GPst

ISSUE 04

WORKING WITHIN THE LAW

DO YOU HAVE WHAT IT TAKES TO BE A FORENSIC PHYSICIAN?

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

PHOTOS: PAUL GRAHAM

Welcome to your GPst

AFTER three challenging years, I have finally completed GP training and now find myself negotiating my way through the world of locum work. Coming to the end of training can be a daunting time for doctors as we face various financial and professional issues from tax returns and pensions to deciding what kind of medicine we want to practise. My article on **page 4** looks back over my experiences and offers some advice for those who are due to complete their training soon.

One challenge that all GP trainees must face is the Clinical Skills Assessment of the MRCGP. GP and medical author Dr Milan Mehta shares some valuable tips on how to pass this vital test in his article on **page 5**. Making decisions on issues of consent in children can be complicated but on **page 6** MDDUS medical adviser Dr Gail Gilmartin highlights some key points to consider.

Intimate examinations can be a distressing experience for patients which makes it all the more important for doctors to be professional and respectful. On **page 12**, MDDUS medical adviser Dr Susan Gibson-Smith discusses how to handle these sensitive situations to help minimise patient complaints.

On **page 14** misdiagnosed leg pain and a delayed referral leads to amputation for one patient in our case study which highlights the need for good record keeping among other things. In our careers article on **page 8**, we look at the opportunities for GPs to work within the criminal justice system in the field of forensic medicine.

And on **page 10**, GP and media doctor Jonty Heaversedge talks about bringing a positive health message to millions of TV viewers as well as his preparations for the planned overhaul of the NHS.

• **Dr Peter Livingstone**
Editor

FOLLOW MDDUS ON TWITTER

KEEP up-to-date with the latest news, features and events on the MDDUS twitter feed. Follow us on twitter **@MDDUS_News** to keep track of the latest advice on a variety of medico-legal topics as well as a range of interviews and articles from our publications.

GREATER PATIENT CHOICE MAY CREATE GREATER RISK

A GOVERNMENT pilot scheme to remove practice boundaries in a bid to increase patient choice raises serious concerns for doctors over accountability and continuity of patient care, MDDUS has warned.

Patients with complex health problems could face difficulties under the plans to allow patients to choose a GP in a location remote from their home address.

The pilot scheme is being launched in England in April 2012 and will operate in parts of London, Manchester and Nottingham.

MDDUS medical adviser Dr Barry Parker said: "The proposal would work well for patients who normally enjoy good health and those looking for short-term intervention for something straightforward, such as an ear infection.

"However, patients with complex health problems undoubtedly benefit from having a single source of care provided by a dedicated practice team that knows them well. The government proposals raise concerns which could jeopardise the quality of that care given to patients."

Under the initiative, patients could remain registered at a practice near their home and have consultations as a 'day' patient at another practice. Another option would be to register as an 'out-of-area' patient, meaning they would rely on their local PCT cluster for care at home or out of hours.

Where care is split between two sources, Dr Parker said communication channels must be very efficient and comprehensive – particularly for drug prescribing, treatment plans and referrals.

The Department of Health said it expects those who take advantage of the new boundary rules "will typically be working-age adults without complex health problems, who are less likely to require home visits."

They added: "All PCT clusters will need to ensure they have arrangements in place to meet these needs."

GMC ANNOUNCES PLAB REVIEW

THE GMC has announced a review of the PLAB test for doctors from outside Europe who wish to register to practise in the UK.

The Professional and Linguistic Assessments Board (PLAB) test is the main route through which doctors who qualified outside the UK or EEA demonstrate their clinical skills before they join the UK medical register. The two-part test is set at the level of skill and knowledge expected of a UK graduate after their first year of training – the end of Foundation Year 1.

An independent expert group will oversee the review process over the next year and is seeking the views of all interested parties. The GMC will also be commissioning research to support the review alongside a literature review on best practice in comparable examinations.

GMC chief executive Niall Dickson said: "The NHS has long relied on the skills and professionalism of doctors who trained outside the UK, and of course it is vital that every doctor coming to work here has the skills to treat patients safely and effectively."

Last year, 4,068 doctors sat the first part of the PLAB test with a 35 per cent pass rate, and 2,637 sat part two with 70 per cent passing and becoming eligible to apply for UK medical registration.

Further information on the PLAB review is at **www.gmc-uk.org.**

MDDUS

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WEBSITE TO SUPPORT UNWELL DOCTORS

A NEW website for doctors who may be concerned about their own health or that of a colleague has been launched by the GMC.

Your Health Matters provides detailed information and advice on the process involved when doctors are referred to the GMC with concerns relating to their health. The website also features case studies showing doctors with a range of health concerns.

GMC chief executive Niall Dickson said: "It would be hard to overstate the anguish and trauma experienced by many doctors whose health has affected their ability to practise. While the GMC must never compromise on standards of patient safety, we are anxious to do what we can to support doctors with health problems and help them back to safe practice wherever possible."

Dr Clare Gerada, Chair of the Royal College of GPs and Medical Director of the Practitioner Health Programme, said: "When a doctor is referred to the GMC it can be one of the most stressful and painful times of their lives. This [website] provides... timely information for doctors who may for health reasons be involved in the GMC's fitness to practise procedures."

The GMC has also announced that it will be undertaking research to assess if its current fitness to practise procedures for doctors with health concerns are striking the right balance.

MDDUS is very experienced in helping doctors with health problems that impact upon their fitness to practise. Whilst the GMC's guidance does not expressly advise doctors to consult their medical defence organisation, MDDUS strongly advises members to seek our advice before contacting the GMC.

AUDIT AWARD FOR TRAINEE GPS

A CASH award is being offered to GP trainees conducting high quality audit projects.

The RCGP Clinical Innovation and Research Centre is offering trainees the chance to secure one of five £1,000 payouts. The Kuenssberg Award is given in recognition of projects that "demonstrate a change in clinical practice or service improvement as a direct result of the audit."

As well as a cash prize, winners will be invited to present their audit work at the Society for Academic Primary Care Annual Scientific Meeting or at the RCGP Annual Conference.

The award is open to Associates in Training and RCGP members in their first five years of practice who are not currently in an academic department of general practice. The deadline for submissions is May 18, 2012 and more information is available at **www.rcgp.org.uk/kuenssbergaward**.

