GPst

ISSUE 08

WHEN TRUST IS BROKEN

SOMETIMES A SIMPLE APOLOGY IS THE BEST SOLUTION

ALSO INSIDE

AN **MDDUS** PUBLICATION

MDDUS

PHOTOS: PAUL GRAHAM

Welcome to your GPst

MANY of you will be in your final year right now, focusing on passing your exams. But in just six months' time you will have to decide where to take your career next. I chose to work as a GP locum and on **page 4** I look at some of the job's pros and cons.

There has been much publicity of late about alleged racial bias in the MRCGP exam. We take a closer look at the facts of the matter on **page 5**. Training to be a doctor can be challenging enough without being subject to bullying or undermining behaviour. Our article on **page 7** offers some advice for trainees.

Even the best doctors can make mistakes or find themselves in professional difficulties. Sometimes the best approach is a simple apology – but what is the best way to say sorry? MDDUS medical adviser Dr Susan Gibson-Smith offers advice on **page 12**. More serious medical mistakes might prompt patients to pursue court action. MDDUS case assistant Rebecca Rymer looks at what it takes to establish clinical negligence on **page 6**.

Keepie-uppies aren't usually in a GP's skill set – but Dr Jane Simpson isn't like most doctors. She tells *GPST* about her passion for football and medicine in our profile on **page 10**.

There are a growing number of opportunities for GPs to develop a special interest in the field of sexual and reproductive health. Find out more in our career article on **page 8**. And finally, our case study on **page 14** looks at how leg pain in an obese patient progressed to gangrene.

• **Dr Peter Livingstone**
Editor

MDDUS

EDITOR:
Dr Peter Livingstone

ASSOCIATE EDITORS:
Joanne Curran
Jim Killgore

DESIGN:
CMYK Design
www.cmyk-design.co.uk

PRINT:
Creative Print Group
www.creativeprintgroup.co.uk

CORRESPONDENCE:
GPst Editor
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

t: 0845 270 2034
e: jcurran@mddus.com
w: www.mddus.com

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NEW MDDUS RISK BLOG SITE

A NEW website featuring blogs on a range of risk topics has been launched by the Risk Management Team at MDDUS.

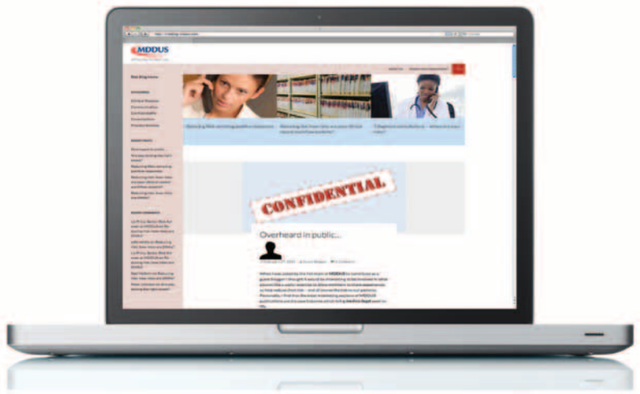
New blogs will be posted on a monthly basis, written by our highly experienced risk advisers. Aimed at doctors, dentists and practice managers, the blogs will be based on real cases and risk analysis of cause of loss in claims across different areas of practice. They are designed to alert members to these risks and allow the sharing of good practice across our membership to improve patient safety.

We will also regularly feature guest bloggers who will highlight current risk areas within their own area of practice.

Recent topics include:

- How risky are your clinical record workflow systems?
- Telephone consultations – where are your risks?
- How risky are DNAs?

Access the full range of blogs at **http://riskblog.mddus.com**



CONSULTATION ASKS IF FEAR OF BEING SUED STIFLES INNOVATION

DOCTORS are being asked if they avoid using pioneering treatments because they are afraid of being sued.

A consultation has been launched by the Department of Health on the proposed new Medical Innovation Bill 2014 which aims to encourage doctors to innovate in medical practice.

Health secretary Jeremy Hunt said: "We want to make sure doctors are not held back if they want to use pioneering treatments to offer a lifeline to dying patients. Innovation has always been at the heart of the NHS and is essential for improving treatments and finding new cures."

The Bill, which applies in England and Wales, seeks to encourage "responsible medical innovation and help prevent irresponsible innovation".

It states: "It is not negligent for a doctor to depart from the existing range of accepted medical treatments for a condition… if the decision to do so is taken responsibly."

A responsible decision is defined as one based on the doctor's opinion that there are "plausible reasons why the proposed treatment might be effective".

Doctors would be expected to make decisions based on a process that is accountable, transparent and allows full consideration by the doctor of all relevant matters, the Bill adds. They should consider the likely consequences of carrying out – or not carrying out – the proposed treatment, and take into account the opinions of both the patient and colleagues.

It clearly states, however, that: "Nothing in this section permits a doctor to provide treatment without consent that is otherwise required by law, or to carry out treatment for the purposes of research or for any purpose other than the patient's best interests."

The consultation runs until April 25 on the DoH website.

DATA PROTECTION AMONG GPs GOOD BUT...

A REPORT on data protection at GP surgeries highlights good overall practice but also failings in some areas including incident reporting and disposal of records.

In 2013/14 the Information Commissioner's Office (ICO) carried out advisory visits to 24 GP surgeries in England and has issued a report on the findings. Most of the surgeries tended to have good data protection policies and awareness of key issues such as data security and patient confidentiality. But the report also highlighted areas needing improvement, including an appreciation of the need to report data breaches.

Improvements were also suggested around faxing and the risks posed by unrestricted internet access. Several surgeries allowed staff to access personal email addresses with the risk of data leakage, hacking and viruses.

BMJ AWARDS SHORTLIST REVEALED

THE nominees for the 2014 BMJ Awards have been announced.

The prestigious awards recognise excellence and innovation in patient care delivered by teams across the UK. Now in their sixth year, they are held in association with MDDUS.

Teams will be judged across 13 categories including the Berwick Patient Safety Team, Clinical Leadership Team, Innovation in Healthcare, and the BMJ Lifetime Achievement Award. MDDUS is also proud to sponsor the Primary Care Team award.

Winners will be announced on May 8 at a gala ceremony in the Park Plaza Hotel, London. Find out more at: **http://thebmjawards.bmj.com/**

FREE PLACES FOR GP TRAINEES AT RCGP CONFERENCE

UP to five free conference places are being offered to GP trainees for the 2014 RCGP conference.

The places will be awarded as prizes in recognition of "original and innovative work undertaken during GP specialty training." The deadline for applications is July 31, 2014.

The RCGP annual conference takes place in Liverpool from 2-4 October with the theme "Futureproof: resilience in practice". There will be discussions on how to develop a strong, resilient general practice for the future that provides the best practice and outcomes for patients.

The deadline for applying for a bursary to attend the conference is July 31, and earlybird discounts are available until June 23.

Find out more at **www.rcgp.org.uk/annualconference**

RCGP MAJORITY OPPOSE ASSISTED DYING

THE Royal College of General Practitioners has reasserted its opposition to any change in the law on assisted dying following a comprehensive consultation of its members.

Seventy seven per cent of the more than 1,700 RCGP members responding to the consultation remain opposed to a change in the law to permit assisted dying. In addition, of the 28 RCGP bodies that took part in the consultation, 20 reported a majority view against a change in the law.

