



# FRONTLINE **MEDICINE**

THE CHALLENGES OF A CAREER IN THE ARMED FORCES



ALSO INSIDE

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TAKING OVER GENERAL PRACTICE?

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CONFIDENTIAL INFORMATION

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PUBLICATION





## Welcome to your GPst

WELCOME to the second edition of *GPST*. This time of year is very busy for all those doing professional examinations and completing their general practice training and I wish you all good luck.

Having worked in primary care for a reasonable period now you will have all built up a good rapport with your patients. However, there are some patients that you may still find challenging. On [page 4](#) I offer some insights on dealing with so-called 'heartsink' patients. They may sometimes tax your time and patience but they still get sick like anyone else.

Confidentiality is key to a successful doctor-patient relationship, but is it ever okay for doctors to share sensitive patient information without consent? MDDUS medico-legal advisor Dr Susan Gibson-Smith offers advice about making public interest disclosures in her informative article on [page 12](#). More and more patient consultations are being held over the phone, and on [page 7](#) MDDUS risk adviser Alan Frame

looks at some of the pitfalls.

Whether it's a free lunch or free tickets to a sporting event, everybody enjoys getting something for nothing. But the new Bribery Act comes into force this year and MDDUS contributing editor Jim Killgore offers some words of caution on [page 6](#). President of the Medical Women's Federation Dr Clarissa Fabre talks about the growing role of women in general practice on [page 10](#), while on [page 5](#) Dr Ian Mason discusses how wildlife photography became more than just a weekend hobby.

Any GPs looking for a more adventurous career might consider joining the armed forces. On [page 8](#) we look at the exciting opportunities available to medics in the Army, Royal Navy and RAF. And finally, the case study on [page 14](#) follows the tragic case of a GP treating a man with an apparently simple headache.

• Dr Peter Livingstone  
Editor

PHOTO: PAUL GRAHAM

## WHAT MAKES A GOOD DOCTOR?

HEALTH professionals are being asked "what makes a good doctor" as part of a major review by the General Medical Council.

The GMC are looking to update their core guidance for doctors, *Good Medical Practice*, which sets out the principles and values that all UK doctors must follow. They have posted an online questionnaire which asks about issues such as whether the current guidance gives enough weight to patients' needs and rights and if it could be made more relevant for doctors in training and doctors in non-clinical roles.

The GMC have described the review as "the start of a wide-ranging conversation about what is good medical practice today." They are seeking the views of patients, the public and doctors through a range of online activities and face-to-face events throughout the UK.

Niall Dickson, GMC Chief Executive, said: "*Good Medical Practice* has a vital role to play in keeping patients safe and improving professional standards.

"The current edition has been used by countries all over the world which look to the UK as a leader in ethical principles for doctors. But we do need to make sure our guidance is up-to-date and reflects changes in the way healthcare is delivered. That is why we are anxious to hear the views of patients, doctors and others working in healthcare about how doctors should be practising today."

A major public consultation on the new draft guidance will run from October 2011 to January 2012. To take part, visit [www.gmc-uk.org/gmp2012](http://www.gmc-uk.org/gmp2012) or sign up for email updates at: [gmp2012@gmc-uk.org](mailto:gmp2012@gmc-uk.org).



## NICE LAUNCHES WEB RESOURCE FOR GENERAL PRACTICE



summaries of the key points for general practice as new guidance is published each month.

There are resources available to support the emerging GP commissioning consortia including links to the NICE quality standards, access to the best evidence to support commissioning, through NHS Evidence, and a range of practical tools and support. The website has four key sections: NICE for my patients, Using NICE guidance in my practice, My NICE resources, and NICE for GP consortia.

The web tool has been welcomed by RCGP chair Dr Clare Gerada. She said it could become "an invaluable new resource" for those working in general practice, adding: "It can be a real challenge to keep up-to-date with NICE guidance, but this new resource will help GPs and their staff develop a systematic approach to identifying and using NICE guidance."

To find out more, visit [www.nice.org.uk/GP](http://www.nice.org.uk/GP)

AN ONLINE resource has been launched to help staff in general practice access NICE evidence and guidance.

GPs, practice managers and practice nurses helped create the web-based tool that offers solutions to enable the uptake of NICE and other national primary care guidance. There is also a section aimed at helping GP consortia.

The resource - part of the NICE website - allows users to quickly access relevant guidance and information, offers tips to ensure the practice team is up-to-date and has advice on how to further their continuing professional development. GPs can view the top 10 NICE guidelines along with



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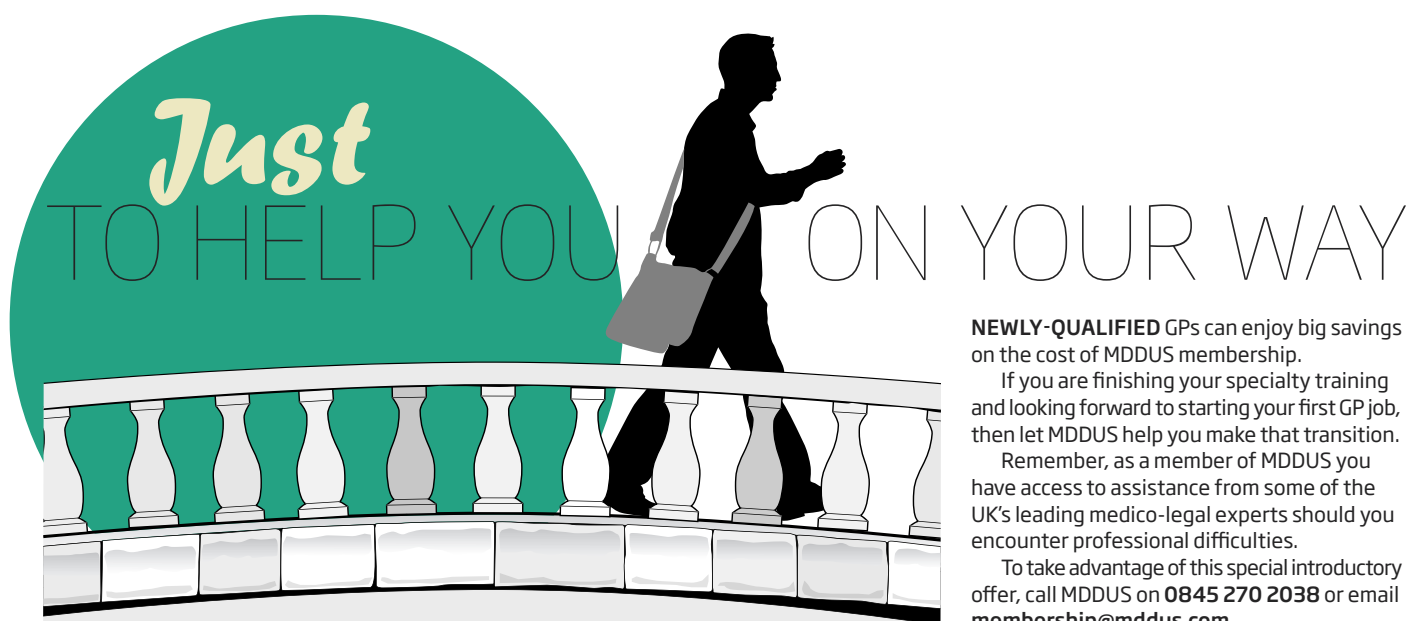
**PRINT:**  
arc colourprint  
[www.arccolour.co.uk](http://www.arccolour.co.uk)

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## GMC REVIEWS EXAMS

**DOCTORS** are being asked for their views on the national professional examinations that most medics need to pass to become specialists or general practitioners.

