GPst

ISSUE 06

ON SKIS ON CALL

SKI PATROL GP MIKE LANGRAN ON SUB-ZERO CARE AND DARING MOUNTAIN RESCUES

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

PHOTOS: PAUL GRAHAM

Welcome to your GPst

AS any new GP will know, the amount of paperwork that we have to deal with is ever more increasing. It can be a real challenge to strike a balance between meeting our administrative demands and providing good patient care. On **page 4**, I look at the red tape I have to deal with in a typical day and hope that government promises to cut bureaucracy are fulfilled.

An issue that sparked much debate was the introduction of fit notes. Two years on, MDDUS editor Jim Killgore looks at the current state of play and future plans on **page 7**.

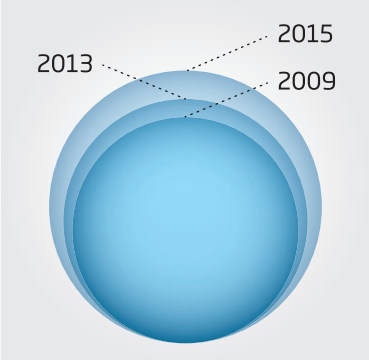
Trainee GPs will spend a lot of time thinking about the MRCGP exam so on **page 5** GP and author Dr Milan Mehta offers some advice on workplace based assessments (WPBAs). Dealing with a patient death is never easy and on **page 6** MDDUS medical adviser Dr Barry Parker explains what to expect if you are called before a coroner's inquest.

Ski patrol doctor and GP Dr Mike Langran talks to Adam Campbell on **page 10** about his unpredictable role at the UK's only general practice to treat large numbers of skiers and snowboarders in the Scottish mountains. A similarly exciting career path is explored on **page 8** where we look at what is involved in becoming a GP with a special interest in urgent and emergency care.

All doctors should treat patients equally, but do you make assumptions about a patient's sexuality that influence the care you provide? Find out on **page 12**. And our case study on **page 14** looks at how the misdiagnosis of a child with an itchy rash had damaging consequences.

• **Dr Peter Livingstone**
Editor

GP TRAINEE NUMBERS SET TO RISE



THE number of GP trainees starting in August 2013 is expected to increase to almost 3,000, according to Department of Health estimates.

Between 2,869 and 2,953 trainees are likely to begin training this summer, an increase on the 2012 figure of 2,689 and a step towards meeting the government's ambitious target of 3,250 trainees a year by 2015.

Figures showed the number of trainees fell in 2011 to 2,677 from 2,743 in 2010 and 2,695 in 2009.

NEW PRESCRIBING GUIDANCE FROM GMC

DOCTORS face tighter rules on self-prescribing and a ban on prescribing performance-enhancing drugs to athletes under new guidance issued by the General Medical Council.

Good practice in prescribing and managing medicines and devices strengthens and broadens current advice to include medical devices and gives key updates on the use of unlicensed medicines.

Under the updated rules, doctors are told they "must not" prescribe for themselves or their families unless it is an emergency where lives or health are at serious risk. Doctors who do prescribe in this way must make a clear record of it and tell their own or the patient's GP (unless they object).

The guidance forbids practitioners from prescribing performance-enhancing drugs or treatments to athletes. Any doctor who suspects an athlete's performance is "improperly enhanced" is urged to "raise concerns in the public interest".

The GMC also maintains its stance that licensed medicines should usually be prescribed "in accordance with the terms of their licence" but allows medicines to be prescribed outside their licence "when it is necessary to do so to meet the specific needs of the patient."

The updated advice, which came into effect in February 2013, incorporates a ban on the remote prescribing of injectable cosmetics such as Botox that came into effect last July. It also reminds doctors they must report any adverse incidents involving drugs or medical devices such as X-ray and other imaging equipment, pacemakers, artificial joints and anaesthetic equipment.

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GPs QUICK TO REFER SUSPECTED CANCER

GPs refer more than 80 per cent of suspected cancer cases within two consultations, new research has revealed.

More than half (58 per cent) of patients were referred after the first consultation while a quarter were referred after two. In only five per cent of cases it took five or more consultations to initiate a referral.

The findings were published in a report in the *British Journal of Cancer* which used data from the English *National Audit of Cancer Diagnosis in Primary Care 2009-2010*. It covered 13,035 people with any of 18 different cancers.

Those diagnosed with multiple myeloma and lung cancer had high proportions of three or more pre-referral consultations (46 per cent and 33 per cent respectively). Breast cancer and melanoma patients were generally referred sooner, with only three per cent and five per cent of each patient group requiring three or more pre-referral consultations.

The researchers concluded: "Developing interventions to reduce the number of pre-referral consultations can help improve the timeliness of cancer diagnosis, and constitutes a priority for early diagnosis initiatives and research."

QUARTER OF GRADUATES MAKE GP FIRST CHOICE

ONLY a quarter of medical graduates say general practice is their first choice of specialty amid concerns over a workforce shortfall.

A new study shows 28 per cent made general practice their first choice career compared with 71 per cent who chose secondary care specialties. This falls well short of the target of 50 per cent of training places allocated for GPs by 2015 which was set by the former health secretary Andrew Lansley.

The figures, revealed in the *Medical Teacher* journal, were based on more than 9,000 questionnaire responses from people who qualified in 2005, 2008 and 2009, one year after they graduated.

MORE CHANCES TO PASS MRCGP

GP trainees could be given more chances to pass the MRCGP following discussions over how to address the high failure rate of international medical graduates.

Under the plans, reported recently in *Pulse*, trainees could be allowed six attempts at the exam rather than the current four, and greater support would also be given to international trainees.

The issue was discussed at a meeting between the RCGP, the British Association of Physicians of Indian Origin (BAPIO) and the British International Doctors Association (BIDA).

The move came after official figures showed that, in 2010/11, the failure rate for international graduates taking the clinical skills assessment (CSA) component of the MRCGP was 63 per cent, compared with just nine per cent for UK graduates. While the RCGP has reportedly ruled out offering an alternative to the CSA, the College is said to be keen to continue working with BAPIO to resolve the issue.

A joint statement issued after the meeting stated that all three parties "acknowledged that there were a number of factors contributing to the lower pass rates of candidates with overseas Primary Medical Qualifications."

Another meeting has been scheduled to discuss the issue further.

PATIENTS TO RATE DOCTORS

PATIENTS are to be given the power to rate the service provided by their doctor under new plans announced by the prime minister.

David Cameron said a new "friends and family" test would be introduced in every hospital in England from April with a view to later extending it to GP practices and community hospitals.

Under the test, patients and staff would be asked whether they would recommend the service to a friend or relative, in a bid to expose unacceptable standards of care. Mr Cameron said it should be applied to all NHS services.

GPs NOT ENGAGING WITH FIT NOTES

DOCTORS are not using the 'fit note' system as intended, according to a survey of HR professionals.

An XpertHR report (**tinyurl.com/a2foutd**) found 62 per cent of HR professionals felt that fit notes had not helped them to better manage sickness absence and 65 per cent said that fit notes had not helped reduce overall absence.

