GPst

ISSUE 05

TACKLING A DIABETES EPIDEMIC

A CAREER AS A GPwSI DIABETES

ALSO INSIDE

AN **MDDUS** PUBLICATION

MDDUS

PHOTOS: PAUL GRAHAM

Welcome to your GPst

IT'S fair to say that we probably all know someone who drinks alcohol. And while research shows moderate drinking could be good for you, the same cannot be said for heavier consumption. Alcohol abuse costs the NHS £3.5 billion a year – but what is the impact on general practice? As a GP, I offer my perspective on **page 4**.

All GP trainees will have to sit the MRCGP's Applied Knowledge Test – a three-hour exam consisting of 200 questions. But fear not, GP and author Dr Chirag Mehta offers some practical tips on how to prepare on **page 5**.

No doctor would welcome being called to give evidence in court, especially if it involved a patient death. But there's a chance that doctors practising in Scotland could be called before a fatal accident inquiry at some point in their career. On **page 6**, MDDUS adviser Dr Barry Parker sheds some light on what these hearings involve and how to prepare for one.

As the number of people in the UK with the condition soars, what better time to consider a career as a GP with a special interest in diabetes? Our careers article on **page 8** looks at the increasingly important role played by primary care in tackling this growing issue.

On **page 10**, we look at what life is like for a GP who works in prisons in our interview with Dr Iain Brew, medical officer at HMP Leeds. And on **page 12** MDDUS medical adviser Dr Susan Gibson-Smith addresses the challenging area of child abuse, with a look at what the GMC's new child protection guidelines mean for GPs.

Finally, our case study on **page 14** looks at the case of a young patient who suffered acute renal failure due to a missed diagnosis of diabetes.

- **Dr Peter Livingstone**
  Editor

MDDUS

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CALL TO REWARD TOP TRAINEES

GP trainees who score high marks in MRCGP exams should be recognised with official awards.

Dr Robin While, chairman of the GP school at the Severn Deanery, believes deaneries should do more to reward excellence. A change in the exam format means high scoring candidates can no longer be recognised with a "distinction".

As a result, Dr While helped set up an annual awards scheme within the deanery last year to officially honour high achievers. It's believed to be the only one of its kind in the UK.

He told *GP*: "We realised two years ago that many of our trainees achieve way more than the completion of MRCGP during their training. They work in deprived areas or countries, for example.

"Recognising this, and because the MRCGP withdrew the outstanding achievement award, the awards were a way to enable people who are outstanding to enhance their record and CV and get a job in an increasingly tough environment."

The Severn Deanery awards scheme uses a judging panel of GP educationalists and lay people to score trainees who have been nominated for an award. Nominees then complete a questionnaire about their achievements and make a presentation at an awards ceremony held at the end of the academic year.

Dr While believes other deaneries should follow suit and set up their own awards programme. He added: "It is something we think should be rolled out to other deaneries. Not as a national competition, but within each."

GPs SHOULD BE WARNED ABOUT VIOLENT PATIENTS

A GROUP of GPs is leading calls for doctors to be informed if patients have a history of violence.

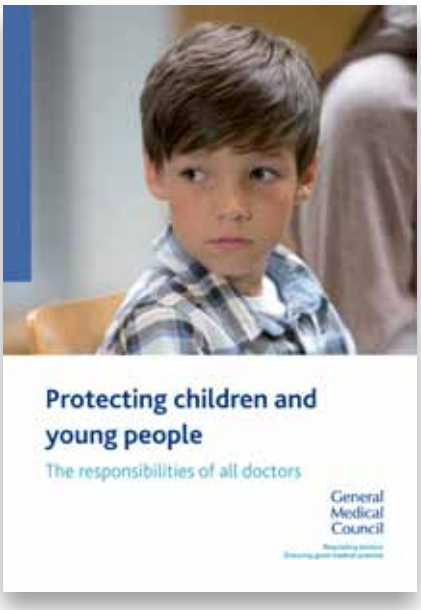
The move follows an incident in Manchester where a practice reportedly registered a new patient and agreed to a home visit without being told he had previously stabbed a GP. The man had recently been released from a violent patients unit.

An article in *GP* reported that Manchester LMC is in discussions with NHS Manchester to ensure GPs are notified if a patient has a history of violence. Current rules do not require PCTs to tell practices of a patient's past if they are deemed to no longer pose a threat.

Manchester LMC chairman Dr John Hughes said an electronic flag should be placed on the record of any patient with a history of violence.

The BMA's GPC chairman Dr Laurence Buckman, who has himself been assaulted and threatened by patients, said that rules must be followed to ensure those released from violent patient units no longer pose a threat. But he added: "If they are assessed and they are deemed no longer a threat, then GPs shouldn't be told. If a conviction is spent, it is spent."

NEW CHILD PROTECTION GUIDANCE



NEW guidance to help doctors protect children from abuse has been issued by the GMC.

Protecting children and young people: the responsibilities of all doctors is aimed at supporting doctors dealing with a wide range of complex child protection issues.

GMC chief executive Niall Dickson said: "Doctors must raise their concerns if they believe a child or young person may be at risk of abuse or neglect – whether or not the child is their patient. They also need to know who to contact for advice if they do have any concerns.

"Doctors who make child protection decisions based on the guidance will be able to justify their actions if a complaint is made against them - provided their conclusions are honestly held and have been pursued through the appropriate channels."

The guidance has been developed following concerns that some recent high-profile cases were deterring some doctors both from working in this area and from raising child protection concerns.

It states: "Taking action will be justified, even if it turns out that the child or young person is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable, and the doctor takes action through appropriate channels."

The full guidance came into effect on 3 September, 2012 and can be accessed at **www.tinyurl.com/86e3b5z** .

➔ SEE PAGE 12 OF THIS ISSUE FOR MORE ON THE NEW GUIDANCE

HOSPITAL PRESCRIBING MODEL COULD HELP GPs

IMPROVEMENTS in prescribing that cut mortality at a UK hospital by more than 16 per cent could be applied in general practice, according to a leading GP.

A prescribing quality improvement programme that aimed to reduce errors in care delivery was introduced at University Hospitals Birmingham NHS Foundation Trust. An evaluation led by Dr Jamie Coleman found the scheme had been successful even though many of the errors avoided were minor.

Under the programme a series of measures were implemented including the recording of missed doses of antibiotics, advanced decision support for prescribers, ward-based dashboards and meetings to discuss care omissions. This led to a 16.2 per cent drop in mortality across the trust.

Dr James Kingsland, a GP and the Department of Health's clinical commissioning network lead for England, told *GP* magazine the programme could be effective in general practice.

