GPst

ISSUE 07

FOCUS ON HEADACHE

SPECIALIST CLINICS STAFFED BY GPwSIs OFFER HOPE TO NEGLECTED SUFFERERS

ALSO INSIDE

AN MDDUS PUBLICATION

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Welcome to your GPst

REFLECTING on my time as a GP trainee I was always unsure about whether my referrals to secondary care were appropriate. This caused me endless worry at times with multiple discussions with my GP tutor. On **page 4**, I address the increasing scrutiny of referrals made by GPs and how to help ensure you refer safely and without worry.

There is a lot to learn during GP training. Two key elements of the MRCGP exam are learning logs and personal development plans, and on **page 5,** GP and author Dr Milan Mehta offers some tips to make the most of these tools. Another element in your professional development is revalidation, a process that all doctors must engage with. Find out more about what is expected of you on **page 6**.

Rural GP Chris Duckham divides his time between treating patients in the far north of Scotland and serving up inventive dishes in his restaurant. On **page 10** he tells Adam Campbell about foraging for bog myrtle and caring for an ageing population.

The RCGP's new chair Dr Maureen Baker knows how important strong leadership skills are for the next generation of UK GPs. On **page 7** she talks about what makes a good leader and offers her views on the future of general practice.

Headache is a key area of special interest for general practice. On **page 8**, Dr David Kernick talks about his work as a GPwSI in headache and the career opportunities available.

End of life care can be a challenging area for GPs and on **page 12** Dr Niall Cameron considers some key ethical arguments in the debate over assisted suicide.

• **Dr Peter Livingstone**
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PHOTOS: PAUL GRAHAM

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MISSED OR DELAYED DIAGNOSES MOST COMMON IN MALPRACTICE

MISSED or delayed diagnoses account for a significant percentage of malpractice claims in primary care according to a systematic review of studies conducted across five countries and published recently in *BMJ Open*.

Researchers in Dublin reviewed 34 studies of malpractice claims in primary care identified in a systematic literature search, including 15 based in the USA, nine in the UK, seven in Australia, one in Canada and two in France. The researchers found that the commonest "medical misadventure" resulting in claims was failure or delay in diagnosis, accounting for 26-63 per cent of all claims across the included studies. These included missed or delayed diagnoses for cancer and myocardial infarction in adults and meningitis in children.

The second commonest domain was medication error, representing 5.6-20 per cent of claims across the included studies. Errors involving antibiotics, anticoagulants, antidepressants, antipsychotics and steroid preparations were most frequent.

The authors state that the prevalence of malpractice claims in primary care varied across countries.

"In the USA and Australia when compared with other clinical disciplines, general practice ranked in the top five specialties accounting for the most claims, representing 7.6-20 per cent of all claims. However, the majority of claims were successfully defended."

HALF OF GP TRAINEES WORK BEYOND COMPETENCE

A GMC survey has revealed that 50.4 per cent of GP trainees have felt forced to cope with clinical problems beyond their competence or experience at some stage in their current post, and of these one in five reported this occurred at least monthly.

The findings emerged in the GMC's recently published *National Annual Survey 2013* which asked 54,000 trainee doctors in the UK for their views on the quality of their training. This year the survey had its highest response rate since it began in 2006, with 97.7 per cent of doctors in training responding.

Among other findings, 34.3 per cent of GP trainees rated the intensity of their workload as 'heavy' or 'very heavy'. Over one in ten (13.8 per cent) reported that they worked beyond their contracted hours on a daily basis; 29.6 per cent said this happened at least weekly.

GP trainees reported the highest satisfaction ratings out of all the those surveyed with 87.9 per cent describing their training as 'excellent' or 'good', compared with 80.8 per cent across all specialties. Surgical trainees had the lowest satisfaction ratings at 77.1 per cent.

Source: GPonline.com

GP COMMUNICATION KEY TO PATIENT SATISFACTION

GOOD communication is the most important factor for patients in overall satisfaction with their GP, according to a recent survey.

The findings of the English General Practice Patient Survey contrast with the primary care priorities set by the government which focus on measures of access such as the ability to book appointments in advance and continuity of care.

Almost 2,170,000 people registered with more than 8,300 primary care practices responded to the 2009/2010 patient survey. Researchers from the University of Cambridge analysed the data and published their results in *Health Expectations* journal. They reported their findings on a scale of 0 to 1 and good doctor-patient communication showed the strongest relationship with overall satisfaction at 0.48, followed by helpfulness of reception staff at 0.22. Quick appointments scored 0.11, phone access 0.09 and advance booking was last at 0.06.

The paper states: "Despite being a policy priority for government, measures of access, including the ability to obtain appointments, were poorly related to overall satisfaction." It also highlights the importance of communication skills education, adding: "Teaching new doctors how to communicate well with their patients is one part of improving physician communication. At least as important may be identifying existing doctors with poor communication skills and developing effective means to improve them."

NEARLY HALF OF GPs RISK BURNOUT

A RECENT survey carried out by *Pulse* has revealed that 43 per cent of GPs are at a high risk of suffering burnout.

Over 1,700 GPs were assessed using the Maslach Burnout Inventory tool which was adapted with input from the Royal College of General Practitioners. It contained questions assessing three key areas signalling a high risk of burnout – emotional exhaustion, depersonalisation and a low level of personal accomplishment.

The survey found that 43 per cent of GPs showed a high risk in all three areas and 99 per cent in at least one. Of particular concern was the finding that 97 per cent of GPs do not believe they are "positively influencing other people's lives or accomplishing much in their role".

Doctors who suffer from burnout should seek help before patient safety is compromised, says MDDUS medical adviser Dr Barry Parker.

"While doctors are caring for patients, they can sometimes neglect to care for themselves," says Dr Parker.

"Speaking to a colleague or their own GP about these issues should not be seen as a sign of weakness. More and more doctors are suffering from stress or health problems as workload increases. Doctors who are concerned about a colleague's wellbeing are advised to be sensitive and encourage them to seek help."

'VIRTUAL CLINICS' PART OF FUTURE VISION FOR GPs

GPs WILL soon be running virtual clinics and routinely consulting with patients online, according to the RCGP's vision of general practice in 2022.

Patients will also have electronic access to their medical records, prescriptions and the referral system, and be more involved with shared decision-making about their care. Consultation times will be more flexible while GPs will undergo enhanced training for their role as "expert" generalist physicians.

These are just some of the goals set out in *The 2022 GP – A Vision for General Practice in the Future NHS*, by the RCGP. It outlines the future role of GPs, including the challenges they will face, and sets a number of key priorities for the profession.