A prime aim of the fit note system - introduced in 2010 - was for doctors to offer employers greater clarity on the nature of any condition preventing an employee returning to work. GPs are asked to tick a "may be fit for work" option and provide more detailed medical information about how the employee can be eased back into work.

In the survey, *Personnel Today* reports that 78 per cent of respondents said the "may be fit for work" option had either never been ticked in any fit notes received or had been ticked in fewer than a quarter of cases over the past two years. And 38 per cent of organisations reported that GPs never provided any comments on fit notes. When doctors did offer advice, 73 per cent of employers went against that advice and made alternative arrangements to facilitate a return to work.

Report author Charlotte Wolff said: "Our research [shows] that doctors appear to be too busy to use the fit note in an intelligent way and frequently have a limited understanding of the nature of the employee's work."

However, 68 per cent of respondents did feel that the introduction of fit notes had helped to stimulate a more open dialogue on employees' return to work after illness.

Read more on p7

fit for

Their introduction sparked controversy but it's hoped planned reforms will resolve doctors' concerns about the often maligned fit note

SEEING RED

Is red tape taking over general practice?

I HAPPENED to read recently that GPs face "death by data collection", with 24 per cent saying they now spend more than half their time dealing with paperwork[1]. Reflecting on a typical day for me in primary care, I could not help but ponder on this statistic and how it applies to me and my colleagues.

We all know how challenging general practice can be from surgeries, telephone consultations, house-calls and dealing with that dreaded paperwork. The advent of electronic document management software like Docman was a revolutionary development in general practice and meant, for the first time, all patient paperwork could be held centrally and accessed easily by the GP. I am always apprehensive every morning when I arrive into my surgery and log onto Docman. I know the postman will have been and I expect to have between 40 and 60 items waiting for me each day. I wonder how I am going to have the time to perform all my other duties along with dealing with this vast amount of paperwork. I tend to quickly scan through the items to check for anything urgent that has to be dealt with before morning surgery. During the course of the morning, however, the pending items on Docman are constantly at the back of my mind and are difficult to get away from.

After clinic I take the bull by the horns and with a sigh I wade my way through this endless paperwork. I come across results and discharge letters from patients who I have never seen before. Even though they may not require any further action I still have to open the patient's clinical records to ensure I don't miss anything. This can take two to three minutes at a time and before you know it an hour has passed. I'm sure this is not an unfamiliar situation for most GPs nowadays.

Although most paperwork is benign and does not require any further action there are some results that must be acted on immediately. I feel my heart racing when I see abnormal results such as elevated potassium or low haemoglobin levels. I deliberate on the best course of action before trying to contact the patient, often ending up exasperated when they prove untraceable. With the urgency that goes hand-in-hand with these abnormal results, there have been times where I have had to drive to a patient's home to notify them of these results and advise they go directly to hospital.

Hospital discharges are another source of red tape and often generate endless pieces of paper that can be totally irrelevant and difficult to interpret. When these land on my desk I do wonder how accurate they are. With patients living longer with multiple morbidities and taking significant amounts of medication it can all be bamboozling at times and make you just want to pull your hair out. (What little I have left!)

When I manage to grab lunch I use the time to trawl my email and wade through all the circulars and latest guidance issued by PCTs, NICE and SIGN along with replies from consultants who I've emailed directly with questions about particular patients. I also get information regarding the updates for QOF along with the generalised running of the surgery from the practice manager. Trying to comprehend all this information at times can lead to "mind-block". This is when I know I've had enough and leave to take a walk around my local park to clear my head for the oncoming afternoon.

Most of you would agree that we are all staying longer at the practice as it's less easy to take work home because of the need to access clinical records or NHS email accounts. This can lead to a poor work-life balance with weekends often spent on administrative work.

And when it comes to QOF, many GPs say they complete multiple forms that are irrelevant to patient care. One told *GP* magazine: "I'm spending too much time on paperwork. I'm trained to treat patients, not tick boxes. We are all suffering death by data collection of dubious validity." Does this sound familiar?

With an ageing population with multiple morbidities, the considerable CQC requirements and other similar demands I suspect that paperwork will only increase and become more complicated. Time management is a must and it is important to delegate tasks but trying to determine what issues can wait and be dealt with routinely and those that require urgent attention can be difficult.

I think we all need to address the issue of workload and try to reduce unnecessary bureaucracy, but achieving that is no easy task. In November 2012, the government launched its Health Red Tape Challenge, seeking ideas on how to reduce the burden of bureaucracy across the health service. The results of this exercise are expected to lead to the scrapping of thousands of government regulations and we can only hope this will ease the pressure on us GPs.

Dr Peter Livingstone is editor of GPST and a GP with a special interest in diabetes

[1] Quarter of GPs spend half their time on paper work. GP survey, 24th January 2012 **www.bit.ly/14kOOxe**

ASSESSMENT IN SITU

Milan Mehta offers some tips on the third component of the MRCGP exam – Workplace Based Assessment

THE MRCGP is designed to be an "integrated" assessment system. Summative assessments such as the Applied Knowledge Test (AKT) and Clinical Skills Assessment (CSA) evaluate candidates in the pressured and unavoidably artificial setting of an exam. But some areas of professional practice are best tested on the job and this is where Workplace Based Assessment (WPBA) comes in.

Preparation and planning are just as important with WPBA. Below are some tips and common pitfalls to avoid. More specific requirements for each type of WPBA can be found on the RCGP website (**www.rcgp.org.uk**).

Case-based Discussion (CBD)

CBDs are mainly done in primary care and it is your responsibility to select cases, so choose them carefully as your ePortfolio must include a balanced variety of patients (e.g. children, elderly, mental health, palliative care). The cases must also reflect a variety of settings (e.g. hospital, GP surgery, home visits, out of hours). It is impossible for one CBD to provide evidence for every competence, so make sure you select cases that will enable your supervisor to cover as many competences as possible during the discussions. One way of achieving this is to ask your supervisor at the start of the discussion which competences they are expecting to look at.

Some trainees make the mistake of not planning ahead, which causes unnecessary anxiety closer to the time of their six-monthly and final reviews. Identify which competences were covered during your last CBD, think ahead which competences are still outstanding and then select subsequent cases to cover them.

Consultation Observation Tool (COT)

Your GP trainer will observe some of your consultations (either directly or by video recording) in order to make holistic judgements about your consultation skills. The discussion that follows, and the feedback your trainer gives you, will be used as evidence in your ePortfolio.

Record several of your consultations on video and select one to be assessed and discussed, or ask your trainer to sit in with you during them. Remember, the more complex your consultations are, the more evidence they will probably generate. Try not to let your consultations exceed 15 minutes, since effective use of time is a positive attribute your trainer will be looking out for. Again, make sure you select a balance of cases and include at least one involving children (aged 10 or younger), older adults (aged 75 or over) and mental health. Don't be afraid to select videos where you think you've performed well, since being able to tell the difference between good and bad consultations is a marker of your professional development.