PART-TIME TRAINEES GET BREAK ON ARCP EVIDENCE

TRAINEES not studying on a full-time basis will no longer have to collect the same amount of evidence for their Annual Review of Competency Progression (ARCP) over a calendar year.

The GMC has offered interim guidance to say that for 'less than full time trainees' (LTFTTs) evidence can be gathered on a pro-rata basis. This approach means that LTFTTs will collect the same amount of evidence as full-time trainees, but over a longer period of time.

Trainees will continue to have regular educational reviews (usually a minimum of once a year). For these interim reviews, supervisors make a judgment of progression for stage of training normally based on pro rata evidence as a minimum. However, there may be situations dependent on individual trainees performance and progression where more than the minimum evidence is required. The RCGP is in full agreement with the GMC that this recommendation is a fairer approach for those trainees affected and is encouraging GP Deaneries to implement the guidance as soon as possible.

The purpose of the ARCP is to ensure that trainees are engaged with the training process, have undertaken appropriate workplace-based assessment and are making satisfactory progress for their stage of training. At present, LTFTTs have to collect the same amount of evidence for their ARCP as their full-time peers. The RCGP agrees that the new approach will ensure that assessment does not take up a disproportionate amount of trainee learning time.

The RCGP Postgraduate Training Board (PTB) has agreed that for gateway ARCP reviews between specialty training years, a trainee must provide the minimum amount of evidence specified by the RCGP. For example, for a trainee working at 50 per cent of full time the required evidence at the end of their ST1 year may be compiled over the equivalent period - i.e. two calendar years.

Since many LTFTTs are not synchronised with the usual assessment cycle of transition in specialty training years in August, the RCGP recommends that the Workplace Based Assessment guidance be applied from the next review scheduled. For the majority of LTFTTs this will be a 'gateway' ARCP in the summer of 2012.

A SURVIVOR'S GUIDE TO GP TRAINING

GPST editor **Dr Peter Livingstone** looks back over his training and offers some words of advice

WHEN I started my training, I was part of the first group to go through the new GP training programme introduced by the RCGP about four years ago. This was a three-year programme based in south Glasgow that involved rotating through various specialties such as psychiatry and paediatrics and included 18 months in general practice. As I'm sure you're all aware the application process was extremely daunting with written examinations and clinical scenarios to contend with. Once I successfully completed it, I was relieved to find myself in my chosen specialty, with the reassuring prospect of three years of regular employment.

Looking back over my experiences in training, there have been highs and lows. Admittedly, I started out with the rather naïve idea that it was all going to be plain sailing but, for all the challenges along the way, I have met some enthusiastic fellow GPs who I now count amongst my life-long friends. A huge bonus was having a great GP mentor who was very supportive. Without this help, I doubt I would have passed my membership exams let alone successfully completed my training.

As I progressed, my knowledge and communication skills improved and I became more confident about making my own decisions about the type of medicine I wanted to practise. The paternalistic medicine that I had applied in hospital was left behind as I embraced a different approach that sought to explore patients' ideas, concerns and expectations. Throughout this process I learned the importance of the "whole picture" in relation to a patient's spiritual, physical, social and mental wellbeing. Building up rapport with patients and their families was an enjoyable experience. Providing such continuity of care is a luxury you are not always afforded in secondary care.

One major challenge of GP training is keeping up with all the paper work, although it's not so much paper as electronic form-filling. I did struggle with the demands of the ePortfolio where GP trainees are required to "record their learning" and log evidence collected through the application of the work place based assessment (WPBA) tools. In addition to this there is also the reflective process to contend with, requiring log entries on a weekly basis. I would recommend keeping this up-to-date as you go along as leaving it all to the last minute is a recipe for disaster.

Learning to deal with stress and pressure is an important skill for trainees. I really felt under pressure during my ST3 year when I was trying to balance full-time work with providing out-of-hours care and studying for exams. The key thing is to try to maintain a healthy work/social life balance as we can all get too easily bogged down.

Thankfully, there was light at the end of the tunnel and I achieved my goal in August 2011. I then had to face the "real-world" where I had no GP mentor and had to search for regular work. My CV was non-existent and needed a lot of work but I would recommend you get this sorted before completion. Hastily put-together CVs are easily spotted and can be the difference between getting regular employment or not. I joined the Glasgow and Lothian GP locum groups and sent my CV electronically to all practices in my health board area.

For any prospective locums, here are 10 tips to help you prepare for the world of work:

1. Ensure your CV is accurate and up-to-date.
2. Send CVs electronically – this saves money on envelopes and postage.
3. Join the GP performers' lists of your local and surrounding areas – if you are willing to travel you are more likely to get work.
4. Join your local locum group – they advertise posts and provide educational evenings.
5. Ensure you have an invoice template – easy to print off at every practice.
6. You are now self-employed – get yourself an accountant; they work wonders.
7. Keep all expenses up-to-date – you will need to claim this against tax deductions.
8. Keep aside a folder for important documents such as CCT and medical indemnity certificates – you will need these for each practice you work in.
9. Start preparing early for your appraisal – it comes around very quickly after completion of training.
10. Finally – enjoy yourself. You have reached your goal.

Dr Peter Livingstone is a locum GP and editor of GPST

GP and medical author **Dr Milan Mehta** offers some practical tips on passing the Clinical Skills Assessment of the MRCGP

MORE READY THAN YOU THINK

THE thing that most GP trainees forget when facing the Clinical Skills Assessment exam of the MRCGP is that they are already doing the majority of the preparation required in their normal surgeries! You will have experience in managing a variety of patients with a multitude of problems. For example, you will have had to deal with challenging patients who are demanding, aggressive, worried and non-compliant. Patients will have seen you about problems ranging from enuresis to terminal metastatic cancer and everything in between. With this wealth of experience at your fingertips, the key now is to make sure you realise this and build upon it.

A few months before...

It is most definitely worth asking your GP trainer (or other GPs in your training practice) to either sit in on some of your consultations as an observer, or for you to video your consultations and discuss them with your GP trainer. This will have several benefits – firstly, you will get used to having a silent observer (either a person or a video camera) present during your consultations, representing the examiner in the CSA stations. Secondly, your GP trainer will give you constructive feedback on all your consultation skills, which will include both communication and clinical management. The more cases you can be observed on, the better prepared and more comfortable you will feel on the day itself.