The use of technology features heavily in the document with the prediction that consultations using Skype or similar means will become more common and that patients will expect to be able to communicate remotely with their GP, attending virtual clinics and making contact via social media or text message.

The report also says at least 10,000 new GPs will be needed across the UK.

But the RCGP makes clear that its vision can only be achieved with major investment in general practice that will enable GPs "to move from an outdated 20th century model of fragmented primary and secondary, health and social care to a modern and efficient 21st century model of integrated 'person-centred' care, based within local communities."

RCGP chair Dr Clare Gerada said: "If GPs, who do 90 per cent of NHS work for nine per cent of the budget, are not properly funded then much of this new vision will not be achievable."

THE RIGHT TIME TO REFER

GPs are coming under increased scrutiny over referral rates and must balance demands to hit targets with satisfying their own clinical judgement

AS a trainee GP, one of the trickiest judgements to make is deciding when it is appropriate to refer a patient to secondary care.

Is a ready willingness to refer indicative of a sensible, cautious approach or a sign of poor practice? Add to that the nagging concern in the back of your mind about the need to cut costs, not to mention the fear of wasting the time of secondary care teams, and it can be difficult to know how to proceed.

Recent figures from NHS England show that referrals made by GPs to secondary care increased by 4.5 per cent in April and May 2013 compared to the same period last year. Such increases put considerable pressure on commissioning budgets as well as on providers.

It is not surprising therefore that some clinical commissioning groups (CCGs, formerly primary care trusts) have tasked GP practices with analysing referrals to identify the reasons for any increase in those made to secondary care. The incentives attached to such schemes have attracted considerable attention due to concerns that they may, inadvertently, influence a doctor's decision to refer.

Often the assumption is that increases in referral rates are caused directly and solely by GPs changing their behaviour. However, in reality there are a wide variety of factors capable of influencing referral rates. These include:

- Those arising from systems adopted by hospitals in response to national policies such as the 18 weeks from referral to treatment target in Scotland
- Changing trends within primary care, such as the rise in the number of multi-disciplinary consultations and GP consultations rates overall
- The GP's own values, skills and experiences.

Some of my colleagues worry that their increasing numbers of referrals may somehow reflect practice inefficiency or a lack of sound diagnostic judgement.

On reflection of my time as a GP trainee I always worried about possibly wasting a consultant's time by referring needlessly. This was not necessarily the case – and in any event would be difficult to prove one way or the other in the absence of a suitable baseline or even a consensus on what constitutes "appropriate" referrals.

One means by which I judge whether or not a referral is appropriate is to look at long-term clinical outcomes following referral. This is a good way of engaging in reflective learning, taking into account what happened and what other treatment options may have been available to you had you not referred. This can be added to your eportfolio along with specified learning needs and objectives. This is also something that will form part of the appraisal process once you complete GP training.

A 2010 report by the King's Fund, *The quality of GP diagnosis and referral*, looked at study findings on the reasons behind GP referrals. Three kinds of referral were described:

- **appropriate referrals** - in which the focus is wholly on patient benefit
- **load-sharing referrals** - in which the intention is to share responsibility with other professionals as part of a planned management strategy that is hoped to be of some benefit to the patient

- **dumping referrals** - in which the primary aim is to relieve pressure on the GP, with little expectation of patient benefit.

The report detailed a number of characteristics of a "high quality referral". These included:

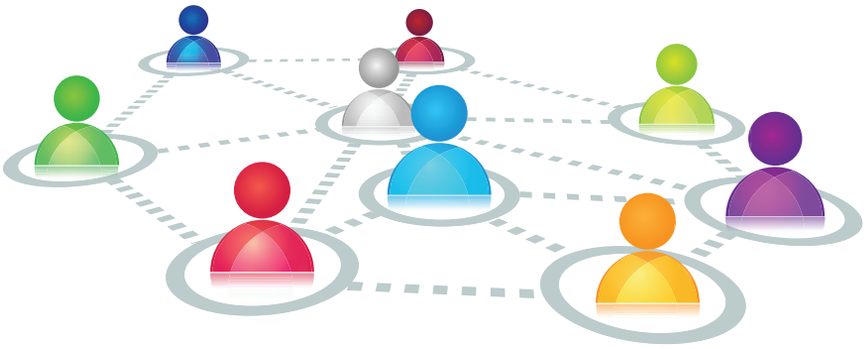
- **Necessity** – are the patients referred as and when necessary?
- **Timeliness** – is this done without delay?
- **Destination** – are patients referred to the most appropriate destination first time?
- **Process** – is the process of referral a high quality one? This means referral letters should contain all the necessary information; the patient should be helped to choose a suitable time and location; and the GP, patient and specialist should have a shared understanding of the purpose/expectations of the referral. Pre-referral management should also be adequate, with specialists stressing the importance of "working up" the patient in primary care.

As a trainee, when I was unsure about whether to refer, or indeed which specialty to refer to (i.e. should it be dermatology or plastic surgery?) I found it helped to liaise with my GP tutor. By looking at the wider picture of the clinical scenario these discussions can also be used as a case-based scenario as required for eportfolio.

In England and Wales other resources that are available if you seek information on what or where to refer include the NICE referral advice guidance (**http://tinyurl.com/2bso72y**) while in Scotland **www.18weeks.scot.nhs.uk** has information on various referral management pathways.

In conclusion, I would say there are no clear-cut rules about when it is appropriate to refer but you should always trust your instinct and if in doubt ask your GP tutor or another senior colleague. They are a mine of information.

Dr Peter Livingstone is a GP and editor of GPST



WORK IN PROGRESS

Milan Mehta offers advice on a key element of the MRCGP exam – learning logs and personal development plans

THERE is a lot of learning to be done during GP training and you will be able to keep track of this by keeping learning logs and personal development plans (PDPs). Technically these form part of the workplace based assessment (WPBA), a topic we covered in the last issue of GPST. However, they are so important that they deserve to be highlighted on their own. More specific requirements for WPBAs can be found on the RCGP website (**www.rcgp.org.uk**).

Learning logs

Your learning will progress during the course of your training, but you need to be able to provide evidence of this to discuss with your supervisor and also with the ARCP (Annual Review of Competence Progression) panel. Therefore, a learning log will be your own personal record of evidence that your learning is progressing.

For each log entry, you can select the option to 'share' which means it will be made available to be read and commented on by your supervisor. Only 'shared' entries will contribute to the evidence that is used by your supervisor and ARCP panels when they come to assess your progress.

Here are some tips to making a successful learning log.

RCGP curriculum headings

Within your entries you must try to cover as much of the curriculum as possible. In your online learning log it can be useful to link entries to a particular curriculum heading where possible. To work smart and save time, try to include entries that cover several curriculum headings.