Multi-Source Feedback (MSF)

This tool collates feedback from colleagues about your professional behaviour and clinical performance which can then be reflected on, used for self-evaluation and included in your ePortfolio. The number of colleagues you need to provide feedback will differ depending on whether you are in a primary or secondary care post. Colleagues you select for MSFs will need to have observed you in the workplace.

Try to ask different colleagues to provide feedback across the MSF cycles. It is sensible to select colleagues that you have a good working relationship with, as they are more likely to give you positive feedback!

However, if a single colleague gives you some minor negative feedback then this is okay as long as it is balanced out by overall positive feedback from everyone else. Your Educational Supervisor will give you the MSF feedback and make sure you try to address any problems that colleagues raise.

Patient Satisfaction Questionnaire (PSQ)

This will provide valuable feedback on your empathy and relationship-building skills during consultations. This is a chance to display your warm, caring side as a GP trainee, and make sure you address every patient's ideas, concerns and expectations, as this will undoubtedly make them leave your consultation with a sense of satisfaction.

Direct Observation of Procedural Skills (DOPS)

There are eight mandatory skills that you need DOPS for, and the rest are optional. Start completing DOPS as early as possible as it is often hard trying to find someone to observe you at the relevant time. The observers should not be other GP trainees or specialty trainees at a similar stage in training to you.

Clinical Evaluation Exercise (MiniCEX)

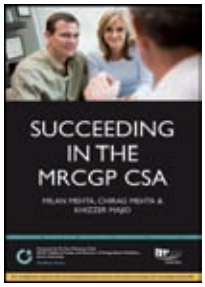
This is the secondary care equivalent of COTs. Again, try to cover a range of clinical problems.

Clinical Supervisor's Report (CSR)

This is usually for hospital posts only and is a structured report from your Clinical Supervisor based on evidence relating to your post (e.g. WPBA tools, ePortfolio entries and feedback from colleagues). At the start of your post, try to identify educational objectives and learning opportunities with your supervisor. Ask your supervisor before the CSR is completed if there are any concerns, so there is enough time to address them.

Every six months you are expected to meet with your educational supervisor and review the evidence collected and plan for the next six months. Just as with anything the trick with WPBA is to keep on top of it. Good luck.

Dr Milan Mehta is a 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***



In the next issue:
Learning Logs and Personal Development Plans

TAKING THE STAND

Would you know what to do if you were called before a coroner's inquest? MDDUS medical adviser **Dr Barry Parker** offers some advice

CORONERS are either lawyers or doctors, sometimes both, who are appointed to inquire into violent or unnatural deaths, sudden deaths of unknown cause or deaths that have occurred in custody. Each year a number of MDDUS members contact us for assistance after they have either been asked to provide reports for the coroner following a death, or been cited to attend a coroner's inquest (CI) as a witness.

CIs are held in England, Wales and Northern Ireland and convened first and foremost to determine who the deceased was and when, where, how and in what circumstances he or she died. (In Scotland, procurator fiscals investigate deaths and Fatal Accident Inquiries are held.) The inquest may be held before the coroner alone or, in certain circumstances, with a jury present.

The coroner decides which witnesses to list and leads the questioning of each witness during the inquest. Other interested parties such as the family may also ask questions of each witness and, although emotions may well be running high, it is for the coroner to keep control of the process.

Possible verdicts on conclusion of an inquest include natural causes, accident or misadventure, suicide, unlawful killing, lawful killing, industrial disease or an open verdict where there is insufficient evidence for any other verdict. Alternatively, the coroner may produce a narrative verdict, setting out the facts and explaining the reasons for his/her decision.

It is important to emphasise that inquests are about what happened rather than who was involved, and the coroner cannot therefore name a specific doctor or make a finding against them in a verdict. Nonetheless, a doctor's individual actions or omissions can sometimes be inferred from the verdict itself and where this is recognised by the family of the deceased, it may encourage them to consider litigation or complain to the GMC afterwards. In addition, there is occasionally press coverage which can be very stressful for our members, though in fact it is usually very transient and subsides rapidly.

How, then, can the MDDUS be of assistance to our members? Firstly, we are very happy to hear from doctors who have been asked to produce a written statement to the coroner. We can advise on the structure and general approach to the statement so that it is clear, relevant and is of greatest assistance to the coroner. If a member is cited to attend as a witness we can go over the events surrounding the death in detail and seek advice from our in-house legal team on whether individual legal representation may be required at the inquest.

Where the doctor is not likely to face criticism, or is somewhat peripheral to events, it would not be usual to be individually represented, as this may draw unwelcome attention unnecessarily. However, if criticism is likely from any source, we may instruct a barrister to attend the inquest to formally represent our members. Prior to the inquest, we will obtain a full set of documents disclosed by the coroner including any expert reports that have been obtained. This can alert us to any potential difficulties that may be encountered on questioning, so that our member is prepared for these.

On the day of the inquest, the barrister will attend the coroner's court to meet our member before the start, and then be present throughout. They cannot, of course, answer for the doctor but can clarify points, question other witnesses, and ensure that our member's account of events comes across well. They may also challenge any irrelevant or inappropriate questioning from any party.

When attending to give evidence, doctors should dress smartly, attend promptly (mobile phone switched off!) and be familiar with the patient's records and any statement they have made to the coroner previously. They should listen carefully to the questions, speak clearly and answer the questions directly, avoiding expanding too much or running off the point. There is no need to fill gaps in conversations in court – if the questioner is looking for more information, they will ask. It is also perfectly okay to ask to refer to the records to assist in responding, and to say that they cannot recall something, if that is the case. They should also make the coroner aware if they are asked a question that is beyond their sphere of knowledge and experience.

Hospital doctors and others who are directly employed by Trusts may be assisted by the Trust's legal department and may not require separate representation by MDDUS. Where possible, it is generally preferable to be represented by one's own employer, but on occasions, conflict may arise between the doctor and the Trust itself, or between different doctors each employed by the same Trust, and in these circumstances MDDUS representation may still be required.

In summary, CIs can be stressful events but adequate preparation is the key to ensuring that the difficulties encountered are minimised and things go as smoothly as possible.

Dr Barry Parker is a medico-legal adviser at MDDUS

fit for

Their introduction sparked controversy but it's hoped planned reforms will resolve doctors' concerns about the often maligned fit note

TO some GPs it seemed little more than double-speak when in April 2010 the traditional 'sick note' yielded to the much more proactive-sounding 'fit note'. But in reality this represented much more than just a simple name change.

Gone now are the old Med 3 and Med 5 forms to sign off patients from work, replaced by a single revised Med 3 Statement of Fitness for Work. GPs consulting with a patient off work for more than seven days must tick a box indicating that the patient is either "not fit for work" or "fit for work taking account of the following advice". And this second option includes more tick boxes judging whether the patient might benefit from a phased return to work and/or altered hours, amended duties or workplace adaptations. The form then invites comments on the "functional effects" of the patient's condition.