Among the range of arguments against a change in legislation was the contention that it would be detrimental to the doctor-patient relationship and would put the most vulnerable groups in society at risk. Respondents also felt that it would be impossible to implement without eliminating the possibility that patients may be in some way coerced into the decision to die.

There was also the worry that a law in support of assisted dying might shift the focus away from investing in palliative care and treatments for terminal illnesses, and that it might instigate a "slippery slope" whereby it would only be a matter of time before assisted dying was extended to those who could not consent due to reasons of incapacity and severe disability.

In addition, some respondents thought that the possibility of a wrong decision being made was too high to take the risk.

NEW FOCUS ON DOMESTIC VIOLENCE

FRONTLINE staff in all social and healthcare services should be trained to recognise the signs of domestic violence and ask relevant questions to help people disclose such abuse.

The recommendations are included in new NICE guidance. It calls for information to be clearly displayed in waiting areas and other suitable places about the support on offer for those affected by domestic violence. Any enquiries made by frontline staff in regard to potential violence or abuse should be done so in private in a kind, sensitive manner and on a one-to-one basis in an environment where the person feels safe.

The guidance also calls for specific training for health and social care professionals in how to respond to domestic violence and abuse. Victim safety should be prioritised and regularly assessed to determine what type of service someone needs - immediately and in the longer term.

Professor Mike Kelly, Director of the Centre for Public Health at NICE, said: "Domestic violence and abuse are far more common than people think. It can affect anyone - particularly women and children, but also men, regardless of age, geographical location, income, relationship type, family set-up or ethnic origin."

THE LOCUM LIFE

Are you cut out for locum work? GP and *GPST* editor **Peter Livingstone** shares his experiences

IT is the big decision all would-be GPs have to make as the end of their training draws near – what do I want to do next?

My training was coming to a close in August 2011 and I knew I wanted a role that gave me some control over where and when I worked. I took the plunge and embarked on the rather daunting process of becoming a GP locum.

For the first time in my life I faced the real implications of not having a permanent job and was without the reassuring support of a consultant or GP trainer. A steep learning curve lay ahead of me and I was extremely nervous. No lecture or tutorial would prepare me for world of locuming.

Two months before my GP training ended I had successfully passed all my exams so I applied for a place on my local health board's GP performers list. I hadn't updated my CV since I applied for training three years previously and a lot had changed in that time. I asked my GP trainer and practice manager to check my final draft and I would urge you to seek similar advice.

Once my CV was sent out, a steady flow of emails and calls came in asking about my availability to work – a good diary is a must.

Unlike other GPs, locums don't benefit from a fixed group of peers so it is a good idea to join a local locum group. I found mine extremely helpful for sourcing long-term jobs along with regular peer group learning. It's also a good way to meet new people. The group I joined organised teaching and support sessions from the health board, explaining the various computer software packages used by GP surgeries in the area. It's important to familiarise yourself with the different systems in your area as it will make your surgeries run more smoothly.

One of the good things about locuming is the ability to work in a variety of practices, from rural to urban, sometimes even returning to the same practices for regular sessions. But one frustrating element of the job is the lack of continuity of care and patient follow-up that comes with moving from practice to practice. To counter this, whenever I came across anything interesting I took a note of it and either rechecked the notes if I was working back in that practice or emailed the practice manager. They were extremely cooperative and helped me write up case-based discussions or significant events for my annual appraisal.

Here are a few tips for starting out as a locum GP:

- Ask yourself how long you would like to work as a locum: is this simply an interim arrangement allowing you to research different practices you might like to join on a permanent basis or are you considering making a career of this to facilitate an overall portfolio career?
- Allow for a quiet period when first starting out (around two to three months) as it will take time to get yourself known as well as getting yourself and your systems organised without too much other pressure. Perhaps diarise how many sessions per week you will be prepared to work in the initial period. Also be aware that work may not be available consistently throughout the year so plan ahead for the lean times.
- Keep on top of your paperwork and record all jobs done as well as basic recording requirements for tax returns, expenses and pensions. Some of these will require daily attention and some monthly. It might be worth hiring an accountant for more complex jobs like end-of-year tax returns.
- Good medical record keeping is crucial for all doctors but especially for locums due to the lack of continuity of care. When using clinical computer systems, ensure your entries are identifiable. Locums are not always given their own login so it might be necessary to add your name or initials to the notes you have made. It's also important to link in with existing systems for the practice you are working in to ensure matters such as referrals and test follow-ups are completed in your absence. A thorough handover of key tasks when leaving a practice is another important measure. It can be useful to note your planned next step of treatment to allow other doctors to pick up where you have left off.
- Keep up-to-date professionally throughout the year and record learning events you have attended. It will make your life a lot easier when it comes to your annual appraisal.
- Find out more information from the National Association of Sessional GPs – **www.nasgp.org.uk**

On the whole, I have found working as a locum GP to be a positive experience. It offers the freedom to choose, generally, where you want to work and for whom. Given the bureaucracy and scrutiny that affect static GP surgeries, being a locum can be a liberating experience allowing you to practise medicine without much of the administrative angst.

Peter Livingstone is a GP and editor of GPST

IS THE CSA RACIALLY BIASED?

THE facts are not in dispute. Failure rates in the clinical skills assessment (CSA) component of the MRCGP exam are disproportionately higher among black and minority ethnic (BME) medical graduates educated either in the UK or abroad.

Adjusting for age, gender and performance against the objective (machine-marked) applied knowledge test (AKT), BME international graduates are almost 15 times more likely to fail the CSA on their first attempt than white UK graduates. Non-white UK medical graduates are 3.5 times as likely to fail on their first attempt as compared to their white colleagues.

It is in the interpretation of these facts that the controversy lies – and which in April will be the subject of a judicial review brought by the British Association of Physicians of Indian Origin (BAPIO). Both the RCGP and the GMC will be defendants in the High Court – the college facing charges that the CSA is discriminatory against non-white exam candidates and the regulator being questioned over its failure to conduct an equality impact assessment of the requirements for RCGP membership.

The GMC might feel understandably put out having to answer to the court in connection to this dispute (though it publicly accepted the decision) as back in March 2013 it commissioned an independent report aimed at getting to the bottom of the growing controversy. Professor Aneez Esmail of the University of Manchester was appointed to conduct a data review of pass rates for different groups of medical graduates undertaking the MRCGP exam. But rather than provide a definitive answer the review only sparked further controversy.

The GMC published the report in September 2013 announcing that Professor Esmail had found that "while there are significant differences in pass rates between different groups of doctors, the way they are assessed in the CSA is not the cause of those differences". In other words there was no racial bias in the conduct and marking of the CSA.

But on the same day the GMC report appeared, the *BMJ* published a paper based on the same review in which Professor Esmail and co-author Chris Roberts stated: "We cannot exclude subjective bias owing to racial discrimination in the marking of the clinical skills assessment as a reason for these differential outcomes."

They added: "Previous training experience and cultural factors (which include physician-patient relationships, and communication and proficiency in spoken English) could help explain these differences between UK candidates and international medical graduates. However, these cultural factors cannot explain differences between white candidates and BME candidates who have trained in the UK, and who would have had similar training experiences and language proficiency."