Evidence of 12 core competences

WPBAs (including learning logs and PDPs) are intended to assess your professional competence in 12 key areas which are derived from the core RCGP curriculum statement *Being a GP*. Your supervisor can only validate your log entries against this list of competences if they feel they are of satisfactory quality. Think early on about which of your competences you still need to collect evidence for and then think of ways you can achieve this. This will save you from including too many entries only focusing on a narrow range of competences, which is a common pitfall.

Reflect, reflect, reflect!

Learning is not just about accumulating lots of facts. It also involves critically thinking about our experiences, describing our feelings and thought processes and also identifying any new learning needs and thinking about how they will be met. A good reflective entry will show that you have good insight into how you are performing and also learning from your daily experiences. Try to demonstrate that you are open, honest and self-aware and describe how each experience makes you feel. See the RCGP website for a typical example of a good entry.

Quantity versus quality

The RCGP website does not state a particular number of entries that are required for a learning log. However, deaneries and local vocational training schemes usually tend to give some guidance on this. But don't get too worked up over numbers of entries; it is much more important to focus on the quality of entries as this is what really demonstrates your learning and competence progression. Make sure you insert log entries as you go along instead of leaving them all until the last minute.

Don't forget your trainer!

They are an invaluable resource and can often help you identify areas of the curriculum and professional competences you still need to provide more evidence for (and also tell you which ones you don't need any more evidence for). They can also make this whole process a lot less scary, and possibly even a fun learning experience for both of you.

Personal development plans

Trainees are required to complete PDPs for a number of reasons. They help you identify and prioritise your learning and check that your actual learning is matching your priorities. They also help you recognise your own strengths and weaknesses (e.g. with multisource feedback) and allow you to build on your current abilities. They will also prepare you for the appraisal process for your lifelong career.

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

Some tips for an effective PDP:

Think SMART!
Specific - make sure your goals are clear and precise.
Measurable - your goals should have a measurable outcome so you know when they have been achieved.
Attainable - goals should be realistic.
Relevant - your learning needs should be relevant to your work environment but also to your long-term career aims.
Time bound - state when you think your goals should be achieved by.

Regular reviews
Start your PDP at the beginning of your training and analyse learning needs with your supervisor ideally every three months but at least at every formal review.

Looking ahead
During your ST3 year with your final PDP, you will soon be making the transition from trainee to independent GP and your PDP should address some issues relevant to this (e.g. employment uncertainty, maintaining your knowledge and skills during gaps in service, etc).

READY FOR REVALIDATION

All doctors – including specialty trainees – must embrace this new system designed to ensure their fitness to practise

REVALIDATION was launched by the General Medical Council in December 2012 and is a process that all doctors who are fully registered with a licence to practise will have to engage with. This includes doctors in specialty training (and those in foundation year 2).

More than 7,500 doctors were revalidated in the first six months, with that tally expected to reach 30,000 by the end of 2013. The majority of the UK's 235,000 licensed doctors should have completed the process by 2016.

Under the system, doctors undergo a continual evaluation of their fitness to practise and will have to provide evidence demonstrating they are up to date. This usually involves one appraisal per year over a five year cycle.

The good news is that for trainee GPs revalidation should be relatively straightforward as their practice is already subject to periodic review.

Designated body

The organisation that will provide you with your regular appraisal and help you with revalidation is known as your designated body. For (fully qualified) GPs who are on a performers list, this is the primary care organisation that manages that list, i.e. NHS England or NHS Health Scotland.

The situation is a little different for doctors in training. In Scotland, your designated body is NHS Education for Scotland while in Wales or Northern Ireland, it is your postgraduate deanery. If you are training in England, your designated body is one of the 13 new Local Education and Training Boards (LETBs) known as, for example, Health Education North West.

It is the responsible officer of this designated body (for trainee GPs, usually the postgraduate dean or NES medical director) who will make a recommendation about you, usually every five years, that you are up to date, fit to practise and should be revalidated.

When?

At the start of 2013, the GMC informed all licensed doctors of their revalidation date. Formal revalidation notices are also sent out four months before a recommendation is due from your responsible officer.

For GP trainees, those with an expected Certificate of Completion of Training (CCT) between April 1, 2013 and March 31, 2018 will revalidate at the point of CCT. Those with a CCT expected after March 31, 2018 (and those trainees who do not currently have an expected CCT date) will revalidate between April 1, 2016 and March 31, 2018. Where necessary, your responsible officer can bring forward your revalidation to align with your expected CCT.

Gathering evidence

Appraisals are based on the General Medical Council's core guidance, *Good Medical Practice*, with more specific requirements detailed in the GMC's appraisal framework.

Fully qualified doctors are expected to maintain a portfolio of supporting information that is drawn from their practice, feedback from patients and colleagues, and participation in continuous professional development (CPD). It should demonstrate how they meet the principles and values of *Good Medical Practice*. Doctors will have to collect some of that information themselves and the rest will come from their designated body.

For trainees, your responsible officers will make a revalidation recommendation to the GMC periodically. They will base this on your participation in the Annual Review of Competence Progression (ARCP) process, or its equivalent the Record of In-Training Assessment (RITA).

You should already be engaged in regular discussions with supervisors about your progress and outstanding learning needs, reflecting on your strengths/weaknesses and achievements/difficulties. This will usually also include information on significant events and complaints/compliments.

The GMC has reassured trainees: "As long as you are doing this, there is nothing extra you need to do to be ready for revalidation."