He said: "There are a whole range of issues to do with quality of prescribing in primary care. There's a whole range of discussions we can have around polypharmacy, antibiotic prescribing and antipsychotics."

Read the study at **www.tinyurl.com/prscrb**

ONLY ONE IN 10 NEW GPs GET PARTNERSHIP

ONLY one in 10 newly qualified GPs secured a partnership post last year, according to a new BMA study.

Just nine of the 91 new GPs taking part in the BMA's cohort study of medical graduates were in a partnership post as of August 2011, when they had received their certificate of completion of training (CCT).

The BMA has been following a group of 431 trainees since they graduated from medical school in 2006.

Most GPs in the cohort were working as a salaried GP (34 per cent) or a locum (22 per cent) after qualifying. However, two-thirds (66 per cent) of the cohort doctors working in general practice wanted ultimately to work as a GP principal.

Ten per cent of the cohort in their third and final year of GP training said that it had been difficult or very difficult to secure a post after qualifying while a quarter had yet to find a job at the time of the survey and a further fifth said getting a job had been very easy.

Just under half (42 per cent) agreed that GP training should be extended beyond three years, in line with the RCGP's plans for a four year programme.

The doctors who completed GP training last August were largely satisfied with the way the training programme had prepared them for their CCT and for qualified practice.

LOCUM GP HANDBOOK

A GUIDE for locum GPs has been published by the BMA.

The *Locum GPs Handbook* is available to BMA members online with print copies available from October 2012. It offers advice on starting out as a locum, setting up your business and establishing a contract for services with providers.

Find out more at: **www.bma.org.uk/sessionalGPs**

DON'T DISCRIMINATE BY SEXUALITY

DOCTORS are reminded of their duty to treat all patients equally, regardless of their sexuality.

The *Gay and Bisexual Men's Health Survey*, from charity Stonewall, showed that one third of gay and bisexual men who have accessed healthcare services in the last year have had a negative experience related to their sexuality.

Discrimination included false assumptions being made about a patient's lifestyle based on their sexuality, failure to offer certain services or refer appropriately, and mishandling of next-of-kin issues in same sex partnerships.

MDDUS medical adviser Dr Barry Parker said: "LGB (lesbian/gay/bisexual) patients have the same needs as heterosexual patients, but there are also specific differences. These are not confined to the area of sexual health, but may include mental health issues arising as a result of the particular social stresses these patients face. LGB patients should be able to talk openly with their doctor about these issues."

Practices should have clear policies on discrimination and confidentiality that are communicated to patients by way of posters or in practice leaflets.

As the annual cost to the NHS of alcohol abuse hits £3.5billion, *GPST* editor **Dr Peter Livingstone** offers his perspective on the impact on primary care

MOST people drink alcohol in this country, whether it's a glass of sherry at Christmas or a few pints at weekends.

There is nothing wrong with moderate drinking and research published in the *BMJ* last year even suggested that small amounts of alcohol can reduce your risk of developing cardiovascular disease.

However, problems begin when alcohol is consumed in large amounts as this can have a major detrimental effect on a person's health, not to mention the wider social impact. Recent figures from the Department of Health show the total cost to the NHS of alcohol abuse has reached £3.5 billion, a rise of 30 per cent in just three years. And a report from the NHS Information Centre showed that, in 2010, alcohol dependency cost the NHS £2.4million in prescription items.

Where I work in the west of Scotland at least half the patients in my morning surgery will have alcohol-related problems. Contrary to what many people may think, those at greatest risk of harm are the non-dependent drinkers. These are people consuming more than the recommended weekly alcohol intake (21 units for men, 14 for women) but who are not classed as 'alcoholics'. And while some may seek help for alcohol-related health problems, others may not yet have reached that stage.

For this reason, I think screening and brief interventions in primary care are a good idea as they can identify drinkers and reduce potential complications. In March, a committee of MPs sparked debate by recommending GPs routinely question patients about their drinking. But while a policy of blanket screening is not necessarily the best way forward, there is a place for GPs to use their judgment and question patients where appropriate.

I recently saw a gentleman who presented with dyspnoea and palpitations. He was worried that it was his heart and thought that stress at work was the cause and denied any use of alcohol or illicit substances. He was admitted to hospital with an irregular tachycardia and treated for atrial fibrillation.

Sometime later in clinic he was disgruntled that the hospital had told him that his recent admission was a result of excessive alcohol consumption. I was shocked as he had always denied any alcohol consumption but it turned out that marital problems had led him to drink heavily over the previous year.

Eventually, he had insight into his excessive drinking and was referred to the community addiction team. He attended Alcoholics Anonymous and has been alcohol-free for six months.

Another patient I treated recently at an afternoon clinic made me realise how alcohol not only affects a person's physical wellbeing but also has psychological and social impacts. This patient was a successful businessman who presented to hospital with pancreatitis secondary to alcohol consumption. Exploring his alcohol intake he admitted to drinking at least a bottle of vodka per day but didn't accept he had a problem. He continued to drive and maintain a job and neither his wife nor work colleagues had expressed concerns regarding his alcohol intake.

I urged him to stop driving while he was drinking but he dismissed my concerns. It put me in a very tricky ethical dilemma and I told him during one of our consultations that I was duty-bound to inform the authorities if he continued to drive under the influence. He became angry and aggressive and stormed out, I suspect, still intoxicated. Following discussions with my GP colleagues and with an MDDUS adviser, I wrote to tell him that I'd have no choice but to inform the DVLA if he continued to drive because he posed a major risk to the public.

It was a very difficult decision to breach patient confidentiality but I eventually informed the DVLA and he subsequently lost his licence and then his job. I felt anxious and disheartened but he gave me no other option. We all have to make decisions in general practice, however some are easier than others.

Amongst the patients I treat for alcohol-related problems are a particularly challenging group familiar to most GPs. They are the ones who regularly promise you the world if only you would give them some chlordiazepoxide to help them abstain from alcohol. They come in week after week promising you they will abstain – despite being intoxicated – and engage with addiction services if you will prescribe medication or help them get their housing benefit.

The road to abstinence is paved with good intentions and I think it is important to be positive with each patient who wishes to give up alcohol. However, we need to remember that patients must take responsibility for their alcohol consumption and, despite our best efforts, some may never refrain from drinking. A difficult fact for any doctor to accept.

So while alcohol in moderation has been shown to be good for you, when it becomes a "crutch" or a way of escaping from reality, problems will occur. And it can be a fine line between the two states. Remember, as Dylan Thomas once wrote: "An alcoholic is someone you don't like who drinks as much as you do!"