Esmail also stated in the *BMJ* paper: "The clinical skills assessment and its marking is based on a well-established pedagogy that is internationally recognised and used widely in postgraduate examinations. However, like any clinical examination, it is subject to bias. We cannot ascertain if the standardised patients (played by actors) behaved differently in front of candidates from non-white ethnic groups. Nor can we confidently exclude bias from the examiners in the way that they assessed non-white candidates."

The RCGP responded with outrage. The then Chair, Professor Clare Gerada, said: "We are shocked and bemused that on the very day that Professor Esmail's official and independent GMC investigation report finds no evidence of discrimination, the same author is publishing a contradictory paper that misleadingly suggests we may be guilty of bias."

BAPIO felt vindicated by the *BMJ* paper and emboldened to press forward with the case on behalf of some of its members whose career ambitions have been thwarted by multiple CSA failures.

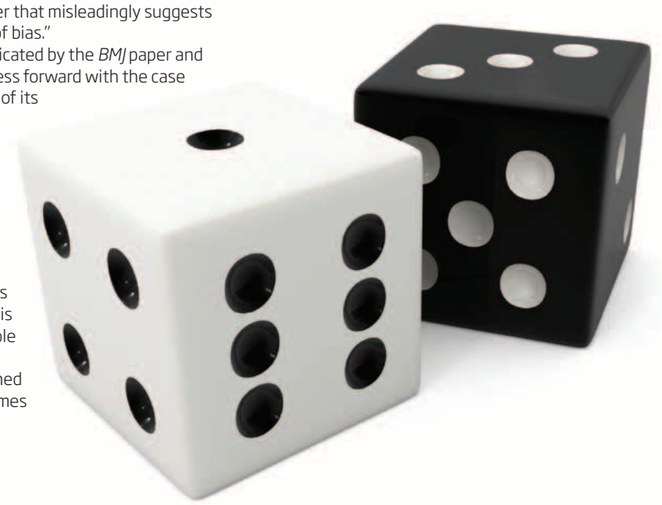
Dr Ramesh Mehta, BAPIO President said: "It is damning that in this day and age the sole reason that UK educated and trained doctors are four times as likely to fail this exam seems to be solely on the basis of their skin colour. A 15-times worse result imposed on international medical graduates, who have passed every assessment set to them before reaching the MRCGP CSA, by using culture and a variety of usual well-rehearsed excuses and platitudes should not wash any more".

The RCGP is not the only college reporting differential pass rates in postgraduate exams. Both the Royal College of Psychiatrists and Royal College of Physicians have published data highlighting an increased failure rate among international medical graduates and British BME doctors. Similar disparities have been documented in Australia and the US. It has also been pointed out that differences in CSA failure rates for all non-UK educated candidates - whether white or BME – were no longer significant after controlling for scores in the AKT, IELTS, and PLAB examinations.

Understanding the barriers to exam success experienced by non-white candidates completing specialist medical training is essential. The issue is certainly not a trivial one for those involved nor for NHS workforce planning. In 2012, non-UK qualifiers accounted for almost a quarter of the GP workforce in the UK.

The judicial review will begin on 8 April and is expected to run for three days.

Jim Killgore is an associate editor of GPST



CLINICAL NEGLIGENCE

When does medical error end up in court? **Rebecca Rymer** explains the legal hurdles in establishing clinical negligence

CLINICAL negligence may seem an obvious concept – especially the way it's bandied about in the media. But when you explore what a clinical negligence case actually involves it is much more complex.

In short, a clinical negligence claim arises when a medical practitioner breaches their duty of care to a patient who in turn suffers an injury as a result of that breach. The existence of a duty of care is a necessary requirement before there can be any consideration of negligence and this duty is surprisingly wide.

Demonstrating that a doctor has breached duty of care is the first major hurdle in any negligence case. Some errors made by GPs are clearly in breach of their duty (i.e. when an incorrect prescription is provided) but it is not always clear cut. Difficulty arises in cases where a GP exercises professional judgment and decides to take one course of action over another, or perhaps decides not to act at all. Certainly within diagnosis and treatment there is scope for genuine differences of opinion and a GP will not necessarily be negligent because a decision taken did not result in the patient's preferred outcome or because another GP would have acted differently.

Bolam test

To demonstrate a breach of duty, the patient must show that a doctor has followed a course of action which is not supported by any reasonable body of medical opinion with the same experience. In a landmark case – *Bolam v Friern Hospital Management Committee (1957)* – a patient had undergone electroconvulsive therapy for his mental illness and the doctor had not administered relaxant drugs, thus causing the patient to suffer a serious fracture. Medical opinion was divided as to whether relaxant drugs should be given in ECT. The court held that the doctor was not negligent and the ruling has become known as the "Bolam test", which states: "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it another way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

The Bolam test has since been modified by the *Bolitho v City and Hackney Health Authority (1997)* case which allows for the court to decide which expert opinion is reasonable. (In Scotland, a similar standard is established by *Hunter v Hanley (1955)*.)

> *"A GP must practise within the confines of their own knowledge and experience"*

In determining breach of duty a doctor is measured against peers rather than some defined (or imagined) level of excellence. If a patient seeks treatment from a GP who makes no claim to any special skill or expertise over and above that, then the patient can only expect that treatment to be provided at a standard considered reasonable and appropriate for an ordinary GP.

However, a GP has the responsibility to ensure they practise within the confines of their own knowledge and experience. Where a doctor fills a more demanding role, a higher standard of care may be applied.

For example, in the case of *Wilsher v Essex Area Health Authority*, an SHO was attending to a premature baby in an intensive care neo-natal unit when he mistakenly inserted a catheter into a vein instead of an artery. He asked a senior registrar to check what he had done but the SR missed the mistake. The court found that the SHO had provided a reasonable standard of care because although he exercised a specialist skill, he was an inexperienced doctor and had appropriately sought the advice and help of his supervisor. The SR was found in breach of his duty for failing to notice the mistake.

Determining causation

Even if a patient can prove that a doctor did not follow a course of action supported by any reasonable body of medical opinion, this is still not sufficient to bring a successful clinical negligence claim. The claimant must also be able to satisfy the test of causation. In other words it must be proved that the negligent treatment resulted in an injury or medical condition, or that a pre-existing injury or condition became worse or the chances of recovery diminished. For example, if a failure to treat a patient made no difference because they would have died in any event, the patient's death cannot be said to have resulted from the doctor's negligence.

However, the patient does not have to prove that the doctor's breach of duty was the sole cause of the injury. It is sufficient for the patient to show that the breach made a material contribution towards the injury.

Conclusion

So, if a patient can prove they were owed a duty of care by their doctor and that duty has been breached leading to an injury then they may be successful in bringing a clinical negligence claim. But thankfully the standard is a rigorous one.

No doctor is immune to mistakes; nor is every mistake grounds for clinical negligence. The law is intended to protect the rights of both patients and doctors.

Rebecca Rymer is a case assistant at MDDUS

UNDERMINING PATIENT SAFETY

Bullying not only creates an unpleasant work environment, it can also threaten patient safety

MEDICAL training is not known for its softly-softly approach when it comes to teaching the vital skills needed to make life-or-death decisions. And while a no-nonsense style may be useful in imparting the vast amount of knowledge doctors need, there is a point at which this can develop into something more sinister and altogether less constructive.