Some doctors are naturally good at patient communication; some are not so good. If you do not already make it a standard part of your consultations, then always ensure you ask about a patient's ideas, concerns and expectations (remember: 'ICE'). Not only does this demonstrate your consulting skills, but it also gives patients a good opportunity to reveal valuable information to you – this applies both in real life and in the CSA exam.

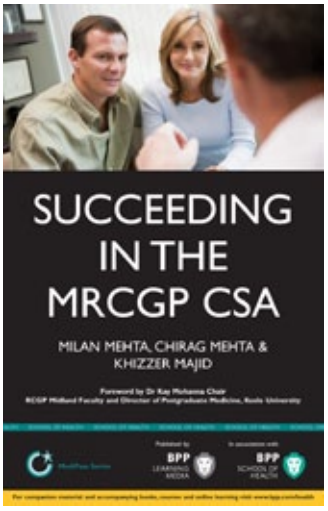
If you feel you have any gaps in your knowledge (e.g. musculoskeletal medicine), then discuss this with your GP trainer in plenty of time so that you can find ways to fill these gaps (e.g. agreeing to let you go to a musculoskeletal clinic).

On the day

In the CSA exam you will see 13 different patients with 10 minute appointments in a mock surgery lasting three hours. Before your surgery starts, you are given a folder containing the names of the patients you will see plus some background information. Make sure you read this thoroughly before the patients come into your room.

I would personally recommend staying in a hotel nearby the night before the exam. This will avoid travelling by car or train on the day and suffering unnecessary travel stress or, at worst, losing your place in the exam if you arrive late. There is no food provided at the CSA exam centre, so make sure you have a full breakfast as you do not want to go hungry and neither you, the patient nor the examiner wish to hear your tummy rumbling during the exam! Make sure you arrive with your complete doctor's bag and necessary equipment, a list of which can be found on the RCGP website (**www. tinyurl.com/gpst01**, click on 'CSA Information for Candidates').

You will be provided with some mock FP10 prescriptions and 'fit notes' – but be aware that anything you write on these will be assessed. There are ways you can possibly avoid having to write on them, by explaining to the patients what would be written on them (e.g. "You need to take amoxicillin 500mg three times daily for one week") and ask them to pick it up from 'reception' later.



I know this is much easier said than done, but my single best tip on the day is to try and pretend as much as possible that this exam is just one of your usual clinics. This will make you feel more relaxed, help you think more clearly and make it easier for you to draw upon your previous GP experience should you be faced with something that challenges you in the exam.

Best of luck!

Dr Milan Mehta is a newly qualified GP and co-author of *Succeeding in the MRCGP CSA: Common scenarios and revision notes for the Clinical Skills Assessment* ***which is part of the MediPass Series published by BPP Learning Media***

AGE OF CONSENT

How old is old enough when it comes to making personal choices regarding sexual health?

A 14-year-old girl named Mary has made an emergency appointment at the GP surgery for a "bad cough". She turns up for the consultation with her 17-year-old sister but does not appear unwell when her name is called in the waiting room.

Inside the consulting room you ask her what seems to be the problem and Mary bursts into tears. "She's pregnant," her sister blurts out. In a few minutes Mary calms down enough to explain that the father is a 15-year-old boy at her school with whom she had consensual sex. He does not know she is pregnant and Mary has no plans to tell him or her parents. Her sister adds: "Our Dad would go mental if he found out."

Mary is adamant she wants you to arrange for an abortion. The family has been with the practice for many years and you suggest that she makes an appointment to discuss the matter with her regular GP in the practice but Mary insists that you deal with the issue. "I just couldn't face Dr Jones," she says.

SUCH scenarios occur more often than you might imagine as our advice call records at MDDUS will attest. Making decisions on issues of consent in children and adolescents can be complicated – especially when the patient is at an age where their maturity and competence to make decisions about serious medical interventions could possibly be in question.

Old enough to choose

Young people are presumed to be competent to make decisions regarding their own medical care at the age of 16 years in the UK. In children under 16 both case and statute law in England and Wales support the broad principle that a child can give consent if able to demonstrate sufficient understanding and intelligence to comprehend what is proposed and the attendant risks. In Scotland, statute law makes similar provision for children under age 16. It is for the doctor to use clinical judgment to decide whether the child possesses a sufficient level of understanding and intelligence.

Younger and 'non-competent' children under age 16 normally require consent from any one person with parental responsibility (e.g. natural mother or father, court-appointed guardian or a carer) prior to any intervention. The courts can also grant consent. In an emergency situation, treatment can proceed without consent provided this is deemed in the best interest of the child.

The GMC offers very specific advice on issues of consent in children in its document *0-18 years: guidance for all doctors*, which is available on the GMC website. Among 'first principles' expressed in the guidance is the recognition that children and young people are "individuals with rights that should be respected". It also states: "When treating children and young people, doctors must also consider parents and others close to them; but their patient must be the doctor's first concern."

In dealing with a patient in Mary's situation the advice from the GMC and MDDUS is to encourage the young person to involve her parents or others in the decision-making process unless there is some reason to suspect this might not be in the patient's best interests. In judging the competence to consent in a child under 16 the GMC states:

"You must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having treatment. Only if they are able to understand, retain, use and weigh this information, and communicate their decision to others can they consent to that investigation or treatment."

In the guidance the GMC also makes specific reference to the provision of contraceptive, abortion and STI advice and treatment to under-16s without parental knowledge or consent. This is permitted provided that the young patient:

- understands all aspects of the advice and its implications

- cannot be persuaded to tell their parents or to allow you to tell them
- in relation to contraception and STIs, is very likely to have sex with or without such treatment
- is likely to suffer physical or mental health problems unless they receive such advice or treatment.

Consultations involving sexual activity in minors should always raise certain questions in your mind even if a patient is judged to be competent to consent. The GMC advises that if a "child or young person is involved in abusive or seriously harmful sexual activity, you must protect them by sharing relevant information with appropriate people or agencies, such as the police or social services, quickly and professionally". You should usually share information about sexual activity where a patient is under the age of 13. Some patients may refuse to name the sexual partner and that in itself may be a cause for concern.

The MDDUS is frequently asked about the fact that sexual activity under the age of 16 is illegal. We advise that the full circumstances of each individual case need to be considered. In general there is no automatic requirement to involve other agencies and due regard must be paid to the young person's capacity, the ages of those involved and the circumstances of the relationship. In any complex case you should seek advice from a suitable colleague, such as an adviser at MDDUS.

What's best for Mary?