Needless to say the introduction of 'fit notes' was not without controversy. Among concerns was that GPs might be drawn into giving opinions beyond their clinical competency. MDDUS adviser Dr Susan Gibson-Smith said at the time: "GPs are not experts in occupational health medicine and we would caution against giving anything other than the most general recommendations for alteration to work place conditions." There were also worries over the added time involved and how effective GPs could really be in getting patients back to work.

But the political will behind the changes was strong given that in the UK an estimated 300,000 people each year fall out of work and into the benefits systems because of health-related issues. Sickness absence is estimated to cost the UK economy £15 billion each year. The Government believes that GPs are well-placed to help deal with the problem.

"GPs will be able to refer complex cases of sickness absence in the same way as they can seek specialist health advice"

So how effective are fit notes? In a survey conducted in 2011 on behalf of the Department for Work and Pensions (DWP), 61 per cent of GPs agreed that fit notes had improved the quality of their discussions with patients about return to work and 70 per cent agreed that fit notes helped their patients make a phased return to work.

But the GPs surveyed also expressed frustration when it came to dealing with more difficult cases, particularly involving mental health issues. Only around 20 per cent of GPs agreed that there were good services locally to which they could refer their patients for either advice or support in returning to work, with 17 per cent uncertain if any such services were available locally. Deficiencies in training were also uncovered with 89 per cent of GPs reporting that they had not received training in health and work within the past 12 months.

In 2011, Dame Carol Black and David Frost CBE were commissioned to take a critical look at sickness absence in Great Britain and in January of this year the Government published its response to the report: *Health at Work – an independent review of sickness absence*. Among major recommendations made in the report and accepted by the Government is the creation of a health and work assessment and advisory service to deliver a state-funded assessment by occupational health professionals for employees after four weeks on sick leave. This should relieve pressure on GPs in more long-term problematic cases requiring greater expertise in occupational health.

The Government has also agreed to revise existing DWP fit note guidance for GPs and doctors to ensure that judgments about fitness to work move away from job-specific assessments. This in part arose out of concerns that GPs were being expected to provide advice on a patient's suitability to perform specific tasks at work. The response paper states: "We do not expect GPs to be workplace experts – employers and employees are best placed to make decisions about how the advice in the fit note could translate into changes to their specific jobs and workplaces."

It is also recognised that GPs need more support to improve knowledge and awareness of the benefits system including information about Work Capability Assessments (WCAs). The DWP has already produced a guide to the benefits system for GPs and this will be further updated to coincide with current welfare reform. In addition the RCGP offers a half-day workshop developed in partnership with the DWP and designed to increase the knowledge, skills and confidence of GPs in dealing with clinical issues relating to work and health and ensure GPs are aware of their responsibilities in regard to fitness to work. There are also online resources for GPs (**www.healthyworkinguk.co.uk**).

The Government response to the Black report has been by and large welcomed. Dame Carol Black commented: "Far too many people with potentially manageable conditions - like stress or back pain - are effectively being signed off work for life, sliding from a short spell of sickness absence to a life of long-term benefit dependency. The changes being made by the government today will begin to change that."

Leicestershire GP and occupational health expert Dr Rob Hampton is also supportive of the move as he said on the *GPonline* website: "At last GPs will be able to refer complex cases of sickness absence in the same way as they can seek specialist healthcare advice for their patients."

Jim Killgore is publications editor at MDDUS

A SENSE OF *URGENCY*

GPs are increasingly choosing to venture into the fast-paced world of emergency medicine

VISITORS to UK emergency departments in recent years might be surprised to discover general practitioners at work amongst the team of specialist hospital doctors and nurses. But as the focus shifts away from distinct primary and secondary care provision, and as health boards and primary care trusts (or CCGs) look for new ways to improve patient care while also saving money and reducing A&E admissions, GPs are playing an increasingly important role.

Opportunities in this field are varied and GPs with a special interest (GPwSIs) in urgent and emergency care can choose to work one or more sessions a week in a variety of settings from hospital A&E or pre-A&E care centres to community locations such as walk-in clinics and the provision of out of hours care.

Entry and training

Many GPs who choose to pursue a special interest do the additional training needed after their GP training, usually while continuing to work part time as a GP. This is still an option for emergency medicine however the training requirements for this specialty can be intense and trainees may find it more manageable to undergo specialist training before they move into GP training.

GPs interested in developing a special interest in emergency medicine (EM) can undertake ACCS (EM) training which is a two year programme (comprising EM, acute medicine, anaesthesia and ITU) which then runs into a third year of EM-specific training targeted at the MCEM examination and would allow trainees to enter an EM ST4 post.

Trainees seeking dual training have the option to stop EM training at the end of ACCS (year two) which would give them a lot of experience and core competences but would only entitle them to work at a junior level in emergency departments (EDs) in the future. By completing the third year and passing the MCEM this would open the door to a more senior middle grade level role.

The competences, training and accreditation required to become a GPwSI in this field are set out in *Guidance and Competences for the Provision of Services Using Practitioners with Special Interests – Urgent and Emergency Care* (**www.tinyurl.com/akdpy42**).

The document highlights the many GPs who are currently providing specialist services or clinical leadership who do not consider themselves to be special interest practitioners. The guidance says it is not intended to undermine these clinicians.

For those who wish to achieve GPwSI status within the formal framework, it advises that training can be acquired in several ways, including both practical and theoretical elements. Examples include experience of working in an ED, a recognised university course (i.e. Diploma in Urgent Care from Middlesex University), self-directed learning with evidence of completed tasks, undertaking a clinical placement or working under direct supervision with a specialist clinician. All GPwSIs in this area must also complete accredited specific consultation and communication skills training relevant to urgent and emergency care.

The British Association for Immediate Care (BASICS) also offers training in pre-hospital emergency medicine for GPs who go on to work alongside the paid emergency services, providing medical support at accidents or while patients are in transit to hospital.

GPwSIs are expected to maintain a personal development portfolio to demonstrate they are maintaining these competences and this would form part of the GP's annual appraisal.

As well as demonstrating sound generalist skills (good communication skills, ability to explain risk and benefits of treatments) GPwSIs in urgent and emergency care will be expected to demonstrate skills in specialist areas including the clinical management of urgent and emergency conditions, provision of urgent care for the elderly, clinical management of children within urgent and emergency care services, and management and leadership.

In practice

GPwSIs in urgent and emergency care provide

an important bridge between primary and secondary care and are often found in the ED either working alongside or within the acute care team. This work is typically carried out for at least one session a week, in combination with their day-to-day general practice duties. Service delivery models vary but a GPwSI may be tasked with attempting to extract patients already booked into the ED in a bid to find alternative treatment or care options. They may see and treat simple problems or attempt to see all walking patients including those who need hospital facilities such as X-ray.

The most successful services tend to be those where strong working relationships are developed with the existing hospital staff and where multi-disciplinary team members share ideas and learn from each other to improve patient care. With this approach it is likely that GPwSIs are fully integrated into the ED, sharing a common reception and operational processes.

Other hospital locations include urgent care centres, pre-A&E urgent care centres, minor illness clinics or A&E clinical assessment units.