Recent research by the General Medical Council revealed thousands of doctors across the UK have been the victim of bullying or undermining behaviour or have witnessed it in their workplace.

The regulator's 2013 National training survey of over 54,000 doctors in training found more than 13 per cent had been bullied or harassed, almost a fifth (19.5 per cent) had seen someone else being bullied and more than a quarter (26.5 per cent) experienced undermining behaviour from a senior colleague.

These findings support research published in the *BMJ* in July 2013 which suggests bullying remains a "significant but under-reported problem" in the NHS.

The GMC survey found doctors near the start of their training are much more likely to raise concerns than those in the later stages of training – 8.7 per cent in the first year of foundation training (F1) versus 2.8 per cent in year eight of specialty training (ST8). This was also true of GPs at the start of training compared to those near the end of their programmes.

An obvious consequence of bullying is that it creates an unpleasant work environment but, more importantly, MDDUS is aware of instances where it has had a negative impact on patient care and safety.

A key risk area relates to communication between colleagues.

MDDUS medical adviser Dr Barry Parker says: "If there is a breakdown in communication or bad atmosphere between colleagues then it is likely that open communication about patient care will be adversely affected, damaging continuity and the team approach to care that is so important."

In addition, research has shown that being the victim of bullying or undermining behaviour can distract medical team members and draw their attention away from crucial tasks, leading to potentially serious errors. This can pose a particular risk in enclosed areas such as operating theatres.

Doctors who do not feel supported at work might also feel less inclined to report and learn from "near misses" or adverse events. Trainee doctors can be particularly vulnerable in such an environment.

Dr Parker adds: "Aggression or rudeness and bullying behaviour can severely impact on their learning and development. Trainee doctors rely on senior colleagues for support and should feel comfortable seeking their advice. They should also be able to look on their senior colleagues as positive role models.

"If they face criticism and are undermined, then this may have an adverse effect on their confidence and performance. It may also make it more difficult for them to seek advice from a senior colleague when this is needed in order to treat patients safely."

The *BMJ* research article from July 2013 also found that male staff and staff with disabilities reported higher levels of bullying. Bullying and witnessing bullying were found to be "associated with lower levels of psychological health and job satisfaction, and higher levels of intention to leave work."

Bullying behaviour also breaches professional standards guidance set out by the GMC and could lead to complaints about a doctor's fitness to practise.

The *BMJ* research noted that: "Managers were the most common source of bullying." But the GMC's *Good Medical Practice* guidance makes it clear that all doctors "must work collaboratively with colleagues, respecting their skills and contributions. You must treat colleagues fairly and with respect and must be aware of how your behaviour may influence others within and outside the team."

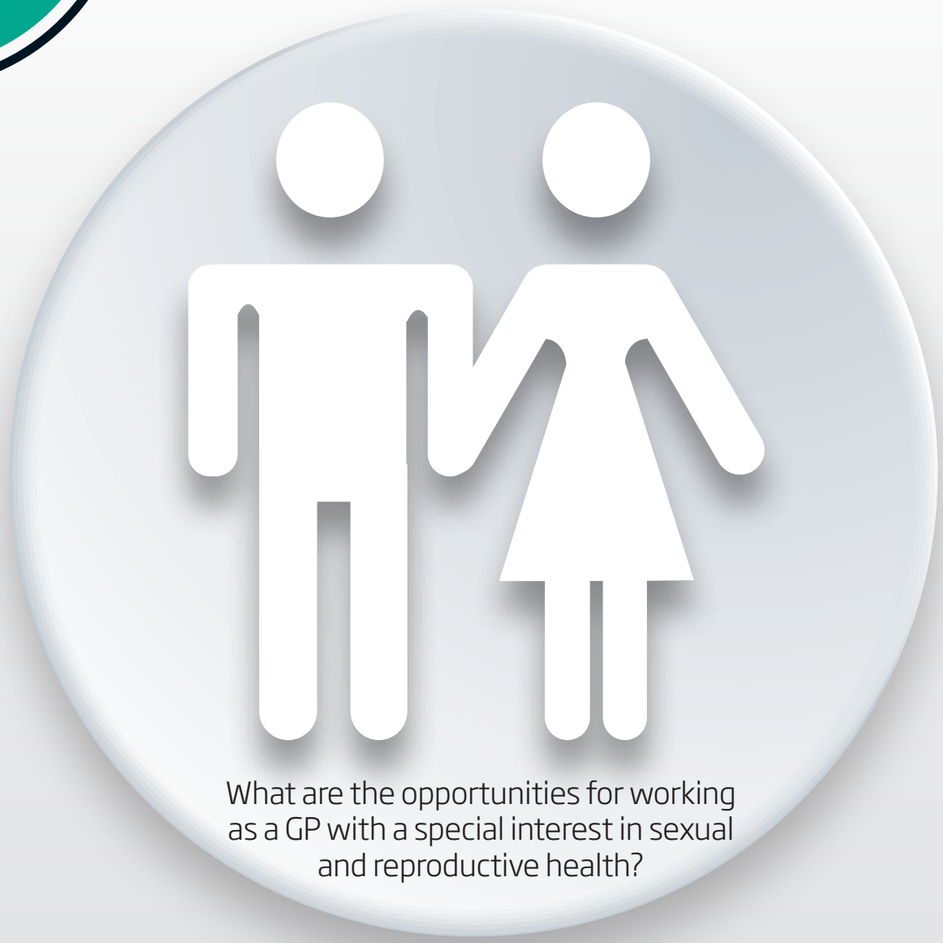
The regulator also warns that: "Undermining or bullying behaviour is in total contradiction with these values – it is more than a simple failure to comply. Serious or persistent failure to follow our guidance puts a doctor's registration at risk."

It is important that doctors with concerns regarding bullying or harassment seek advice before the problem escalates and has a negative impact on their work. In such cases it can be helpful to discuss the matter with a trusted colleague or an MDDUS adviser.

Equally, individuals who are responsible for bullying or harassment are in need of advice and support as this type of behaviour may be symptomatic of issues such as stress or burnout. Those who exhibit such behaviours should be encouraged to seek help or risk a GMC complaint that could have serious consequences for their professional practice.

MDDUS is very experienced in helping healthcare professionals with health problems that impact upon their fitness to practise. Members with concerns about their behaviour are encouraged to discuss the matter with an MDDUS adviser.

Joanne Curran is an associate editor of GPST



What are the opportunities for working as a GP with a special interest in sexual and reproductive health?

LET'S TALK ABOUT SEX...

THE UK has often been cited as having the worst sexual health in Europe. And while recent statistics have shown improvements are being made, there remains a need for GPs with a special interest (GPwSI) in this field.

Official figures paint a mixed picture. A report by the Office for National Statistics in 2013 showed the estimated number of pregnancies amongst under-18s is at its lowest level since records began in 1969. In contrast, the number of pregnancies in women of all ages is at its second highest level.

Meanwhile, last February the Health Protection Agency raised concerns that fewer gay/bisexual men in the UK are using condoms, fuelling a rise in HIV infections in those groups.