In Mary's case we would advise the GP to carefully check through the relevant clinical aspects, for example the duration of the pregnancy, how the pregnancy was confirmed and the patient's general health. Clearly, Mary would also need to be advised about the medical aspects of her request for a termination of pregnancy.

She is obviously very young at 14 and whilst she has a supportive older sister, it would be helpful if Mary could discuss matters with her mother. Her sister has indicated that their father would be very angry but it should be explained to the patient that there are advantages of informing at least one of her parents. In cases where the family is known to a practice it can be helpful to have prior knowledge of how parents might react in these circumstances. Mary has also indicated that she "could not face Dr Jones", but she should be made aware that it is essential that relevant information about the consultation is shared and available in her records.

It is essential that during the consultation the doctor forms a clear view about the patient's capacity. If there is any doubt that she is not sufficiently mature and lacks capacity, this will have to be explored with the patient and further steps taken to liaise with a parent. The involvement of the 17-year-old sister is helpful, but she would not be a valid proxy in circumstances where the 14-year-old lacked the capacity to make decisions on her own behalf. If the 14-year-old is deemed capable of making her own decisions the sister can certainly provide valuable support.

In circumstances where the patient is deemed competent and is insistent on referral for termination of pregnancy, having been fully advised of the likely procedures and their risks, an appropriate referral should be made. In view of the patient's young age it would be helpful to speak to one of the local gynaecologists/family planning doctors directly to be aware of their own procedures and protocols and the patient advised accordingly.

A range of practical aspects will also need to be considered such as transportation to and from hospital, time away from the family, etc. Quite often young patients do not fully appreciate that it can be difficult to attend other facilities without the knowledge of at least one parent.

Seek further advice

Situations such as these are complex and unique, and each case has to be assessed very carefully on its individual features. It is important to remember that your decisions may be called into question by subsequent events and complaints and you must be prepared to justify your actions. In all cases where there is any difficulty we advise members to discuss a case with colleagues and to seek our input for detailed advice.

Dr Gail Gilmartin, medico-legal adviser, with Jim Killgore, editor MDDUS Summons

WORKING WITHIN THE LAW

Being a forensic physician is challenging and often involves long hours, but it's a role ideally suited to GPs

THE role of forensic physician is becoming an increasingly popular choice amongst GPs. The work is varied and challenging and brings doctors into contact with some of society's most demanding patients. General practice training is ideal for forensic work due to the varied skills and patient types involved.

The bulk of a forensic physician's workload will concern the care of people who are detained in police custody where a doctor is required to determine fitness to be detained or fitness to be interviewed. It often means dealing with people who have drink or drug addiction problems.

Along with this standard custodial work, forensic physicians (FPs) will be expected to develop expertise in the documentation and interpretation of injury. They will be called upon to examine and provide medical treatment to victims of assault and those individuals who find themselves in police custody. Many FPs in the UK practise clinical forensic medicine part-time, in addition to normal general practice, and much of it is based around a duty system that often involves anti-social hours.

The job is not for the faint-hearted as FPs will inevitably find themselves giving evidence in court as a professional witness, writing statements and carrying out examinations on vulnerable patients including victims of sexual assault.

Training

The new Faculty of Forensic and Legal Medicine (FFLM), part of the Royal College of Physicians, has a remit to set minimum standards for forensic practice in the UK, which still vary significantly.

No prior experience or formal training is required to apply for a post as forensic physician, but competition is fierce so you will have to be persistent. Training usually involves shadowing and attendance at a recognised in-house training course such as the twice-yearly residential course in Durham run by the NPIA (National Police Improvement Agency). Bear in mind if you are full time, you will improve skills in some areas, but won't be doing much in other specialties such as paediatrics or gynaecology.

Last year the government announced plans to close the publically funded Forensic Science Service and for the work to be carried out by private forensics companies from March 2012. Under these new arrangements, it is likely that doctors will need a postgraduate qualification for their area(s) of work, but currently that is not the case.

The FFLM can provide more in-depth information to doctors who are interested in working within the specialty.

In practice

To do this work a non-judgmental attitude is a must – you will come into contact with the most vulnerable and sometimes the most challenging patients in society. The work can be demanding as it will inevitably mean attendance at magistrate's, crown and/or coroner's/sheriff court, but with a bit of experience the nerves should settle.

You may be challenged by patients, doctors, police or solicitors so you will need to feel comfortable explaining and giving opinions, whether it is a normal day at work or in a legal setting. Statement writing is a regular part of the workload, so being organised and timely with deadlines is important. An interest in mental health, substance misuse or ethics is beneficial but not essential.

Clinical forensic work encompasses many areas including custody work where FPs, formerly known as police surgeons, carry out sexual offences examinations (for victims), visit prisons and treat patients with substance misuse problems.

Typically, around 85 per cent of a forensic physician's workload concerns custodial work

and shifts are usually 12 hours, involving out-of-hours work. Over the last five or so years, provision has been shifting from the public to the private sector and now almost all police forces have outsourced custody work to private providers, so terms and conditions of employment will vary.

On shift you cover a 'patch' and will be expected to travel between police custody suites, with occasional visits to A&E or private residences. A typical day might include treating those withdrawing from drink or drugs, documenting bodily injuries, assessing fitness for interview, advising police on a detainee's medication and taking blood samples for drink drive offences. But even when you are confronted with the task of assessing the most intoxicated, aggressive patient it is usually fairly straightforward due to the proximity of police officers. Provided you exercise some common sense in these situations, your safety is unlikely to be at risk. While this all sounds tough to deal with, there is usually friendly banter with police officers and custody nurses.

FPs can also carry out prison work, which follows normal working hours. You would be the only GP onsite (caring for 1,200 inmates), and would be accompanied by a nurse during consultations. Prisoners tend not to take good care of themselves so there is plenty of disease to diagnose and chronic conditions to manage. A typical day can present a mix of patients: one who is grateful for simply having his eczema sorted out while the next may be disengaged with authority figures and having poorly controlled epilepsy. No prior training is required, however, the RCGP has a working group for Secure Environments and offers a certificate in Substance Misuse. Work can be found through locum agencies, or ask your health board/PCT.

As a career option, forensic medicine does have its downsides - shifts are not very family-friendly, training can be patchy and independence can sometimes feel like isolation. But it also offers interesting, independent, flexible working and there's scope to do as much or as little as you like. Your communication skills will be developed to the maximum and being an FP seems to generate interest (and respect) from others.

