospital.



**M**r and Mrs Y raise a claim of medical negligence against Dr Q and Dr R for failing to diagnose their child and failure to refer. They allege that if the child had received hospital treatment sooner, she would have survived. An initial complaint against Dr H is withdrawn following expert advice.

MDDUS represents Dr Q while Dr R is represented by another medical defence organisation. An expert report commissioned by MDDUS is critical of the notes taken by Dr Q for not including enough detail of the consultation, including the presence or absence of relevant symptoms. Dr Q claimed she had checked for signs of meningitis but did not note any specifics of the examination. The report also concludes that an inability to detect any clinical signs that might have explained the child's high temperature should have prompted Dr Q to look for other possible signs. The report also criticises Dr R for not arranging for the child to be examined, despite her having been unwell for more than a week.

MDDUS also obtains expert evidence in regard to causation which determines that

had Dr Q or Dr R referred the child at the time of consultation then this would have made a material difference to the eventual outcome in the case.

Due to the conflicting claims made between the parents and the doctors in regard to the child's symptoms and subsequent care, and the absence of comprehensive medical notes to substantiate Dr Q's position, MDDUS agrees a settlement with Mr and Mrs Y which is shared equally by Dr R's MDO.

**KEY POINTS**

- Be aware that classic signs of meningitis (neck stiffness, bulging fontanelle, high-pitched cry) are often absent in infants with bacterial meningitis.
- Always take comprehensive notes - including positive and negative test results - when examining a febrile child.
- Be familiar with standard clinical guidelines when dealing with feverish illness in children.

**ONE WEEK LATER**

The baby dies of an intracranial bleed among other complications from the meningitis.



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# Diary

Welcome to Diary - sadly relegated to the back page of GPST for reasons which will all too soon become obvious. Please feel free to send us any like items for future editions at [gpst@mddus.com](mailto:gpst@mddus.com)

● **SMART PILL TO GO** Diary has often yearned for a postprandial smart pill to help with the *Guardian* crossword - or for you it might be something to help face the daunting prospect of sitting the MRCP exam. Well, take heart - a brain compound called kynurenic acid has been linked to cognition. University of Maryland scientists found the acid inhibits brain receptors that stimulate learning and memory. The discovery could possibly lead to development of a drug to aid learning in healthy people. No word yet on potential advance orders...

● **MUST-HAVE MEDICAL APPS** The medical charity Arrhythmia Alliance has released an iPhone application that aims to help detect heart rhythm disorders. The 'Know Your Pulse' app provides users with an onscreen guide to record pulse readings over 30 seconds and then advises whether they may be suffering an irregular or unusually fast or slow heartbeat. The app is part of a larger campaign aiming to improve knowledge of cardiac arrhythmias and raise awareness of the importance of regular pulse checks during normal patient check-ups. Let's just hope it's more successful than the NHS drinks tracker application released in December last year. This was launched to allow iPhone users to keep track of drink consumed in alcoholic units so as to discourage people from overindulging. Within days of the tracker being released it was being described on the internet as an "awesome game" with users trying to beat their "top score".

● **NO FREE LUNCH IN BOSTON** A new ban in the state of Massachusetts on drug companies providing free lunches to doctors is hitting local restaurants so hard they are lobbying to have the law changed. No such problem in Los Angeles where there is a company called Dr Lunch devoted entirely to providing free drug company lunches for medics - and business is booming.

● **LAST WORD IN GORE CHIC** A French "transmedia artist" named Olivier Goulet has released a range of bags, accessories and overgarments called SkinBag which are fashioned from synthetic material to look like skin, muscle and internal organs. Nothing says it better than the company's own publicity material. "You can view the SkinBags as bodily extensions; external organs which serve as holdalls for items we have around us....an invitation to explore ourselves and our environment. It is created as a guide to human mutation, that painful journey from egocentric individualism towards an optimal collective identification and networking." Or a rubber scrotum to hold your mobile phone. See [www.skinbag.net](http://www.skinbag.net)

● **WOOLLY BREASTS** More helpful and decidedly less creepy are the 150 knitted woolly breasts recently commissioned by the NHS from the Somerset Mothers' Union. These are to be used to demonstrate breastfeeding techniques to new mothers. The USA is - of course - light years ahead in the field, with organisations such as Knitted Knockers long producing prosthetic breasts for women affected by breast cancer.

● **CEREBELLUM NOT ESSENTIAL** Journalists are often accused of using only selected parts of their brains and this certainly has proved no serious handicap for Diary. But it turns out it is possible to live a relatively normal life without a cerebellum. The journal *Brain* recently published a retrospective case study from 1939 of a 76-year-old man who died of heart disease and at autopsy was found to have absent cerebellar hemispheres and yet possessed enough motor skills to hold down a job as a manual labourer.

● **ENOUGH ABOUT QUALITY OF LIFE - HOW ABOUT DEATH?** So where would you need to set up practice in order to enjoy the best quality of life? Vienna, it turns out, with Baghdad being the least salubrious - or so claims the Mercer's 2010 Quality of Living survey. But if you're looking for the best place to shuffle off this mortal coil it could be Britain. The UK has been rated top in the world for 'quality of death' according to an index on end-of-life care devised by The Economist Intelligence Unit (EIU). The index was commissioned by the Lien Foundation and ranks 40 countries according to their provision of end-of-life care. The UK tops the table which is based on indicators such as public awareness, training availability, access to pain killers and doctor-patient transparency.

● **DATA INSECURITY** Just having a data protection policy in place is sometimes not enough. A report on the Information Commissioner's Office (ICO) website tells how a USB data stick used routinely to back-up clinical administrative databases went missing from Her Majesty's Prison Preston. A thorough search never turned up the data stick which held medical details relating to over 6,000 patients who were or had been incarcerated at the prison. It later emerged that the data stick had indeed been encrypted but unfortunately the password had been attached to the device on a slip of paper.

● **AND FINALLY, DIABETIC PETS** Diary is an avid reader of *Anthrozoos: A Multidisciplinary Journal of the Interactions of People and Animals*. A recent study from the journal caught our eye. Canadian researchers found that - on the rare occasion, surely - when the pets of diabetics also develop the disease it prompts their owners to better control their own physical activity, diet and sugar levels. Please direct your suggestions for any practical application of these findings directly to *Anthrozoos*.



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MDDUS are once again offering two £1,000 awards to successful applicants from GP practices where both the trainee (commencing training in August 2010) and trainer are MDDUS members.

We recognise that financial constraints are often a barrier for GP trainees interested in pursuing some of the varied educational opportunities available. MDDUS grants can be used for any form of educational training including attendance at courses, conferences and seminars, practice training and the purchase of textbooks.

Please note that only proposals which reach the MDDUS by the deadline of March 31, 2011 will be considered.

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For more details, including full terms and conditions, contact [kwalsh@mddus.com](mailto:kwalsh@mddus.com)