Entry and training

Training can be acquired in several ways for GPwSIs in sexual and reproductive health and would include both practical and theoretical elements. Common elements include working under the supervision of a specialist or consultant in sexual health/genito-urinary medicine; self-directed learning; a recognised university course or accredited training. An attachment in a community contraceptive clinic/GUM clinic is also beneficial to enable the practical development of skills in STI management, common contraceptive problems, intra-uterine devices/intra-uterine systems (IUD/IUS) and contraceptive implant fittings under appropriate supervision to acquire sufficient expertise and help with network development.

The RCGP sets out a number of competences for GPwSIs in sexual health (**http://tinyurl.com/krjbkxb**) although practitioners are not expected to have all those listed. These include:

- Screening and health promotion
- Taking a sexual history
- Genital examination
- Advice about safer sex
- Contraception
- HIV
- Sexual assault and female genital mutilation
- Managing children and young people within the sexual health service
- Partner notification
- Referral pathways
- Epidemiology.

As a minimum, it is recommended that the GPwSI takes the Sexually Transmitted Infection Foundation (STIF) course (or equivalent) and completes the associated logbook of competences and/or holds the DFSRH – the Diploma of the Faculty of Sexual and Reproductive Healthcare, with the appropriate letters of competency in sub-dermal implants and intra-uterine techniques.

Some practitioners may wish to obtain the Diploma in GU Med and/or HIV as their learning objectives or membership of the Faculty of Sexual and Reproductive Healthcare. Clinicians wishing to offer IUD/IUS and sub-dermal contraceptive implant services should have completed training and have been deemed competent to provide such services.

It is also recommended to join an appropriate faculty/professional group/primary care sexual health organisation – such as the FSRH – to help further develop knowledge and skills.

The job

The approach to sexual health varies across the UK. In England, responsibility for commissioning most sexual health services now falls to local authorities. The Department of Health published its *Framework for Sexual Health Improvement in England* last year which highlighted the need to reduce unintended pregnancies and sexually transmitted infections and to improve the outcomes of people with HIV by ensuring early diagnosis. It also seeks to tackle prejudices and to protect children from abuse.

The Scottish Government launched its latest sexual health framework in 2011, setting out a four-year plan to reduce blood borne viruses, STIs and unintended pregnancies. It also seeks to encourage more positive attitudes towards sexual health and to reduce inequalities.

GPwSIs might find themselves working in a variety of settings, whether in their own practice, a community hospital, as part of non-statutory agencies (i.e. NHS walk-in centres, health promotion units, units within an NHS trust) or other primary care setting.

Typical clinical services provided by a GPwSI might include:

- Provision of all forms of contraception including LARC (long acting reversible contraceptive) methods
- Managing contraceptive problems and providing contraception for women with medical problems
- Assessment of, and screening for, STIs and blood borne viruses
- Involvement in proactive STI control, i.e. disease screening
- Reducing sexual health inequalities by ensuring services are available for at-risk and vulnerable groups
- The delivery of psychosexual care
- Offering tests and treatment for STIs in men and women, as well as groups with special needs such as young people and injecting drug users
- Training others in the competencies required for providing LARC, complicated contraception and provision of sexual health services providing support for local practices in contraception and sexual health.

With the advent of GP commissioning, there may be increased opportunities for GPwSIs in England to forge a career solely in sexual and reproductive health, bidding for contracts in provision of specialised contraception or similar services.

Useful links:

- Faculty of Sexual and Reproductive Healthcare **www.fsrh.org.uk**
- Medical Foundation for Aids and Sexual Health (MedFASH) - **http://www.medfash.org.uk**
- British Association of Sexual Health and HIV **www.bashh.org**
- HIV Pharmacy Association **http://www.hivpa.org**

Q&A

Jenny Brotherston, GPwSI Sexual Health and Women's Service, Hull

What attracted you to a career as a GPwSI in sexual and reproductive health?
I have always been interested in both sexual health and women's health. I had considered a career in gynaecology but I wanted to start a family before I was 30 and at that time the GP career route was better suited to part-time completion than hospital training.

During my GP training I achieved DFFP (now DFSRH) and DRCOG and worked in evening family planning clinics as a community medical officer. Once I qualified, I also took on the role of clinical assistant in menopause at Hull Royal Infirmary and then staff grade doctor in a GUM clinic. I became accredited as a GPwSI sexual health in 2004.

What do you enjoy most about the job?
Being a GPwSI means that I can offer a truly holistic service to my patients. No other model of clinic can, for example, offer a woman concerned about a breast lump, who has vasomotor symptoms and a recent change of partner, a breast examination alongside an STI screen and menopause management all at the same appointment.

I also enjoy being able to spend a bit more time with patients, who are often grateful that someone has finally listened and explained things to them in greater depth.

Are there any downsides?
The seeming dichotomy of a generalist becoming a specialist has sometimes left GPwSIs unsure of their position among consultant colleagues. As time goes by, however, and especially now that the FSRH and the RCGP are working so closely together, I feel the role of the GPwSI is becoming more established in the world of sexual health.

What do you find most challenging?
The uncertainty of the perpetual change in management structure. Since becoming accredited, my employing organisation has changed twice and, with the new NHS structure, we have to re-tender our own service at the end of this year.

What about the role has most surprised you?
Three GP colleagues and I set up the GP specialist sexual health and women's service in an area of high deprivation, teenage pregnancy and chlamydia rates, with few female GPs. We offer contraception, GUM, community gynaecology and menopause care all at one appointment. The surprise is that I've been successful in developing an enduring service that survives all the changes that happen around it. I didn't know I had this entrepreneurial side.

What is your most memorable experience so far?
Teaching has always been an important and rewarding part of my role as a GPwSI. Following a conference that I organised and presented at last July, I was sent a draft dissertation a local GP had written for a postgraduate medical education certificate. He had chosen to use the example of my lecturing style, comparing and contrasting with another disappointing lecturer, to illustrate the value of the traditional lecture in the hands of a skilled educator. It cannot be often that one receives such an accolade as to be chosen as the subject of a dissertation!

What advice would you give to a trainee GP considering a career as a GPwSI sexual and reproductive health?
Trainees have more opportunities open to them now. There is a new career route to become a consultant in sexual and reproductive health directly with FSRH. To work in sexual health alongside general practice, I would advise studying for DFSRH and the STIF competencies. CCGs are also working with the RCGP to review the standard setting for GPwSIs in sexual and reproductive health.

ON THE BALL

GP Jane Simpson talks about mixing her passion for football with her love of medicine

THERE can't be many GPs who can boast a football keepy-uppy record of more than 2,500 touches. But London-based Dr Jane Simpson is not like most GPs. Her skill at keeping a ball in the air without letting it hit the ground would be the envy of many players and is a result of her lifelong passion for the beautiful game.

Sport has played a central role in Jane's life for as long as she can remember. Growing up going to matches with her Sheffield United supporter Dad, she was kicking a ball around with her two football-mad brothers from a young age. "The sport I first remember playing was football," she says. "I started playing for a team aged eight and haven't really taken much time off since then."

> *"Coaching and playing football gives you an in-built discipline and an extra level of confidence"*

Now 30, Jane – who plays centre midfield – says football has opened up many exciting opportunities. "As a teenager, I was particularly involved in playing and gained several FA coaching qualifications. This meant that, for a number of years, I could work part-time for the Millwall Community Scheme, going into schools to coach football in between studying for my A-levels. Coaching and playing football gives you an in-built discipline. As part of a team you are committed to training twice a week and playing on a Sunday so you need to take care of yourself and stay fit.

