GPst

ISSUE 03

ULTRA MARATHON MAN

PROFILE OF GP AND ADVENTURER ANDREW MURRAY

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

PHOTO: PAUL GRAHAM

Welcome to your GPst

IT'S BEEN five years since I graduated in medicine and I have just recently completed my general practice training. Like many other doctors in my position, I now face the daunting task of searching for regular work that will ultimately lead to a permanent position. The past five years have been such an enjoyable experience and, when I think about how I arrived at this point, it has much to do with my earlier life, when I grew up as a "son of the surgery". My article on page 4 recalls what it was like growing up surrounded by general practice.

Your first GP appraisal can be a daunting prospect but help is at hand from GP trainer Janice Oliver who offers some tips and techniques on page 5 on how to prepare for this important milestone.

Assessing whether an adult patient has the capacity to decide about their medical treatment can be challenging, but MDDUS medical adviser Dr Barry Parker offers advice on page 6. Meanwhile, overcoming language barriers is the theme of our article on page 7 which looks at how doctors should treat patients who don't speak English.

The idea of discussing religion with patients is a controversial one and is currently the subject of a case before the GMC. On page 12, MDDUS medical adviser Dr Susan Gibson-Smith discusses how to handle this sensitive issue.

On page 10, we find out about the amazing achievements of ultramarathon runner and GP Dr Andrew Murray who has pushed himself to the limits in aid of charity and now hopes to help get the nation more active. Our careers article on page 8 looks at what's involved in becoming a GP with a special interest in dermatology while the case study on page 14 looks at a case of malaria misdiagnosis.

• **Dr Peter Livingstone**
Editor

COVER PHOTO: © RICHARD ELSE

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EXTEND GP TRAINING TO BOOST DEMENTIA SKILLS

GP TRAINING should be extended to include sufficient training on treating dementia, according to a report by an influential group of MPs and peers.

The All Party Parliamentary Group on Dementia said the training programme should be lengthened in line with other specialties because GPs lack the confidence and skills to effectively treat dementia. The group also recommended the introduction of ongoing specialist community training.

Dementia treatment cost an estimated £20billion in 2010 and the figure is expected to reach £27billion by 2018. But fewer than half of those with the condition are diagnosed, leaving many people to struggle without much-needed support, the report says.

The report concluded: "The confidence and skills of some general practitioners in recognising dementia continues to be inadequate. Increasing the length of GP training so that it is equivalent to other specialisms would allow for improved coverage of dementia within the GP curriculum."

The Department of Health (DoH) has commissioned the RCGP to produce a business case for Medical Education England on the extension of specific specialty training for general practice from a minimum of three years to a possible five. This extension was recommended in the Tooke Report on the Independent Inquiry into Modernising Medical Careers (Aspiring to Excellence).

The submission date for the RCGP is December 2011 and it is expected the DoH will make a decision on the issue sometime in 2012. The RCGP is keen to hear any views about the initiative via email at **reviewofspecialtytraining@rcgp.org.uk**

CQC REGISTRATION FOR GP PRACTICES SET FOR 2013

GP PRACTICES in England will have to register with the Care Quality Commission by April 2013, the Department of Health has confirmed.

Registration had originally been scheduled for April 2012 and will now be delayed for one year. GP leaders campaigned recently for it to be introduced even later than 2013 to avoid clashing with the introduction of revalidation and GPs assuming responsibility for commissioning.

In their response to the consultation, the BMA's General Practitioners Committee (GPC) said: "We have concerns about the capacity of the CQC to manage the registration and compliance of all primary medical services providers from April 2013, and would suggest that consideration is given to a more flexible approach."

But the DoH said registration with the CQC would go ahead in April 2013, as set out in its consultation proposals published in June. Out of hours providers that are not GP practices looking after their own patients will still be expected to register with the CQC by April 2012.

GUIDANCE ON PROTECTING VULNERABLE ADULTS

DOCTORS are reminded of their duty to protect vulnerable adults from abuse or neglect in new guidance from the BMA.

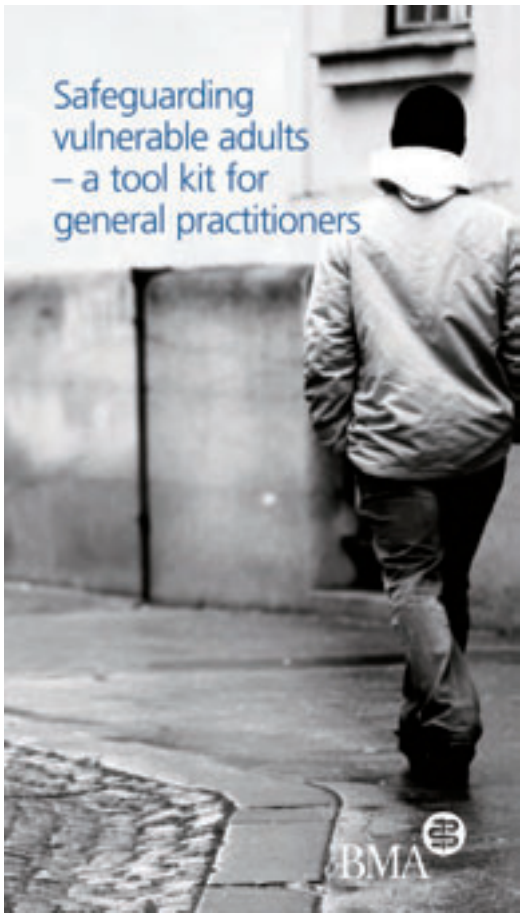
Safeguarding vulnerable adults – a toolkit for general practitioners aims to provide step-by-step instructions on issues such as identifying vulnerable adults and offers advice to doctors who suspect patients are being abused.

The toolkit comprises a series of cards, each of which contain a checklist of key points. It stresses that safeguarding vulnerable adults is not the same as child protection and that doctors should help vulnerable adults lead independent lives.

The information pack guides doctors through various scenarios, including an elderly woman in the early stages of Alzheimer's who wants to live in her own home.

The Department of Health commissioned the BMA to produce the toolkit following concerns over a lack of clarity on the issue.

Read *Safeguarding vulnerable adults – a toolkit for general practitioners* at **www.tinyurl.com/3mkp2mn**



GPs WORRY PROFESSION FACES WORKFORCE CRISIS

HALF of GPs responding to a recent online survey expressed worries that the GP profession could be heading towards a workforce crisis.

And a further 49 per cent felt that doctors' training is likely to weaken over the next five years given current changes in the healthcare system.

The survey of 1,095 GPs was conducted by the online medical news service *OnMedica* which also targeted the views of GP trainers.

Among the reasons why the GPs felt training would weaken was a belief that funding issues will mean the overall quality of training will suffer and that training will become more fragmented with fewer training posts available for junior doctors.

GP trainers rated the difficulty of juggling service commitments to practice and training as their biggest frustration closely followed by the use of electronic documents (eportfolio) associated with GP training.

Some 68 per cent of GP trainers felt that the number of clinical entries required to be recorded in the eportfolio by trainees in the GP registrar year is excessive, with numbers evenly split on whether or not there were too many assessments in the ST3 year.