This year around 3,500 doctors are expected to join the General Medical Council's specialist register, with a further 2,300 entering the GP register. The regulator wants to know about three specific issues: how long an exam pass should be valid for; the maximum length of time a doctor can wait between passing an exam and entering or re-entering training; and whether there should be a limit on the number of re-sits.

The consultation, which covers exam regulation rather than content, runs until March 31, 2011. For more details, visit: [www.tinyurl.com/4f12ob7](http://www.tinyurl.com/4f12ob7)

## NEW ONLINE GUIDE FOR DOCTORS TREATING MIGRANT PATIENTS

**A GUIDE** to assessing and treating migrant patients has been launched online for GPs.

The *Migrant Health Guide* offers a "one-stop-shop" of information about caring for patients who have moved to the UK from abroad. It recognises the fact that migrants often have more complex health needs than UK-born patients.

The free guide - from the Health Protection Agency - covers various health issues including infectious diseases like TB and HIV which are more common in some other parts of the world. It offers help for both GPs and nurses in diagnosing and managing a range of conditions relevant to patients from other countries. It emphasises the importance of early diagnosis and prompt treatment.

HPA developed the guide in collaboration with a team of clinical and public health experts as well as primary care practitioners. The Royal College of General Practitioners and the Royal College of Nursing have both endorsed it.

Dr Jane Jones from the HPA said: "With the launch of the *Migrant Health Guide*, doctors and nurses will have at their fingertips a wealth of information and



resources on the health issues that are associated with over 100 specific countries - and we have designed the content in such a way that it can be accessed within the confines of a ten minute consultation."

Read the *Migrant Health Guide* at [www.hpa.org.uk/migranthealthguide](http://www.hpa.org.uk/migranthealthguide)

## RISK OF GAPS IN MEDICAL TRAINING, GMC WARNS

**GOVERNMENT** plans to overhaul doctors' training could push down standards, the GMC has warned.

Moves to abolish SHA-based postgraduate deaneries could "compromise" trainee doctors and lead to serious gaps in training being ignored, according to GMC chief executive Niall Dickson. His comments come as the regulator prepares its response to the Government's workforce white paper consultation which proposes to hand responsibility for education and workforce planning from deaneries to new "skills networks".

These new networks will see GPs, local authorities, social care and public health providers holding and allocating funding for education locally, taking on functions currently provided at regional deaneries.

Mr Dickson told *Pulse* magazine that trainee doctors' education could be skewed by the immediate demands of local services. The Government has said the move will make the system less "top-down" but the GMC fears it could lower training standards. Mr Dickson also expressed concern that no mention has so far been made of how these new organisations would be independently regulated.

He said: "We have to ensure trainees aren't compromised in terms of learning and development because service requirements have to be met. We believe we need local education champions. We currently rely on the postgraduate deaneries to perform these functions. Under the current proposals, deaneries appear to be going."

He added: "Simply handing this over to employers is not the answer. We need an independent voice that can provide us with assurance. You need someone independent who could say 'it's going wrong in this speciality', who will blow the whistle if something isn't right."

The GMC was due to issue a formal response to the consultation before it closes on March 31, 2011.





## THE TROUBLE WITH PATIENTS

Managing challenging or “heartsink” patients can be stressful and can increase medico-legal risk. *GPST* editor **Dr Peter Livingstone** looks at ways of handling these relationships effectively

**A**S WE PROGRESS through our GP training I am sure most of us will come across two or three “heartsink” patients at some point. Though it might not be the most sensitive term – you know who they are. The ones who, as soon as you see their notes, make you think “oh no, not again” or “that’s all I need today”. Heartsink patients are said to account for 11 per cent of the GP workload and have been defined as “high-demand patients with whom GPs have repeated, difficult and extended encounters leading to strong dysfunctional or emotional reactions” such as overwhelming fear, exasperation, anger and frustration.

It’s important to be aware of these patients because there is a risk they may end up having unnecessary investigations or treatment. This can be distressing for them as well as a waste of money, resources and valuable clinical time. From a medico-legal point of view, there is also a risk that heartsink patients who become genuinely ill may be ignored or treated inappropriately because of their history.

### Characteristics

Heartsinks can take many forms, but research suggests they are more likely to be female, aged over 40, single/divorced/widowed or experiencing personal problems. If they are single, they are often isolated and may have co-existing depression.

In his article, ‘Taking care of the hateful patient’, Dr James Groves places heartsink patients into specific groups. Do any of these sound familiar?

- Dependent clinger – seeks constant reassurance or attention.
- Entitled demander – demands treatment through guilt-induction or intimidation.

- Manipulative help rejecter – insists no regimen is helping.
- Self-destructive denier – refuses to stop harmful behaviour.
- Somatisers – those with medically unexplained physical symptoms.

As a GP trainee you may feel that you have more heartsink patients than some of your colleagues. Statistics show that doctors are more likely to experience this type of patient relationship if they have a greater perceived workload, low job satisfaction, a lack of competence or a lack of appropriate qualifications.

But there are other factors that can give rise to problematic patient relationships. These can include:

- a lack of two-way communication
- failing to understand the patient’s ideas, concerns and expectations
- failing to appreciate the way the illness affects the patient’s life
- failing to appreciate the way the patient copes with the illness.

It is important to be aware of how you communicate with patients and to make improvements where necessary. Never become complacent when dealing with heartsinks – they can become very ill so never simply dismiss them.

### Ground rules

When dealing with challenging patients, it’s important to build rapport, so listen attentively, empathise, avoid confrontation, make eye contact and seek a solution through a shared understanding of the problem. Patients should be encouraged to take more responsibility for their own health and using

diaries can help them gain an insight into their illness.

Studies also emphasise the importance of a firm, structured and consistent approach. It can be helpful to speak to other doctors in your practice about the patient to limit their ability to consult different GPs for different opinions or referrals. You should also recognise your own feelings and keep control of a) yourself, b) the consultation and c) the situation.