Links

- The Faculty of Forensic and Legal Medicine - **www.fflm.ac.uk**

Dr Sarah Redvers is a GP and trainee forensic physician

Q&A
Dr Sarah Redvers, GP and trainee forensic physician

• What attracted you to the role of forensic physician?
The senior partner at our practice won the contract to provide primary care services for the local prison and, as a salaried GP at my training practice, I was up for a change of scene. I saw more pathology in one morning than in a fortnight of general practice and this inspired me to take on Custody medicine. Responsibility, independence and the legal side attract me.

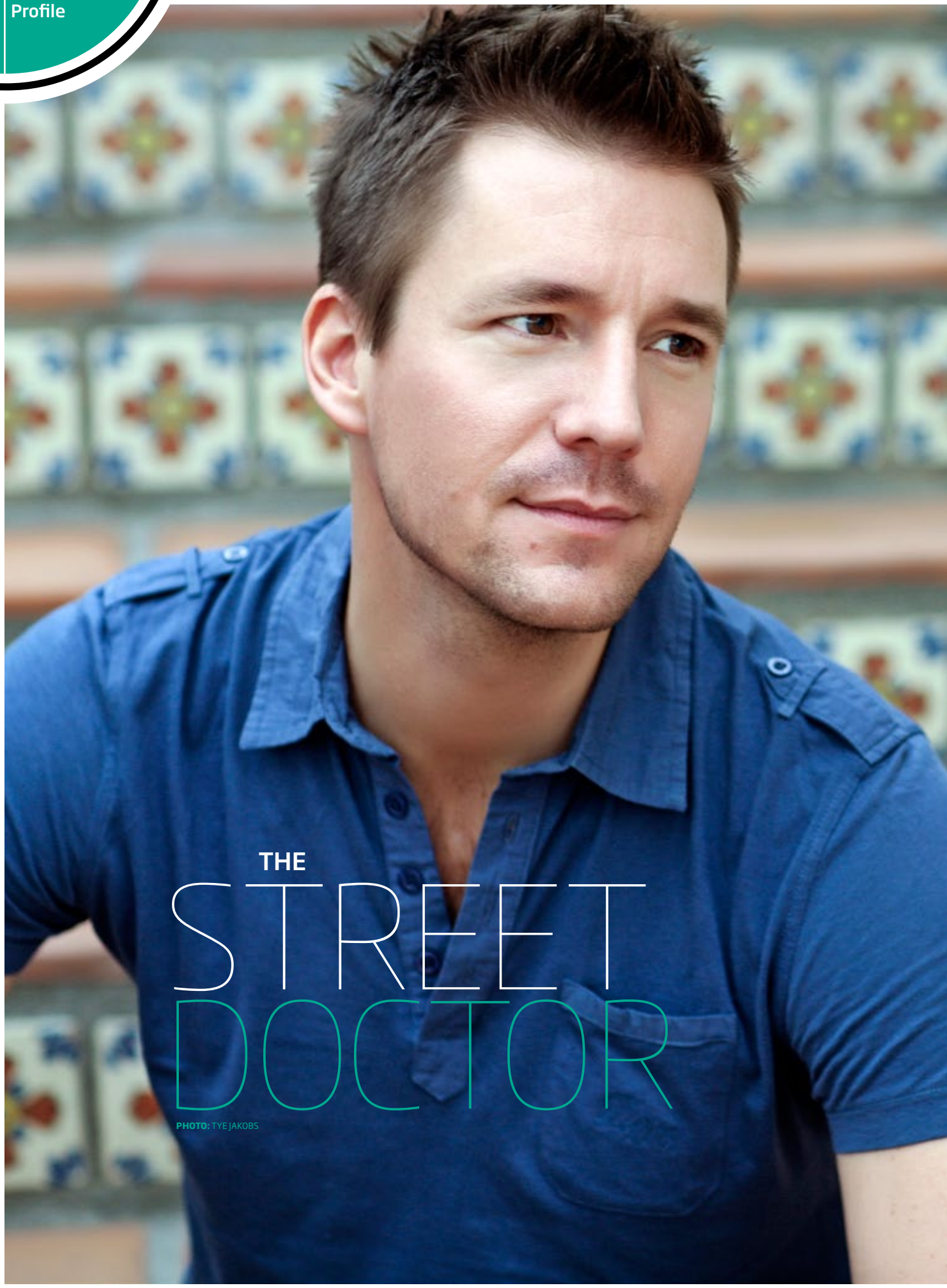
• What do you find most challenging about the job?
It can be a tiring environment, but balancing forensic and GP work stops burnout on both sides. I realised early on there will be disgruntled customers some days, but it can be difficult learning not to take it personally. Sometimes, working independently means feeling isolated, so I'm always mindful to get to training events and catch up with colleagues.

• Has anything surprised you about the role?
Forensic medicine is an up-and-coming specialty. Already I've been involved in training other forensic physicians, GPs and police officers and I've been asked to do work for the Faculty of Forensic and Legal Medicine. It has opened doors for teaching, appraisals and research.

• What do you consider the most important personal characteristic in a good forensic physician?
Unflappability. The ability to stay calm under pressure comes in particularly handy when dealing with a detainee in a cell who has taken loads of amphetamine and, equally, when standing up in court to give evidence.

• What is your most memorable experience so far?
Being called out to my first 'sudden death'. A young, alcohol-dependent woman was found at home. The house had been cordoned off so I examined the body for injuries and took in the surrounding paraphernalia. The investigating officer and I discussed possible causes for her death and it felt slightly like being in a TV drama - I was both thrilled and nervous to be the first 'medical input' for the case. It's not often you consider foul play in your differential diagnoses.

• Is there any advice you could give to a GP trainee considering becoming a forensic physician?
A lot of doctors worry about personal safety, but the only times I've felt vulnerable were doing hospital jobs. I finished my GP training five years ago and would never have envisaged doing what I do now. Don't be afraid of dipping your toe in (one shift /session a week) and see if it's for you.



THE STREET DOCTOR

PHOTO: TYE JAKOBS

GP and TV doctor **Jonty Heaversedge** tells *GPST* about consulting with patients in the street and how he's preparing for the changes in UK general practice

DIAGNOSING patients in the middle of the street is not the kind of practice most GPs are used to. But Dr Jonty Heaversedge is not like most GPs. The 40-year-old Londoner has become a familiar face in recent years thanks largely to the BBC1 programme *Street Doctor* where he was one of four GPs travelling the UK consulting with people 'on the street'. He has also worked on BBC children's anti-smoking programme *The Smokehouse* and presented BBC1 show *Lifegivers*, highlighting organ donation. He regularly features on TV news and radio programmes and has co-authored the book, *The Mindful Manifesto*, which highlights the health benefits of meditation.