See the full results at **www.tinyurl.com/3d92ppm**

'SHARED DECISION-MAKING' GUIDELINES FOR DOCTORS

DOCTORS should take time to discuss treatment options with patients and encourage them to talk about their condition, according to a new report from the King's Fund.

Making shared decision-making a reality: No decision about me, without me aims to set out how clinicians can engage in 'shared decision-making' with patients during consultations. The report is a response to health secretary Andrew Lansley's vision of an NHS that places patients' needs, wishes and preferences at the heart of clinical decision-making.

The King's Fund define shared decision-making as "a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences". Their report details the skills and resources required to implement it and also outlines what action is needed to make this vision a reality.

According to the report, the principle of shared decision-making in the context of a clinical consultation is that it should:

- support patients to articulate their understanding of their condition and of what they hope treatment (or self-management support) will achieve
- inform patients about their condition, about the treatment or support options available, and about the benefits and risks of each
- ensure that patients and clinicians arrive at a decision based on mutual understanding of this information
- record and implement the decision reached.

The importance of communication skills is highlighted in the report which suggests that tools to help patients make decisions are just as important as guidelines for doctors.

Links:

Making shared decision-making a reality: No decision about me, without me - **www.tinyurl.com/3sfh8m8**

KEEPING IT IN THE FAMILY

GPST editor **Dr Peter Livingstone** recalls growing up as a 'son of the surgery' in rural Northern Ireland

FOR those of you who don't know me I am a third-generation doctor in my family. This is not a unique phenomenon, particularly in remote and rural areas where medicine as an "art and skill" is handed down from generation to generation. Therefore it was only natural that what was handed down to my father should in turn be handed down to me.

The rural area that I grew up in during the Northern Ireland Troubles was a place where certain elements of the law were not always adhered to. Violence was a regular occurrence and could be seen both locally and on the news. Yet my house was a tranquil and stable place set apart from the harsh realities outside. My father was the local GP who had established himself following my grandfather's retirement some 10 years before I was born. The practice covered a radius of 20 miles so the majority of my school friends and neighbours were all my father's patients.

My earliest recollection of general practice was when I was six or seven, lying in bed hearing the back door closing and the car speeding off in the middle of the night as my dad went to a sick or dying patient. He may not have returned until I was getting ready for school but still would have made it into his morning clinic where 40 patients awaited him. At that time there was no appointment system in place and patients would just turn up. It puts the present GP working day into context.

There was one particular episode I remember when my father returned home from a full night of doing calls, during which he had delivered an expected home birth that had turned into a difficult case. He looked grey and old as he came in that morning and was muttering to himself before he got washed and went on to work. Years later during a conversation about home births he mentioned that this particular episode had been his last ever delivery and recalled the difficulties that it had presented for him, his partner and the community midwife. There are clearly some memories that never seem to fade.

While I was growing up the house was always busy either with patients attending during on-call periods or the phone constantly ringing. Naturally the children were never allowed to answer the phone but I was always intrigued to know why people were calling or visiting.

Occasionally my father would allow us to watch minor procedures being carried out – with the patient's consent – which included things like the removal of small foreign objects from eyes or fishing hooks from hands or ears. My siblings and I would all gather around and gleefully watch my dad carefully and painstakingly carry out the procedure before erupting in sheer delight as the offending object was finally removed.

My schooling in medical practice began early as my father would often talk to us about his work. There were evenings spent around the dinner table when he would tell us all about the interesting illnesses or diseases he had come across while treating patients that day. He would give us the interesting facts about the patients and explore the management of their conditions. This also included informal lessons on where certain medications came from, such as digoxin (digitalis) from the foxglove leaves that were blowing in the garden outside.

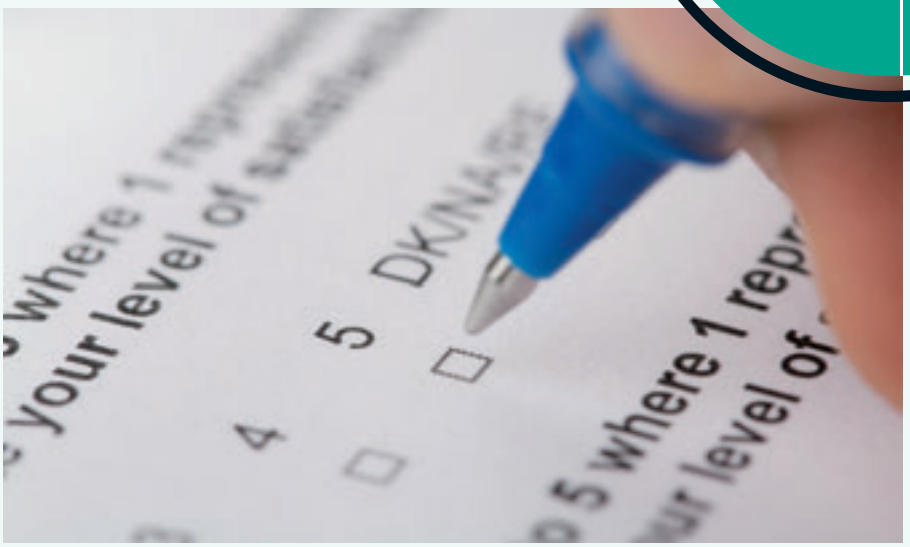
From an early age he always quoted the Hippocratic Oath to all his children to underline the importance of his duty to ensure that he passed on his vocation to future generations. The seed had been planted and throughout school I worked towards a career in science that would hopefully lead to medicine. My father knew I wasn't academically the brightest and that any decision to pursue a career in medicine was ultimately one I had to make for myself.

Growing up, I learned how varied the role of a GP is and experienced first-hand the vital part they play in their patients' lives, in both a physical and emotional capacity. It was this experience that ultimately influenced my career decisions and inspired me to choose primary care. While I was aware that the job could sometimes be demanding and challenging for my dad, on the whole I could see it also gave him a great deal of joy. I have no doubt in my mind that without his nurturing and the experiences I had growing up around general practice that I would not be where I am today.

Dr Peter Livingstone is a GP and editor of GPST

SURVIVING APPRAISAL

With revalidation on the horizon, a good appraisal is more important than ever for GPs



GP APPRAISAL has been a statutory requirement for all general practitioners since April 2002. Since then, revalidation has been just over the horizon, tantalising us all. The primary aim of the GP appraisal scheme has been to help doctors reflect on all aspects of their practice, identify their personal educational and development needs and formulate a plan around how these will be achieved. It is believed that appraisal will form the bulk of supporting information, formerly known as "evidence", which will satisfy the requirements of revalidation.

Revalidation is the process by which all licensed doctors must demonstrate every five years that they are up to date and fit to practise. At the moment, the planned start date for revalidation is January 2013, and in March 2011, the GMC published two documents which indicate what will be required. Both are available on the GMC website and make an interesting read: *Good Medical Practice; Framework for appraisal and revalidation* and *Supporting information for appraisal and revalidation*.