For frequent attenders, it can help to agree boundaries or limits on frequency of attendance and to help them create a list of their most troubling problems. Don’t try to handle the work load on your own: delegate to a practice nurse, self-help groups, counsellors or psychologists. In some situations, it might be appropriate to consider a delayed response to encourage the patient to take ownership of the problem.

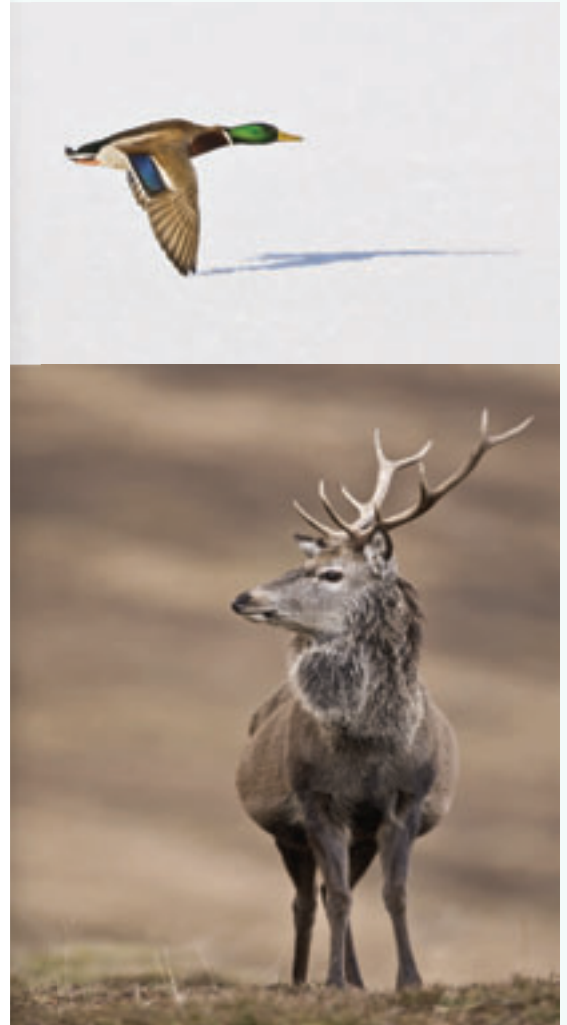
In the case of a patient I treated, I felt she was using me more as an emotional crutch than as a clinician. Her consultations were often longer and more demanding involving multiple non-specific symptoms. I felt powerless to do anything and we were constantly going round in circles. When I eventually plucked up the courage to ask “how can I help you with these problems?” she said that she simply needed someone to “off-load” on and that I was the only one who listened to her. She knew I wouldn’t judge her and that I could provide a non-biased opinion. She still occasionally comes to see me for a chat but her biological symptoms have all resolved and my consultations run to time.

One final important point to remember is that heartsink patients are the doctor’s problem and not the patient’s. It is a matter of attitude and if you are finding a particular patient difficult then stop to consider why this is. Explore your own feelings towards the problem as this may be a reflection of the patient’s own feelings. If you can find the source of the problem it should help you to address it.

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

## STILL LIFE

How one Scottish GP found new purpose through the lens of a camera



PHOTOS: IAN MASON

**P**ATIENCE is a necessity in a good wildlife photographer – and Dr Ian Mason should know as he is among the best. Last year one of his images was shortlisted for the British Wildlife Photography Award and he has twice been highly commended in the contest.

What is all the more remarkable is the fact that Ian only took up photography seriously five years ago when working as a GP in Charlestown in Fife not far from the city of Edinburgh.

"I went on safari to Zambia and was really captivated by the wildlife," he says.

"I had picked an old second-hand Canon 10D camera for the trip – and that's when I realised the huge potential of digital photography."

On his return Ian began taking photographs of mostly birdlife in the woods and wetlands near his home. The hobby became a refuge from the hustle and bustle of general practice.

"It certainly helped me to relax and think about life in general," he says.

Some of the images would end up as prints hanging in his GP surgery to be appreciated

only by his patients. But most of the images languished on his computer hard drive. And then a year ago Ian's life changed dramatically when he suffered a stroke and decided to retire early from general practice.

"The recovery has been fairly slow but good – not 100 per cent but it doesn't stop me from taking photographs, which is important."

Retirement meant that Ian had extra time on his hands so he decided to make more of his photography. He began selling prints of his work both through his exhibitions and also online, donating the proceeds to charities including Chest Heart Stroke Scotland and The Stroke Association. So far he has donated over £1000 in profits and is certain to raise more in the coming years with growing print sales and Christmas cards.

"Until I started this all my images just lay on my computer and I was the only person seeing them. Now they are being put to good use and hopefully people will benefit."

More of Ian's photography can be seen on his website at [www.ianmasonnaturephotography.com](http://www.ianmasonnaturephotography.com)

*Profile by Jim Killgore, contributing editor*

*"It certainly helped me to relax and think about life in general"*





## JUST A MINUTE OF YOUR TIME, DOCTOR

2011 will see the new UK Bribery Act come into force, meaning an even closer eye on the cherished freebie

**A**N OFFER of free centre court tickets at Wimbledon might not be easy for anyone to turn down. So it proved when drug reps for the pharmaceutical giant Abbott Laboratories invited a group of London consultants to enjoy "full hospitality" at the tennis tournament in 2004.

An anonymous whistleblower triggered an investigation by the Association of the British Pharmaceutical Industry (ABPI) who later ruled that the company breached industry code of practice. The company also faced accusations that it had treated doctors to greyhound racing in Manchester as well as a night out at a lapdancing club for one hospital doctor.

Such activities are strictly forbidden by the ABPI code which was adopted by the pharmaceutical industry to police its own conduct. But offering expensive freebies could soon lead to worse penalties than industry censure. Later this year The Bribery Act 2011 is due to come into force making it a crime to offer financial or other advantages with the intention of inducing a person to perform an "action improperly". And the Act goes even further making it illegal for doctors to request, agree to receive, or accept an inducement.

That's not to say that prosecutors are out to get doctors - the Act is aimed mainly at major corporate corruption. It will provide the UK some of the strictest anti-bribery sanctions in the world, including the offence of failure to prevent bribery by persons working on behalf of a business. It will also increase the maximum penalty for bribery from seven to 10 years imprisonment with an unlimited fine.

It is yet unclear just how the new Act will

apply to doctors and drug reps. Joint guidance for prosecutors is currently being drawn up by the Director of Public Prosecutions and the Serious Fraud Office and will be available later this year. The Lord Advocate will govern the issuing of prosecutor guidance in Scotland where the Act will also apply.