Dr Peter Livingstone is a GP locum and editor of GPST

APPLYING YOUR KNOWLEDGE

GP trainees have less than a minute to answer each question in the MRCGP's Applied Knowledge Test. GP and author **Dr Chirag Mehta** offers some practical tips on how to prepare for this challenge

IT is a challenge that all GP trainees will face during their training and one that tests time management skills almost as much as a knowledge of general practice.

Successfully completing the Applied Knowledge Test (AKT) of the MRCGP is intended to demonstrate your ability to apply knowledge and interpret information as an independent GP.

Only candidates in ST2 or above are eligible to take this exam which lasts for three hours and consists of 200 questions. It normally takes place at Pearson Vue test centres across the UK three times a year (in January, May and October). The questions are made up of a variety of single best answers, extended matching questions, data interpretation, picture/video, table/algorithm and also free text.

Approximately 80 per cent of the questions are on clinical medicine, 10 per cent on organisational, ethical and legal issues and the remaining 10 per cent on critical appraisal and evidence-based practice.

A few months before...

Once you have decided to take the exam ensure that you apply online as early as possible as allocation of exam sessions and venues is on a first come, first served basis. I would suggest preparing well in advance – at least three months before you intend to sit the exam. Make sure that you are familiar with the RCGP curriculum and read up on any weak areas. It's important to identify your personal learning needs and target your learning accordingly. There are many good revision resources available online and Onexamination, Pastest and Pass Medicine have a large bank of practice questions. I also found many of the AKT revision books on the market very useful.

I also recommend using other key resources such as the *Oxford Handbook of General Practice*, the *British National Formulary*, *BMJ*, *BJGP* and the RCGP's publication for GP trainees *Innovait*. It is also advisable to familiarise yourself with GMC guidance, NICE and SIGN guidelines and to follow the RCGP Essential Knowledge Updates (**www.tinyurl.com/d5mzsn4**).

Draw up a revision timetable to address topics set out in the curriculum. Personally I found that short periods of reading and self-testing, rather than long sessions, worked very well in conjunction with using prior clinical experience and the resources mentioned above. If you prefer working through topics in groups then it might be useful to form a study group. You can also ask your trainer to help guide your learning, perhaps in the form of tutorials, or you could request to cover topics that you are struggling with in your VTS sessions.

The RCGP website has a helpful section providing information on the AKT (**www.tinyurl.com/985c87w**). This allows you to browse feedback on recent exams and means you can find out exactly which areas candidates struggled with. For example, in the recent exam in April 2012 candidates had difficulty in areas such as quantitative research and confidentiality. The RCGP website also offers a presentation for trainees and I would recommend taking a look at this. Make sure you try out the tutorial on the Pearson Vue website to familiarise yourself with the system beforehand.

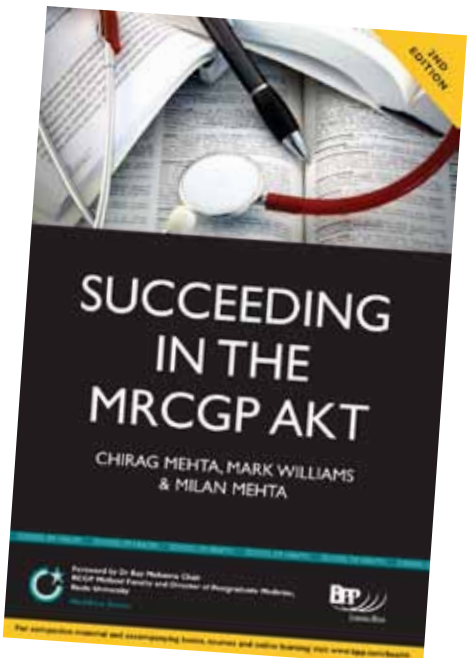
On the day...

Make sure you know where the centre is, arrive early and ensure you have brought the necessary documents required – this usually includes a valid passport or UK photocard driving licence and something showing your name and signature such as a credit card.

Read all the questions carefully and make sure you enter your chosen answer correctly. If you are stuck move on to the next question and you can go back to it. Remember there is no negative marking so if you do not know, guess (there is nothing to lose!) If you have time left then go back and check your answers. I always feel if after reading the question you have an answer in mind and it is an option then it's probably correct.

The most important tip I can offer is time management. Ensure you watch the clock, 200 questions in three hours is 54 seconds for each question but some questions will be quicker, others longer. Remember that most people pass first time. Good luck!

Dr Chirag Mehta is a GP and co-author of Succeeding in the MRCGP AKT



A DAY IN COURT

Being called to give evidence before a fatal accident inquiry can be daunting. MDDUS medical adviser **Dr Barry Parker** sheds some light on what the process involves

IT is quite possible in the course of your professional career that you will at some point be cited to give evidence during a formal investigation into a patient's death.

In Scotland, these investigations are known as fatal accident inquiries (FAIs). For most doctors, particularly doctors in training, being called before such an inquiry can be worrying. But gaining an understanding of the process and how to prepare can help minimise stress.

FAIs are unique to Scotland and are called when the procurator fiscal (the public prosecutor) has investigated a death and the Crown Office decides that a formal inquiry is required (the equivalent procedure in England, Wales and Northern Ireland is the coroner's inquest). Some are mandatory, for example after deaths at work or in custody, and the rest are discretionary, when it is deemed to be in the public interest.

They are held before a sheriff in the sheriff court serving the area where the death occurred. The aim of an FAI is to establish the time, place and cause of death; any reasonable precautions that may have avoided death; any systemic defects that contributed to death and any other relevant factors that the sheriff wishes to comment on. The civil rule of 'balance of probabilities' is used to decide on evidence presented. It can unfortunately take several years following a death before an FAI is held and several months after the FAI before the sheriff issues a judgement, known as a determination, setting out the circumstances of the death and other relevant findings.

How can we help?

MDDUS understands that giving evidence in these circumstances can be daunting, even if the doctor involved is not particularly concerned that anything untoward has happened. We therefore welcome calls from members as soon as they hear they are to attend an FAI – or even sooner. If a death has occurred and you are worried that it may result in an FAI, please call an MDDUS medical adviser.

When preparing for an FAI, an adviser will review what has happened and, if necessary, arrange a meeting to discuss matters further with an MDDUS solicitor. We can explain the FAI procedures, what to expect when giving evidence and, most importantly, decide whether it is necessary to provide legal representation for the doctor.