GPwSIs in this field can also be found in community settings, manning urgent care centres, minor illness clinics, minor injury units, providing out of hours services, or working with the ambulance service aiming to treat patients in their homes.

Whatever the role, it is clear that GPs pursuing a special interest in this field can look forward to a challenging and exciting career.

Joanne Curran is an associate editor of GPST

Q&A

Dr Ewen Mcleod, full-time GP working part-time in Aberdeen Royal Infirmary.

He is vice chair of independent charity the British Association for Immediate Care (BASICS) Scotland.

- **What attracted you to a career in urgent and emergency care?**
  I decided to get involved in emergency medicine following my personal experience of an enjoyable and worthwhile training experience as a GP VTS (vocational training scheme) in Aberdeen, particularly in the emergency department (ED) of Aberdeen Royal Infirmary. This was followed by a further two years post-GP VTS both in the paediatric ED and adult ED. I made the move from an ATLS (advanced trauma life support) viewpoint to BASICS pre-hospital care under the guidance of the present medical director of BASICS Scotland, Dr Colville Laird. This was prior to taking up the post of rural GP 44 miles from Aberdeen.

- **What do you enjoy most about the job?**
  I most enjoy sharing my primary care experience and management with ED colleagues, including emergency nurse practitioners. As well as being BASICS Scotland vice chair, I am also the Scottish Ambulance Service lead and one of the medical consultants for the Sandpiper Trust who support the provision of pre-hospital equipment to doctors and nurses via BASICS Scotland. This equipment mainly takes the form of the Sandpiper bag which was designed to be a standardised portable and effective immediate care medical kit for doctors and nurses in remote parts of Scotland.

- **Are there any downsides?**
  The only downside is the distance I have to travel to reach my local ED.

- **What do you find most challenging?**
  The most challenging aspect is keeping abreast of departmental and specialist services policies and procedures as I only work one session per week.

- **What about the role has most surprised you?**
  I have been most surprised with the expression on the faces of both my primary care patients and ED patients when I admit to working in both areas.

- **What is your most memorable experience so far?**
  My most memorable experience was escorting an attempted hanging patient from my community with my local paramedic crew to my ED and being able to assist with his ED management through to admission to a secondary care bed. A journey very few of my GP colleagues can experience.

- **What advice would you give to a trainee GP considering a career in emergency care?**
  I would advise trainees considering a career to complete their GP VTS first and then undertake further time and training within their local ED. Membership of an organisation such as BASICS/ BASICS Scotland brings many resources and contacts vital to a healthy experience of both ED and pre-hospital care.

SNOW PATROL: GP Dr Mike Langran (left) works with CairnGorm Mountain ski patrol providing emergency medical assistance to injured skiers. Right: Around 70,000 skiers visit the mountain each year.

ON SKIS, ON CALL

Adam Campbell talks to GP **Mike Langran**, who provides emergency medical cover on the slopes of Scotland's busiest ski resort

WHEN Dr Mike Langran says he's "by no means the world's best skier", logic tells me he is probably hiding his light under a bushel. For one thing, as the volunteer ski patrol doctor at CairnGorm Mountain in the Scottish Highlands, he spends more time on the slopes than most snow sports enthusiasts.

In the winter months, when not in his GP's surgery at the nearby Aviemore Medical Practice, Mike will often swap his white coat for a ski jacket and head up the mountain where he provides medical cover for visitors out and about on the ski resort.

It's a service he's been offering on a volunteer basis for well over a decade, having got involved somewhat by accident in 1999. At the time he was already a partner at the Aviemore practice and had been collecting data on injury patterns from snow sports, a long-term research project in collaboration with the Centre for Rural Health in Inverness that is still ongoing.

"Inevitably I got to meet the ski patrol and I started getting involved in some of the accidents on the mountain when I was skiing myself. And then, in 1999, I sort of formally became the ski patrol doctor and part of the team. I've been with them ever since."

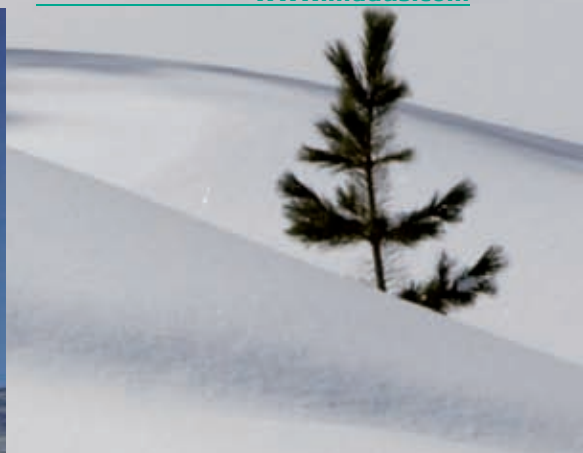
Snow patrol

In general, throughout the season, he will be at the resort most weekends, and one or two days a week at the height of the season. And even when not on the mountain, if the ski patrol needs help, he and his medical partners are always at the end of the line. "Just yesterday I had a call looking for advice on someone who was injured and asking if they were doing the right thing. We have a very good working relationship."

The full-time members of the ski patrol are extremely professional and experienced in terms of stabilising casualties and getting them off the mountain, says Mike. But where his expertise comes into its own is in the more serious emergencies, such as a head injury or a potential spinal injury.

"They don't need me for every injury and every illness, but I have a particular advantage when people are in a lot of pain," he says. "I can give people stronger pain relief that works more quickly."

Among the many challenges of working outside in winter is actually getting to the patient, particularly as the more serious injuries often occur when a skier has left the beaten track. "I've been involved in some rescues in some very hairy situations on the



"I've been involved in rescues in some very hairy situations on the mountain"

mountain where we've been on sheet ice and amongst rocks. But we'll use ropes and anchors and whatever we need to keep safe."

Only the previous week, Mike says, he was part of an attempt to rescue three walkers who had been buried by an avalanche under four metres of snow. "Sadly the outcome wasn't as we had hoped." Although they managed to get them to hospital in Aberdeen, they later died.

Sub-zero emergency care

Administering care in sub-zero temperatures and amid gale-force winds adds further to the challenge: "We are often dealing with casualties in very cold, windy conditions and you can't assess them as you would do in a clinical setting. It's a balancing act between being able to assess them properly while not overexposing them or yourself. So we have to adapt the casualty management accordingly."

One such adaptation involves using 'intranasal diamorphine', where diamorphine solution is dripped into the nose or via an atomiser. All the patient has to do to get reasonably effective pain relief is sniff. "It's particularly good in children, because they are usually frightened and if you come along with a big needle and hurt them you tend to lose their confidence."

Another adaptation is a bluetooth electronic stethoscope, developed by an Inverness company, which can even be placed over clothing. This means that as the person is being transported Mike can still listen to their heart and breath sounds. "It enables me to monitor them without having to constantlystop and lift up their clothing, delaying the transfer."

In addition to the training and resources, much of the effectiveness of the ski patrol's work lies in the teamwork, says Mike. "We're all pals, we all socialise together. That really does help when you find yourself in stressful situations – to be with people you know and whom you trust."

