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AN **MDDUS**
PUBLICATION





Welcome to your GPst

THE number of ways in which patients can contact us seems to have increased considerably in recent years, thanks in no small part to the rise of social media. But it is vital to maintain professional boundaries and to keep our work and personal lives separate wherever possible. In my article on [page 4](#), I look at the challenges of handling Facebook friend requests from patients and offer advice on how to avoid falling foul of the GMC.

Communicating in a way patients can understand is crucial to the process of informed consent. Our article on [page 7](#) offers tips on making yourself understood. All doctors who handle patient information must comply with the Data Protection Act, but knowing what to do with personal details can be tricky. MDDUS adviser Dr Barry Parker gives an overview of this important legislation on [page 6](#).

Reporting a colleague that you think poses a threat to

patient safety is difficult for any doctor, but can be especially challenging for trainees. On [page 12](#), MDDUS adviser Dr Susan Gibson-Smith offers advice using a scenario involving alcohol addiction in a senior GP partner. Meanwhile, our case study on [page 14](#) looks at a failure to diagnose appendicitis.

Comic books are an unusual sideline for your average GP, but on [page 10](#) Dr Ian Williams talks about how he is using his passion for creating graphic novels to bring to life some of the challenges of practising medicine.

On [page 5](#) we discuss Lord Falconer's Assisted Dying Bill which has sparked fierce debate in the profession. And in our career article on [page 8](#), dignity and compassion are high on the agenda for GPs looking to develop a special interest in palliative care.

• **Dr Peter Livingstone**
Editor

TRAINEES SHUN GP PARTNERSHIPS

THE vast majority of new GPs plan to avoid partnership roles in favour of locum or salaried work, a new survey shows.

Only 15 per cent said they planned to look for a partnership "in the current climate". Seventy-seven per cent said they would rather take up locum or salaried work, citing a desire for flexibility and a dislike of commitment.

More than 2,000 GP trainees across the UK responded to a survey by Wessex LMCs, including 700 who are due to qualify this summer.

Just under half (47 per cent) said they would consider a partnership in five years' time, blaming factors such as political uncertainty and long working hours. Concerns were also raised about the future provision of out-of-hours care.

Responses also highlighted a level of disillusionment amongst trainees, with a quarter saying they planned to take a break of more than two years out of general practice at some point in their career. A further 12 per cent plan to leave the country within the next 12 months and five per cent were already mentioning burnout or exhaustion.

Most comments (83 per cent) about trainees' impression of general practice were negative, the survey found.

Wessex LMCs CEO Dr Nigel



Watson said: "It is sad to see younger doctors becoming disillusioned before they have really commenced on their career - disillusioned doctors leaving general practice means ultimately less appointments for patients and increasingly overstretched services.

"General practice is a fantastic career - we need to work hard to re-establish general practice as an appealing and positive career choice."

The survey highlighted a trend for GPs to pursue a "portfolio career", with 40 per cent saying they would look to develop a special interest in education or in a hospital specialty.

More than 1,400 suggestions were made on how to reverse the downward trend in recruitment. Common themes included ending the constant negative media and government attention, greater respect from hospital doctors, more GP funding and more GP foundation placements.

There were also calls for trainee surgeons and other doctors to spend time in general practice to increase their understanding of the challenges GPs face.

SUSPENSION SHOULD NOT MEAN LIST REMOVAL

SUSPENDED doctors should only be removed from the performers list after a full investigation by their regulatory body, according to proposals from the Department of Health in England.

A consultation is underway into plans to relax regulations that came into force last April requiring NHS England to remove healthcare practitioners who had been suspended by the General Medical Council. The list removal was carried out even in cases of interim suspensions which regulators say are not intended to punish clinicians.

The DoH has described the 2013 rules as "disproportionate" and is looking to revert back to NHS regulations from 2004. This means NHS England would only be obliged to remove a practitioner who was suspended following a full investigation by their regulatory body.

Interim suspension orders are designed to act as a short-term measure to protect the public where a concern has been raised about a clinician's fitness to practise. They allow time for the facts of a case to be investigated.

Two options are under consideration and both would mean the doctor would continue to be paid while suspended. The consultation ends on September 25.

SOCIAL MEDIA ENCOURAGING INCREASE IN COMPLAINTS

SOCIAL media and negative press coverage of the medical profession are helping to fuel a surge in complaints against doctors, new research shows.

Complaints to the GMC by the general public about doctors' fitness to practise almost doubled from 3,615 in 2007 to 6,154 in 2012.

This prompted the regulator to commission a research team from Plymouth University Peninsula Schools of Medicine and Dentistry to investigate the trend. However, the GMC made it clear there is no evidence to suggest the rise is due to falling standards.