Not everyone will require this: if a doctor is unlikely to be criticised by anyone, or is fairly peripheral to events, it may be appropriate to attend without separate representation. Where there is vulnerability, however, legal representation may be important to protect the doctor's interests. This is a decision that will be made once we have heard the circumstances surrounding the death.

NHS hospital doctors may be represented by the Central Legal Office acting for the hospital concerned but, where any conflict of interest emerges, they may require separate MDDUS representation.

Being prepared

Prior to an FAI, the doctor is likely to have been asked for a statement by the procurator fiscal and should be familiar with the contents of that statement. A familiarity with the medical records is also useful. When giving evidence at the FAI, the procurator fiscal or depute will lead the questioning, and then questions may be asked by anyone represented at the inquiry, such as the family or other agencies involved in the care. The sheriff may ask questions at any time.

Advice on attending an FAI is much the same as for any court appearance. This includes arriving in good time (mobile phone switched off!), dressing smartly and preparing for a long wait as timing can be unpredictable. When giving evidence, remember to listen carefully to the question and answer clearly and concisely – do not be tempted to fill silences. It is fine to indicate that you need sight of the records to respond, if that is the case, and it is also fine to say that you don't recall something, or indeed that it is beyond your sphere of knowledge or competence to answer.

FAIs are held in public, and may be attended by the press. Clearly it is important to give no statement to the press after the event, even if approached directly, save perhaps to indicate that you have given your evidence to the court and have nothing to add.

The determination itself will not include an adverse finding against an individual doctor, but there can be implied criticism of actions if precautions are highlighted that may have avoided death. The sheriff may also be critical of evidence given when he writes his accompanying narrative account of proceedings. Although the determination cannot be used as a basis of a claim, it may be used to initiate a complaint of serious professional conduct before the GMC.

Happily, for most doctors giving evidence, this does not occur, and attendance is a routine matter. However, MDDUS are keen to ensure that members are well supported throughout and if doctors are at all concerned they should make contact sooner rather than later to advise us of the situation.

Dr Barry Parker is a medico-legal adviser at MDDUS

In the next issue of *GPST*, Define/Discuss will look at coroner's inquests

A major study of general practice prescribing has found that one in 20 scripts contain an error. Can GPs do better?

GP PRESCRIBING – ROOM FOR IMPROVEMENT

A DOCTOR working late in a GP surgery struggles through a large number of repeat prescription requests. He comes across one for a 68-year-old man under treatment for osteoarthritis for more than six years. The patient suffers from pain in his back and legs and has been prescribed 10mg morphine sulphate tablets (MST) – two pills to be taken twice daily.

In copying the details by hand from a printed repeat request to a prescription form the GP mistakenly adds a zero to the dosage – making it 100mg MST. The patient fills the prescription at the pharmacy and takes two tablets before going to bed. He wakes up during the night feeling unwell and is violently sick the next morning. His wife calls for an ambulance but he is pronounced dead in his home a short time later.

THIS scenario is based on an actual case in the MDDUS files and highlights how a simple error can sometimes lead to tragic consequences. Of course most prescribing errors do not end in the patient's death but that's not to say they aren't common and sometimes serious.

A recent study commissioned by the General Medical Council (GMC) looked in detail at prescribing errors among GPs. Fifteen general practices with diverse characteristics from three primary care trusts were examined with a 2 per cent random sample of patient records in each practice. This amounted to 1,777 individual patient records and the examination of 6,048 unique prescription items.

The researchers found that as many as one in 20 prescriptions written by GPs contains an error. In England alone, with 900 million items prescribed each year, that amounts to 45 million errors. Most errors were classed as mild or moderate, but around one in every 550 prescription items was judged to contain a serious error – equating to 1.6 million prescription items per year across England.

Looking at the statistics on a per patient basis the researchers concluded that more than one in eight patients put on medication after seeing their GP are given a prescription containing an error. The risk of prescribing errors increases according to patient age with children and over-75s twice as likely to have an error. The number of medicines taken also is a factor – each additional medicine increased error risk by 16 per cent.

Among the most common types of prescribing errors were incomplete information on the prescription, dose/strength errors and incorrect timing of doses. Among errors in monitoring prescribed medications, such as for patients taking the anticoagulant warfarin, the most common type was a "failure to request monitoring".

A number of contributing factors were identified including deficiencies in GP prescribing training, pressure and distractions at work, lack of robust systems for ensuring patients receive necessary blood tests and problems relating to GPs using computer systems, including the overriding of important drug interaction alerts.

Many of the GPs consulted in focus groups for the GMC study felt that undergraduate therapeutic training was insufficiently taught at university and that the "jump" from being a GP trainee to a salaried GP was too high in terms of hands-on experience.

Poor communication combined with the quasi-autonomous role of practice nurses was also considered to be a key factor in prescribing errors, as were high workload, time pressures and the associated stress for practice staff. The failure of appointment systems to cope with patient demand was perceived as a particular source of stress. Distractions and interruptions were common for some GPs and thought to be an important cause of error.

Professor Tony Avery of the University of Nottingham's medical school, who led the research, said: "Few prescriptions were associated with significant risks to patients but it's important that we do everything we can to avoid all errors... Prescribing is a skill, and it is one that all doctors should take time to develop and keep up-to-date."

The report offers a number of practice and personal prescriber strategies to reduce errors and is worth reading. It encourages all GPs to:

- Read aloud printed prescriptions to help ensure patient understanding and to allow the prescriber to check the accuracy of the prescription.
- Clarify prescribing recommendations made by specialists where these go beyond the GP's comfort zone.
- Review newly prescribed medicines within six weeks.
- Add medicines to the repeat list only when patients are stable on them.
- Confirm important information with patients even when they are well known to the prescriber.
- Ensure that prescribers are competent to use all of the important features of e-prescribing and other IT-support systems.

Professor Sir Peter Rubin, Chair of the General Medical Council, said: "GPs are typically very busy, so we have to ensure they can give prescribing the priority it needs. Using effective computer systems to ensure potential errors are flagged and patients are monitored correctly is a very important way to minimise errors. Doctors and patients could also benefit from greater involvement from pharmacists in supporting prescribing and monitoring."

Consult the GMC report at **www.tinyurl.com/cptg42u**

Jim Killgore is an associate editor at MDDUS

TACKLING A DIABETES EPID

As the number of people being diagnosed with the condition soars, the time could be right to consider becoming a GP with a special interest in diabetes

DIABETES is nearly four times as common as all types of cancer combined and is fast becoming a major 21st century crisis. Around 2.9 million people in the UK have been diagnosed with a form of the disease but it's thought that as many as 850,000 people have type 2 diabetes but do not yet know.