Ski-injury.com

While the ski patrol team is trained and ready for all emergencies, Mike is keen to emphasise that snow sports are a relatively safe pastime with only around three skiers or snowboarders per day for every 1,000 on the slopes, getting an injury of any kind. It is a message he has long been passionate about spreading, and it led him, over a decade ago, to launch a website (**www.ski-injury.com**) on the subject.

"I realised there wasn't very good information for people who were skiing or snowboarding about how to keep safe on the slopes. Also, there were lots of myths out there about how dangerous these sports were and what the risk of injury was, whereas in fact that didn't correlate with the actual data that was being collected. So I decided that was a gap that could be filled."

Over time the site has grown into something of an Aladdin's Cave of statistics and information on all aspects of snow sports safety and research into associated injuries. It is the top site on Google for ski injury searches and, since its inception, has had millions of hits.

As a result, Mike gets plenty of email enquiries, ranging from people who want advice on starting their children skiing and snowboarding, on how to prevent re-injury and on what to do to keep skiing despite the wear and tear of advancing age. "I get emails from GPs and other doctors who have got injured patients, from lawyers who are looking for information and technical advice, and, of course, from journalists."

Indeed, four years ago, Mike felt the full force of the international media after actress Natasha Richardson died at a Canadian ski resort following what seemed an innocuous injury. With his site appearing at the top of Google, his opinions on matters such as the compulsory wearing of helmets (he is against, despite wearing one himself) were furiously sought. "I had enquiries from all over the world. It was quite surreal for a couple of days."

Research opportunities

Mike's profile in the area of ski safety doesn't stop at the website or with media enquiries. He is also UK national secretary for the International Society for Skiing Traumatology and Winter Sports Medicine (SITEMSH) and was elected president of the International Society for Skiing Safety (ISSS) in 2011. Both organisations hold regular international conferences bringing together leading experts in the fields.

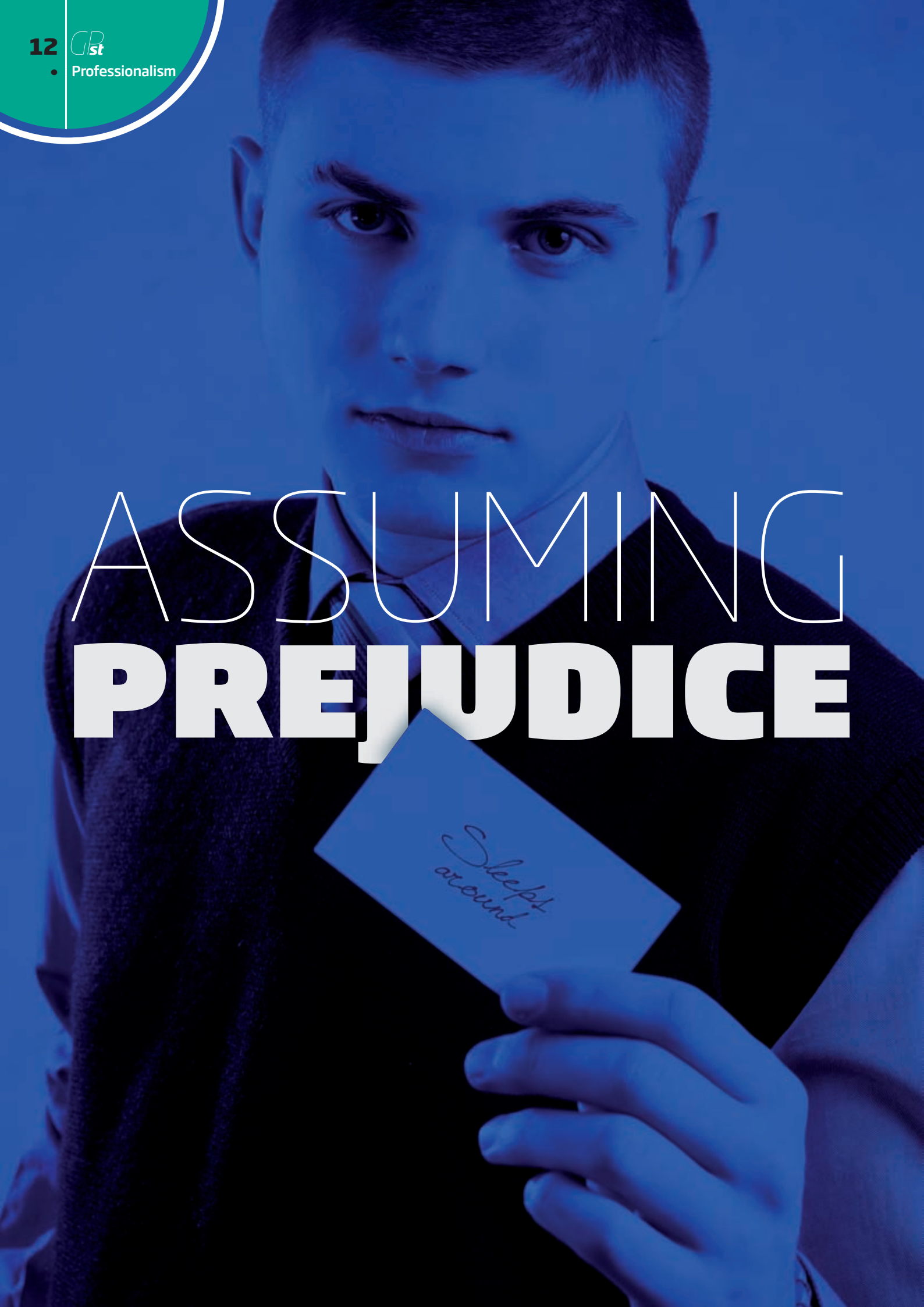
"My particular interest is in epidemiology, what's happening on the slopes, but others of my colleagues are interested in equipment design, binding function, the design of slopes and the design of jumps."

As ISSS president, Mike is also keen to facilitate access to the field of ski medicine for medical students and junior doctors. To that end the ISSS has put together a package of support for young researchers who want to come and present at their conferences. They are also setting up a portal to match young medics with clinics in ski areas that can offer placements for electives or research projects. "Hopefully, that's something we'll be able to offer next season," he says.

Through the ISSS and SITEMSH, Mike has managed to combine his love of medicine and snow sports into an international role, but his day-to-day contribution in this respect remains very much on the ground in the Highlands, whether it is in his practice in Aviemore or out providing care on the mountain at what he fondly refers to as his "branch surgery".

"It's all about keeping people skiing and snowboarding," he says. "When you like these sports there's nothing worse than seeing someone injured, who can't do what you enjoy yourself."

Adam Campbell is a freelance journalist and regular contributor to MDDUS publications



ASSUMING PREJUDICE

Do you make assumptions about your patients' sexuality?

MOST doctors would no doubt like to think they treat all patients equally, regardless of race, gender, beliefs or sexuality. But have you ever stopped to think about the assumptions you make about patients' lifestyles and the impact that might have on the treatment you provide?