In a recent speech, the attorney general Dominic Grieve made the point that hospitality and promotional activity "are not illegal per se and the act is not intended to clamp down on legitimate expenditure of this type." He distinguished this with "lavish hospitality and similar expenditure" that could be clearly interpreted as a bribe and said that deciding between the two should not be difficult. Ultimately a jury will make that call.

However, it's unlikely that the prosecution guidance will differ much from existing guidelines governing the relationship between healthcare professionals and medical reps in the UK. For doctors the clearest advice is set out by the GMC in *Good Medical Practice* which advises: "You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues."

Drug companies are subject to more detailed regulations as provided by the ABPI code. Here strict restrictions are placed on the provision of samples, promotional aids, meetings, hospitality, subsistence, travel and accommodation. For example, companies can sponsor presentations in GP practices but such sponsorship must be disclosed in all papers relating to the meeting and any published proceedings. It must be the scientific or educational content that attracts

delegates to a meeting, not lavish or deluxe venues. No payment can be made to doctors or other prescribers for room rentals.

Subsistence must be strictly limited to the main purpose of the event and hospitality cannot be offered to spouses or other such people unless they qualify as a delegate in their own right. Companies can sponsor attendance at educational meetings as long as the requirements of the Code are met but air travel must be strictly economy class.

The Code also states that no gift or benefit in kind should be offered or given as an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. Promotional items must be inexpensive - the limit is £6, excluding VAT - and must be relevant to the recipient's profession. Items must not bear a product name but can bear a company name and the involvement of the pharmaceutical company must always be made clear. The same is true for sponsored educational events.

The Code also applies to what representatives say as well as the materials they use. Representatives are expected to maintain a high standard of ethical conduct and must not use inducements or subterfuge to get a meeting. This is not to say that drug reps may not be a very useful source of information on medicines both for doctors and patients.

But the message is clear - be careful what you accept from any industry rep as it may prove a perk too far.

*Jim Killgore is a contributing editor at MDDUS*





# HOLD THE PHONE

An increasing number of patient consultations are being conducted by phone. MDDUS risk adviser **Alan Frame** looks at some of the pitfalls

SOME 10-20 per cent of daytime contacts between patients and GP surgeries are now by phone according to latest estimates.

'First contact' with GP out-of hours services is usually by telephone, with a significant proportion of contacts being managed entirely over the phone. This is significant as around 70 per cent of primary care consultations are now provided by these services.

So do patients approve?

A comparative study of telephone and face-to-face appointments published last year by a group of primary care researchers reported that overall satisfaction with both forms of consultation was high in both GP and patient groups (over 90 per cent). But it was the quality of some telephone consultations that was found wanting.

In the study published in *Quality and Safety Healthcare*, 19 GPs from nine practices evaluated audio recordings of 106 telephone and face-to-face consultations and concluded that those by phone were significantly less likely to meet the RCGP quality assessment criteria requiring GPs to "obtain sufficient information to include or exclude likely relevant diagnoses". Telephone consultations were much shorter and involved less data gathering, rapport building and counselling than face-to-face consultations.

Dr Brian McKinstry, lead researcher, commented: "Telephone consultations may be more safely suited to follow-up appointments and care of long-term conditions where an initial assessment and provisional diagnosis has already been made."

So where do the clinical and medico-legal risks and pitfalls lie? Our experience at MDDUS is that three general themes tend to arise:

1. Failure to see the patient when appropriate.

2. Failure to pass on important information (e.g. a test result)

3. Failure to provide sufficient advice in the event of a deterioration.

There are certainly ways to minimise such risks during telephone consultations. A sound structure for clinical encounters by telephone is actually very similar to that in face-to-face consultations. The doctor needs to:

- Verify the patient's identity.
- Establish the relevant clinical facts.
- Obtain the patient's perspective about the issues at hand.
- "Examine" (ask the patient or other third party to describe things, e.g. skin lesions).
- Reach a decision about what is likely to be going on and convey this to the patient.
- Come up with a management plan which can be understood by the patient.
- Put a 'safety net' in place should things not go as well as expected. That is, make sure the patient is clear what they must do if things do not improve or deteriorate.
- Take comprehensive notes of what is discussed/advised.

The absence of both proximity and visual cues during telephone conversations means that the doctor needs to compensate. When on the phone it can help to talk more slowly and clearly than normal (the so-called 'telephone voice'). More questions than normal should be asked to ascertain and be certain about your facts and to

ensure the patient clearly understands what is being said. You should consider asking the patient to write down the details of any agreed management plan, and what to do if things don't go as expected.

Valuable clues can be drawn from the tone and nuance of the patient's voice on the telephone in the absence of visual cues from body language. Is there any incongruity with what is actually being said?

It would also be advisable to adopt a lower decision-making threshold about reverting to a face-to-face consultation, and being cautious about any delays. Remember that a two-hour gap before physical consultation is long enough for serious deteriorations in acute cases.

Some practical risk reduction measures to consider include:

- Ask for dedicated and protected telephone consultation time.
- Increase and improve levels of documentation.
- Ask about and use standardised protocols for managing the more common conditions, similar to those used by NHS Direct and NHS 24, with a low-decision making threshold for organising face-to-face consultations.
- Request training in the telephone consultation process.

No doubt there will be increased pressure in future for GPs to deal with patients via telephone as it reduces contact time and costs. And there may even come a time when video phones or Skype are utilised. Will this provide more effective and less risky remote patient consultations? Time will tell.

**Alan Frame** is risk adviser at MDDUS



# FRONTLINE MEDICINE

A career in the armed forces offers GPs the unique combination of job security, adventure and foreign travel

**H**ARDLY a week goes by without fresh media reports on the activities of Britain's armed forces abroad.

Troops can find themselves deployed to any number of far-flung destinations from war zones in Iraq and Afghanistan to bases in Germany, Cyprus or Brunei. And wherever they are posted, GPs and other medical officers will follow to care for military personnel and their families. Despite the sometimes harrowing reports from conflict zones, the Army, Royal Navy and Royal Air Force still attract strong interest from doctors wishing to pursue military careers.

For many, the appeal is clear. Working as a military GP – or 'medical officer' – offers challenges and opportunities that an ordinary practitioner might never experience, whether it's sports and adventure training, working on board a submarine, jumping out of helicopters or practising medicine under extreme pressure in conflict zones.

Life can be unpredictable for military doctors who are expected to go wherever they are needed. Some medical officers will provide medical support to troops on the frontline and therefore must master the same basic military skills and tactics, such as map reading, basic fieldcraft and how and when to fire their personal weapon. They must also be prepared to follow orders which may mean personal wishes and ambitions cannot always be accommodated.

Life as a military GP also means working with a different type of patient from civilian practice. These are largely young, fit men – with few elderly patients. There are a number of Army and RAF medical centres who also care for soldiers' dependents, and in some instances GPs in the military enjoy a higher doctor-to-patient ratio.