The figures are staggering and are a major source of concern for healthcare professionals across the UK. As part of the attempt to fight this rising tide, the Department of Health is carving out a greater role for primary care physicians in the prevention, early detection and treatment of this condition.

Part of this strategy involves a greater role for GPs with a special interest (GPwSI) in diabetes.

A GPwSI is a doctor, working principally in the community, who takes referrals that may otherwise have gone directly to a secondary care consultant and delivers a clinical service beyond the scope of their core generalist role.

They will have demonstrated appropriate competences to deliver those services without direct supervision. In some cases they work with the specialist team to present the views of general practice in discussions on local guidance and policy, and also provide advice on commissioning

There are many GPs who currently provide specialist diabetes services but who do not consider themselves to be special interest practitioners. For those doctors who do wish to achieve official GPwSI status, there is a formally accredited framework set out by the Department of Health in their document *Guidance and competences for the provision of services using practitioners with special interests – Diabetes.* (**www.tinyurl.com/bpq7ewm**)

Training

The GPwSI competency framework document for diabetes details the type of evidence and competences that may be expected from GPwSIs in diabetes during the accreditation process.

The competences are as follows:

- Understand the clinical management of diabetes
- Provide and monitor drug therapy for clinical management of diabetes
- Manage the delivery of diabetes care
- Deal with diabetic emergencies
- Understand the special needs of older people with diabetes
- Understand and manage the complications of diabetes:
  - screening
  - microvascular disease
  - eye disease
  - renal disease and hypertension
  - neuropathy, foot disease and erectile dysfunction.

GPwSIs are expected to demonstrate that they have completed recognised training which may include acknowledgement of prior learning and expertise. Training can be acquired in several ways and would be expected to include both practical and theoretical elements. It is essential to undertake attachments to specialist care diabetes services over a reasonable period of time to reach the necessary level of competence.

Other routes through training include gaining experience of working in relevant departments; self-directed learning with evidence of completion of individual tasks; attendance at recognised meetings/lectures/tutorials on specific relevant topics; practising as a trainee under the supervision of a diabetes specialist/consultant in the secondary care service; and completing a recognised university course.

Recognised courses include the postgraduate diploma in diabetes for practitioners with a special interest, offered by

the University of Bradford. The part-time course comprises a large element of work-based and shared learning. Warwick Medical School also provide a certificate in diabetes care while Cardiff University offer a postgraduate diploma in diabetes.

In practice

GPwSIs are most likely to work in the community, normally with links to the specialist care sector. The core activities of a GPwSI diabetes will vary depending on local needs and resources. Examples of the types of clinical services that practitioners could deliver include:

- Addressing the needs of hard-to-reach patient groups, e.g. household / care home residents
- Working within a multidisciplinary team environment under locally agreed protocols for the management of non-urgent / routine / ongoing care diabetes
- Dealing with patients with new or progressing problems, including starting insulin and GLP1 medication
- Providing primary care input into local policy and guideline development.

Practitioners may also be commissioned to provide relevant elements of diabetes care such as specialist eye and foot care and a specialist dietetic service. Complications from diabetes affect every organ in the body making it a potential area of interest for doctors with interests in a range of specialties, from cardiology to neurology.

A big feature of primary care diabetes clinical services is the focus on multidisciplinary team work, so if you are the type of person who enjoys working in this way then taking an interest in this field presents an ideal opportunity.

Links:

- The Primary Care Diabetes Society **www.pcdsociety.org**
- Association of British Clinical Diabetologists **www.diabetologists-abcd.org.uk**

Q&A

Dr Peter Livingstone, Locum GP with a special interest in diabetes

What attracted you to a career as a GPwSI in diabetes?
I found the science of diabetes extremely interesting from the cellular level. With the use of insulin or medication I found I could make patients better and prevent secondary complications. The area is so vast and the management is constantly changing and I enjoy the challenge that presents.

What do you enjoy most about the job?
Team work! Prior to the commencement of each clinic the team, which consists of me, the consultant, diabetic specialist nurses, dietician and podiatrist, all sit down together and discuss each individual patient, reflecting on their previous attendance and glycaemic control and what further options are available.

Are there any downsides?
Some patients are in denial in relation to their diagnosis of diabetes and therefore do not take any responsibility for their diabetes. I struggle at times watching people being admitted with diabetic ketoacidosis or developing secondary complications such as severe retinopathy knowing full well that if they had accepted their diagnosis they would not be in that situation.

What do you find most challenging?
The management of diabetes is constantly changing, whether it is insulin pumps, pancreatic islet cell transplantations or medication. It can be difficult keeping up-to-date with new medications and technology so there is a lot of reading to be done.

What about the role has most surprised you?
It is nice to find yourself in a position where you can actually make a difference to individuals' lives by doing something simple such as slightly adjusting a patient's medication or insulin as this can have a major improvement on their glycaemic control.

What is your most memorable experience so far?
Watching a gentleman who I thought was going to have a below-knee amputation due to a severe neuropathic ulcer walk again after intensive treatment from the multi-disciplinary team.

What advice would you give to a trainee GP considering a career as a GPwSI diabetes?
I did my postgraduate diploma in diabetes and would recommend this to anyone. This is a two-year, long distance course which critically evaluated the evidence on the management of diabetes. This is not essential for the job but sets you in good stead. If you show interest in this area you should find you are almost certain to get a job somewhere!

Prison GP **Dr Iain Brew** talks about the challenges and rewards of working behind bars

AT first glance, Dr Iain Brew's first job as a GP in the Shetland Islands couldn't be further removed from his current role. His base off the north east of Scotland was remote, extraordinary, wild at times and involved a broad spectrum of clinical practice.

Now working as a full-time GP at a sprawling urban prison, Iain still finds his job can be remote, extraordinary and wild at times with a varied and busy clinical case load. And while the Victorian-built prison in which he practises doesn't boast quite the same scenic beauty as the Shetlands, Iain wouldn't have it any other way.

He began prison work in 2001 when a friend asked him to help with evening work at HM Prison Lincoln. "I thought it would be something a bit different," he says, "but I really liked it." He never looked back, working part-time at Lincoln before eventually becoming a full-time GP at HMP Leeds in 2006.

"My first impressions of prison work proved to be right. The patients – and to me they are always patients first and prisoners second – are medically very needy. There is a great deal of advanced pathology going on – psychiatric as well as physical – as this is a population who do not normally engage well with the health service. You would not encounter such textbook pathology in a local surgery.

"I also felt this was a needy group who traditionally have not received good care within the prison service. Only since 2004, when prison health started to be commissioned by the NHS, has it been a requirement to have qualified GPs in prisons."