One common assumption a doctor can make is in regard to a patient's sexuality. Unless they have been informed otherwise, it is likely a GP will assume their patient is heterosexual and subsequent health advice could be influenced by this.

Recent research carried out in this area found that lesbian, gay and bisexual (LGB) patients are still subject to discrimination and poor care so why not pause for a moment and consider the assumptions you make and the treatment you provide for your patients? Any form of discrimination is wrong and could spark patient complaints that may lead to charges of professional misconduct.

A report on the *Guardian*'s Healthcare Professionals Network in September described the experiences of a lesbian patient in Stockport who said: "The GP at my surgery consistently and frequently assumes I am straight, ending up in embarrassed conversations when they realise their mistake. I feel I am treated abnormally and discriminated against regularly."

Charity Stonewall recently produced its *Gay and Bisexual Men's Health Survey* in which 34 per cent of gay and bisexual men who accessed healthcare services in the previous year reported having a "negative experience" related to their sexuality.

One 24-year-old who responded to the survey said: "My GP assumes I sleep around just because I'm gay", while another says he was given medical advice that "assumed I was HIV positive".

A 40-year-old respondent said: "I came out to my new local GP and when I informed her she physically moved back in her chair", while another described being unable to "be myself" with health professionals, explaining: "If I thought that they were trained and sensitive to lesbian, gay and bisexual issues then perhaps I would be able to. My main concern is coming out and having to talk about my sexual health rather than my real health issues."

One respondent reported overhearing a receptionist say on his arrival at the surgery: "The poof is here for his appointment" and another commented: "There was no visible commitment to equality. I saw lots of posters about services for disabled people and the elderly, but nothing for lesbian, gay and bisexual people."

The *Guardian*'s report highlighted results from the independent *GP Patient Survey 2011* in which almost 10,000 LGB people responded. It found that these patients were almost twice as likely to rate their GP as poor or very poor, when compared to heterosexual people, across a range of measures.

One in 10 lesbian, gay, bisexual and trans individuals have avoided using public services for fear of homophobia, while one in five healthcare professionals have admitted to being homophobic.

Confidentiality is also a big issue for LGB patients. One person who responded to the Stonewall survey said: "My doctors had written on a letter I took to the hospital after breaking my wrist HOMOSEXUAL in big letters for the A&E staff to see. Also, every time I saw a different doctor and they would pull my details up on the computer it would say HOMOSEXUAL in big letters."

Expectations

The General Medical Council makes it clear that doctors "must never discriminate unfairly against patients. Nor must they allow their personal views about their patient's sexual orientation to prejudice their assessment of their clinical needs or delay or restrict their access to care."

The regulator, in conjunction with Stonewall, has produced an information leaflet (**www.tinyurl.com/cbyrlqs**) for this patient group informing them what they should expect from the doctors treating them and what to do if they experience poor care. It highlights elements of *Good Medical Practice* which tells doctors "you must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress." This applies to doctors' personal beliefs about sexual orientation. It adds that it is unlawful under the Equality Act 2010 for doctors to discriminate against LGB patients.

"The specific health needs of LGB patients relate to much more than just their sexual health"

The leaflet goes on to highlight issues raised by Stonewall such as an incident where a doctor refused to offer a smear test to lesbians or another case where the doctor told others a patient is gay when this had nothing to do with their treatment.

A major factor in overcoming discriminatory practice is ensuring healthcare professionals are suitably informed and receive appropriate training in how to treat LGB patients. Consider using inclusive language, referring to "partner" rather than husband/wife. It is equally important not to make assumptions about a patient's lifestyle, while practices and hospitals should ensure they have relevant information posters and leaflets available for LGB patients.

Stonewall also make a number of other recommendations for healthcare professionals. The first is the importance of understanding the specific health needs of LGB patients which relate to much more than just sexual health. Figures show they are more likely to attempt suicide, self-harm, take drugs, experience domestic abuse and have depression than straight peers.

The recommendations also encourage practices and hospitals to have a clear, visible policy that states discrimination will not be tolerated against people due to their sexuality. They also advise healthcare professionals have a clear policy on confidentiality to reassure LGB patients who may be considering disclosing their sexuality. It's recommended also that a sexual orientation field should be made available on all confidential electronic patient record systems.

Doctors are also encouraged to undergo training to better equip them to treat LGB patients. The Stonewall survey found only a quarter of gay and bisexual men said their healthcare professional acknowledged their sexuality after they had come out and only one in eight said they were told their partner was welcome to be present during a consultation.

In February 2011 Manchester-based charity the Lesbian and Gay Foundation launched Pride in Practice (**www.lgf.org.uk/prideinpractice**), a benchmarking tool (backed by the RCGP) that identifies GP surgeries that are fully committed to ensuring LGB patients are treated fairly and able to discuss issues openly with healthcare providers. Surgeries interested in registering are sent a toolkit containing factsheets and other resources outlining how they can make positive changes. Practices then undertake a self-assessment and are awarded a gold, silver or bronze Pride in Practice charter mark plaque, depending on the level of service they provide to LGB patients.

So remember, don't make assumptions or judgements about a patient's sexuality or lifestyle, acknowledge their sexual orientation if they do discuss it with you, always treat them with respect and dignity and make sure you understand the specific health needs of LGB patients.

Joanne Curran is an associate editor of GPST

DIAGNOSIS/MANAGEMENT

AN ITCHY SCALP

DAY 1
Mrs K brings her eight-year-old son Sam into a busy London general practice. The boy is suffering from an itchy circular rash on his cheek and is examined by Dr R. The GP makes a diagnosis of ringworm and prescribes Daktacort cream – an antifungal/anti-inflammatory agent.

DAY 6
Mrs K brings Sam back into the surgery, now with a red and itchy scalp. Sam is seen this time by locum Dr B who examines the boy and records a diagnosis of seborrhea capitis. He prescribes Betnovate – a steroid lotion – to be applied once daily and coal tar shampoo to be used every second day.

DAY 17
Sam comes back into the surgery with his mother complaining that his scalp is even more raw and itchy. He is seen by a different GP – Dr S. The doctor examines Sam and records in the notes "periorbital oedema and itchy scalp ++". The GP also notes flakiness on the scalp which he records as being consistent with a reaction to the previous treatment. He prescribes an antihistamine and Capasal shampoo. He tells Mrs K to bring Sam back if the symptoms do not resolve.

DAY 20
Dr R sees Sam again for an emergency appointment. The boy has developed a scalp abscess which has burst, discharging a considerable amount of pus. Dr R re-examines the scalp and finds it tender/boggy. He prescribes amoxicillin and arranges for a review in two days.

DAY 22
Sam returns to the surgery for review and Dr R sees no improvement in the boy's condition. The GP makes an emergency referral for that same day. Sam is seen by a paediatric dermatologist who makes the diagnosis of a probable kerion – a reaction to ringworm in the scalp. The boy is admitted to hospital and laboratory investigations confirm a fungal infection. He is given both fungal and antibiotic treatment and is in hospital for 10 days.