The role of an appraiser is not to judge you, but to guide you in providing supporting information and in preparing for revalidation. Your appraiser will be interested in what you did with the information and your reflections on that information, not simply that you collected it and maintained it in a portfolio. Your appraiser will want to know what you think the supporting information says about your practice and how you intend to develop or modify your practice as a result of that reflection. For example, how you responded to a significant event and any changes to your work as a result.

There are six types of supporting information that you will be expected to provide and discuss at your appraisal, some of them at least once in each five year cycle. They are:

1. Continuing professional development.
2. Quality improvement activity – for example audit.
3. Significant events – likely two per year.
4. Feedback from colleagues – one multisource feedback (MSF or 360 degree feedback) in the first three years.
5. Feedback from patients – one patient survey within the first three years.
6. Review of complaints and compliments.

For the moment, it is important to recognise that the tools for MSF and patient feedback are still being developed and pilots are ongoing but they are not yet compulsory. However, many GPs are bringing this type of evidence to their appraisal now in preparation for revalidation and also because they wish to use these tools for their professional development. For example, the NES Partnership (educational resource for general practice CPD in the West of Scotland), based at Central Quay in Glasgow is offering places on the MSF pilot.

Most GPs remain engaged with the process which, like going to the dentist or completing your tax return, is never as bad as you think. If you wish to satisfy the needs of revalidation and get the most out of your appraisal, I would suggest you consider the following

- Plan ahead. Contact your host board/PCT to join the performers' list three to four months before you finish your training.
- If you are going overseas after your vocational training, get some advice about how this may affect your appraisal and revalidation prospects. There should be a local appraisal adviser/lead GP appraiser in every health board/PCT.
- Keep a log book or portfolio of all your learning needs and learning activities and try to keep notes of learning outcomes or impact/benefit to patients. This allows you to demonstrate that you are continuing to meet the attributes set out in the GMC framework above.
- Think about the RCGP CPD credits system, which is simply a mechanism of documenting your supporting information, allowing you to consider your educational activities in terms of relevance to your role(s), the variation in different activities and their impact. See the guide on the RCGP website.
- Don't think that you are prohibited from undertaking activities such as significant event analysis, patient surveys, MSF and audit – they are all possible. Seek advice from your appraiser or associate adviser as all of these activities will play a part in your supporting information over the revalidation five year period.
- Work with your colleagues. Keep examples of agendas and minutes of meetings you've attended. In Scotland, consider joining Practice Based Small Group Learning (PBSGL) or Young Principal Groups.
- Consider resources and use them. This includes: NES, health boards, PCTs, RCGP, appraisers, local appraisal advisers, and associate advisers. The Scottish appraisal (SOAR) and NHS Appraisal for Doctors Group websites have information to support CPD, appraisal and revalidation, including the appraisal toolkit for both Scotland and England.
- If in doubt, contact your appraiser for advice. You should be allocated an appraiser within a few months of joining the performers' list.

In summary, appraisal should be a non-threatening process and is confidential unless the appraiser has concerns about patient safety in line with GMC guidance. I'm sure you will find it stimulating and informative.

Links

- Scottish Online Appraisal Resource (SOAR) **www.scottishappraisal.scot.nhs.uk**
- NHS Appraisal for Doctors Group **www.appraisalsupport.nhs.uk**
- NES Partnership **www.gpcpd.nes.scot.nhs.uk**
- PRACTICE BASED SMALL GROUP LEARNING **www.tinyurl.com/44lkak4**

Janice Oliver is an appraisal adviser for the Greater Glasgow and Clyde area

WHO DECIDES?

Assessing whether an adult patient has the capacity to decide about their medical treatment can be daunting. MDDUS medical adviser **Dr Barry Parker** offers some advice

THE TREATMENT of adults with incapacity generates a large number of calls to MDDUS. The legislation designed to protect incapacitated adults can appear daunting, but its aim is simple – to ensure patients who cannot make or communicate decisions for themselves about medical treatment have those decisions made on their behalf in their best interests.

In Scotland, the relevant legislation is the Adults with Incapacity (Scotland) Act 2000, while in England and Wales the Mental Capacity Act 2005 applies. In Northern Ireland, decision-making is governed by common law. Both Acts have a number of common themes: decisions must be made on the basis of most benefit to/best interests of the patient, the least restrictive option should be preferred, account should be taken of the patient's previous expressed wishes if known, and the views of relatives and carers should be taken into consideration.

Both Acts have provision for a legally recognised proxy decision-maker to be identified by the patient before capacity is lost (welfare attorney in Scotland, lasting power of attorney in England) and for court appointed decision-makers once capacity is lost (welfare guardians in Scotland, court appointed deputies in England).

Key differences include the requirement in Scotland only to complete a prescribed certificate of incapacity form for treatments under the Act, which can be signed by doctors, but also by appropriately trained dentists, nurses and opticians. In England, specific provision is made for independent mental capacity advocates to be appointed to support an incapable adult who has no family or friends, and advance directives refusing treatment are recognised as legally binding in the English Act only. A special Court of Protection exists in England to oversee the workings of the Act.

Assessing capacity can cause anxiety for doctors who do not specialise in this field, but the principles are straightforward – on questioning the patient, a view must be taken on whether there is understanding of the treatment offered, the reasons for the treatment and the potential side-effects or consequences. There must be an ability to retain this information long enough to make a decision, and the patient must be capable of communicating the decision clearly, with support where necessary. In those with memory impairment, consistency of response on repeated interview is important. It is also important to remember that capacity is task-specific – for example, a patient may have difficulty with the *Times* crossword but still be able to decide on an amputation.

Patients with fluctuating capacity can be a particular challenge, and in difficult or borderline cases it is useful to seek a second opinion from a specialist in this area.

FAQs

If a patient's relative says they have power of attorney, can they discuss the patient's care and decide on treatment?

Firstly, confirm whether the patient concerned has lost capacity – the proxy decision-making powers only come into force when the patient is incapable of decision-making. If capacity is retained, treatment should be the same as for any other individual in terms of consent. Secondly, clarify which type of attorney power is held – these can be for financial or welfare decisions or both. Only powers covering welfare would be relevant for medical treatment decisions.

What happens if there is disagreement between a power of attorney and medical staff over the patient's best interests?

Every attempt should be made to reach a consensus when possible. The GMC advice on resolving disagreements includes involving an independent advocate, consulting a more experienced colleague, holding a case conference or using local mediation services. The Mental Welfare Commission (Scotland) may also assist. If all of this fails, seek legal advice on applying to the appropriate court or statutory body for review or an independent ruling.

Which doctor should complete a certificate of incapacity for treatment in Scotland?

The doctor providing or authorising the treatment is responsible for this as he would normally be responsible for obtaining informed consent from the patient. If the patient is not well known to the doctor and there is uncertainty over capacity, seek further information from the doctor who knows the patient best.

What happens in an emergency, when there is no time to seek information from relatives/carers and no advance directive by the patient?

The normal certification process specified in the Adults with Incapacity (Scotland) Act is not required where treatment is needed in an emergency to preserve life or prevent serious deterioration in health. In England, similar direction is contained in the Mental Capacity Act, with treatment allowed in these circumstances on a 'best interest' basis. GMC guidance on consent reinforces this advice, and reminds doctors that the 'least restrictive option' in terms of treatment should be preferred.