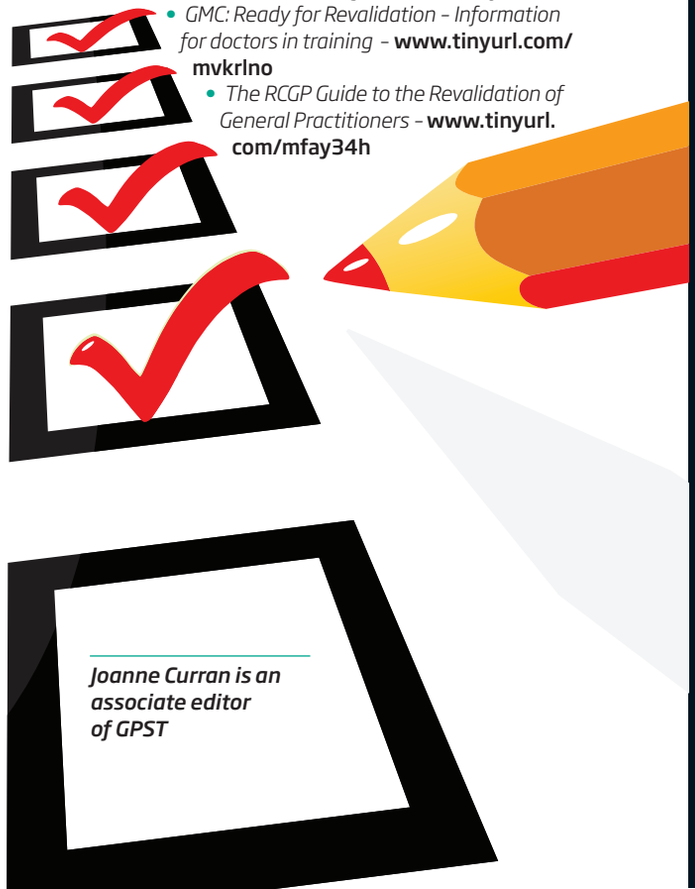
The RCGP Guide to the Revalidation of General Practitioners advises trainees that in order to comply with revalidation: "Full engagement in Workplace-Based Assessment is likely to suffice." It adds that "in most cases GPs will revalidate five years after CCT. If, however, a doctor takes longer than five years to complete training from the point that they are licensed, the Postgraduate Dean would (in most cases) make a recommendation to the GMC prior to the completion of CCT."

The recommendation

A doctor's responsible officer will make a recommendation to the GMC usually every five years (this may vary for trainee GPs), that the doctor is up to date, is fit to practise and should be revalidated. This will be based on appraisals from the previous five years. The GMC will then carry out a series of checks to make sure there are no other concerns relating to the doctor and, if no concerns exist, the doctor will be revalidated. This means they can continue to hold their licence to practise.

Sources:

- *General Medical Council – How revalidation will work* - **www.tinyurl.com/kce7js4**
- *GMC: Ready for Revalidation – Information for doctors in training* – **www.tinyurl.com/mvkrlno**
- *The RCGP Guide to the Revalidation of General Practitioners* – **www.tinyurl.com/mfay34h**



Joanne Curran is an associate editor of GPST

PHOTO: RCGP

Dr Maureen Baker takes over as RCGP chair later this year. She tells *GPST* what makes a good leader and offers her views on the future of general practice

TAKING THE LEAD

WHEN Dr Maureen Baker steps into the role of RCGP chair, she will become one of the UK's most high profile GPs, helping to lead the biggest royal college in the country.

It is no small task to provide a voice for more than 46,000 members, but Dr Baker comes equipped with a wealth of experience. She has been a practising GP for almost 30 years (currently based in Lincoln) and for almost 15 years has held various leadership positions throughout the College.

She served 10 years as RCGP honorary secretary from 1999, is a member of the RCGP Trustee Board and is RCGP lead for emergency planning and preparedness. She played a leading role in preparing for and dealing with the 2009 influenza pandemic. Dr Baker is also clinical director for patient safety at the Health and Social Care Information Centre.

In 2004 she was awarded a CBE for her services to medicine and has had a prolific academic career.

Dr Baker will take over the role of chair from Professor Clare Gerada (in November 2013) at a time of great change for general practice. She has cited rising workload and poor morale amongst the many challenges facing GPs but remains optimistic about the future.

In a column for the Connecting for Health website, Dr Baker underlined the importance of emerging technologies in supporting and enhancing patient care, adding: "Over the next few years, the challenges for GP leadership will be significant. But GPs in general respond well to challenge and we can expect to see a new generation of GP leaders working with patients to make care better for everyone."

There have been numerous reports about the increasing pressure on NHS patient care and lack of resources. What role will GPs play in helping the NHS to meet these challenges now and in the future?

General practice is the foundation stone of the NHS, keeping our health service effective and sustainable. It is essential that general practice is better resourced to meet the increasing demands from rising population, an increased proportion of elderly patients, ever-increasing incidence of multimorbidity and a baby boom.

What new skill sets will trainee GPs require to keep pace with the major changes in UK general practice?

GPs, as the expert medical generalists, need to be able to manage patients with multimorbidity effectively and safely. They need to be able to use, and adapt to, new and emerging technologies and be able to adapt to the changes that the information revolution is bringing about within the consultation.

Should GP trainees undergo more leadership training?

GPs are leaders of practice teams and leaders within their healthcare communities. Effective leadership skills are part of the core skillset of all GPs. Opportunities to develop and enhance leadership skills need to be incorporated into GP training and this is one of a number of reasons why extended and enhanced GP training needs to be accepted and rolled out.

What are the qualities of a "good" GP leader?

I would say it is important for GP leaders to have vision and an ability to listen and adapt. They should also show kindness and a willingness to create and develop a strong patient safety culture.

What do trainees need to know about clinical commissioning?

Firstly, that every clinical decision is de facto a commissioning decision. Secondly, be aware of how commissioning works for and against individual patients and how to engage in the system for maximum patient benefit. Thirdly, how to influence commissioning decisions in the best interests of our patients.

What will be your priorities as RCGP chair?

I will be seeking to shift resources into general practice in order to benefit patients and to ensure the safety and sustainability of the NHS. I will also focus on enhancing the GP workforce, with particular emphasis on addressing health inequalities. Another priority will be reducing the emphasis of managerial, target-driven imperatives in the consultation in favour of a more holistic, patient-centred approach.

When you assume your role as RCGP chair, will you follow Professor Gerada's lead and embrace social media?

I already have - you can find me on Twitter @MaureenZk60

What advice would you give to doctors starting out as GPs?

I think it's important for new GPs to build and develop a patient safety culture to support you in practising safely and effectively and to give professional satisfaction and an enjoyable working environment. Also, to always be kind - to patients, staff and yourself. And, don't forget to enjoy your training and your new career.

Interview by Joanne Curran, associate editor of GPST

FOCUS ON HEADA

GPs with special interest in headache offer hope in a debilitating though often neglected condition

THE ECONOMIC, social and personal burden of headache in the community is substantial. Migraine alone has been found to affect 7.6 per cent of males and 18.3 per cent of females in England. Measures of health-related quality of life in migraine sufferers are similar to patients with other chronic conditions such as arthritis and diabetes, and worse than those with asthma. Other studies have shown that one in three migraine sufferers believe that their problem controls their life and the impact extends to family and friends.

The majority of headache sufferers are reluctant to seek help and when they do the condition is often poorly managed by the GP. Despite the fact that 80 per cent of GP headache consultations are migraine, a large UK primary care database study of new onset headache found that 70 per cent of consultations did not receive a diagnosis at presentation, and of those, only 5 per cent received a diagnosis in the following year.