Researchers said increasing complaints were a result of "broad cultural changes in society, including changing expectations, nostalgia for a 'golden age' of healthcare, and a desire to raise grievances altruistically".

A culture has developed in which people are now more likely to raise grievances, the researchers noted, with complaints networks and social media making it easier to complain. People are more likely to discuss their experiences using forums such as Twitter and Facebook, where information could be easily accessed and exchanged.

Clinical care remains the largest cause of complaints, but there has been a large increase in concerns about doctor-patient communication. Analysis showed a large number of complaints made to the GMC were dropped because they were beyond the regulator's remit, suggesting there may be problems with the wider complaint handling system and culture.

While attitudes towards the medical profession are "positive overall", negative press coverage is blamed for "chipping away" at their reputation, resulting in an increased number of people making so-called "me too" complaints to the GMC.

The report also noted that patients now have greater ownership of their health, are better informed, are developing higher expectations and are treating doctors with less deference than in the past.



TOUGHER SANCTIONS PLAN FOR DOCTORS

DOCTORS who harm patients could face sanctions even if they have improved their practice under new proposals from the General Medical Council.

They would also be made to apologise to patients if they have previously failed to do so and refusing to say sorry could lead to a tougher sanction.

The proposals are part of a major consultation by the regulator looking at how serious complaints should be dealt with.

Under the plans, doctors could face restrictions on their practice, suspension or even be erased from the register if it is shown that they knew, or should have known, they were causing harm to patients in serious cases. This could happen even if they have subsequently improved their practice. The GMC is seeking views

from the profession and the public on a number of measures.

This includes taking a tougher stance in cases where doctors fail to raise concerns about a colleague's fitness to practise or take prompt action where a patient's basic care needs are not being met.

The proposals also target doctors who bully colleagues and put patients at risk or those who discriminate against others in their professional or personal life.

GMC Chief Executive Niall Dickson said that while the "vast majority" of cases involve "one-off clinical errors" that are not pursued by the regulator, doctors must be held to account in the most serious cases.

The consultation runs until November 14 and the findings will be published next year.

FAILING GP PRACTICES TOLD TO IMPROVE OR BE SHUT DOWN



GP practices in England providing poor care will be given a deadline to make improvements, or face closure if they fail.

A new "special measures" regime is being introduced from October by the Care Quality Commission (CQC).

The move will coincide with the start of a new ratings system under which practices will be classed as outstanding, good, requires improvement or inadequate.

The CQC said it will work closely with NHS England to pilot the scheme, which will operate "in close consultation" with other professional bodies including the General Medical Council and the Royal College of GPs.

Under the new regime, practices found to be inadequate will have six months to improve. Those who fail to do so will be put into special measures and given a further six months to meet the required standards. At the end of this process, those who still fall short will have their CQC registration cancelled and their contract with NHS England terminated.

For practices that are believed to be putting patients at risk, the CQC will have the power to put them straight into special measures.

The scheme is similar to one the CQC already operates in NHS hospital trusts and there are plans to extend it next year to the adult social care sector.

Professor Steve Field, the CQC's chief inspector of GPs, said: "Most GP practices provide good care. But we can't allow those that provide poor care to continue to let their patients have an inadequate service."

The scheme was given a cautious welcome by RCGP chair Dr Maureen Baker who agreed that poor care "must be addressed" but said struggling practices must be supported.



EDITOR:
Dr Peter Livingstone

CONTENT EDITOR:
Dr Susan Gibson-Smith

ASSOCIATE EDITOR:
Joanne Curran



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

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

ACCESS
ALL AREAS

GPST editor **Dr Peter Livingstone** looks at the challenges of maintaining professional boundaries with patients in a digital age

THE first time a patient sent me a friend request on Facebook I remember being surprised that they would be remotely interested in seeing what I got up to in my spare time.

As a GP at a busy urban practice I see dozens of patients every week, some of whom attend regularly and I have come to know quite well. The doctor-patient relationship is a unique and privileged one. Mutual respect and trust are essential as we are privy to extremely sensitive, private information that our patient may never have shared with anyone else.

Despite this close relationship, it is vital to maintain boundaries and resist where possible the blurring of the personal and professional. In this respect it is important to remember that, as doctors, a greater degree of responsibility and influence still rests with us.

The GMC's *Good Medical Practice* guidance is clear that "you must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them". But the rise of social media (not to mention the use of other technology in healthcare such as email and mobile phones) has only served to increase the number of ways patients can connect with doctors and we must take a cautious approach.

In your own training you may have been asked by a patient to accept them as a Facebook "friend". I have been asked a few times and politely declined each request. In one case this was followed by a challenging consultation where the patient was clearly annoyed. I tried to explain that, as their GP, it would be inappropriate to have them as a "friend" on Facebook but they seemed dissatisfied by my response and failed to see the need for such a professional boundary.