What do I do if I believe a power of attorney is abusing his authority?

In Scotland, either the local authority or the Mental Welfare Commission can be contacted with concerns. The Office of the Public Guardian oversees financial powers of attorney only. In England, the Office of the Public Guardian oversees lasting powers of attorney for both welfare and financial matters.

Dr Barry Parker is a medico-legal adviser at MDDUS

A FAILURE TO COMMUNICATE

Communicating with patients can sometimes be a challenge in the best of circumstances. But what if they don't speak English?

THE PHRASE 'limited English proficiency' is becoming much more familiar to doctors across the UK as our society grows increasingly multicultural.

The significance of language and cultural differences between doctor and patient is such that the BMA has identified them as "the most important barriers to healthcare in Britain". So how can you overcome these barriers?

Patients with limited English come from a variety of backgrounds, from EU and Commonwealth economic migrants to asylum seekers and refugees. Whatever the circumstances, when a language is not shared between doctor and patient it is advised to use a trained interpreter as failure to do so could lead to medico-legal problems.

One case handled by MDDUS involved a member who relied on a patient's husband to translate for her. But it later emerged that his interpretation of his wife's medical needs was wholly inaccurate and this led to a complex complaint.

Using a professional interpreter is more likely to result in effective communication between you and your patient but there are a number of important steps to follow to minimise the risk of a misunderstanding.

Firstly, it is important to confirm the interpreter is qualified and appropriate for the consultation. The skills required of a trained interpreter are detailed in a Code of Conduct published by the National Register of Public Service Interpreters.

Before the consultation starts, tell the interpreter that you must hear all the information offered by the patient. In order to encourage an open and effective consultation a few rules of thumb can be applied:

- Speak slowly and in short sentences, and request that the patient does the same.
- Reassure the patient that the same respect of confidentiality applies.
- Maintain eye contact and speak directly to the patient in the first person.
- Avoid the use of medical jargon and metaphors which may be difficult to translate.
- Ask one question at a time and if the required information is important try asking in different ways to ensure understanding and consistency of the details obtained.
- Make sure that everything you say is translated.
- Make sure you say everything that you would if you were consulting with an English-speaking patient and leave extra time to allow for the translation process.
- It is helpful to meet and brief the interpreter first – particularly for difficult meetings such as breaking bad news – to ensure that the aim of the consultation and important issues are clear.

It is important to approach the consultation in the same way as you would any consultation, ensuring the patient is centre of your attention. Greet the patient directly in order to establish contact. Check via the interpreter that the patient is comfortable with the situation and ensure the patient sits closest to you and is not tempted to shy away behind the interpreter.

As always, be aware of tone of voice and your own body language, as well as the patient's non-verbal responses, but remember that gestures may have different meanings in different cultures. A good interpreter should be able to provide guidance if offence is likely to be caused. Finally, remember to document the presence of the interpreter and provide an account of the information shared. Make sure you also note the interpreter's name and contact details.

If it is not practical to have a trained interpreter attend in person, there are other options to consider, including:

- an 'ad hoc' interpreter (often a relative or friend)
- a multi-lingual healthcare professional
- a telephone interpreter.

Be cautious if using an ad hoc interpreter. While patients may prefer to consult through someone they know, there is always the worry that using an informal interpreter could undermine both patient confidentiality and the objectivity of the consultation. There is also no guarantee of how well an untrained interpreter understands both languages or can effectively communicate what both parties are saying. They are unlikely to have the relevant experience of medical terminology and phrases of a trained interpreter.

The use of relatives or friends may also make it difficult for the patient to discuss sensitive issues, such as the case where a 12-year-old boy was brought along by his mother to interpret during her smear appointment. In more serious circumstances, these encounters may allow a relative to hide abuse or exert undue influence over the patient and their medical care.

In cases where a translator is not immediately available, one useful resource is the *Emergency Multilingual Phrasebook*, produced for the NHS by the British Red Cross. It lists key medical questions in 36 languages to help first-contact staff communicate with patients and make an initial assessment while an interpreter is contacted. It tells you how to ask things like "When did you become ill?" and "Have you any bleeding?" in languages from Albanian to Vietnamese. It can be downloaded from the Department of Health website at **www.tinyurl.com/645423**

Joanne Curran is associate editor of GPST

SKIN DOCTORS

With dermatological referrals increasing – what better time to consider becoming a GP with a special interest in dermatology?

THE treatment of skin disorders is estimated to take up almost a fifth of GPs' consultation time while increasing demand for outpatient appointments has seen waiting lists rise in recent years.

The specialty has been highlighted by the Department of Health (DoH) as an area where GPs with a special interest (GPwSI) could have a significant impact by reducing waiting lists and delivering modern, patient-centred care.

A GPwSI is defined as a doctor who:

- takes referrals that may otherwise have gone directly to a secondary care consultant
- is first and foremost a generalist
- is able to act without direct supervision
- has a level of skill or competence that exceeds the core competences of the individual's *normal professional role* and
- is accredited to deliver specialist clinical services directly to patients.

Dermatology GPwSIs have various training options: dermatology (Group 1); dermatology and skin surgery (Group 2); and dermatology, skin surgery and community skin cancer (Group 3).

Training

A GPwSI competency framework for dermatology was developed in 2007 and updated in 2011. The revised GPwSI guidance also provides detailed information to ensure that accreditors know the kind of evidence and competences that may be expected to be seen and tested during the accreditation process set out in *Implementing care closer to home: Convenient quality care for patients, Part 3: The accreditation of GPs and Pharmacists with Special Interests*.

The competences required to deliver a GPwSI service are seen as a development of generalist skills as outlined by the RCGP and BAD in *Dermatology for General Practice Trainees*. There follows on from this a curriculum for GPwSI training. This is considered to be the minimum core curriculum for any generalist wishing to offer more specialist dermatology diagnosis and management services.

Practitioners are expected to show they have completed recognised training, which may include acknowledgement of prior learning and experience. This can be acquired in different ways:

- Relevant, current or recent experience (within the last five years) in a specialist dermatology department
- Successful completion of an appropriate postgraduate qualification in dermatology and/or dermatological surgery (e.g. diploma) – this is recommended as a good way of obtaining and demonstrating structured learning
- Self-directed learning via the internet with evidence of the completion of individual tasks
- Attendance at recognised meetings/lectures/tutorials on specific relevant dermatological topics.

Practical training is tailored to the service requirements of the GPwSI, who must attend sufficient clinics to obtain the necessary training and experience to demonstrate the competences required for accreditation.

A number of different teaching and learning methods include:

- Attachment to a dermatology unit under the supervision of a consultant dermatologist (or plastic surgeon for surgical skills)
- A periodic case note review by the supervising consultant
- Attendance at a structured course of lectures/tutorials designed to cover basic dermatology
- A combination of clinical assessments and direct observation of practical skills.

Postgraduate diploma courses in clinical dermatology are offered by universities including Cardiff University and the University of London (Queen Mary College) with final examinations at the end of the course. However, possession of the diploma does not endorse the practitioner to work as a specialist in dermatology as they would still need to meet the requirements set out in DoH guidelines.