Headache is often stigmatised and the majority of migraineurs have never consulted their GP despite high levels of disability. Of those who do consult, most only have a single consultation, and for many, pharmacists and opticians are alternative options for advice. The reasons for poor consultation rates are not known but may include a belief that nothing can be done and poor previous experience with headache consultations.

Management of headache services

Up to 30 per cent of neurology referrals are for headache but only a small number of neurologists have a special interest in the area and many referrals are inappropriate for a secondary care setting. There is no difference in impact between neurology headache referrals and patients managed in primary care, but referred patients consult more frequently and have higher levels of headache-related anxiety. Apart from reassurance that no serious pathology is present, inevitably with an inappropriate brain scan (secondary care imaging rates have been shown to be as high as 60 per cent), in many cases the needs of headache sufferers remain unmet.

The British Association for the Study of Headache (BASH) has proposed that intermediate care headache clinics staffed by general practitioners with a special interest (GPwSI) should support GP colleagues who would continue to provide first-line headache care. This development is in line with NHS policy where the hope is that intermediate care will provide more effective and efficient service delivery in local settings. The suitability of this model for headache care has also been recently endorsed by the Royal College of Physicians and the Association of British Neurologists. Local stakeholders can define pathways of care depending on local circumstances and expertise.

Role of the GPwSI in headache

In general, a GPwSI is a practitioner with additional training and experience in a specific clinical area who takes referrals for the assessment/treatment of patients that may otherwise have been referred directly to a secondary care consultant. In the case of headache the GP has had further training in the causes and consequences of headache and is qualified to assess, diagnose and treat with medication or other means and refer for other services. They are also required to maintain and update their skills in headache management.

The specific activities of headache GPwSIs depend much on the local service configuration. They work in a variety of settings from specialist headache clinics in primary care health centres to hospital-based clinics staffed with both neurologists and specially trained headache nurses.

Apart from treating patients the job also includes raising awareness of primary and community practitioners' roles in the prevention, identification and care of headache. It may also involve teaching trainee GPs, qualified GPs and other staff.

Training and accreditation

Career opportunities for GPs with a special interest in headache are very much determined by local frameworks but a guideline for competences in the provision of services is published by the RCGP and Royal Pharmaceutical Society. This states that training can be acquired in different ways but would be expected to include both practical and theoretical elements. These could include:

- Experience (current or previous) of working in relevant departments
- Self-directed learning with evidence of the completion of individual tasks
- Attendance at recognised meetings/lectures/ tutorials on specific relevant topics
- As a trainee or other post under the supervision of a specialist or consultant in headache in the secondary care service

- As part of a vocational training programme
- As a clinical placement agreed locally
- As part of a recognised university course
- Successfully completing a postgraduate course in headache management
- Evidence of working under direct supervision with a specialist clinician in relevant clinical areas.

BASH has also published frameworks for appraisal and training, accreditation and re-accreditation together with management pathways that can be adapted for local circumstances. These can be found on **www.exeterheadacheclinic.org.uk** together with other material to support the commissioning of headache services.

A young GP who would like to develop skills towards becoming a GPwSI in headache is advised to contact a local headache clinic (see the BASH website below for a locator map) and ask about training opportunities and the possibility of sitting in on a clinic. You can also join BASH.

Dr David Kernick is a GP with a special interest in headache at the Exeter Headache Clinic at the St Thomas Health Centre

Some useful sites

- **www.bash.org.uk**
  British Association for the Study of Headache guidelines. BASH has a GPwSI group. (Contact david.kernick@nhs.net)

- **www.exeterheadacheclinic.org.uk**
  Contains support for commissioners, patient information and advice sheets which can be downloaded.

Patient organisations

- **www.migrainetrust.org** Migraine Trust

- **www.migraine.org.uk** Migraine Action Association

Q&A
Dr David Kernick, GP with special interest in headache

How did you become a GP with a special interest in headache?
I drifted into an interest in headache on the back of a research grant. I have to admit that at the time headache was rather "heart sink" to me. The PCT had some money left over at the end of the financial year, I helped one or two of their executives who had a problem with migraine and things seem to evolve from there. These days service development is far more planned!

What opportunities are there for the development of GPwSI headache services?
Invariably headache contains biopsychosocial elements and the GP is well placed to manage this condition. In general, neurologists are not interested in headache and patients referred to secondary care can receive inappropriate investigation and their needs are often not met. Headache is the most common neurological presentation and commissioners will be looking at ways to reduce these referrals. GPs with a special interest can offer better services at reduced costs and also provide educational input for their colleagues who often find headache difficult to manage.

What do you most enjoy about the role?
Although most of what we see is migraine, every case is very different. In many cases you can turn around the lives of people when their problem is having a significant impact upon them and their families. Having 45 minutes to spend with a patient is a real luxury and it makes you realise how much more we could sort out with our own patient's problems if we had more than the pressurised 10 minutes.

What do you find most challenging about the job?
Overlooking a serious secondary pathology is always a cause for concern. Sooner or later a coincidental brain tumour will present. All one can do is to follow established guidelines and have a documented conversation with the patient about the pros and cons of imaging. Our imaging rates are very low and in most cases a scan is unnecessary.

Do you need a background in neurology to develop an interest in this area?
Although a basic knowledge of neurology is important, particularly for excluding secondary pathologies, this is no more than a competent GP would be expected to know. In 95 per cent of headache presentations, the underlying pathophysiology is not known and the focus is on clinical pattern recognition and not the nuances of neuroanatomy. Clinical experience is probably the most important attribute.

DO YOU EAT BOG MYRTLE?

Ten years ago GP Chris Duckham moved to the far north of Scotland and now divides his time between treating patients and serving up inventive dishes in his renowned restaurant

THERE are many reasons why the Côte du Nord restaurant in Kirtomy in the Scottish Highlands stands out from the crowd. It is remote, Kirtomy being a 30-strong hamlet lying 50 miles west of John O'Groats. It is also tiny, seating a mere eight people three nights a week. And it is probably the only restaurant for 100 miles where you will find hand-foraged reindeer moss and wood sorrel garnishing aspects of a 10-course tasting menu, not to mention salted cod balls dusted with finely ground pork crackling and a lobster bisque accompaniment served in a pipette – all rather cleverly, if a little bizarrely, presented atop a large, round stone from the local beach.

What's more, the Côte du Nord's owner/chef, Chris Duckham, is also the local GP. He is based three days a week in a small practice in Tongue, where he looks after 550 patients, and works an additional two days on a locum basis in Thurso, over in the direction of John O'Groats.