HMP Leeds is a Category B men's prison with a population of 1,150. It's a local prison taking both remand and short-stay prisoners but also accommodates a number of 'lifers' awaiting a placement elsewhere.

Iain is part of a team comprising two part-time GPs and a clinical director – the equivalent of 1.6 full-time equivalents. That may seem sufficient considering the population, but research shows prisoners consult four to five times more than average. Iain confirms this: "We have an annual turnover of about 6,000 [consultations] – that's 500 per cent of our patients."

Proactive

One of Iain's interests is chronic disease management and he is clinical lead for a city-wide team of nurses covering three prisons. They take a proactive approach, actively seeking out new prisoners identified in reception screening as having a medical diagnosis.

Iain's real passion though is for hepatitis C work and he runs a successful in-house treatment service in conjunction with the local hepatology department. The service has earned widespread praise with interest in rolling out the model UK-wide. He has also helped develop an online training course in hep B and C treatment with the RCGP.

Over the past five years, the service has treated 75 patients – people who, Iain says, probably won't have accessed sustained help before. He explains: "We give them antiviral treatments and have excellent completion and SVR (sustained viral response) rates – in other words 'cure'."

Encouraged by clinical director, Nat Wright, also a member of the RCGP's 15-strong Secure Environments Group, Iain has completed a literature review of hep C treatment in primary care globally (currently in publication), and is evaluating research involving the first 50 patients through hep B treatment. Having a captive audience means research ethics are high on the agenda.

His overall clinical remit at Leeds is wide. "We try to treat as much as we can within the prison as it costs the NHS to send patients to hospital escorted by prison officers. With the support of specialists, we manage everything from sexual health, joint injections and IV antibiotics to palliative care."

Safeguards

A key element of Iain's job is the importance of safe prescribing. About a quarter of the prison is on methadone and another five per cent are on buprenorphine as an opiate substitute. The substance misuse group accounts for 70 per cent of patients and, consequently, drug-seeking behaviour is common.

As a result, the GPs have to be consistent in explaining why a drug may not be suitable. For example pregabalin, prescribed for pain management, has opiate and benzodiazepine

E JOB

type effects and causes euphoria. Consequently it is highly valued. Iain outlines the size of the problem: "Out of 25 patients I saw yesterday, six had prolonged discussions with me about their need for pregabalin."

Security and prescription considerations are manifold: no glass bottles or aerosols as they could be weapons, no gum-based nicotine to make impressions of keys or block locks. No injectables. Iain also has to assess a genuine need for hospitalisation, as most escapes happen in court or in hospital.

Prison GP, Dr Iain Brew

"We have to be alive to psychiatric diagnosis. I ask patients about suicide several times a day."

Despite his work environment, Iain says he rarely feels threatened and there is seldom the need to have prison officers sit in on consultations.

"Very occasionally prisoners try to threaten, especially about their desires for medication. The highest risk comes from the mentally unwell."

On occasion, it does get "wild at times". Says Iain: "Things got hairy recently during an evening reception clinic when a long-term prisoner opened his dialysis fistula with a biro, refused to go to hospital with paramedics and allowed himself to bleed out until losing consciousness.

"There was no DNAR in place due to his mental fluctuations and IV access was impossible due to previous drug use. We were only able to deliver first aid to him and thought we were going to lose him at one point. At the same time, another prisoner was withdrawing very badly from alcohol and had a series of seizures requiring diazepam followed by a detox script."

While this may sound alarming, Iain adds: "When thinking about safety, I have been in more danger in GP practices than in prison due to the uniformed staff and alarm bell system."

Alongside drug abuse, mental health issues are also common with half of patients diagnosed with personality disorders. Iain says: "We have to be alive to psychiatric diagnosis. I ask patients about suicide directly several times a day."

What has surprised him most about his patients? Iain is unequivocal in his response: "Their humanity. When I started out I had a '*Daily Mail* reader' attitude but prisoners are just people like you and me. They have often been excluded socially from a very young age.

"There are some really intelligent people here. If they had applied themselves within the law they would have been brilliant. So I feel compassion and some sadness for how things could have been different."

Downsides are pressure and intense scrutiny. While GPs have to deal with endless requests for drugs they also have to ensure patients feel they are properly treated.

"For me, examining people well is part of that," says Iain, "but any death in custody, even natural-causes deaths, is extremely involved." First there's a 48-hour review of clinical care; a police investigation; prison and probation ombudsman statements; a clinical reviewer who will scrutinise records of care; and eventually a coroner's inquest (with jury) often up to three years after the death.

Iain believes the job is challenging but rewarding and is keen for trainee doctors to find out more. He stresses that prison doctors need to be confident in their assessment and be able to switch off at the end of the day.

He would encourage trainees to get involved. "We have foundation doctors in one day a week as GP attachments, and medical students doing their intercalated BSc," he says. "Anyone interested should try to contact their local prison. I know prison GPs are keen to encourage that; I certainly am."

Alison Bird is a freelance writer

Deciding when to raise concerns over suspected child abuse can be a difficult judgement to make. **Dr Susan Gibson-Smith** offers advice and discusses new GMC guidance

A TOUGH CALL

It had been a busy morning as duty doc, with three house calls and a full emergency surgery, when a message flashed on my screen. 'Please call Mrs Jones, social worker, asap. She wants to discuss medical information about Lilly R (21/5/2009), child protection matter.' I know that information sharing is really important in child protection but what about confidentiality? What should I tell this social worker? I decide to ask my trainer before making the call.

CHILD protection is a very difficult area of practice that can involve making decisions with far reaching consequences in emotionally charged situations, sometimes against parents' wishes. One high-profile example of this happened in Orkney in 1991 when nine children were removed from their homes following allegations of child abuse. The children denied anything had occurred and medical examinations produced no evidence of abuse. The charges were eventually dismissed by a judge but the media attention had a huge impact on those involved.

In contrast, reviews into the tragic abuse of Victoria Climbié in 2000 and Baby P in August 2007 concluded that a lack of preventative action and information sharing between organisations were key factors in the failure to prevent the children's deaths.

Knowing when it is appropriate to act can be a difficult judgement call for any healthcare professional to make. It is essential that all patients, including young people, can be confident that the information they share with their doctor remains confidential. But, equally, it is vital that all doctors have the confidence to act without fear of reprisal if they believe a child or young person may be the victim of abuse or neglect.

New GMC guidance *Protecting children and young people the responsibilities of all doctors,*

which has recently come into effect, seeks to clarify this issue. It states that "taking action will be justified, even if it turns out that the child or young person is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable and the doctor takes action through appropriate channels."