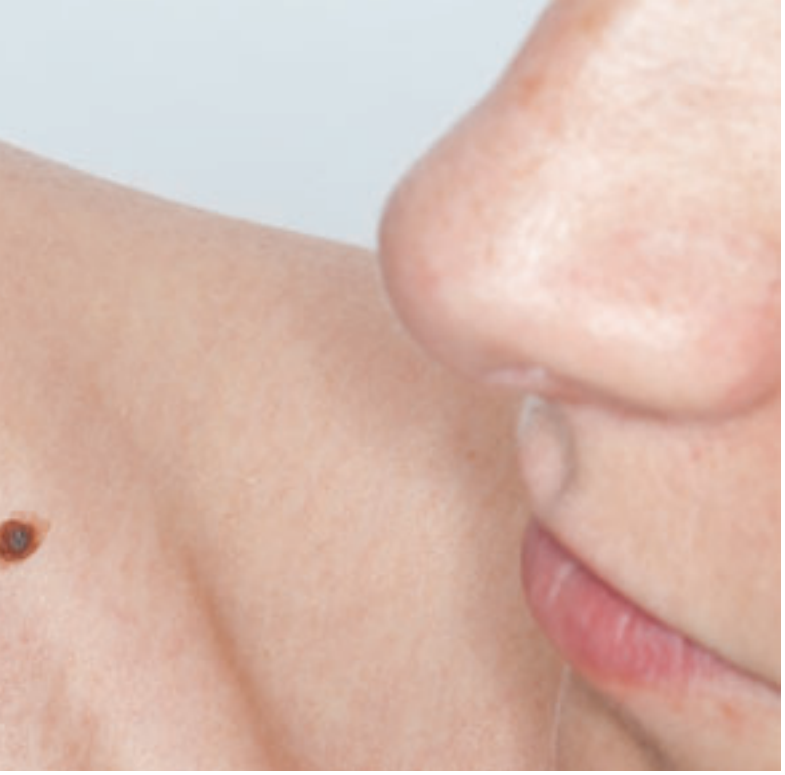
GPs interested in becoming GPwSIs are encouraged to approach their health board/PCT/GP consortium to make proposals or to get advice on services required locally. Trainees with special interests may consider doing a diploma or other training during their vocational training scheme, although this is not essential.

In practice

The proposed dermatology service is likely to be accredited first, and the dermatology GPwSI will then be accredited in the context of the service to be provided and the competences required to provide it.

Accredited GPwSIs can take referrals from local GPs to carry out clinical services beyond the scope of traditional general practice. Most will continue to be practising GPs, and will only perform GPwSI duties for a limited number of time slots (or sessions) per week.

Accredited GPwSIs are normally appointed and paid for by the health board/PCT/GP consortium based on local need and must also have their service accredited. Trusts may also employ GPwSIs to deliver



services within the hospital or for contracted community dermatology services but employment contracts and financial arrangements will differ between areas.

GPwSIs can choose to set up a number of different service models, including:

- A community based service with strong links to the local dermatology department.
- A community based clinic for patients with chronic skin problems such as psoriasis, eczema or leg ulcers, all within a multidisciplinary setting.
- Specialist or enhanced skin surgery performed by trained GPs with suitable facilities.

There are a number of essential elements in providing a GPwSI dermatology service, including access to consultant dermatology support, support from a trained dermatology specialist nurse and adequate consulting rooms with good facilities for diagnosis and treatment procedures. Ideally, there would be a computer link to the hospital-based dermatology department with telemedicine facilities.

The future

The changes set out in the 2010 White Paper *Equity and Excellence: Liberating the NHS* will, as they are implemented, have an impact on the way in which GPwSI services in England are commissioned and accredited. But while some of the details of the process will be subject to change, the principles set out in DoH guidance are expected to remain valid.

Links:

- Doctors interested in becoming a GPwSI in dermatology should consider membership of the Primary Care Dermatology Society – www.pcds.org.uk
- British Association of Dermatologists – www.bad.org.uk
- *Revised guidance and competences for the provision of services using GPs with Special Interests (GPwSIs) Dermatology and skin surgery* www.tinyurl.com/3o48mas
- *Providing care for people with skin conditions: guidance and resources for commissioners (NHS Primary Care Commissioning 2008)* www.tinyurl.com/3ukx8kz

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Q&A

Dr Fiona Collier,
GPwSI in dermatology

- **What attracted you to a career as a GPwSI in dermatology?**
  I worked as a part-time clinical assistant in dermatology while having a break from general practice and I found it a fascinating field. After returning to general practice I decided to do the Cardiff diploma in practical dermatology and was fortunate to pick up a session in dermatology at the department I had previously worked in. I then approached our local dermatology department about creating a GPwSI post. This coincided with a redesign of dermatology services, and they incorporated three posts into their plan.

- **What do you enjoy most about the job?**
  It's refreshing to be able to concentrate on one aspect of a patient's problems. I find in general practice, patients often throw in their skin problem as a third or fourth item on their list and it's hard to do it justice. It's also very interesting to see the health service from the secondary care viewpoint and speak to hospital colleagues who are often interested/puzzled by various aspects of primary care. The GPwSIs are very much part of the multi-disciplinary team in dermatology and I enjoy the support and exchange of ideas within the team.

- **Are there any downsides?**
  One problem with being a GPwSI is that this is a 'non-standard' post, with a locally-negotiated contract. This means that we have no automatic right to any salary increase awarded to other NHS staff and have to argue our case for any uplift in our remuneration.

- **What do you find most challenging?**
  It can be challenging to balance the demands of the two different jobs, particularly ensuring I am back in the practice on time for my commitments there. Also, I must admit that quite a lot of my GP consultations have a dermatology flavour, due to intra-practice referrals, and patients hearing by word-of-mouth that I am interested in skin conditions. I don't mind this at all, but it means that my other patients can have some difficulty in getting appointments.

- **What about the role has most surprised you?**
  I hadn't realised how much other areas of my practice would benefit from spending time getting more expertise in a particular area. It seemed to rejuvenate my enthusiasm for keeping up-to-date and improving my skills in other aspects of general practice.

- **What is your most memorable experience so far?**
  My most memorable experience was giving a talk to local GP colleagues about a particular skin disease, hidradenitis suppurativa, which I felt was a neglected and under-diagnosed condition. I was quite apprehensive about lecturing to my peers, but they were very supportive and it was a very positive experience.

- **What advice would you give to a trainee GP considering a career as a GPwSI in dermatology?**
  Sit in on some dermatology clinics to see if you enjoy it – it's not everyone's cup of tea. Then investigate the various options for a postgraduate diploma in dermatology. Many of these are now largely distance learning, with local clinical attachments. The diploma gives you a solid knowledge base and training in the specific clinical skills of dermatology. It's worth trying to make links with your local dermatology department, so they know your face if any opportunities arise. I think having a special interest helps maintain enthusiasm and balance in general practice and it's something I'd recommend to any GP at any stage in their career.