"Also, standing in front of 30 eight-year-old kids and making sure they have clear direction gives you a certain level of confidence!"

Jane played for the Millwall Lionesses from age nine until she was 18 and was also in the England under-16 training squad. She adds, modestly: "I was quite good at that point."

Science skills

Playing football was not the only skill Jane developed at secondary school, however. Showing an aptitude for science, she debated whether to study physiotherapy or medicine at university. "I was encouraged by teachers and family to take medicine – I think I made the best decision." She studied at Sheffield University – which allowed regular attendance at United matches – then returned to London for her foundation training.

Even during her studies Jane found time for football, opting to spend five years at Sheffield Wednesday whose women's team was better than United's (although the move wasn't so well-received by her United-mad family). It was while playing for Wednesday that she experienced one of her sporting career highlights. "We won the County Cup playing against one of the best teams in the country, the Doncaster Belles," she remembers. "They were the favourites but we pulled off a great performance to win 1-0. I scored the winning goal, which was a fantastic moment."

Completing her foundation training at Lewisham hospital, Jane initially planned to specialise in emergency medicine. For her medical elective, she went to South Africa for two months, working in the emergency department of a hospital in Cape Town. "That was the best experience of my medical career," she says. "I was 22, and went there on my own, not knowing anyone. I was working in quite a deprived hospital, with a real lack of equipment and very poorly patients presenting quite late with their medical conditions.

"This meant I saw things I would never have seen at home and I was also able to contribute in a way which, as a medical student in England, would not have been possible. South Africa is a great country, the people were amazing."

No to nightshift

Despite her love of A&E, Jane soon decided the work-life balance it presented wasn't for her. "I just couldn't see myself doing nightshift," she says. "I experienced many other areas of medicine when I was working in the hospital, but none of them really grabbed me. It was then I decided that general practice would give me a bit of everything, so I started my three years of GP training, qualifying in 2012."

Despite the hours being more favourable and the work being equally rewarding, Jane has found her role as a locum in south-east London also presents its challenges. "Working in A&E, a lot of the people are acute cases, so you have to act quickly, which draws on very different skills from GP – it's more practical skills which come into play, which I enjoy. In GP, you see more chronic illness and, being honest, I feel this specialty is much more challenging. Seeing 40 patients a day with different problems can be mentally and physically draining.

PASSION: Dr Jane Simpson (back row, third from right) with her team the London Corinthians

BIG LEAGUE: Jane visits FC Barcelona's home at the Nou Camp

PHOTOS: DR JANE SIMPSON

"What I very much enjoy about it, though, is the continuity of care, getting to know people and families."

Combining passions

After completing her specialty training, Jane took six months out and travelled to South East Asia - taking in Cambodia, Vietnam and Thailand - giving her time to think about where she wanted her medical career to go next. "I was already aware of the sports medicine and exercise masters at Queen Mary University, London, and applied as soon as I came back. It's a full-time course over one year, which started last September. I received a training bursary from Arthritis Research UK to help with the fees, which I am very grateful for.

"I am loving every second of the course as it brings together my lifelong love of sport with my medical career. The course at Queen Mary University is the longest standing of its kind in the UK, so the people who come to lecture are top quality. I'll be honest, it hasn't always been easy - the musculoskeletal part of the course in particular has been tricky, and also the research based aspect - it's a very evidence based course, but this has been very enlightening and encouraged me to look at things differently. In particular, I find the football medicine module very interesting, which is taken by the doctor for Arsenal."

Balancing her part-time work as a locum with study does not leave much time for playing sport, but that's not holding Jane back. "Football is the one sport I would play in the snow, wind or rain," she laughs. "I started playing again this year for a local team, the London Corinthians."

And just last week she began work as a doctor for Millwall FC Academy, an under-21s men's team in the English second league. "The job came about through the sports medicine and exercise course," she says. "So far it's just great, there are really experienced physios there so I know I will learn a lot, and I'm providing emergency pitch-side treatment, which means I'm there watching all their games."

As for the future, Jane hopes to continue as a part-time GP and, once she has finished her masters course, take up a clinical role at a football club.

She says: "Every GP is different and I imagine the majority will look for a specialty or something different they can do alongside their practice. It's definitely worth looking for graduate courses available in things you are interested in - you can study all sorts of subjects which could take your career in another direction entirely."

Link:

- Find out more about Arthritis Research UK's training bursaries at **www.arthritisresearchuk.org/health-professionals-and-students**

Rowan Morrison is a writer based in Edinburgh

SAYING SORRY

Apologising when things go wrong can prevent a simple mistake from escalating into a more serious complaint

THERE are many opportunities for mistakes to happen in the practice of medicine. Missed or delayed diagnosis, prescribing errors, forgotten referrals, failure to action abnormal results, breaches of confidentiality and communication errors are just a few examples.

High-profile scandals involving poor patient care, such as the failings at Mid Staffordshire Hospital, have reduced public trust in the NHS and doctors. It is hardly surprising that the number of complaints and claims is rising steeply.

In January, the health secretary Jeremy Hunt said: "Doctors and nurses must apologise for care failings and should be more open and honest when things go wrong, say sorry to patients and help win back trust in the NHS". In response to the Francis inquiry into the events at Mid Staffs, the government plans to introduce a new statutory duty of candour this year.

Consider the following scenario:

The face at the reception window is angry and weary and pale. "My daughter is in ITU fighting for her life with a ruptured ectopic pregnancy. She saw one of your doctors yesterday who said at her age not to worry because her irregular bleeding was just the menopause. She nearly died." My heart goes ice cold. I had seen the daughter yesterday, a lovely lady aged 47, but the mother doesn't know this. What do I do? The mother is not complaining just reporting what happened. Should I speak to her and apologise or will that make it worse? If I say sorry will the family sue me, or should I just wait and see what happens next?

Open and honest

In its guidance *Good Medical Practice*, the General Medical Council is clear about what doctors should do if something goes wrong:

You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress you should:

- **Put matters right, if that is possible**
- **Offer an apology**
- **Explain fully and promptly what has happened and the likely short-term and long-term effects.**

Importantly, the GMC goes on to advise: "Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology."

Dr Dorothy Armstrong professional adviser to the Scottish Public Service Ombudsman (SPSO) supports this position. In a recent article for the SPSO, she says that in her experience a complainant's biggest regret is often that the staff member involved in a mistake or wrongdoing simply was not honest or apologetic. In many cases, she adds, an apology or the truth about what had happened may have prevented a complaint being made or escalated to the Ombudsman.

Fear of liability

As GP trainees at the coalface of patient interaction and the delivery of primary care, you are ideally placed to try to defuse a situation that could escalate to a complaint. Be open, be honest, be truthful. Say sorry.

But, as shown in our scenario, doctors sometimes worry that an apology may be interpreted as an admission of liability in any potential litigation – a bit like with car insurance.

The NHS Litigation Authority, the body which oversees claims made against the health service, has published a four-page guidance booklet for staff called *Saying Sorry*.