Jonty qualified from the Royal Free Hospital School of Medicine and went on to earn a second degree in psychology and a masters in mental health from the University of London. He currently works as a GP partner at an inner city practice in east London.

How did you get involved in 'media medicine'?

By chance, really. Friends encouraged me to screen test for ***Street Doctor*** and I ended up doing three series. Since then I have been involved in a number of other shows raising awareness of various health issues. Media medicine was never an ambition of mine at medical school but I really enjoy the challenges it brings and, perhaps most importantly, it is fun.

How does your work as a GP compare with your media work?

The practice and my patients are at the heart of everything I do. They keep my feet on the ground and offer me encouragement, support and some honest criticism. My day job gives me the credibility and confidence to appear on TV and, at one level, they both involve the same thing – talking to people. I put as much effort into helping one patient in my consulting room understand their condition as I do when I am talking to millions of people on the TV.

Which part of your career is most rewarding?

I think each aspect of my career brings its own rewards and both enhance my medical practice in different ways. My practice offers security and stability as well as the rewards of real relationships with my patients and their families. The media work I do challenges me to be more creative and to step out of the safety of my consulting room. This brings with it great rewards but also significant risk – not everyone is going to like me or agree with me and, as well as many compliments, I have had to deal with criticism from both other doctors and the public.

What inspired you to write your book, *The Mindful Manifesto*?

I attended a Buddhist meditation centre for a number of years and found the teachings and practices really helpful. Fundamentally, meditation allowed me to develop a much gentler, more compassionate relationship with my mind and body and it gave me the confidence and courage to take on new challenges. I started talking to a journalist friend from the centre, Ed Halliwell, about meditation (or mindfulness) and together we wrote *The Mindful Manifesto* where we attempt to raise awareness of its potential benefits to individuals and wider society. I feel truly proud to have contributed to the book – it has had a great reception and we are very excited because it is coming out in the States this year.

Programmes like *Street Doctor* and *Embarrassing Bodies* have sparked an increase in doctors treating patients on TV. What is the value of these types of shows?

This is a tricky question. I have always been quite clear in the TV work I have done that it should never cause additional discomfort or embarrassment, and that it should be informative and attempt to engage with patients who might not otherwise go to their GP. The BBC were equally rigorous in ensuring these principles were met and we had very few complaints about *Street Doctor*. As a doctor you have the professional responsibility to ensure that every patient is treated with dignity and respect and I have turned down a number of programmes where I have not felt this is the case. However, we also have to try to influence the wider population to take better care of their health. This will at times involve working with other professions (such as the media) who have experience in engaging the public – and yes, at the end of the day this will require medical programmes to be 'entertaining'. In my view, however, this should never ever be at the expense of the patient.

What is your most memorable *Street Doctor* encounter?

There were so many but undoubtedly the most memorable was with Jim. I met him in Oxford at a market and like so many middle aged men he had been putting off going to see a doctor. He had been losing weight and it was apparent on examination that he was anaemic. I arranged blood tests that confirmed this and then organised a scan that identified a retroperitoneal mass that was subsequently confirmed to be a lymphoma. He was an amazing man and, although he has now sadly died, I hope that by picking up his cancer when we did he had a longer life and that his generosity in allowing us to share his diagnosis may have encouraged others to seek help sooner.

Would you ever give up your GP work to pursue a media career full time?

Absolutely not. My media work is underpinned by my work in the practice and without this I think I would lose all credibility as a TV doctor. I am also very well aware, from a purely selfish perspective, that the media is a pretty fickle industry and very few presenters have long careers. I am happy just to enjoy what I am doing right now and I feel it balances well with my work in the practice.

What are the most important lessons young doctors should learn?

How to look after themselves and how to care for their patients with compassion and kindness.

Describe a typical working week.

I spend four days a week in the practice although I have recently become a GP Commissioning Lead for an area in south east London so I spend an increasing amount of time dashing between meetings. I still do a fair amount of media work and am currently developing a couple of TV ideas. With all of the changes we are going through in the health service at the moment I am regularly contacted for comment by a range of news and current affairs programmes but I tend to say no to requests for comment that are political and stick to items relating to improving patient care. I continue to contribute to shows like *This Morning* on a regular basis which I really enjoy.

How do you like to spend your free time?

What free time?! My life is pretty busy and right now I feel as though I am spread too thinly and this is taking its toll. I have just turned 40 and this has made me think about my life and the need to have more time to relax and enjoy myself. I try to spend more time at home with my partner or seeing friends and I also try to keep fit.

What projects do you have coming up?

Like most GPs I am quite preoccupied with the challenges we face in the NHS. The next few years are going to require some difficult decisions to be made both in my practice and in the local health economy. I have been studying a Masters in Healthcare Commissioning to try and get my head around what the government's proposed changes will actually mean for GPs and to ensure that locally we are prepared for whatever challenges these bring. This is taking up a lot of my energy but I also have a couple of exciting TV projects that I hope will work out.

UP CLOSE

Intimate examinations can be a distressing experience. MDDUS medical adviser **Dr Susan Gibson-Smith** offers some advice on how best to approach these sensitive situations

DOCTORS are routinely required to examine the most intimate areas of a patient's body and it is something that can quickly become routine.

But while it may be an everyday common occurrence for GPs, this kind of medical attention can often be embarrassing or distressing for patients. And unless doctors are careful to fully explain how an intimate examination will be conducted and gain informed consent, there is a risk they could find themselves the subject of a patient complaint.

Consider the following scenario:

It was a routine consultation for a repeat prescription for the contraceptive pill. The computer screen flagged up that this Polish lady was due a smear test so, to save time, I decided to take the smear sample myself rather than have her come back. I advised her she was due a smear test and asked if she would mind if I did it during the consultation. She nodded and lay down on the examination couch. Her record indicated she had had a smear before so I didn't foresee any problems. I took the smear without difficulty but it was only afterwards that I noticed something was wrong. Her eyes filled with tears as she told me she hadn't realised what I had asked her, that she had not wanted this examination and would be writing a letter of complaint about me to the practice manager. I was shaken by this, after all I was only trying to help her and stop her having to come back. I had her best interests at heart, so surely I had done nothing wrong?