So far so unique. But there's more, as the Côte du Nord must surely be one of only a few restaurants in existence where the menu is handed to diners, not at the beginning of the evening but at the end. The GP-cum-chef doesn't have a specific name for his counterintuitive approach to fine dining, but it all makes perfect sense when he explains how it came about.

Element of surprise

"People used to phone up and ask what was on the menu. I'd tell them and they'd say, 'Well you can't eat that,' because I'd told them one of the courses included reindeer moss, which is the edible lichen that grows between the heather," says Chris.

"I was getting completely burnt out, I was seeing 60 patients a day and it was completely nuts"

"So we'd have these bizarre conversations. I'd say, 'Do you eat bog myrtle or primrose flowers?' And people thought I was taking the mickey. So now I don't tell anybody what's on the menu at all. You don't get a menu when you arrive. You get one at the end. It's like a souvenir menu. We explain what the dishes are when we serve them."

These days, when making a booking, people are simply asked what they won't eat, and Chris makes sure that whatever it is doesn't end up on their plate. The result is that, right until the food is set before them, diners know only what they're not going to eat.

It's an unusual approach but it works. "I was worried at first that people wouldn't like it because they would be out of their comfort zone. But most of the people who want to come here are pretty adventurous, so in fact it's been the opposite. It's really popular."

The numbers of diners Chris can accommodate might be small but everything else about his offering is full-size. There are the up to 10 courses, with an option for matching wines. There are broths brewed up in front of customers in an old-fashioned coffee siphon, savoury tuilles flavoured with squid ink and dotted with chicken liver parfait, squid ink mayonnaise, wild herbs and leaves, beef flavoured with heather tea and all manner of fish and shellfish.

Going wild

What he is aiming for in his dishes, he says, is "a taste of the area" that he moved to from Lincolnshire 10 years ago to escape the "hamster wheel" existence he felt he had been living. "Everything on the menu is either sourced locally or wild. We'd never have anything like aubergines or courgettes. The only things that are brought in from afar are the standard things like coffee," he says.

They even churn their own butter and make their own sea salt. "We get a huge pan at the start of the season, the biggest pan we can fit in the kitchen, and bring sea water up from the bay and boil it down. That gives us enough salt to last for a season."

That many of his ingredients are free helps to explain prices that, considering the ingenuity

Chris Duckham on the forage for ingredients

PHOTO: CHRIS DUCKHAM

of the dishes, are remarkably low. "The foraged bits don't cost anything. The broth at the moment is made from mackerel bone stock and we get given mackerel – people go fishing, they get too many mackerel and they throw some at me. We buy the lobsters from a local fisherman and we often get the crabs free, because otherwise they just chuck them back."

Untrained as a chef, Chris got the fine dining bug while helping out in a friend's restaurant many years ago. Unperturbed by an appearance on *Masterchef* in 1992, where he got knocked out in the first televised round, when he and his wife Tina moved up to the Highlands with their two children, they decided to make a go of it.

First they rented a room in the local pub one night a week, but after moving into a former guest house, with a good-sized dining room and kitchen and a separate entrance, they decided to expand their horizons.

Chris handles the sourcing of the food – including foraging for wild herbs, heather sorrel and mushrooms on the hillside, and gathering sea lettuce below the tide line – as well as the prepping and all the cooking. Tina does the rest, from the meeting-and-greeting to the service and the post-prandial bottle-washing.

Work/life balance

Seven years on, the result is plenty of bookings, a slew of effusive five-star reviews on TripAdvisor and an entry in this year's Michelin Red Guide. Naturally, he's extremely pleased with the way things have turned out. "It is busy this year. I'm surprised, given the recession and the fact that some of the holiday cottages aren't as busy as they normally are. But word has got around and folk are beating a path to our door."

Most of their guests come from a distance, either tourists staying in holiday cottages in the area or people who drive up and spend the night in a local B&B. But some locals come too and it is not unknown for Chris's patients to come and experience the other side of his dual career.

It's all quite a change from the life he had in Lincolnshire, where he worked as a GP after studying and training in his home town of Leeds. The move north came about after a frank assessment of his work–life balance. "I was getting completely burnt out," he says. "I was seeing 60 patients a day and it was completely nuts. I never used to see the kids and I felt like one of those hamsters on a wheel and thought, it's time for a change."

The practice in Tongue, where he works on a job-share three days a week, is considerably quieter but the remoteness does bring its own challenges. The nearest hospital is 45 miles away in Thurso, it's three hours in the ambulance to Inverness and the number of support staff is small. "When you're on call, you're it really," he says.

The remoteness has another, indirect effect. Because of the lack of employment opportunities, young people tend to move away. Added to the fact that people often retire to the area, it means the number of elderly patients is very high. "Apart from one other practice, which I think is in Lewis, at Tongue we have the highest percentage of over-75s and over-85s of any other practice in the UK."

As a result, he says, his patients "often have multiple co-morbidities but then thankfully, because we are never that busy at Tongue, you get a bit more time to spend with them".

Running a restaurant no matter how small or how infrequently, takes time and energy and he couldn't manage it if he wasn't able to take half-days on Wednesdays and Fridays. But the employment situation for doctors in this part of the world allows him to do this. "I'm quite lucky like that. For my sessions in Thurso, as I am in effect a locum, I can dictate my terms. So during the season I can say I want to do half-days but come October when the restaurant closes I will do full days again."

It's exactly the kind of breathing space he was looking for when he decided to up sticks and move to the far north, and it has given him the chance to combine the two things he loves, medicine and cooking, into one well-stirred pot.

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END-OF-LIFE OR ENDING LIFE

Can care extend to hastening death? Dr Niall Cameron considers some key ethical arguments in the debate over assisted suicide

A RECENT case heard before the Court of Appeal in London addressed a controversial and ongoing ethical debate in medicine today. Three appellants sought to change the law on assisted suicide in order to allow a relative or doctor to help them end their lives. One had described his life following a catastrophic stroke as undignified, distressing and intolerable and said that he wished to end his life but was unable to do so because of his physical disabilities. The Court rejected their appeal.

In his judgement, the Lord Chief Justice Lord Judge said: "The circumstances in which life may be deliberately ended before it has completed its natural course, and if so in what circumstances, and by whom, raises profoundly sensitive questions about the nature of our society, and its values and standards, on which passionate but contradictory opinions are held."

This case and the furore surrounding the Liverpool Care Pathway have refocused the attention of the media and public on the questions of how patients at the end of life are treated and whether they should be allowed or assisted to end their lives prematurely.