It clearly states: "Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. Of those that have suffered harm as a result of their healthcare 50 per cent wanted an apology and explanation.

"Patients their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has occurred.

"Saying sorry is NOT an admission of legal liability, it is the right thing to do."

This is a view shared by MDDUS and we would always advise doctors to offer an apology where appropriate. As a medical adviser, I often provide assistance to doctors who are facing upsetting and troublesome complaints. When advising how to draft a written response to a complaint, I usually recommend that the opening paragraph includes firstly an acknowledgment of receipt of the complaint and secondly an expression of condolence to the complainant and their family for the perceived harm suffered. It is good practice to then assure the complainant that their concerns have been taken seriously and also give an account of the investigation that has taken place. It is also helpful to include a paragraph detailing any lessons that have been learned by the doctors/practice to prevent a similar event happening again.

Dr Dorothy Armstrong advocates the 3 R's approach to saying sorry:

Regret

It is important to recognise that something has gone wrong by acknowledging the wrongdoing, even if you are not at fault. Saying sorry, in a meaningful and sincere manner, is crucial. Often this first step is enough to de-escalate the situation.

Reason

Even if you feel criticised and hurt, it's really important to provide a reason (if there is one) for the mistake, but to avoid being defensive. Make sure you are clear that the wrongdoing was not intentional or personal, so keep to the facts. Try to put yourself in the complainant's shoes and step back from the situation. Stay objective.

Remedy

Try to resolve the mistake there and then, if you can. Ask the complainant what they would like to happen and take responsibility to investigate, if required, and to provide feedback to them as soon as is practicable. Encourage colleagues to be proactive too.

So, back to our opening scenario and what our doctor should do…

In this case, it would be appropriate to speak to the patient's mother in more detail. Consider an approach such as: "I am very sorry to hear what has happened to your daughter. Why don't you come in to my room for a minute?"

Before beginning a conversation, bear in mind that you cannot say anything that would breach the patient's confidentiality. It may be worth thinking back to the consultation – did the doctor take a good history? Was the patient happy with the diagnosis and management plan that was discussed? Regardless of what happened in the consultation, it is important not to be defensive, after all something terrible has happened. Our doctor can be sorry without being guilty.

The conversation with the patient's mother might go something like this: "You must have had a very distressing and stressful time of it last night. I was the doctor who saw your daughter yesterday, I am really sorry to hear what has happened to her after I saw her. I would like to assure you we will fully investigate what has happened to see if there is anything that I could have done differently at the time and, if so, to stop this happening to someone else. I am sorry for all the upset you have had. Is there anything you would like me to do at the moment to help?"

Each situation/complaint is different so advice will vary depending on the circumstances. If in doubt, contact MDDUS for advice on how to proceed.

Useful resources:

- The SPSO: **http://tinyurl.com/mn88qar**
- NHS Litigation Authority: **http://tinyurl.com/o8zjqun**

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

DELAYED REFERRAL

REST PAIN

DAY ONE
A 54-year-old man, Mr N, attends his local GP surgery complaining of pain in his left calf and toes. The patient is obese and a smoker and suffers from hypertension. He is seen by Dr D who notes in the history that the pain began three days ago and is worse in bed at night. Dr D examines the foot and finds it cool to touch and describes the colour as "slightly dusky". She also notes that peripheral pulses are evident on palpation. The GP refers the patient to a vascular clinic and in the referral letter asks for an urgent appointment.

DAY FIVE
Mr N re-attends the surgery and this time is seen by Dr C. The consultation is described as a "review appointment". The GP notes again pain in the left leg and foot. On examination he finds reduced peripheral pulses but adequate capillary return no different from the right leg. Dr C questions whether the pain is more neuropathic than ischaemic. He prescribes the analgesic dihydrocodeine and instructs Mr N to return if there is no improvement.

DAY NINE
Early that morning Mr N phones the surgery to make an emergency appointment. He feels intense pain in his left heel. A third GP – Dr B – examines the patient. He notes that the foot is cyanosed with poor capillary return. He forms the opinion that this is due to "poor circulation" and notes the request for referral made by Dr D. He arranges for a review in two days and prescribes ibuprofen.

DAY 10
Having missed a week of work Mr N returns to the surgery and sees Dr C again. The patient is now complaining of knee pain with irritated skin down the leg. He has been using Sudocrem but to no avail. The patient refuses to remove his shoe saying the problem is "his leg not his foot". On examination the GP notes thin-walled blisters on the leg and mentions the possibility of pemphigus. He advises Mr N to keep the skin clean and to continue with the Sudocrem if the blisters burst. A referral is made to a dermatologist. No mention is made of any vascular problem in this consultation.

DAY 21
Two days before his hospital appointment Mr N returns to the surgery worried that the skin condition on his leg has become infected. He is seen this time by Dr D – the GP he first consulted with on Day 1. Dr D records that the patient has a leg ulcer that is oozing profusely and looks infected. She prescribes an antibiotic and sends him to the practice nurse to have the leg dressed. The nurse records that the leg is in "terrible shape". Mr N again refuses to remove his shoes but the nurse notes that his socks are soaking wet and that there is a strong smell.

DAY 23
Mr N attends an outpatient clinic at the local hospital and is seen by a vascular surgeon. He notes that the patient has rest pain and gangrene in the left foot. The leg is blistered and ulcerated below the knee with large patches of non-viable tissue. A duplex scan shows that the entire arterial tree is occluded in the lower left leg. The surgeon is unsure of the aetiology but suspects a ruptured plaque. The only option at this stage is above-knee amputation. The surgery is carried out with no complications and Mr N is discharged five days later.

SIX months later a letter of claim for clinical negligence is received by the practice from solicitors acting on behalf of Mr N. It alleges a failure in duty of care in not realising that the patient's blistered leg was due to ischaemia. Emergency hospital admission would have avoided the need for amputation.

MDDUS acting on behalf of its GP members commissions a report from an expert in primary care. The expert offers the opinion that Dr D was correct in making an urgent referral to the vascular clinic – but an immediate referral would have been more prudent. Checking the patient records the expert also discovers that Dr D's referral letter was not typed and sent until six days after the initial consultation. This is clearly poor practice management.

The expert also considers the actions of the other doctors involved and judges that they all missed opportunities to hasten Mr N's referral to hospital. In particular Dr C failed to note the connection between the patient's skin condition and the potential ischaemia identified in the notes and earlier examination.

Considering the final consultation before Mr N attended hospital, the expert is critical of Dr D's decision not to have the patient admitted to hospital immediately given the serious state of his leg.

The expert advises that there was a collective failure on the part of all the doctors involved and a serious lack of continuity of care. An additional report on causation by an expert in vascular surgery confirms that had immediate action been taken in the case Mr N would have had a reasonable chance of avoiding amputation.

MDDUS lawyers and advisers agree with our GP members to settle the case for a reasonable sum.

Key points

- Ensure practice systems prioritise urgent referrals and any delays are flagged.
- Examine how a lack of continuity of care in your practice might compromise patient safety.

Diary

ANY critic who ever thought to accuse Diary of being either too high-brow or too low-brow shall surely be silenced by our latest offering. We proudly boast tales of Mozart, academic publishing and urine drinking...