Consent

The principle that "every person has the right to have his bodily integrity protected against invasion by others" has long been recognised in common law and has been defined in case law in many jurisdictions, perhaps most classically by Justice Benjamin Cardozo in his 1914 ruling in New York:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault."

When considered in these terms, it is clear why the process of securing informed consent is so vitally important in medicine, not only for the patient's benefit but also to protect the doctor from any accusations of wrong-doing.

For consent to be valid it must be informed, competent and freely given. It must then be recorded, clearly and contemporaneously, in the medical notes. The General Medical Council provide more detailed information in their core guidance *Good Medical Practice* (paragraph 36) and in supplementary guidance *Seeking patients' consent: The ethical considerations*. Failure to follow this guidance, particularly in intimate examinations, could put your registration at risk so it is essential you familiarise yourself with it.

Intimate examination

So what constitutes an intimate examination? Most people would agree this is likely to include examination of the breasts, genitalia and rectum, but definitions can vary from patient to patient. In some cases, a patient may perceive an intimate examination as one where the doctor touches them or even moves close to them. A patient's culture or belief system can influence their views of intimate examinations and it is worth reading the GMC guidance *Personal Beliefs and Medical Practice* for more information.

Another GMC guidance document that is useful when considering intimate examinations is *Maintaining Boundaries*. This emphasises the doctor's duty to explain why the examination is required in a way the patient can understand and to allow them to ask questions before beginning the examination. It also stresses the need for

AND PERSONAL

doctors to take and record the patient's consent. When undressing, the patient should be given privacy and during the examination you should try to keep them covered as much as possible to maintain their dignity. It is not appropriate to help the patient undress unless they have specifically asked for your assistance.

During the examination it is important to keep explaining what you are doing and ask permission from the patient if this differs from what was originally agreed. It is okay to chat to the patient to make them feel at ease but keep the conversation relevant and avoid making any unnecessary comments which may be open to misinterpretation. You should also be prepared to stop the examination if the patient asks you to.

Chaperones

Before carrying out an intimate examination, it is important to ask the patient if they would like an impartial observer to act as a chaperone during the consultation. This applies whether or not you are the same gender as the patient.

The chaperone does not have to be medically qualified but should be sensitive and respectful of the patient's dignity and confidentiality. He or she should be prepared to reassure the patient if they show signs of distress or discomfort and be familiar with the procedures involved in a routine intimate examination. The chaperone must also be prepared to raise concerns about a doctor's behaviour where necessary. In some circumstances a member of practice staff or a relative or friend of the patient may be an acceptable chaperone.

It is important that any discussion about a chaperone is noted in the medical record, including the chaperone's name. If the patient does not want a chaperone and you are happy to proceed, then it should be noted that a chaperone was offered and declined. If either the doctor or patient does not wish the examination to proceed without a chaperone or either party is uncomfortable with the choice of chaperone, you can offer to delay the examination until a suitable chaperone is available. Any decision that is made should take into account the patient's best interests.

"BE PREPARED TO STOP THE EXAMINATION IF THE PATIENT ASKS YOU TO"

A failure to communicate

Let's return to the scenario. It is easy now to see that the consent taken in this case was not informed. The doctor failed to adequately explain what she intended to do and instead relied on the assumption that the patient, having previously had a smear test, would understand what she was talking about. Importantly, the doctor also failed to check the patient understood what she had been told. It was also extremely remiss for the doctor not to offer the patient a chaperone.

It is not uncommon for GPs to consult with patients who speak little or no English. In these cases, it is the doctor's duty to ensure arrangements are made to meet the patient's language and communication needs. An interpreter can usually be arranged in advance through your health board or PCT.

In the scenario, the fact this patient is Polish should have prompted the doctor to be especially vigilant in checking her understanding. Beware the patient who smiles and nods but actually has very little understanding of what is being said. Check frequently that patients do understand fully what you are saying and, if in doubt, offer to organise an interpreter or ask them to return with an appropriate person who can assist at the review appointment. This is especially important when it comes to intimate examinations where the potential for misunderstanding is great and can lead to very serious consequences for the doctor.

Hopefully after reading this article you will not make the same mistakes, but please do not hesitate to contact MDDUS for advice if you are ever in any doubt.

Dr Susan Gibson-Smith is a medical adviser at MDDUS

REFERRAL DELAY

A PAINFUL LEG

DAY ONE

A 72-year-old woman – Mrs T – attends her GP surgery complaining of right leg pain of about nine days duration felt mainly on walking. In addition she suffers from occasional dizziness but has no chest pain or dyspnoea. Her regular GP – Dr L – examines Mrs T and finds her heart rate is 150 beats per minute and blood pressure is 160/88. He notes a weak left femoral pulse but a good pulse on the right. No pulses are felt below this level on either leg. He also notes that the right foot is rather colder than the left.

Dr L makes a diagnosis of right popliteal thrombosis and raises the possibility of paroxysmal sinus tachycardia. He refers Mrs T to the local hospital and here she is examined by an SHO who notes in summary: "Painful right leg but good pulses and perfusion. No DVT clinically. ECG shows only left ventricular strain. No further investigation or treatment initiated". Mrs T is discharged home.

DAY 23

Mrs T is driven by her husband to the A&E department of the hospital. She tells the attending doctor that her leg is bothering her day and night – keeping her awake. He examines her and notes: "Nil to find. Painful right leg. No DVT." She is sent home with a Tubigrip.

DAY 31

Another GP with the practice – Dr D – is called out to visit Mrs T at home. Her husband tells the receptionist that his wife is complaining her leg "feels a ton weight" and it looks cold and white. Dr D undertakes a quick examination and records "Feet healthy. Pulses fine." She diagnoses right-leg sciatica aggravated by a shortened left leg from a previous hip fracture and prescribes a painkiller.

DAY 36 AND BEYOND

Mrs T arrives again at A&E with severe constant pain in her right calf and thigh. The right foot is found to be cold and cyanosed with a diminished arterial pulse. The attending doctor makes a diagnosis of critical ischaemia with impaired circulation due to a right femoral embolus. The patient is placed immediately on intravenous heparin. Six days later she undergoes a right femoral bypass operation followed in a few days by a right popliteal graft embolectomy. Sadly these procedures prove unsuccessful and the only viable option is an above-knee amputation.