## Entry and training

There is demand for GPs in all three services with most doctors entering through cadetships that offer sponsorship usually during the final three years of their medical degree. The army and navy only take fully trained GPs as direct entry post-graduate applicants but graduates can also join the RAF either at the end of F2 (before specialist training) or once they have completed ST. Some fully qualified GPs are eligible for a 'Golden Hello' when entering the military, with the RAF and the Army offering an incentive worth £50,000.

The retention rate for military GPs is generally slightly lower than the

NHS because of family ties and because pay does not match the highest NHS GP salaries – although it is above average. The forces also offer competitive allowances and pension schemes and a structured career path that mirrors the civilian route.

Prior military experience is not required as all three forces provide officer training for new entrants, but it's advisable to have a good level of fitness before applying. Medical officers are also expected to have strong leadership skills and motivation.

## RAF

Direct entrants undergo the 11-week Special Entrant and Re-Entrant (SERE) officer training course at the RAF College Cranwell in Lincolnshire. RAF GPs have a varied career and you could serve in a station medical centre or in a field hospital in Afghanistan. You may even have the opportunity to work as part of the Aeromedical Evacuation Team flying on board one of the aircraft returning casualties to the UK.

As a station medical officer, you'll provide primary care for personnel and sometimes their families. You'll be treating a wide variety of people – from pilots who have to deal with the pressures of fast-jet missions, to RAF Regiment Gunners who must be fit to work under extreme pressure. Medical officers are normally deployed on operations (such as Afghanistan) for four-month deployments, usually every 18 to 24 months.

Qualified GPs must join before their 55th birthday and pay varies depending on your seniority and specialty. The usual length of service starts at six years. Find out more at [raf.mod.uk/careers](http://raf.mod.uk/careers).

## Army

Qualified GPs attend the Professionally Qualified Officer (PQO) course at the Royal Military Academy Sandhurst. The course is based directly on the Regular Commissioning Course and is aimed towards officers who hold professional qualifications such as doctors, nurses, dentists, physiotherapists, vets, lawyers and chaplains. The course lasts for ten weeks and is focused towards officership, command and leadership with military training in both the field and the classroom.

Following the PQO course the officers from the Army Medical Services will then complete their Entry Officers Course at the Defence Medical Services Training Centre in Hampshire. The course lasts three weeks and builds on the information which was taught on the PQO course and





PHOTOGRAPHS COURTESY OF RAF

is geared towards operational medical planning and support.

Finally, army doctors complete a 10-14 week postgraduate medical officers course which specifically prepares them to become a military doctor. This includes input from the consultant advisors within the Army and provides training on battlefield advanced trauma and life support, as well as teaching doctors the principles of delivering medical care under austere conditions with limited resources.

GPs then serve as regimental medical officers caring for soldiers and their families in military practices in the UK and abroad. Many accompany their regiments on tours of duty for up to six months every two to three years, but this can be more frequent. As with the other forces, there are many opportunities for travel and adventure training as well as the prospect of short notice emergency situations anywhere in the world. Service starts at six years and qualified doctors must join before their 55th birthday. Visit [www.armyjobs.mod.uk](http://www.armyjobs.mod.uk)

## Royal Navy

Qualified doctors enter the navy on a short commission of three to six years. The job is open to men and women although only men can serve as medical officers in the Submarine Service. Unlike in other forces, navy GP practices in the UK don't cater for families, so GPs tend to do two days in a navy practice and three days in a general one.

Medical officers are part of the navy's senior management team, making it a wide-ranging and challenging role. GPs can practise on shore, on board ships or submarines, fly in helicopters or even earn the coveted green beret of a Royal Marines Commando.

Applicants must be under 54 and Medical Officers (Submariner) need full British citizenship. For more information visit [royalnavy.mod.uk/careers](http://royalnavy.mod.uk/careers)

## Part-time

For doctors who are unsure about committing fully to an armed forces career, roles are available in the Territorial Army, RAF Reserves and Royal Navy Reserves. These roles can usually fit around your main medical career and involve regular training sessions throughout the year, including weekend stays and usually a fortnight-long training camp each year.

*Joanne Curran is associate editor of GPST*



## Q&A

**Squadron Leader Cat Davison,**  
*GP with the RAF, based at Tactical Medical Wing  
on the Deployable Aeromedical Response Team*

### • What attracted you to a career as a military GP?

I was attracted by the excitement of being paid to travel. I knew early on in my career that I didn't want to qualify as a GP and do the same job for 30 years! I researched the Royal Air Force and discovered I could apply to be sponsored through university. I joined in the fourth year of my medical degree on the RAF medical cadetship scheme and completed my training through the RAF in 2008.

### • What do you enjoy most about the job?

The variety of the job. I work as a GP all around the world, in different environments, with many different people and cultures. Last year I worked in the UK in a medical centre, Cyprus on the rugby pitch, USA and Jordan in the desert and Belize in the jungle.

### • Are there any downsides?

If you're in a long term or serious relationship, the separation can be a challenge. You need an understanding partner! You also need to be flexible and happy with change. A detachment or tour abroad you thought was six months can suddenly be brought forward but you adapt and use your colleagues to help

### • What do you find most challenging?

We as military doctors maintain the high standards of care expected in a local UK hospital. Working in austere or hostile environments without the benefit of traditional facilities and maintaining a standard of care can be a challenge, although lateral thinking and team work play a huge part.

### • What about the role has most surprised you?

The wide variety of locations and sub-specialisations within the GP career stream. GPs are supported to pursue interests in areas such as aviation medicine (opportunities to undertake a diploma), sports medicine, public health and occupational medicine (a diploma or further study to become a consultant). No two RAF GPs have the same skill sets. We have all done GP training, but as we progress we have all found an interest and been encouraged to study further.

### • What is your most memorable experience so far?

There are many from the last five years in full time uniform. Although filling a tooth with a DIY dental kit in the middle of the desert followed that day by assisting a vet operating on a military dog, rates highly.

### • What advice would you give to a trainee GP considering a career in the armed forces?

Go for it and find out about the job. You only live once and what have you got to lose from a phone call and then a chat with an RAF GP to find out more?

# NOT TAKING OVER JUST CATCHING UP



President of the Medical Women's Federation  
**Dr Clarissa Fabre** discusses the role of women in general practice and her hopes for the future

**T**HE OLD ADAGE goes that working women "can't have it all" – they must choose between either a successful career or

a happy family life. Either way, something's got to give. But as president of the Medical Women's Federation, Dr Clarissa Fabre's ambition is for women doctors to have the chance to succeed both professionally and personally.