The guidance makes clear that child abuse covers not only physical or sexual abuse but also emotional neglect, including fabricated or induced illness.

Justification

Doctors who make decisions in line with the eight principles set out in the GMC guidance will be able to justify their actions if they are called into question.

The principles are as follows:

1. **All children and young people have a right to be protected from abuse and neglect** – all doctors have a duty to act on any concerns they have about the safety or welfare of a child or young person.

2. **All doctors must consider the needs and wellbeing of children and young people** – this applies even where the child is not your patient, i.e. if you are treating an adult relative.

3. **Children and young people are individuals with rights** – doctors must not unfairly discriminate against a child or young person for any reason.

4. **Children and young people have a right to be involved in their own care** – this includes the right to receive information that is appropriate to their maturity and understanding, the right to be heard and the right to be involved in major decisions about them in line with their developing capacity.

5. **Decisions made about children and young people must be made in their best interests** - see appendix 2 of the guidance for factors to be considered when assessing best interest.

6. **Children, young people and their families have a right to receive confidential medical care and advice** – but this must not prevent doctors from sharing information if this is necessary to protect children and young people from abuse or neglect.

7. **Decisions about child protection are best made with others** – consulting with colleagues and other agencies with appropriate expertise is encouraged.

8. **Doctors must be competent and work within their competence to deal with child protection issues** – doctors must keep up-to-date with best practice through training appropriate to their role. If they are unsure how to meet their responsibilities to children and young people, doctors must get advice from a named or designated professional, a lead clinician or, if they are not available, an experienced colleague.

It is advisable to read the guidance for more in-depth information.

Making the call

Back to our trainee doctor's scenario which relates to issues of confidentiality and information sharing.

Bear in mind that confidentiality is not an absolute duty and can be breached in certain circumstances, for example in response to a court order or when the breach can be justified in the public interest. This can occur when the benefits to the child/young person of sharing the information outweigh both the public and the individual's interest in keeping the information confidential.

Before deciding whether to share information it's important to have sufficient details. The doctor in our scenario does not yet have enough information and rightly spoke to her trainer who advised she contact the child's social worker for more details. In particular he suggested finding out what degree of risk the social worker believed Lilly to be facing.

Consent

It is good practice to ask for consent before sharing confidential information unless there is a compelling reason for not doing so. Such reasons include an increased risk of harm to the child should there be a delay in seeking consent.

When seeking consent, it is important to approach the correct person. Where a child lacks the capacity to decide for themselves, you should approach the person with parental responsibility. By law, a mother always has parental responsibility for her child but not all fathers do. In relation to children born after December 1, 2003 (England and Wales), April 15, 2002 (Northern Ireland) and May 4, 2006 (Scotland), both biological parents have parental responsibility if they are registered on a child's birth certificate. It's important to always check if a father does have parental responsibility.

Adoptive parents have responsibility, as does a person appointed as a child's special guardian and local authorities can also possess parental responsibility if there is a care order relating to a child. Married step-parents and registered civil partners can apply to the courts for a parental responsibility order. (Find out more in the MDDUS *Essential Guide to Consent* at **www.tinyurl.com/d5k3c4w**)

When seeking consent, be sure to explain why you want to share the information and how it will benefit the child. You should also explain what information you will share and with whom, as well as where they can go for independent advice. Record the details of your discussion in the medical record including the name of the person who gave consent.

If consent is refused you must weigh the harm that is likely to arise from not sharing the information against the possible harm both to the patient and to the overall trust between doctor and patients of all ages arising from divulging that information. If a child or young person is at risk of or is suffering abuse or neglect it is usually in their best interests to share information with the appropriate agency. It is extremely unlikely that a doctor would be criticised for this unless they are acting maliciously.

It is very important to inform a parent or guardian of your decision to breach confidentiality unless you think this will put the child at further risk. It is also important to record the reason for your decision to breach and any steps you took to try to obtain consent prior to breaching.

If you remain unsure about whether to disclose information, seek advice from your local child protection unit or, alternatively, contact an MDDUS adviser.

Dr Susan Gibson-Smith is a medical adviser at MDDUS

DIAGNOSIS

CONFLICTING ACCOUNTS

DAY ONE

Mrs P attends the GP surgery along with her 11-year-old son Noah. Her regular family doctor is on holiday so she is seen by Dr L. Noah has a very sore throat and is also complaining of headaches and feeling "tired all the time". Dr L examines Noah's throat and records: "Inflamed tonsils; white sloughs". The GP diagnoses tonsillitis and prescribes erythromycin rather than the usual first choice of a penicillin, as Noah had been taking co-amoxiclav five weeks earlier for a chest infection. In addition she issues a prescription for amphotericin lozenges just in case there is a co-existing fungal infection secondary to the recent use of antibiotics. No other symptoms or concerns are mentioned in the patient notes.

DAY FIVE

Noah arrives in A&E with his parents who report he has been feeling sick and dizzy for two weeks and his weight has dropped half a stone in a month. Noah also claims to be almost constantly thirsty and needing the toilet. On examination Noah is found to be very unwell with significant dehydration and a blood test shows he is hyperglycaemic. A diagnosis of diabetic ketoacidosis is made and Noah is started on IV insulin and rehydration.

DAY SEVEN

Noah is transferred to a paediatric nephrology unit having developed acute renal failure and hypertension. He undergoes two sessions of haemodialysis and there are worries he may have developed renal papillary necrosis. Noah spends another week in hospital before being discharged home, with his kidneys having recovered sufficient renal function.

MONTH SIX

Noah attends a paediatric nephrology clinic and tests indicate his renal function is back to normal. An earlier ultrasound of his kidneys has found no sign of lasting damage. He is discharged from renal follow-up.

SEVEN months later Dr L receives a letter of claim from solicitors acting on behalf of Noah and his parents alleging clinical negligence for failing to investigate and diagnose his diabetes and thus preventing acute renal failure secondary to ketoacidosis. This resulted in the boy having to undergo haemodialysis.

In the letter of claim it is alleged by Mrs P that during the consultation she alerted Dr L to Noah's recent weight loss and his persistent thirst. In addition she claims to have brought a sample of Noah's urine to the surgery "reasonably thinking it would need to be tested". None of this is recorded in the patient notes.

The letter also highlights the fact that Dr L had diagnosed oral thrush as evidenced by her prescription for amphotericin lozenges. Oral thrush is rare in children and it is claimed that this should have alerted Dr L to the possibility of a significant underlying disorder. Given the combination of symptoms, not considering a diagnosis of juvenile diabetes and ordering tests to confirm this constituted a serious breach of duty.