MARATHON MAN

GP **Dr Andrew Murray** has run to the Sahara, raced across the Arctic and is a keen mountaineer. He talks to *GPST* about his passion for adventure and his desire to make the nation more active

THERE aren't many doctors who would recommend running 100 miles across the Arctic wastes with a broken leg, but that's just one of the many challenges faced by Dr Andrew Murray, Edinburgh-based GP and sports and exercise registrar.

Andrew, 31, is an ultramarathon runner – regularly taking part in extremely demanding races in some of the world's most hostile environments. Most recently, he completed the Scotland2Sahara Charity Run from John O'Groats to the Sahara desert – an astonishing 2,659 miles run in 78 consecutive days, averaging 34 miles a day. Featured on the BBC's *Adventure Show* in a piece called 'The Ultimate Marathon Man', the aim of this outstanding achievement was to raise money for the Yamaa Trust, a charity which works to tackle poverty in the south Gobi region of Mongolia.

He is clearly made of hardy stuff. "The Arctic race, where I fractured the tibia in my lower leg, was 150 miles without any support, with an average temperature of minus 52 degrees with windchill," he says. "I also had to drag all my stuff behind me in a sledge. Because of the sort of race it was, there was no option to stop, so I had to keep going even though I was injured.

"In the same year, I'd run desert races in temperatures of 45 degrees. It was really good fun. I like challenging myself by going into completely different environments and seeing the way different people live. I've also run in the jungles of Indonesia, and taken part in the Marathon des Sables, a six-day, 151 mile endurance race across the Sahara."

Andrew first discovered ultramarathons when he was travelling in Nepal and a friend left some valuables six miles and 1,000 feet back up a mountain. Luckily for his friend, Andrew volunteered to "jog back up to get them" and, on the way, met some runners training for the Everest Marathon. Inspired, he decided to give it a go himself.

He says: "I'd never run a marathon before, but it sounded like a good idea. And Mount Everest is spectacular, so I decided I could do a big run and combine it with seeing a bit of the world."

PHOTOS: © RICHARD ELSE

"One of the things I love most about the challenges is pitting my wits against the environment"

Going the distance

But it was a race in Outer Mongolia, the Gobi Challenge, which gave him the idea for Scotland2Sahara: "I had never seen anything like it, the environment in the Gobi region is ridiculously hostile, people are living in extreme poverty, but they want to share whatever they have with you. It made me determined to raise money for them."

Determination to raise money for a worthy cause is one thing, but finding the will to run 2,659 miles in consecutive days is quite another. Andrew seems surprised by the suggestion that his type of running would be completely beyond the reach of most people, although he does admit to being a "targeted and goal orientated person".

This kind of understatement is typical of his gentle manner, which comes with a very dry and self-deprecating humour you imagine serves him well in the middle of nowhere with only the sound of his feet pounding the snow or sand for company.

So how does he prepare for an ultramarathon? "Mental preparation is the most difficult thing," he says. "You have to be very adaptable. Of course, you have a practical plan, making sure you have everything you need for the environment you'll be running in, for example, but there are a lot of things you can't predict.

"Every single run I do there's a moment where I think I can't go on, when your legs tell you that you want to stop. Experience helps, because you know it will eventually get better. During the Scotland2Sahara run, the fact that I was running every single day, I was constantly tired and I felt like the world was conspiring against me. But it was also amazing, knowing I was part of this adventure and, honestly, that's one of the things I love most about it, pitting your wits against the environment."

Alongside maintaining some work as a GP, Andrew is a keen mountaineer, and has scaled the highest peaks on four continents. He also runs Marathon Medical Services with his friend Dr Duncan Goodall, providing medical services to marathons, races and expedition in the UK and beyond. The role has seen him travel to six continents and the North Pole, working with some of the world's top athletes.

Having medical knowledge has also helped him stay in tune with his own body, although pushing himself beyond known limits is perhaps part of the appeal.

"All the advice in medical textbooks says that if you run more than four consecutive marathons, then your body will start to decline and break down, you will get loads of overuse injuries," Andrew explains. "Knowing this would happen was maybe unhelpful in a way, but it was also good because I could take action to prevent it. The biggest problem I had was actually anaemia, with my feet slapping against the road over and over, and losing some blood in my pee, but I saw what was happening so I started to take iron tablets."

He also planned his route from Scotland to the Sahara so he could take a sports medical exam in the morning, then run 30-odd miles afterwards, through one of the harshest UK winters in living memory.

His worst moment came not in the heat and sand of the Sahara towards the end of the run, but in the cold and dark of London near the beginning, he explains. "When I was running in England, my Achilles tendons were killing me on each step – they are twice the size of a normal person's. I was running through incredibly deep snow, nothing was open, all the roads were closed. I was thinking 'what am I doing? It's not going to get any better anytime soon.' That was my lowest point."

Main picture and above: *Andrew Murray tackles the gruelling Scotland to Sahara run. He is wearing protective gaiters to stop sand getting into his shoes.*

But Andrew struggled through, driven not only by his promise to raise funds for the Yamaa trust and his impending wedding to fiancée Jennie Reeves but also his passion for highlighting the benefits of physical activity.

Beyond marathons

He now plans to focus on working with the government and other agencies to try to make the nation more active. He is currently one of four registrars in Scotland in the new specialty of sports and exercise medicine, which includes training on safely prescribing exercise in individuals and managing musculoskeletal injuries.

He says: "I work very hard to support this agenda, and am pleased to say progress is already being made.

"Only 35 to 45 per cent of Scots get enough exercise a week, which is shocking when you realise the recommended amount equates to just 2.5 hours. It's an exciting thing to be involved with and I'm grateful I've had the support of so many people, including the RCGP. Doctors have a terrific role to play in promoting activity."

Andrew recently published a book, *Running Beyond Limits**, which details his epic journeys and physical endurance, and has an introduction written by the great adventurer and explorer Sir Ranulph Fiennes. Modest as ever, Andrew says: "It took me ages to write, I'm really not that clever!"

Many would beg to differ. Indeed, his achievements in medicine, running and fundraising were recognised by youth organisation JCI Scotland in August, when he won the Outstanding Young Person of Scotland Award.

As for the next challenge, Andrew says: "There are a few hills I want to climb, a few runs I want to do, but I think my wife would like me to take a break for a while!"

* To order, visit: **www.mountain-media.co.uk**

Rowan Morrison is a freelance writer and a partner at Bird Morrison, Edinburgh

A SHARED FAITH?