Dr Fabre moved to the UK after qualifying in Sydney, Australia, with plans to pursue a career in paediatrics. She eventually moved into general practice following a seven-year career break to raise her three children and has worked in the UK for more than 30 years. She joined the MWF in 1978 as a junior doctor when she came up against barriers in her own career and could find few opportunities for flexible training.

She was a full-time principal at a practice in East Sussex before reducing her role to half-time following her election as MWF president last May. Her two daughters are specialist trainees in paediatrics and haematology.

**A recent report showed that women GPs in Scotland now outnumber men and that general practice in the UK will eventually be 70 per cent female. Is this a good thing?**

I would not say it is a good thing or a bad thing. Perhaps 50:50 would be ideal. The main point is that women GPs should not all become salaried doctors or locums, while all the men become partners and control what happens in general practice.

**Are there any negatives about this so-called "feminisation of the workforce"?**

I do hate that phrase! Women now make up 57 per cent of medical students and the level has been stable for several years. Women are not 'taking over', they are catching up. I would be concerned if 90 per cent of GPs were women, but 70 per cent is fine.

**What challenges do women face in general practice today?**

Things have not really improved in the past 10 or 20 years for women. I

am in favour of partnership-based general practice but the trend today is towards a salaried service with a few entrepreneurial GPs or private companies in charge. A two-tier system has developed. I would encourage young GPs to aim for

partnership, especially after they have had their children.

**Will the way general practice operates have to change to meet women's needs?**

Over the last few years, the situation has worsened in relation to women's needs. The Retainer and Returner Schemes, and the Flexible Career Scheme were excellent in providing part-time working opportunities, but all of these have dwindled or disappeared. It is essential that women with young children are able to work and train part-time in general practice. I have heard of women doctors being accepted onto training schemes and then having to withdraw because they could not find a job-share. This is unacceptable.

**Are women GPs treated equally?**

Yes, women are paid equally and I personally have never felt any discrimination from my male colleagues. However, I am concerned about what happens when a woman doctor becomes pregnant. At present it is left to the discretion of Primary Care Organisations (PCOs) or Health Boards as to whether they make any payments to help cover locums while she is on maternity leave. Some PCOs pay the full amount (£1,500 per week) while others pay nothing at all. This is discouraging practices from taking on a woman doctor. The MWF is campaigning strongly to make the PCO payments non-discretionary and to ensure salaried doctors have sound contracts. Once a woman doctor has had all her babies, the sky is the limit.

**Dame Carol Black once said that a feminised workforce would "lose both status and influence". Do you agree?**

No, I do not, and I think Dame Carol's statement was very unfortunate. However, as a consequence, the Royal College of Physicians in England funded a large 2009 study, *Women in Medicine: the Future*. For the



first time, we had accurate figures on what happened to women in medicine. It also highlighted the importance of encouraging women to go for leadership roles.

#### **What are the implications for female GPs under the Government's health white paper?**

There are no specific implications for female GPs. MWF has always stressed that women GPs at all levels should become involved with the White Paper, although there will be great temptations to remain on the sidelines. There has been discussion recently that some sessional GPs are being excluded from voting for GP consortia board positions, which is completely unacceptable.

#### **What advice would you offer GP trainees in the face of such major changes?**

General practice is still a wonderful branch of medicine to go into. It is very popular, especially because it is well-paid and family-friendly. Remember that you may have to mark time while you are having your family. You should never impose on your colleagues and always pull your weight. Put yourself forward for new challenges when the time for you is right – you will find these challenges extremely rewarding.

#### **What brought you into medicine and do you still enjoy being a GP?**

My family are not medical, but a good friend was a medical student and encouraged me to study medicine. I love my job. After my training I joined a single-handed doctor nearing retirement in a village in East Sussex. Over the years the practice has grown from 2,000 to 8,000 patients, and we now have four partners, two assistants, medical students and GP registrars.

#### **You have two daughters training to be doctors – how do their experiences of training differ from yours?**

Like many hospital doctors nowadays they are frustrated at the way junior doctors are treated as pawns to be shuffled around by managers who are concerned only to fill the rotas. Many of my daughters' friends are in general practice and they often say it would have been easier for them in that specialty. They are both on maternity leave at the moment and I tell them repeatedly to keep their training ticking over while they have their babies, and then their careers can continue full-

pace. A career break these days of more than a year is not advisable.

#### **What is a typical working week at the MWF like for you?**

I visit our London office every couple of weeks and we have regular meetings throughout the year but most of my work is done by email. At present I'm concerned with many issues including the threats to the availability of part-time training positions and maternity leave because of understaffing issues, and also the importance of leadership training and mentoring. I am also interested in broader women's issues and spend time writing for the press, addressing members' concerns, and attending dinners or meetings with people whom we are trying to influence, such as politicians, leaders of the BMA and the Royal Colleges and doctors and civil servants in the Department of Health.

#### **What future role do you see for the MWF in general practice?**

We must do our best to ensure that:

- there are opportunities for doctors to become partners
- salaried doctors are treated fairly
- women are not disadvantaged too greatly by taking time off to have babies
- the Retainer and Returner Schemes are made more robust and accessible
- maternity locum payments are protected and made non-discretionary.

#### **Why are women so under-represented in senior positions?**

Women must be encouraged to go for the senior positions. They often feel, usually wrongly, that they are under-qualified for a position, or they are reluctant to re-apply if not initially successful. Mentoring and role models are very important. I do not believe in positive discrimination, but MWF has an important role in showing young women that everything is possible.

*Interview by Joanne Curran, associate editor of GPST*



# A PRIVATE MATTER?

MDDUS medico-legal adviser  
**Dr Susan Gibson-Smith**  
considers when it's okay to disclose  
patient details without consent

**H**IPPOCRATES wrote in the 4th century BC: "Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one."

Confidentiality is the bedrock of the relationship between doctor and patient and has evolved to become a key principle of good medical practice as enshrined in guidance issued by the General Medical Council. The therapeutic relationship is one based on trust and doctors must take care not to undermine that trust by failing to keep personal details and discussions confidential. But that's not to say all cases are clear cut. Consider the following scenario:

*I had been seeing Mrs Smith for several months in regard to mild anxiety symptoms. This consultation was for a 'cough and spit', routine enough but she was very reluctant to be examined, asking simply for an antibiotic and a fit note for her work. In view of the pleuritic chest pain she was complaining of I persuaded her of the importance of my examining her chest. The bruises on her chest wall were several and fist-sized and the welt on her lower back was raw. With some encouragement she went on to show me her arms and legs, peppered with further bruises and some cigarette-shaped burn marks.*

*"He was really bad at the weekend. He thought I had been flirting when we were out on Friday. When he has had a drink there is no reasoning with him. I was really worried this time he might kill me."*

*I asked her if she had considered reporting this to the police. She said she would never do that. She said he really didn't mean it and it was only when he had had too much to drink that he became violent. What duty do I have to respect her right to confidentiality or to breach it against her consent but for her own benefit?*

Confidential medical care is recognised in law as being in the public interest and it is a patient's right to expect that information about them will be held in confidence. However, whilst there is a clear public good in having a confidential medical service, it is also recognised that confidentiality is not an absolute duty and there can be circumstances in which it is entirely appropriate to disclose confidential information. These circumstances can be grouped under three broad headings.