The aim of removing or at the very least minimising the distress that can be experienced by dying patients unites all health professionals. Despite the best efforts of palliative care, this remains an aspiration we are far from achieving and may be unable to achieve for every dying patient. It is not hard to envisage a situation as described above where the quality of life becomes so grim, so desperate, that death appears preferable.

Shared decision-making at the end of life raises many challenges and the associated ethical issues can give rise to some of the most difficult and controversial questions that doctors face. The temptation may be to avoid becoming involved in what can be an emotive and highly charged debate, viewing the issue as too complex, too sensitive and one in which we as individuals lack expertise and confidence. Doctors may prefer to remain neutral, avoid becoming embroiled and allow regulators, politicians and the courts to take the lead.

But it is likely that all of us will have direct experience of patients at the end of life. We will have been involved in decision-making processes and will have encountered the ethical conflicts that can arise. It is this direct involvement and experience that I think permits and, arguably, requires health professionals to contribute to this debate and why the public and politicians look to us to inform the discussion.

Although an article such as this cannot do justice to the full scope of the debate, my intention is to set out some of the key ethical issues that inform the discussion and need to be considered by us all.

My body, my choice

No simple route map can help us navigate through this moral maze but the approach developed by the American bioethicists Beauchamp and Childress remains highly influential. They suggested consideration of four prima facie duties: respect for autonomy, beneficence, non-maleficence and justice.

Active reflection on these principles could offer an approachable, replicable and inclusive analytical framework that could help doctors make reasoned decisions when faced with an ethical dilemma. The attraction of such an approach is clear, but when you attempt to address what might appear to be a relatively unambiguous moral dilemma, it becomes evident that the principles can compete for priority. Given the social environment in which they were developed, it is perhaps not surprising that the individual's right to self determination expressed in the principle of autonomy has emerged as the over-riding principle trumping all others. This principle was articulated by the presiding judge in a landmark 1914 court decision (*Schloendorff v. Society of New York Hospital*):

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body…".

The principle of autonomy generates a number of rights: the right to control personal information (confidentiality), the right to make decisions about medical treatment (informed consent) and the right to refuse treatment even when this seems irrational to others.

Respect for these rights also informs the actions we can reasonably expect of others. It follows that doctors have a duty to respect an autonomous patient's wishes and to maximise their autonomy wherever possible, and should not interfere in any way that restricts the autonomy of an individual. The introduction of advance directives reflected a desire to preserve the right to autonomy even when an individual has lost their ability to be involved in decision making. Most often these directives attempt to anticipate end-of-life issues and specify what treatment the individual will accept and what treatment they would decline.

Respect for autonomy is not only an ethical but a legal requirement and it has been clearly established that treating a competent individual against their wishes or as described in an advance directive constitutes assault.

If the principle of autonomy allows a competent individual to refuse treatment even if the refusal of the treatment is likely to lead to death, it follows that there is a right to be allowed to die (it is now common to ask patients if they wish to be resuscitated). Whilst it can be acknowledged, albeit uneasily, that competent adults are at liberty to commit suicide, does autonomy also confer a right to commit suicide and, to go even further, does it confer a duty on doctors or others to assist when an autonomous individual wishes but is unable to end their own life?

Tony Nicklinson – one of the appellants mentioned above – had sought a change in the law so his wife would not face prosecution for assisting his suicide. His case was unsuccessful; however, he did end his life but only after several days of refusing food and water rather than by being helped to take a fatal overdose. As we have seen, as an autonomous individual he had the right to refuse treatment, and for others to have tried to keep him alive against his wishes would have been illegal. Yet it also would have been, and remains, illegal for his wife to have assisted him as he wished.

It is not surprising that, whilst acknowledging the importance of respecting autonomy, many will have great difficulty in accepting that the same principle that underpins confidentiality and informed consent should inevitably lead to endorsement of a right to assisted suicide.

There is a recognised unease with accepting the over-arching primacy of autonomy and how this has been translated into the culture of individual rights and the duties placed on others as a result. It can be argued that this approach has become associated with a consumerist, libertarian approach to medical care that compromises the autonomy of other individuals and not only trumps the other principles but appears to disregard them completely.

Do no harm

The reality is that we already restrict the autonomy of individuals when it conflicts with other ethical principles; we do not prescribe antibiotics to everyone who requests them nor do we permit smoking in public places.

Supporters of assisted suicide will argue that the principle of non maleficence – first do no harm (primum non nocere) – also supports their case. On initial examination the concept of not doing harm seems intuitively correct, readily acceptable and appears to fit easily and consistently with the other prima facie duties and reflects current examples of best practice.

However, what if there are competing harms? How should we behave when the harm of being kept alive and prolonging dying

Assisted Suicide and the Law

- The 1961 Suicide Act makes it an offence to encourage or assist a suicide in England and Wales. However, in the last few years many UK citizens have travelled to Dignitas in Switzerland to end their lives - no relative or friend who has accompanied them has been prosecuted. In Scotland the situation is more uncertain as there is no specific legislation concerning assisted suicide. In other countries, such as Belgium, Luxembourg and the Netherlands, legislation has been introduced to allow assisted dying.
- In 2010 the Director of Public Prosecutions issued guidance regarding the factors which would be considered when deciding if someone would face prosecution for assisting in a suicide. Although indicating that the individual circumstances of each case would still need to be investigated, these included whether it was a "voluntary, clear, settled and informed" decision and those assisting would have to demonstrate that they had acted out of compassion and with no financial motivation.
- In 2012, MSP Margo MacDonald launched a second bid to change the law on assisted suicide in Scotland. The aim is to make it legal to assist competent adults with a terminal illness to end their lives. Following consultation, the draft proposal received enough support from MSPs to go forward. No timetable for debating the draft legislation has been agreed. Similar bills have been proposed in the UK parliament.

appears to be greater than the harm of death itself? If the means to end suffering is available should we not at the very least permit those who choose to do so, to take this course of action?

Although many may find these arguments persuasive there are several equally eloquent and well-reasoned ethical objections to following the example of Holland and Switzerland. Not least among these is the belief that many members of the public and health professionals hold regarding the sanctity of life. This belief may be a tenet of religious principles or may equally arise from a moral standpoint that, whatever the circumstances, it is always wrong to deliberately kill someone and it is equally wrong to help someone kill themselves no matter how voluntary this decision is. It could be argued that when treatment is withdrawn or withheld, the intention is to let the patient die and it will have the same consequence as actively intervening to end their life – but many would reject the proposal that these actions have the same moral equivalence.

"What if there are competing harms? How should we behave when the harm of being kept alive and prolonging dying appears to be greater than the harm of death itself?"