When is it appropriate to discuss religion and personal beliefs with patients? MDDUS medical adviser **Dr Susan Gibson-Smith** offers some guidance

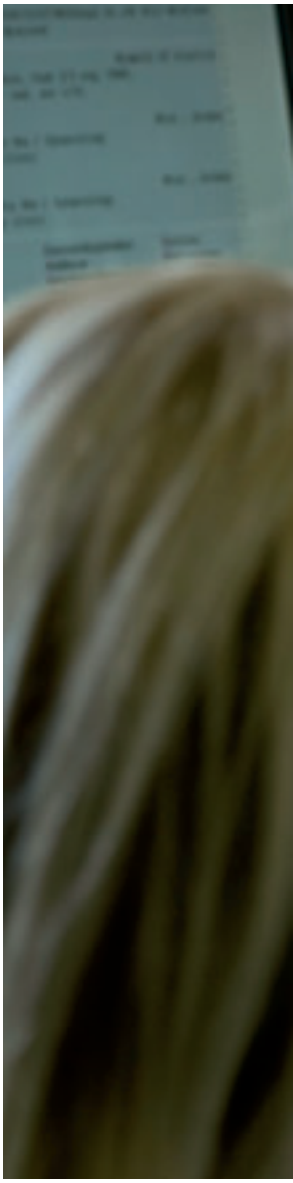

PHOTO: LIFE IN VIEW/ SCIENCE PHOTO LIBRARY

THE issue of doctors discussing their faith with patients is a contentious one and it has sparked intense debate on all sides.

It made headline news in May 2011 when a complaint was made to the General Medical Council by the mother of a 24-year-old man about a GP in the south of England. She claimed the doctor had pushed religion on her son by discussing Christianity with the vulnerable young patient. The GMC investigated the complaint and issued a formal warning to the doctor, stating that his actions risked "bringing his profession into disrepute".

The doctor has since challenged the warning – which would remain on his record for five years – and denies abusing his position but he may now face a GMC fitness to practise hearing. The case raises important questions for doctors. Consider the following scenario:

"I just feel so confused, why would this happen to me, to my child? I can't make sense of it. It's so unfair!" Tears stream down Mrs Brown's face. She made the appointment to get a fit note to excuse her from work. Her 11-year-old daughter Jasmine had recently been admitted to hospital for investigations and she had just received the diagnosis of Crohn's disease.

As an ST3 I know it's part of my role as her GP to listen to Mrs Brown's concerns and expectations regarding her daughter's condition and to provide information and advice. But how far should my support for her go? She is clearly psychologically distressed and counselling may help her come to terms with the diagnosis. However, as a Christian it is my personal belief that she could also find spiritual comfort in the knowledge that there is a God who cares for her and her daughter. Should I say anything about this? What is the right thing to do?

Rights and responsibilities

Just like everyone else, doctors have their own cultural and individual core values and personal belief systems which affect their day-to-day practice. These values can at times conflict with the views of patients, and may give rise to concerns about carrying out or recommending particular procedures.

Referring a pregnant patient for a termination procedure or prescribing contraception are examples of clinical situations where doctors can be conflicted between their duty of care to their patient and their own views. Doctors are entitled to basic human rights including freedom of thought, conscience and religion. But patients also have entitlements to care and treatment to meet clinical needs.

So what is the right thing to do in a situation where your own personal beliefs conflict with a patient's rights? It is important to be aware of the GMC's guidance on this matter in *Good Medical Practice* and also in the supplementary guidance *Personal Beliefs and Medical Practice*.

The guidance is very clear regarding doctors' personal beliefs:

"You must not allow any personal views that you hold about patients to prejudice your assessment of their clinical needs or delay or restrict their access to care. This includes your views about a patient's age, colour, culture, disability, ethnic or natural origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status."

Personal beliefs, therefore, must not influence assessment of clinical need or delay or restrict access to care. So if a patient requests a termination, must a doctor make that referral even if it conflicts with their own personal beliefs?

The guidance explains that patients have a right to be given information about their condition and the options available to them. It states:

"Patients may ask you to perform, advise on or refer them for a treatment or procedure which is not prohibited by law or statutory code of practice but to which you may have a conscientious objection. In such cases you must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right."

Where patients are not able to make their own alternative arrangements, the guidance clearly highlights the doctor's duty to ensure arrangements are made, without delay, for another doctor to take over their care. The guidance warns doctors – regardless of their personal beliefs – not to obstruct patients from accessing services or leave them with nowhere to turn, and to always respect their views.

The same duty of openness that is expected of doctors in person also covers printed information such as practice leaflets. Literature must detail any treatments or procedures that you may have chosen not to provide or arrange due to a conscientious objection, but which are not otherwise prohibited.

So in the case of a doctor with a conscientious objection to termination, he or she clearly has a duty to inform the patient of the treatment options available and make the necessary arrangements for her to access the care she is entitled to. For trainees, in practical terms, this would involve discussing the matter with your GP trainer and coming to an agreement as to how to manage this situation appropriately. It is always better to discuss this hypothetically before it arises in a live consultation.

A fine line

And now for Mrs Brown – should the doctor disclose her faith in an attempt to support the patient through this difficult time in her life? The guidance from the GMC is very clear on this matter in warning doctors that they must not talk to patients about their personal beliefs – whether they are political, religious or moral – in a way that might exploit their vulnerability or cause them distress.

However it then goes on to state that, for some patients, acknowledging their beliefs or religious practices might form an important part of a holistic approach to their care. In some cases, discussing personal beliefs in a sensitive way may be beneficial and allow the doctor to work in partnership with the patient to address their treatment needs.

But there is a fine line to be tread. On the one hand, doctors are advised to respect patients' rights to hold religious beliefs and to take those beliefs into account whenever they may be relevant to treatment options. But on the other hand, doctors must respect a patient's wishes if it is clear they do not want to discuss personal beliefs.

"Personal belief must not influence assessment of clinical need"

Back when I was a trainee I was advised by my trainer to use this gem of an open question that I have employed many times since: "Do you have a faith that would help you cope at a time like this?"

This question allows the doctor to sensitively explore the patient's own beliefs, if they wish to share them, without imposing their own beliefs on to a patient when they are feeling most vulnerable.

If Mrs Brown were to answer yes to this question, the doctor could explore the support her faith could provide her. If she says no and has no interest in such things then that is the end of the matter. Either way her wishes are respected.

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

REFERRAL DELAY

A BAD TRIP

ONE MONTH EARLIER

Mr C – a 31 year old – attends his GP surgery for advice on inoculations and other treatment in preparation for a trip he is taking to Senegal. The GP – Dr M – notes in the patient records that Mr C has already been vaccinated for tetanus, polio and hepatitis A. He is given a typhoid vaccination and is prescribed doxycycline and Malarone tablets to prevent malaria

DAY ONE

Two days after returning from Senegal Mr C's partner phones the out-of-hours GP late in the evening and reports that he his very unwell, suffering with diarrhoea, vomiting and a high temperature. She also informs the GP that prior to and during the first part of their holiday in Senegal Mr C had been taking anti-malarial tablets but that they had made him sick so he stopped. She explained they both had been bitten by mosquitoes during the trip. The out-of-hours GP advises that Mr C should contact his GP in the morning.

DAY TWO

Mr C's partner speaks with Dr M that next morning and explains that Mr C has been ill in bed for the last 36 hours. She also tells him about the Senegal holiday and how Mr C had stopped taking his anti-malarial tablets four days into the trip. The GP advises her that a nasty virus is making the rounds and that Mr C should stay in bed and see how he feels after the weekend. Dr M notes in the record after the telephone consultation: "Unwell after Senegal trip. No diarrhoea at present, fever down, flu symptoms".