*"In certain circumstances there will be a clear public interest in disclosing confidential information."*

### **Disclosure with patient consent**

Obviously if a patient consents to the disclosure then it is entirely appropriate to share that information. However, it is advisable to check that the patient has been given sufficient information about the scope, purpose and likely consequences of the disclosure to be sure that the consent is fully informed. It is also worth checking the date when the consent was given as this can expire over time. If in doubt it is always worthwhile to check again with the patient.

### **Disclosure as required by law**

Doctors must adhere to certain specific statutory requirements under which patient consent may not be required, for example notification of a known or suspected case of infectious disease. Various regulatory bodies, such as the Ombudsman or the GMC, also have statutory powers to access patients' records without consent as part of their duties to investigate complaints, accidents or a health professional's fitness to practise. If you are asked to provide information about a patient it is your responsibility to satisfy yourself that such disclosure is required by law or can be justified in the public interest. Even in cases where patient consent is not required GMC guidance states that you should inform the patient about such disclosures unless doing so would undermine the purpose of the disclosure.

Doctors also must disclose information if ordered to do so by a judge or a presiding officer of a court (e.g. sheriff or magistrate) but do retain the right to object if they believe the information they are being asked to disclose is irrelevant, such as information about a patient's relative who is not involved in the proceedings. It is important to ensure that anyone ordering disclosure has the power to do so, for example solicitors or police officers cannot compel disclosure.

### **Disclosure in the public interest**

In certain circumstances there will be a clear public interest in disclosing confidential information, such as in protecting individuals or society from risk of serious harm. The GMC advise that:

"Personal information may, therefore, be disclosed in the public interest without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential."

Examples of this would be disclosing confidential medical information to the DVLA of a patient with epilepsy or dementia who is persisting to drive, or informing sexual contacts of patients with serious communicable diseases, or informing the police about knife and gun crime. The GMC provides supplementary guidance on these and other confidentiality matters at [www.gmc-uk.org](http://www.gmc-uk.org).

The bottom line is that doctors have the responsibility to weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and to the overall trust between doctors and patients, arising from the release of that information.

The guidance goes on to say that even if you are considering making a public interest disclosure you should still consider obtaining consent from the patient and inform them that a disclosure will be made in the public interest, unless you believe that to do so would put you or others at risk of serious harm, or would undermine the purpose of the disclosure.

If you do make a public interest disclosure you must document in the patient's record your reasons for disclosing this information without consent and also any steps you have taken to seek the patient's consent, to inform them about the disclosure and your reasons for not doing so. This is very important as you need to provide evidence of your decision-making process so that you can justify your reasons should you be called upon to do so at a later date.

### **Back to Mrs Smith**

So how does this help me decide what to do with Mrs Smith?

*I clearly do not have her consent to go to the police with this information and there is no legislation which would compel me to breach her confidentiality. I must therefore decide whether the benefits of disclosure outweigh both the public and Mrs Smith's interest in keeping the information confidential. On reflection I consider that the disclosure might protect Mrs Smith from harm but not society in general, as there is no evidence that her husband is a threat to any other adult and I know that there are no children involved, so there is not a child protection issue.*

*GMC guidance on disclosures to protect the patient is quite clear: "It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection, and to warn them of the risks of refusing to consent; but you should usually abide by a competent adult patient's refusal to consent to disclosure even if their decision leaves them but nobody else at risk of serious harm. You should do your best to provide patients with the information and support they need to make decisions in their own interests, for example by arranging contact with agencies that support victims of domestic violence."*

*On balance I decide not to tell the police as I believe it is in Mrs Smith's best interests that she continues to have trust in me as her doctor at the present time and to destroy that would cause more harm. Over the next few months I continue to see her and with the support of a counsellor she eventually decides to leave her abusive husband.*

If you are ever in any doubt about confidentiality or whether you should disclose personal information about a patient without consent then please do not hesitate to pick up the phone to a medico-legal adviser at the MDDUS who, doctor-to-doctor, will guide you through your decision making.

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

## MISSED DIAGNOSIS

## PERSISTENT HEADACHE

## DAY ONE

A 45-year-old father of two - Mr G - attends an out-of-hours GP unit complaining of severe headaches over the preceding week. He is examined by Dr A who records: "right-sided frontal headache over the past week with associated nausea but no vomiting. No reported visual upset or peripheral neurological symptoms. No recent injury. Fully orientated on examination; afebrile; no meningism and no abnormality of discs." Dr A prescribes the analgesic co-codamol and sends the patient home.



## DAY THREE

Mr G's wife phones her local general practice just after opening time requesting a house call due to her husband's severe persisting headache. Dr B attends the patient later that morning. He makes handwritten notes of the visit recording again a "frontal/crown headache" over the previous week with nausea and some vomiting. The patient's wife reports that the prescribed analgesics have had no effect. Dr B records no visual disturbance/recent URTI, photophobia or neck stiffness. He examines the patient and notes: "Full range of movement of neck." Dr B makes a diagnosis of migraine and administers an injection of Cyclimorph - a combination drug of morphine and an anti-emetic. He instructs the patient to contact the practice again if the symptoms worsen or do not settle. He records this advice.



## DAY SIX

Mr G is brought into the GP surgery by his wife. He is seen as an emergency patient by Dr C whose handwritten notes state "thumping pain towards back of the neck keeping the patient awake at night". No visual upset is noted but nausea is still present. Otherwise all other findings are normal. The GP also notes "No neck stiffness, no rash. Kernig's sign negative." He prescribes co-codamol again.



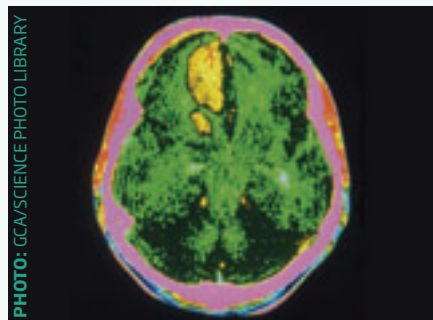
## DAY 15

Mr G develops a severe frontal headache and collapses. An ambulance is called and he is admitted to the Accident and Emergency Department and is found to be comatose. A CT scan reveals an extensive subarachnoid haemorrhage (SAH) with an intracerebral blood clot. Mr G is transferred to the ICU but remains unresponsive and is pronounced dead. A subsequent neuropathological report reveals the presence of a burst aneurysm in an arterial vessel.