On reflection, society's expectations of GPs and attitudes towards them are changing. I had never really thought about it until that consultation and it made me re-evaluate the way I use sites like Facebook. I never imagined patients would seek me out on social media but I quickly tightened up my privacy settings to make sure only friends could access my personal profile.

Connecting with patients at a personal level on these websites is fraught with difficulty. The BMA recommends that doctors (and medical students) should politely refuse any approach, providing an explanation as to why it would be inappropriate. Even with the most innocent of

intentions, you run the risk of breaching patient confidentiality and of falling foul of the GMC's rules on "improper" relationships with patients.

Maintaining these boundaries is a bit easier for those who work in bigger, urban practices and also if, like me, you live outside of your practice catchment area. But those who live and work in rural practices have to take extra care to avoid difficulties arising.

I remember growing up in a rural part of Northern Ireland where my father was the village GP, practising from home. We were an integrated part of our local community and everyone knew where we lived and had our home telephone number. The majority of my parents' friends, and my school friends, were his patients and the house was always busy.

This was at a time where mobiles were still a rarity and social media was unheard of but GPs were regularly working on-call from home. It was very difficult for my parents to try and separate their personal and professional lives. If they wanted to go out for food and drink they would drive to another town or village. But if something ever needed fixed around the house, he'd always have to hire one of his patients to do it. What else could you do in a village when there was no one else to ask?!

If my father was still practising today, he may well be in the position of receiving Facebook requests from genuine friends who also happen to be his patients – a tricky situation many rural GPs will no doubt have to negotiate. In these circumstances, a doctor would have to exercise their professional judgement and common sense, being ever mindful of the need to maintain boundaries.

The RCGP published its *Social Media Highway Code* in 2012 which advised doctors to apply old fashioned "Wild West" principles when using social media. Medical professionals, the guidance said, should be guided by honesty, hospitality, fair play, loyalty, trust, consideration and respect in the same way as cowboys "in the frontier of the newly discovered Wild West". The list of 10 rules encourages doctors to be aware of the image they present online, recognise that the personal and professional can't always be separated and to engage with the public but be cautious of giving personal advice.

If we are able to adopt these principles we ensure that the risk of inappropriate patient contact is kept to a minimum.

Dr Peter Livingstone is a GP and editor of *GPST*

ASSISTED DYING

Lord Falconer's Assisted Dying Bill prompts strong views on both sides of the profession

MOST of us tend to assume that the *British Medical Journal* acts as a mouthpiece for the policies of the British Medical Association. It is after all a wholly owned subsidiary. Yet recently the Chair of the BMA was at pains to point out that the *BMJ* "quite rightly has editorial independence".

The reason behind this statement was a clash of opinion over the divisive issue of assisted dying.

In July of this year the Assisted Dying Bill – sponsored by Lord Falconer of Thornton – had its second reading in the House of Lords. The bill would allow terminally ill patients to seek medical assistance to end their lives. In an editorial published in advance of the debate, *BMJ* UK editor Tony Delamothe along with patient editor Rosamond Snow and editor-in-chief Fiona Godlee expressed their hopes that the bill eventually becomes law.

This prompted a statement from Dr Mark Porter, Chair of BMA Council, who said: "There are strongly held views within the medical profession on both sides of this complex and emotive issue. The BMA remains firmly opposed to legalising assisted dying. This issue has been regularly debated at the BMA's policy forming annual conference and recent calls for a change in the law have persistently been rejected.

"Its [the *BMJ*'s] position on assisted dying is an editorial decision and does not reflect the views of the BMA or the medical profession. Our focus must be on making sure every patient can access the very best of palliative care, which empowers patients to make decisions over their care."

Lord Falconer's bill would apply only to patients aged 18 years or older who are expected to die within six months. The process would require a "clear and settled intention" and would be dependent upon a request being made by the person concerned and no one else, including doctor, family or partner.

Only patients resident in England and Wales for at least one year would be eligible under the bill: no one would be allowed to travel to these countries for assisted death. A patient would be required to sign a declaration in the presence of an independent witness and this would need to be countersigned by two physicians – one being an "attending doctor," usually the patient's GP or consultant, and the other being an "independent doctor" from a different practice or clinical team.

Both doctors would need to examine the patient and agree on the prognosis as well as their capacity to make a decision to end their own life. The doctors would also need to judge

consequences."

The policy also reflects concerns that assisted dying could put vulnerable people at risk of harm through coercion by relatives or even by the medical establishment in an overstretched NHS. Even more fundamentally the BMA feels that such a change would be contrary to the ethics of clinical practice which is to improve quality of life and "not to foreshorten it". It believes that effective and high-quality palliative care can alleviate distressing symptoms associated with the dying process and allay most patients' fears.