A slippery slope

Slippery slope arguments are often used in ethical debates. Put simply they suggest that although you may embark on a course of action with clearly expressed limitations to the scope of this intervention, almost inevitably these boundaries will be loosened and the scope of the action will be extended beyond what was originally envisaged. So, if the introduction of assisted suicide is permitted, even if tightly regulated and restricted to a few specific clinical circumstances, before we know it the remit of this intervention will have been extended and ultimately could lead to patients who are helpless, vulnerable and whose care is costly being pressurised or coerced into state-sponsored euthanasia. There are echoes of this argument in the furore over the Liverpool Care Pathway where some commentators portrayed the decision to withdraw active treatment which was considered futile and inappropriate more as a decision based on a desire by the NHS to save resources.

A variant of the slippery slope argument suggests that if patient A has a certain condition and as a result decides to and is permitted to end his life this inevitably devalues and makes less meaningful the existence of patient B who has the same condition but has no desire to end his life. How can Patient B and all others in that situation possibly wish to carry on living in circumstances which Patient A found so intolerable and distressing?

This argument is also reflected in the concern that although some patients may already choose to end their lives because they do not wish to be an emotional or financial burden on their family or the NHS, more will feel increasingly compelled to follow this course of action if assisted suicide is legalised. This could in turn lead to unscrupulous relatives or care providers pressurising or coercing patients into acquiescing to this course of action.

Erosion of trust?

Justifiable concern has also been expressed about the effect the acceptance of physician-assisted suicide would have on how doctors view themselves and are viewed by patients and society. It has been argued that pursuing this particular course of action appears to be counter to both our intuitive and professional standards and would diminish our own perception of our professional value and our ability to intervene and influence other areas. It could also decrease the trust between patients and doctors and destabilise the covenant that allows us to act as advocates for many of the most vulnerable members of society.

This remains a complex and extremely contentious issue where the concept of unintended harm can seem an appropriate argument for both sides of the debate to employ. However, as we have seen with the coverage of the Liverpool Care Pathway, there is a need for a more informed, reasoned and thoughtful discussion that considers all the competing arguments.

Dr Niall Cameron is a GP and associate adviser at NES

Diary

"HOW many goodly creatures are there here! How beauteous mankind is! O brave new world, That has such people in't." So might you describe that waiting room full of patients. Diary asks you but tarry a moment and consider...

● **THERE WILL BE BLOOD** Razors are not usually part of a GP's medical kit, but they are a more familiar sight in India. Recent reports from Delhi show the ancient tradition of bloodletting is thriving. *The Daily Mail* published images of patients undergoing the treatment at an open air clinic. To facilitate blood flow, patients must stand in the heat for half an hour then be wrapped in rope while practitioners make tiny nicks in the skin of the affected area of the body. Bloodletting involves instigating controlled bleeding in an attempt to rid the body of so-called "polluted blood". The technique is said to have been modelled on the process of menstruation. It was discredited in Europe at the end of the 19th century but is enjoying something of a comeback. A study published in the journal *BMC Medicine* in 2012 suggested the treatment could help reduce blood pressure and LDL cholesterol. Although, perhaps statins would be less risky?

● **PET PROTECTION...FROM** It's a far more dangerous world out there than you might imagine for GPs dispatched on home visits. Recent figures show there were almost 60,000 assaults against NHS staff in England in 2011/12 – some of these not by patients but their dogs. New proposals put forward by NHS Protect's Legal Protection Unit would see laws relating to dog attacks in public places extended to cover private premises. This means owners would be held responsible for the behaviour of their pets during home visits by medical staff. Speaking to the *Pulse*, Liverpool GP and chair of Sefton LMC Dr Andrew Mimnagh was just a bit sceptical: "Fingers crossed it might improve things but at the end of the day it's not going to stop you getting bitten if there's a sick patient who needs attention and they cannot control a dog due to their ill health.... Dogs are quite territorial and as usual it's not the dog barking loudly at you at the door you need to worry about but the ones that are waiting quietly inside for you." Maybe the NHS could encourage GPs to adopt an approach familiar to the US gun lobby. Bring a bigger dog!

● **MUCKY MITTS ONLY** one in 20 people wash their hands for long enough to kill germs after using the toilet, according to a US study by Michigan State University. To make things worse, a third don't use soap while 10 per cent don't wash their hands at all. Men were singled out as the worst offenders. Researchers monitored the habits of 3,749 people using public toilets. The findings caused surprise as past research has suggested thorough hand washing occurs at a higher rate. A vigorous hand wash with soap and water for 15 to 20 seconds can effectively kill most infection-causing germs. However, most people washed their hands for an average of just six seconds. Nearly half of all food borne illness outbreaks are said to be caused by a failure to properly wash hands. Now pass the sanitiser...

● **FAME MAY BECKON** Role models for patients may be one thing but would you class yourself as a GP with a "relaxed style who definitely enjoys having a drink or perhaps the odd cigarette"? Someone with "everyman appeal who does not necessarily believe you need to live like a saint to be happy and healthy". If so you could be destined for TV fame. The producers of Channel Four's *Embarrassing Bodies* are looking for GPs or hospital doctors based in the north of England who could be a "counterpoint to many of the groomed, conventional, super toned medical professionals already on television". Or so says assistant producer of Maverick TV Sue Ng. Sadly the deadline might have already passed but CVs – suitably tailored to impress – may still be welcome.

● **OFFICE SUPPLIES** Doctors may some day be buying 3D printers to knock up spare body parts for patients. Scientists at Massachusetts General Hospital have used the gadget, combined with cartilage from sheep, to create an artificial ear. They printed custom models that were then placed under the skin of lab rats. Next, they grew the required number of cartilage cells to fit before the ear was moulded on a flexible wire frame. The synthetic lobe is being prepared for clinical trials in the hope they could be used in transplant operations. It's claimed realistic looking ears could be produced for individual patients on a "rapid timescale".

● **THE SLEEP COUNCIL** Nothing is more embarrassing than nodding off in a practice meeting – especially if you're the newbie. Perhaps you are among the 40 per cent of Britons not getting the recommended six to nine hours of sleep per night. In March, the Sleep Council released its first ever *Great British Bedtime Report* after surveying 5,000 people. The report found that the average Brit goes to bed at 11.15pm and gets just six hours and 35 minutes sleep per night. Almost half of Brits say that stress or worry keeps them awake at night and – not surprisingly these days – high earners (£65 – £75,000) get the best sleep of all. "Sleeping well is as crucial to our health and wellbeing as eating a healthy diet or exercising regularly," says Jessica Alexander of The Sleep Council. "We want to see sleep moved up the political agenda". She has obviously never watched live debate in the House of Lords.

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