**A** FEW months later the practice receives notification of a claim of negligence being raised by Mrs G against all the GPs involved in her husband's care. Her solicitors allege that had the doctors correctly interpreted the ongoing and unremitting severe headaches as a sign of "warning leaks" of an impending SAH, Mr G could have been referred for neurosurgical intervention to repair the intracranial aneurysm, preventing his death.

MDDUS, who represents both Dr B and Dr C, commissions expert reports from a primary care specialist and a neurosurgeon. The GP expert cites the relative rarity of SAH and the well-documented difficulty in distinguishing the signs of early 'warning leaks' from those of more common conditions such as migraine or tension headache. The long time frame - nine days from the first report of headaches - also supports a non-serious cause, as does the long gap in seeking medical advice before Mr G's collapse. Both doctors undertook a full and appropriate history and examination noting the absence of photophobia and neck stiffness that might lead to a diagnosis of SA or meningitis. In the opinion of the GP expert, the clinical actions of both doctors were entirely appropriate and consistent with a reasonable standard of care.

Expert opinion from the neurosurgeon also highlights the difficulty of diagnosing a



slow onset SAH but confirms that had Mr G been investigated in hospital in the weeks before his collapse the aneurysm could have been repaired.

Another expert opinion commissioned by the solicitors acting for Mrs G takes a different view on the case stating that the prudent course of action given the ongoing severe headache and nausea would have been an urgent referral. The GP expert also criticises the administration of Cyclimorph by Dr B which may have exacerbated the patient's condition.

Considering the risks of defending the case in court with legal costs likely to be in excess of any potential damages awarded, MDDUS opts to settle out of court.

## KEY POINTS

- Have a high index of suspicion in unremitting severe headaches with nausea and vomiting - although SAH rarely presents in general practice.
- Keep accurate notes of all clinical findings (positive and negative) and advice to patients in order to clearly justify clinical decision-making.
- Decisions to defend cases in court or pursue an economic settlement are often pragmatic based on risk.



# Diary



**T**HANKS to all our GPST readers for your contributions to this latest instalment of Diary. Total: zero. Okay – maybe we need an inducement. So send us your best doctor gag for next issue and the most witty gets a £50 Waterstone's voucher. Reply to [gpst@mddus.com](mailto:gpst@mddus.com)

● **FURTIVE FAGS** Life offers Diary so few opportunities to feel smug so thank heaven for the public smoking ban. Seeing all those nicotine heads huddled about wind-swept dual purpose rubbish bins warms the heart – the heavier the snow and rain, the better. Imagine our outrage then at reports that “smoking shelters” are being re-introduced outside UK hospitals for “health reasons”. Not the health of smokers but the rest of us. It seems patients are increasingly sneaking fags in all sorts of unsafe places, stairwells, toilets, closets, oxygen stores. Makes for a quicker end than passive smoking.

● **SNEEZE TIMEBOMB** Just the news GPs have been waiting for to cheer them up. Scientists have discovered it takes just a single sneeze from a flu sufferer to spread germs around an entire room. And the tiny infected droplets can hang around spreading contamination all day. Breathing in these microscopic specks can infect a person within an hour. US researchers at Virginia Tech reported the discovery and their findings will surely make the prospect of sharing your consulting room with all that coughing and spluttering all the more appealing. So long as you don't breathe, everything should be fine.

● **MORE ANTIBIOTICS... AND A QUARTER POUND FOUGERUS** Sainsbury's recently announced that it has increased the number of its new in-store GP practices with four more doctors. RCGP chair Dr Clare Gerada has advised the supermarket chain rather unkindly to “stick to selling fruit and vegetables”. Diary asks is there any possible connection here to a contest run recently by the publisher Elsevier in which students had to distinguish medical terms from certain cheese varieties? Consider the terms Charbon, raclette, lenègre or fougerus. Would you have guessed, respectively: an old name for anthrax; a hard cheese with a subtle flavour; acquired complete heart block due to primary degeneration of the conduction system; a type of Brie. One can see the potential for confusion.

● **OMG!** Joining the list of modern techno ailments, from keypad elbow to Blackberry thumb, is a new threat – smart phone wrinkles. Dr Jean-Louis Sebah – cosmetic surgeon to the stars – says peering at a small screen causes your face to scrunch up, creating tension lines around and between the brows. Not to worry. Dr Sebah suggests a quick jab of Botox will sort you out in no time. Just pop into Sainsbury's...

● **REMEMBER LAST SUMMER?** Something sure to give you smart phone wrinkles – an Australian website now allows patients with chlamydia to send both personal and anonymous notification texts and emails to former sexual partners. Researchers have reported in the journal *Sexually Transmitted Diseases* that traffic on the site rose substantially over a period of 11 months showing the value of emerging technologies in both encouraging and facilitating partner notification in battling the spread of STDs.

● **MORE CLOWNING AROUND** A recent study of 219 women undergoing IVF conducted by an Israeli team has found that the odds of treatment success were greater among women who were entertained by a professional “medical clown” just after embryos were transferred to their wombs. Diary offers no comment – just an involuntary shudder.

● **ONE MORE FOR THE ROAD** Seeing the scale of insanity that went into the collapse of the global economy one might be excused for wondering if some senior banking executives were simply drunk. Maybe so. The 2009 Health Survey for England found that people in the highest income households are more likely to consume twice the daily recommended alcohol intake and 23 per cent of top earners drink on five days or more per week compared to 14 per cent living in the lowest earning homes. No doubt that includes doctors. Source: BMJ

● **HEAD RUSH** The next time you need to give yourself a boost under pressure, think twice before reaching for the coffee. A new study has concluded that while a cup of Joe can boost the brainpower of women, it has the opposite effect on men. Researchers from Bristol University studied 64 men and women and found the men's performance in set tasks was “greatly impaired” if they drank caffeinated coffee. It impaired their memories and slowed their decision-making. Women were able to complete tasks 100 seconds faster if they had been given caffeine. Source: *The Journal of Applied Psychology*.

● **SAY WHAT?** Things are different in Britain when it comes to sexual behaviour – and especially up North where NHS Doncaster recently published a *Glossary of Yorkshire Medical Terms* to help European (and probably many UK doctors) interpret the local dialect and common phrases. Diary's favourite among many is “my husband is good to me” – the translation being he doesn't expect sex. There is also a startlingly vast array of slang words for penis, including widgy, winkle, Uncle Sam, thingy, sparrow, old man, Percy, chip and tail. Other entries include a mind-boggling variety of euphemisms for menstruation. These include phrases such as: Barnsley's at home, Got me friend, Had a show, I've got a visitor, as well as the baffling On my Honda.

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