DAY FOUR

Mr C's condition does not improve over the weekend and his partner phones the surgery on Monday morning and leaves a message on the answer machine. A different GP – Dr T – phones back at lunchtime and says he will attend Mr C at home after the evening surgery. Dr T arrives after 6pm and is provided the same history given to Dr M. He examines Mr C and notes that he is pyrexial. He advises that a blood test will be necessary to confirm or rule out a diagnosis of malaria. He provides a test form and instructions to a walk-in centre at a local hospital where the blood sample can be taken.

DAY FIVE

Mr C's partner phones the surgery in the morning to say he is too unwell to leave his bed and travel to the hospital. She asks if a nurse can attend the house to draw the blood sample. The surgery informs her that this would not be possible and that he must either attend the hospital or come to the surgery that Friday when a practice nurse would be available.

Late that afternoon the partner grows more concerned about Mr C's deteriorating condition and phones the out-of-hours service. Another GP attends Mr C at home later that evening. Given the history and symptoms, this GP concludes that Mr C is obviously suffering from malaria. He phones for an ambulance and Mr C is admitted to hospital. Bloods are drawn and the test results early the next morning confirm that Mr C has falciparum malaria. He is transferred to a tropical infectious disease unit and started on IV quinine.

SIX months later the practice receives a letter from solicitors representing Mr C claiming damages on his behalf for clinical negligence. The allegations include a breach of duty of care on behalf of Dr M for not considering fully the history of his recent trip to Senegal and inability to tolerate the anti-malarial drugs before reaching the conclusion that it could be a viral illness. The letter further charges that Dr T should have acted more urgently on his suspicion that Mr C could be suffering from malaria and thus ensured a prompt referral. It is alleged that the delay in diagnosis exacerbated his illness and led to unnecessary suffering and anxiety as well as an extended period of recuperation. Mr C also claims that in the days after his discharge from hospital he suffered from hair loss (telogen effluvium) as a result of his high fever.

MDDUS commissions an expert report on behalf of our member, Dr M, along with another MDO representing Dr T. The expert concludes that had Mr C been given a blood test and diagnosed on the day the surgery was first contacted he would have suffered fewer complications and a shorter hospital admission, and enjoyed a quicker recovery. The hair loss would still have occurred but would have been less severe.

In considering the risks of defending the case in court with the associated legal costs it was decided by MDDUS and the other MDO involved to negotiate a joint out-of-court settlement.

KEY POINTS

- Have a high index of suspicion with flu-like symptoms in patients returning from malarial regions.
- Inform patients travelling in such regions of the importance of maintaining malaria prophylaxis and avoiding mosquito bites by covering up, using insect repellents and sleeping under a mosquito net.
- Prompt diagnosis and treatment is a matter of urgency in malaria as infection can be fatal.

Diary

ARE YOU SITTING COMFORTABLY?

WHAT CRISIS? Time was when a young professional person could expect reality to "bed-in" slowly – job, marriage, house, kids, cellulite, hair loss – before hitting the inevitable mid-life crisis. Sadly now you can jump right in straight out of training. Introducing the "quarterlife crisis" which afflicts twenty and thirtysomethings and is defined as a sense of feeling "locked in" to a job or relationship. "It's an illusory sense of being trapped," says Dr Oliver Robinson, a University of Greenwich researcher who recently published research on the phenomenon. "You can leave but feel you can't..." Not necessarily a bad thing apparently, according to Robinson and his colleagues who surveyed 50 people aged between 25 and 35. "A minority of participants described getting caught in a loop, but the majority reflected on a difficult time which was a catalyst for important positive change." Just as well – it can take years to save up for a convertible Lamborghini and/or cosmetic surgery.

VINTAGE SURGERY Nose jobs in the 19th century were brutal, according to a new book by surgeon John Stevenson. Scissors, quills, pins and needles were used to correct misshapen noses - and there's no mention of anaesthesia. Patients seeking cosmetic help include a baron who lost the tip of his nose in a duelling accident. Chris Albury, of Dominic Winter Auctions which is selling the tome, said: "It shows that celebrities today are not the first in this country to go under the surgeon's knife to improve the look of their noses."

UNDER YOUR SKIN A hand-held gadget designed to help patients understand the healing process projects X-ray images of bone structure, muscle tissue, tendons and nerves onto their skin. The AnatOnMe consists of a projector, camera and laser pointer and can display stock images of six injury types. The doctor can use the camera to take images and video of the patient and document their progress as well as checking they are doing therapy exercises correctly. Researchers on the Redmond campus in Washington hope the device will help doctors encourage patients to stick to courses of prescription drugs and physiotherapy.

EXTREME MEASURES A GP recently had to call in the police to warn a patient that he had a life-threatening condition. Michael Spence, 64, from Essex hadn't left a contact number with the doctor but tests sent to the hospital showed he was at risk of a fatal stroke due to a suspected blood clot in his neck. Two officers duly chapped on his door and told him to phone the hospital immediately. They only left once he'd arranged to go to A&E for treatment. Mr Spence told the *Daily Mail*: "I'm sure I wouldn't be here now if it hadn't been for the GP, the wonderful team on Benfleet Ward and the policewomen." Diary assumes dialling 999 to contact patients would not normally be the recommended approach.

OH THE IRONY Straight from the file marked "misguided good intentions" comes this fundraising campaign by a fast food restaurant. A KFC franchise in Utah is asking customers to support the fight against diabetes by purchasing an 800-calorie Mega Jug of sugary soft drinks, according to website theweek.com. For every $2.99 half-gallon drink it sells, the restaurant is promising to give $1 to the Juvenile Diabetes Research Foundation. The move has met with some criticism from anti-obesity activists but a JDRF spokesman pointed out that type 1 diabetes is not caused by diet or obesity. A fair point, but as any doctor knows, regularly downing a drink containing 56 spoonfuls of sugar may well set customers on the road to type 2 diabetes.

PRESCRIPTION PUFFING Doctors in Iceland could be thrust onto the frontline of the country's anti-smoking campaign under a proposed new initiative. The parliament in Reykjavik is considering a proposal to ban the sale of cigarettes and make them a prescription-only product. Under the plan, cigs would be distributed by pharmacies only to people with a valid medical certificate. Only around 15 per cent of Icelanders smoke regularly, giving it the lowest smoking rates in Europe. But the plans are not expected to be accepted into law. Spare a thought for any poor doctor expected to stand between a smoker and their cigarette.

18,000 MILE COMMUTE One lucky experienced GP will have the chance to truly get away from it all as the new chief medical officer on the Falkland Islands. A recent job advert invited GPs with "a sense of adventure" to consider hopping on an 18-hour flight and moving to the south Atlantic territory. All local medics are based in the 28-bed GP-led King Edward VII Memorial Hospital. The new CMO will be expected to undertake varied duties, from general practice care to police surgeon duties and even advising the government on "all health matters".

HANDY HINTS Apparently the key to spotting future top doctors lies in the length of their second and fourth fingers. Italian researchers found medical students with a lower finger length ratio (known as 2D:4D) in their right hands were more likely to be successful. Italian university researchers used callipers to measure the fingers of 48 male medical students and found those who passed their medical school admissions test had a significantly lower 2D:4D ratio than those who failed.

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