The letter concludes that had simple diagnostic tests been carried out to detect either high glucose levels or the presence of ketones, Noah would have been quickly admitted to hospital with intravenous treatment and insulin therapy. This would have avoided the later renal complications.

Dr L contacts MDDUS for assistance. In her letter of response to the allegations she claims that Mrs P had made no mention of weight loss or thirst during the original consultation. Nor did she bring a urine sample as it would certainly have been tested given the symptoms described. Dr L claims she was only aware of symptoms suggestive of an upper respiratory infection.

MDDUS commissions an opinion from a GP expert. In considering only those facts recorded in the patient notes, the expert judges that Dr L's management of Noah was in accordance with acceptable standards – although he does acknowledge that oral thrush is rare in children. But he adds: "If the claimant's version of events is accepted, the symptoms were so typical of diabetes that Dr L's failure to further investigate would constitute care well below what would be acceptable in a competent general practitioner". The case is clearly one of the family's word against that of the doctor.

Examining all the facts of the case MDDUS lawyers judge that there is a reasonable risk that a court could decide to accept the claimant's version of events. It is decided that the offer of a small settlement with no admission of liability is the most prudent course given the potential cost of a protracted legal battle. Dr L agrees and the case is settled.

KEY POINTS

- Good records provide the best defence – but sometimes not even this is enough.
- MDDUS must take a pragmatic approach when deciding how best to proceed in negligence claims – balancing all interests.

Diary

WELCOME back to Diary - if indeed you have come back. Otherwise you must be either a newbie or occupying some realm of metaphysics beyond our comprehension. In any case...

- **INTO THE WILD** Budding GPs might be interested in an opportunity to leave the rat race behind for more secluded climes. It's been widely reported recently that the remote Scottish island of Jura in the Inner Hebrides has gone all-out in the search for a new permanent GP. Islanders desperate to attract a resident doctor have turned to social media, and set up a dedicated Facebook page (www.facebook.com/PerfectPracticeJura) to advertise what they describe as "a dream job for the right person". Jura boasts picturesque beaches, an abundance of wildlife, next-to-no crime and a world famous whisky distillery, with a free bottle of malt on offer as a finder's fee. Due to the island's remoteness, however, the new GP would be permanently on call and would be expected to fulfil a wide range of duties. The first task for the last full-time GP was reportedly changing the tyre on the island's ambulance.

- **PET RESCUE** A GP has hit the headlines for putting his medical skills to unorthodox use – by giving mouth-to-mouth to his pet tortoise. Dr Ben Waterfall from Barnstaple told *GP* how he leapt into action after discovering eight-year-old Atlas submerged in his water container, having stopped breathing and blinking. Crediting his medical training for his quick reaction, Dr Waterfall said he spent six minutes breathing into the reptile's nostrils before seeing signs of life. He said: "We were always told that with drowning you should give people a go. It kicked in without thinking about it." Fortunately, Atlas has made a full recovery following a course of antibiotics, although Dr Waterfall admitted he was unable to tell if his pet had suffered any sort of brain damage.

- **APP-ATHETIC** Not long ago Diary came across a cartoon by Stephen Collins in the *Guardian* newspaper. A couple are lying on a hillside and a passenger jet flies high over head. The woman says: "You know Brad, sometimes I like to come up here and just watch the planes. I like to wonder where they're going...New York...Paris...Cairo... maybe even Ulaanbaatar... And I like to think of the people on them, and how their lives might be changed by this journey, and how maybe, just maybe, one day it'll be me, flying away from this dreary little town, with its dreary little dreams...Y' know?" The man holds his smartphone up toward the plane – "Blip, blip" – and says: "It is going to Luton." The final panel in the cartoon reads: "APPS: SPOILING THINGS SINCE 2008."

- **E-PIDERMIS** Sticking with the hi-tech theme, US scientists have invented "electronic skin" patches that monitor patients' vital signs and will ultimately be able to wirelessly transmit the data to a doctor. It could mean the end of patients being attached to machines for hours of treatment or monitoring. The patches can track brain, heart or muscle activity while the patient is at home. The patches are transferred to the skin like a temporary tattoo, with water and a backing that peels off, while a spray-on bandage keeps it waterproof.

- **RANCID REMEDIES** And from hi-tech to extremely lo-tech... Eating body parts, the sweat of a dying man, ground-up remains of embalmed bodies and distilled brain pulp are just some of the treatments dreamed up by proponents of 'corpse medicine'. Australian academic Louise Noble has researched a range of stomach-churning remedies on the practice which was popular from the 12th to 17th century. Practitioners thought a dying man's sweat would cure haemorrhoids while distilled brain pulp of a violently killed man was used to cure cranial ills. Meanwhile, gladiators' liver and blood was used to treat epilepsy.
Source: *Daily Mail*

- **DIGESTIVE DRAMA** Next time you reach for that Hob Nob in the practice biscuit tin, spare a thought for staff at the Department of Health. The *Independent* reports that an "urgent review" has been ordered after it was revealed the DoH had spent £109,017 in three months buying "tea and biscuits" for meetings with staff and visitors. Responding to the mild outrage, a DoH spokesman said the bill was actually a "marked improvement" compared to the first three months of last year when officials notched up £137,000 on light refreshments, and in 2010 when they spent £194,000. One suspects more biscuit down-sizing to come.

- **MEDICINAL CHOCOLATE** On the subject of snacks, an Australian study published in the *BMJ* revealed dark chocolate has antihypertensive, anti-inflammatory, antithrombotic and metabolic effects, which are attributed to its high polyphenol content. Research suggests regular consumption reduces systolic blood pressure and plasma cholesterol concentrations. The study explores the rather ludicrous prospect that eating dark chocolate could be cost effective in the primary prevention of cardiovascular events. While it isn't as effective as statins or ACE inhibitors, this may be offset by better compliance and fewer adverse effects. Prescription for Bourneville, anyone?

- **GIE US A FIVER** Or to the non-Glaswegian – hand over my five dollar consultation fee, please. This is apparently how much an 87-year-old family doctor in Rushville, Illinois has been charging his patients per visit since the 1970s. Dr Russell Dohner has become something of a national hero in the US as the country awaits a Supreme Court decision on the Affordable Care Act and the future of healthcare costs. These can be crippling, with a family of four dependent on an employment-based insurance plan expected to pay $20,000 – or about 40 per cent of median household income – on medical expenses each year. That's not to say Dr Dohner is completely immune to inflation: before the 1970s he charged two dollars a visit.

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