Six months later intimations are made by solicitors on behalf of Mrs T alleging clinical negligence against the GPs and hospital doctors involved in her care.

THE second GP in the case – Dr D – is an MDDUS member and she forwards a copy of a letter from Mrs T's solicitors in which they allege she failed (at the home visit on Day 31) to take a full and accurate history, carry out an adequate examination and subsequently to refer the patient promptly for specialist treatment on the basis of the symptoms exhibited.

Numerous reports are prepared in regard to the case from medical experts both in primary and specialist secondary (vascular) care. All are in agreement that the first GP, Dr L, acted correctly in referring Mrs T to hospital with suspected popliteal thrombosis. But it was judged that the patient's care in A&E on both occasions was below reasonable expected standards with no relevant investigations carried out in regard to a clear risk of impaired arterial circulation.

The experts also criticise Dr D's treatment of the patient stating that she dismissed the findings of her colleague Dr L without sufficient consideration – possibly on the basis of the hospital reports. Going by the patient's records, Dr D did not appear to take an appropriate history apart from noting the five weeks of pain/numbness. She mentioned taking pulses but not which, or what was meant by "Feet healthy". No details were recorded in the notes of Dr D doing a neurological examination – straight leg raising, nature and site of pain – sufficient to justify a diagnosis of right-side sciatica.

An expert vascular surgeon commenting on the case judges that the delay between Dr D's examination and Mrs T's subsequent diagnosis of critical ischaemia resulted in "progressive deterioration of the status of the leg". He states: "Femoral-popliteal bypass grafts performed before a limb reaches the stage of critical ischaemia have a 70-80 per cent probability of being successful. With delay the prospects of successful arterial repair progressively diminish."

Six months later Mrs T suffers a stroke and dies and her husband instructs the solicitors to abandon the claim.

Key points

- Ensure that you justify clinical judgments in the patient's notes especially if at odds with earlier decisions or diagnoses.
- Make complete records of all examinations undertaken.
- Ensure the notes record not only a diagnosis but the reasoning behind that diagnosis.

Diary

SO MUCH absurdity, so few column inches. Welcome back to Diary where we ask for interesting and entertaining medical anecdotes from our readers, get nothing in reply and so make up our own. But let us not be bitter...

● **I HAVE AN APP FOR THAT** News that the Department of Health could soon be directing GPs to "prescribe" patient apps had Diary struggling not to swallow its own scepticism much like a bottle-fed baby does air. At a recent event held to showcase the best ideas for new and existing health smartphone apps, Health Secretary Andrew Lansley said: "So many people use apps every day to keep up with their friends, with the news, find out when the next bus will turn up or which train to catch. I want to make using apps to track blood pressure, to find the nearest source of support when you need it and to get practical help in staying healthy the norm." Sounds like much more fun than *Ragdoll Blaster 2*.

● **TO BOLDLY GO...** Perhaps more useful than a smartphone app playing Stayin' Alive to time CPR compressions would be a bleeping Star-Trek-like tricorder allowing GPs to scan patients, record vital signs and diagnose diseases. If only the DoH could promise that. Enter the Qualcomm Foundation which is sponsoring a contest to come up with a similar type device. Using wireless sensors, imaging technologies and other portable non-invasive technologies the winning tricorder must capture key health data used to diagnose a set of 15 diseases. But you only have until 2014 to claim the £6.5 million prize.

● **RESEARCH WORTH A PUNCHLINE** A review that was recently published in *Clinical Ophthalmology* looked at ocular injuries recorded between 2000 and 2002 in the Home and Leisure Accident Surveillance System. Some 1,640 incidents involving writing implements were reported and yet not a single one caused by fencing foils or similar weapons (even toys) – thus proving, the authors conclude, that when it comes to eye trauma the pen is indeed mightier than the sword.

● **DOCTOR, DOCTOR** Do you have a favourite Doctor, Doctor gag? Send it to us at gpst@mddus.com. And just to get the ball rolling –

Patient: Doctor, doctor, I feel like a moth.
Doctor: You should see a psychologist.
Patient: I was on my way there but I noticed your light was on.

● **STENCH OF BETRAYAL** More interesting research to ponder – this time published in the *Journal of Sexual Medicine*. A study in Russia has shown that men with sexually transmitted diseases could be undone by their body odour. Researchers asked women to smell sweat gathered from the armpits of a cadre of men age 17-25 of whom just under half were infected with *Neisseria gonorrhoeae*. The women consistently rated the sweat of infected men as more unpleasant. Send any practical applications via postcard.

● **AND THE OSCAR FOR BEST SICKNESS PERFORMANCE GOES TO...** Implausible news emerges of a scheme designed to lighten the load of GPs burdened by fit notes. The Allied Health Professionals Federation suggests members including drama therapists, art therapists and physiotherapists could start issuing assessment certificates directly to employers and patients. The plans have been hatched following consultation with the Department of Health and the Department of Work and Pensions. The independent assessments would not replace the Med3, which GPs will still be required to issue in order for patients to claim state benefits. The form will, however, state whether patients are 'not fit for work' or 'may be fit for work' if certain advice is followed. This can be used as evidence for sick pay or it can be presented to GPs who can "cut and paste it" into a fit note, thus saving time.

● **A LESSON FROM THE BARD** Reading Shakespeare could give physicians a fresh insight into the links between emotion and illness, says retired doctor Kenneth Heaton. According to a BBC report, he believes the Bard's many descriptions of psychological illnesses could help modern medics diagnose conditions linked to emotional disturbance.

● **NO PREVIOUS HISTORY OF SUICIDES** Not to pick on medical secretaries – goodness knows they have a hard enough job. But in a random surf of medical-related guff, Diary came across a collection of notes allegedly entered by NHS secretaries in Glasgow. Here are but a few:

"The patient is tearful and crying constantly. She also appears to be depressed."

"Rectal examination revealed a normal size thyroid."

"She is numb from her toes down."

"Occasional, constant infrequent headaches."

"The lab test indicated abnormal lover function."

"Skin: somewhat pale, but present."

"Large brown stool ambulating in the hall."

"The patient has been depressed since she began seeing me in 1993."

"When she fainted, her eyes rolled around the room."

"The patient was in his usual state of good health until his airplane ran out of fuel and crashed."

"Between you and me, we ought to be able to get this lady pregnant."

"The patient had no previous history of suicides."

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