32 DAYS AND BEYOND
Sam suffers complications during and after his period in hospital including a possible adverse reaction to an antifungal drug. There is significant hair loss in the worst affected areas of the scalp with re-growth of hair in these areas poor. Two years later Sam undergoes plastic surgery with excision of scalp skin in the areas affected by alopecia but there is still patchy hair loss and scarring. The boy is taunted and bullied at primary and secondary school because of his condition and his education suffers due to absenteeism.

THREE years after Sam first presented with his infection a letter is received by the surgery from solicitors acting on behalf of the patient, alleging negligence in the diagnosis and management of his tinea capitis. All three GPs are named in the action.

MDDUS is contacted by the practice. An adviser commissions an expert medical report on the case. Documents including a statement of the allegations, the patient records and written accounts by each GP are examined by a primary care expert.

Commenting on the case the expert first questions why Dr B did not seem to consider the possibility of tinea capitis at the second consultation when Sam presented with an itchy inflamed scalp – especially considering the recent diagnosis of ringworm on the boy's cheek. This error was further compounded by the prescription of Betnovate lotion which contains the potent steroid betamethasone. Such steroids can suppress immunity and are contraindicated in suspected infection.

The expert offers no criticism of Dr S's actions in the third consultation. Seborrheic dermatitis/cradle cap are clinical features compatible with a possible adverse reaction to the earlier treatment and would have made diagnosis of the underlying condition difficult. His prescription of an antihistamine and medicated shampoo is judged reasonable in the circumstances. But another expert commenting on the case disagrees, taking the view that this consultation was a missed opportunity to reassess the diagnosis.

In considering the prescription of an antibiotic and the further two-day delay in making an emergency referral, the expert is supportive of Dr R's action in that pus is usually the result of bacterial rather than fungal infection. Amoxicillin is the standard antibiotic used for such infections. A two-day review to assess the response to therapy suggests an adequate degree of concern.

Given the expert's criticism of Dr B's failure to consider tinea capitis and the later missed opportunity to reassess the diagnosis, MDDUS advisers and lawyers judge that the best course of action is to pursue an early settlement of the case with no admission of liability. The practice agrees.

KEY POINTS

- Keep clear notes justifying diagnoses/ treatment plans.
- Diagnoses and management plans can and should always be questioned.

Diary

It's been a tough winter for GPs so what better way to welcome the Spring than with another fun-packed Diary and tales of vomit and fungal toenails? Oh...

● CAUGHT IN THE CROSSFIRE If you're tired of being puked on by norovirus-afflicted patients then spare a thought for scientists at the Health and Safety Laboratory in Derbyshire. They have spent weeks in the company of Larry the "humanoid vomiting system" watching him be sick continuously. Loaded up with "vomitus substitute", the projectile vomiting robot is helping researchers determine how far infections can reach in a bid to learn how to stop the spread of the norovirus. His vomit is fluorescent which means even the smallest patches of sick can be traced as they are launched across the room. It takes fewer than 20 virus particles to infect someone with norovirus and the number of cases in the UK of late has risen sharply. Now pass the disinfectant...

● EAT YOUR HEART OUT CAKE SHOP Recently the Pathology Museum at St Bart's in London held a three-day exhibition/event that featured a shop offering pathological specimens rendered in cake. Among the deliciously disgusting items reportedly on sale were red blood cell cupcakes, fungal toenail cookies and polycystic kidney cakes – not to mention an enormous edible skinless head. The event was curated by Emma Thomas, a freelance artist working in the "medium of cake". Over 20 cakemakers including students and academics contributed designs to help raise awareness of disease. Thomas' next project is an edible autopsy which she plans to slice up and serve to a select audience. Count me out.

● WHAT'S APP? A cautionary tale for tech lovers comes from US researchers who published a report in *JAMA Dermatology*. They found three quarters of smartphone applications designed to assess the likelihood of malignancy in photos of skin lesions wrongly diagnosed at least 30 per cent of melanomas as "unconcerning". It raises fears that unregulated apps could falsely reassure patients that they don't need to seek medical advice, leading to delays in diagnosis. They tested four apps and found an enormous variation in performance with sensitivity ranging from 6.8 per cent to 98.1 per cent. Not surprisingly, the best app was one that submitted images to a qualified dermatologist while the poorest used an algorithm to analyse images.

● THE JOYS OF AGEING Reassuring news indeed for any patients with age-related complaints. According to an article in the *Daily Mail*, there are many reasons to be cheerful about getting older. Apparently, after the age of 50 we tend to be less affected by seasonal allergies like hayfever, we have fewer migraines, we are less sweaty (thanks to shrinking sweat glands), we are more competitive and we even have better sex. Add that to fewer colds, less sensitive teeth, increased happiness and better stamina and middle age is starting to sound positively appealing. Just don't mention creaky joints, bad backs and the menopause...

● LET THEM EAT NUTS AND BERRIES Diary recently paid a visit to the Edinburgh Royal Infirmary and was much impressed by the large pick 'n' mix stand given pride of place in the central lobby newsagent. One can only imagine Professor Terence Stephenson of The Academy of Medical Royal Colleges bursting in like Jesus in the temple, brandishing *Measuring up: the medical profession's prescription for the nation's obesity crisis*. "You are just consuming neat sugar. Your body didn't evolve to handle this kind of thing," he might shout, as quoted recently in the *Guardian* newspaper. No doubt on our next visit it will be a selection of dried figs and blanched almonds.

● PULL THE PLUG On paper the Summary Care Record sounds like a no-brainer – a system by which a doctor can access NHS records, anywhere, anytime, no matter how famous the patient (though with an audit trail). To date some 23 million SCRs have been created for patients in England. Impressive numbers justifying the astronomical investment until you consider a recent statement by Dr Paul Cundy, chair of the GPC's information technology subcommittee. Dr Cundy calculates that given the current low utilisation rate, each viewing to date has effectively cost an estimated £1,200. He commented: "The system is an absolute disgrace and the plug should be pulled out on it as soon as possible". Diary is unqualified to comment.

● YOU ARE WHAT YOU WEE Hanging about toilets in central London sounds like a dubious way of spending a research grant. Not so when the resulting study gets published in the *Quarterly Journal of Medicine*. Anonymous urine samples where collected from stand-alone, four person portable urinals across the city centre in order to study the use of "novel psychoactive substances". Seven established recreational drugs were detected in 11 urinals including cocaine, cannabis and methamphetamine but the researchers also detected drugs currently uncontrolled in the UK including methylhexaneamine, and methiopropamine. The "legal high" hordenine was found in all 12 urinals and metabolites of the anabolic steroid nandrolone were found in two. Several interesting conclusions are offered in the article abstract though sadly nothing on the crucial question: what is the connection between drug use and portable toilets?

● BEAM ME UP, DOC The pesky process of diagnosis could be simplified thanks to the development of a Star Trek-style tricorder X-ray device. An engineering team at the University of Missouri has invented a compact source of X-rays and other forms of radiation the size of a stick of chewing gum. They predict a prototype hand-held X-ray scanner could emerge in a few years' time that "could improve medical services in remote and impoverished regions and reduce healthcare expenses everywhere."

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