● **WILD WEST PUBLISHING** Getting an article or research paper accepted by a respected academic journal is a sought-after achievement for many doctors. But a recent sting operation by US journalist John Bohannon has raised some doubts about the process. He wrote a spoof medical paper full of easily detectable flaws and submitted it to 304 open access journals. A report in the *BMJ* revealed that more than half accepted the paper, leading Bohannon to declare "an emerging Wild West in academic publishing" with new journals profiting from the open access model in which authors, not readers, pay publication costs. Bohannon made up the names of authors and affiliations – including the flamboyantly named Ocorrafoo Cobange of Wassee Institute of Medicine – and submitted variations of a basic paper claiming to have found anticancer properties in a molecule extracted from a lichen. A number of journal editors have since promised to review their acceptance processes. Diary would like to hope its eagle-eyed publication editors would never let such errors slip through our net.

● **URINE THERAPY** A spritely 91-year-old man believes he has found the elixir of youth – his own urine. Mark Ambrose, who lives with his partner in the south of Spain, told *MailOnline* that he drinks a glass of the stuff a day and also massages it into his skin. Mr Ambrose swears the unlikely supplement helps him look "no more than 65-70 years of age" and allows him to lead an active lifestyle. He's been downing pee for three years after stumbling across the idea while searching the internet for a back pain cure. Advocates of urine therapy, which dates back to Biblical times, say the liquid can disinfect wounds and contains beneficial proteins, vitamins and minerals. Perhaps a remedy best recommended for only the most open-minded of patients.

● **WHAT A FEELING** Diary believes that all GPs should be encouraged to browse the "Reviews and ratings" section of the NHS Choices website. Although, perhaps not so much for those five-star ratings praising excellent clinical skills or courteous staff or waiting room musak that could inspire a flashmob. More bitter truth can be found in opinions offered at the lower end of the scale. Say for example: "On my last visit the doctor I saw was more interested in their own personal call on their mobile from their friend, did not seem interested in me and looked bored, was miserable and you could not fill the back of a postcard the amount of time they talked to me. I have never heard anything good said about this place and will look for somewhere else." Even worse: "The doctors were rude, when I said there were a couple of things, was interrupted before I could go on and told to make another appointment. Bizarre! Do not bother registering here as you will regret it."

● **BUMP AWAY THE GERMS** Who needs nasty germ-infested handshakes when you can simply fist bump your fellow GPs instead? Doctors in the US are apparently considering using the unorthodox greeting to reduce the spread of infection. Research by surgeons at the West Virginia University found an old fashioned handshake exposes three times as much skin surface as pounding knuckles, with contact lasting almost three times as long. As expected, a shake also transmitted more bacteria. It's not known where the fist bump originated, but it has been famously deployed by the likes of Barack Obama and even the Dalai Lama. It could yet prove to be a secret weapon in the war against germs.

● **CLASSIC CALLS** Does your practice favour a catchy pop tune or something a little more upmarket to entertain callers while they wait? A survey has revealed Mozart is the top choice for local councils' "on hold" music. *Eine Kleine Nachtmusik* and *Symphony No 40* were the Mozart pieces deemed most suitable by local authority bosses, according to the Press Association. Selections from Debussy, Handel and Strauss were also popular, no doubt thanks to the fact these classics are out of copyright and can be played free of charge. Elsewhere, Lincolnshire County Council has reported that middle-of-the road pop songs by Simply Red and the Lighthouse Family are the most effective in keeping people on the line. The authority says the number of people hanging up while on hold has more than halved since it replaced traditional hold music with commercial tracks. However, the council did admit fault in its use of the Lighthouse Family's *Ocean Drive*, describing the move as "a deplorable lapse in judgement."

● **...AND HOUSE CALLS** In the year 2012 Diary mourned the loss of the treasured TV series *House* – a medical drama that rewrote the classic diagnostic aphorism: "when you hear hoofbeats, don't think of zebras". Zebras were far too obvious for Dr Gregory House – consider the okapi or maybe the saola (one of the world's rarest ungulates according to Wiki). Over eight series House diagnosed every obscure condition from Von Hippel–Lindau disease to alien hand syndrome. But the programme was not without some educational value in the real world it turns out. Doctors in Germany were baffled by a patient displaying a puzzling range of symptoms including hypothyroidism, oesophagitis, fever, increasing deafness, loss of sight and heart failure. He was then referred to the Marburg University clinic where medics noted that the case bore a striking similarity to one that featured on House in which a patient had been diagnosed with cobalt poisoning caused by debris from a metal hip replacement. Mystery solved.

CALL FOR DIARY ITEMS
Do you have any tidbits, anecdotes or absurdities in a similar vein to the items above? Please write in or email them to **PM@mddus.com**

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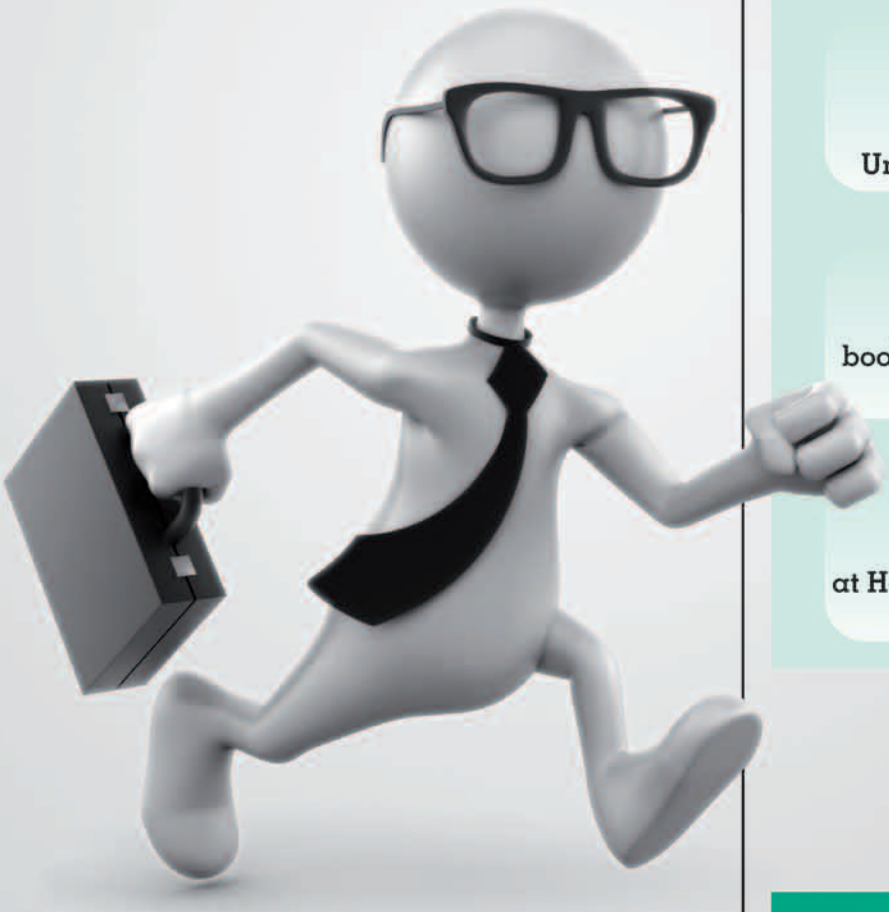

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