But to the *BMJ* editors it is primarily a question of patient autonomy. In their editorial they write: "People should be able to exercise choice over their lives, which should include how and when they die, when death is imminent. In recent decades, respect for autonomy has emerged as the cardinal principle in medical ethics and underpins developments in informed consent, patient confidentiality, and advance directives."

Countering claims that such a policy might make assisted dying routine, they point to experience from US state Oregon where a similar law has operated for the last 17 years. Assisted deaths accounted for 2.2 per 1,000 of total deaths in the state last year. Extrapolating that data to England and Wales they estimate that a general practice of 9,300 patients would issue one prescription for life-ending medication every five or six years, with only one patient actually taking such medication every eight to nine years.

They believe that Lord Falconer's bill offers sufficient safeguards to protect against coercion or abuse and the difficulties in assessing capacity. But their views are in the minority among the medical establishment. In addition to the BMA, other institutions opposed to a change in the law include the Royal College of General Practitioners, the Royal College of Surgeons and the Royal College of Physicians.

The bill has a long way to go until it reaches a vote in the House of Commons and that will not likely occur until after the next general election. But it is certainly an issue to watch.

Jim Killgore is an associate editor of *GPST*

"Respect for autonomy has become the cardinal principle in medical ethics"

that the decision was voluntary and fully informed. Only then would the attending doctor write a prescription for the necessary medication to be supplied after a 14-day "cooling off" period (or six days if the patient is expected to die within the month).

The patient would have to self-administer the medication (a crucial difference between assisted dying and voluntary euthanasia), either orally or by a syringe driver or other delivery mechanism. An assisting healthcare professional could lawfully put the medication in the syringe but the patient would need to take the final act in ending their life.

The BMA's policy on assisted dying is published on its website. Among the key reasons it opposes the proposed law is the worry that legalising assisted dying would weaken society's prohibition on killing and undermine the safeguards against non-voluntary euthanasia. "Society could embark on a 'slippery slope' with undesirable

THE DATA PROTECTION ACT

MDDUS medical adviser **Dr Barry Parker** outlines what you need to know about this important legislation

It is crucial that all doctors comply with the Data Protection Act (1998) when handling patient information, but the Act itself is rather long and complicated and we frequently receive requests for advice on its workings.

The principles, however, are simple and apply to anyone responsible for processing personal patient information. ("Processing" broadly means collecting, using, disclosing, retaining or disposing of personal data.)

The guidance states:

- Personal data should be processed fairly and lawfully
- It should only be obtained for a specific purpose(s) and not be processed in any manner that is incompatible with that purpose
- It should be adequate, relevant and not excessive for the purpose
- It should be kept accurate and up to date
- It should not be kept for longer than is necessary for the purpose
- It should be processed in accordance with the legal rights of the data subject under the Act
- Appropriate steps should be taken to prevent loss or damage or unauthorised or unlawful disclosure
- It should not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures adequate protection.

The person with overall responsibility for safeguarding records/personal data is known as the data controller and the patient is the data subject. The patient is entitled to request access to, or a copy of all of their electronic and paper records. Their written request should be granted within 40 days, but certain information should not be disclosed. This includes third party information unrelated to the patient, for example about a sibling or parent. (Other health professionals involved in the care do not count as third parties.) Responses should also exclude any information which, if disclosed, may lead to serious harm to the patient or another individual.

The Act only refers to living patients and

is distinct from Freedom of Information Act requests which are for general information about a public body rather than personal health information. Common queries include:

Can I charge for providing information under the terms of the Act?

There is no charge for patients who wish to view their records, but a charge of up to £50 can be made for copies of paper records, or up to £10 for copies of electronic records. This includes postage costs.

Do data subjects have to provide a reason for requesting disclosure of their records?

No. Occasionally doctors may feel that a request is being made in anticipation of litigation but this does not affect the patient's rights under the Act and such requests should be dealt with in the usual way.

Can parents make a request for their children's records?

Anyone with parental responsibility may make such a request and, providing it appears to be in the best interests of the child's health and welfare, it can normally be agreed. However, when the child is deemed competent, then consent for disclosure should be sought from them. As a working rule, a child aged 12 or over with normal capacity would be regarded as competent in this respect unless other factors exist.

What if someone requests information on a patient with incapacity?

Adults with incapacity legislation differs slightly in Scotland and England, but the principles are similar. If the patient has a legally appointed proxy they are entitled to receive relevant medical information in order to carry out their duties in relation to the patient. If no legal proxy exists, decisions on disclosure should be made on a 'best interests' or 'overall benefit' basis.

What if a patient wants to amend their record?

If the doctor agrees with the proposed amendment, i.e. where an entry is incorrect, they may amend the record, making a contemporaneous entry to indicate what has been done and why. If

not, an offer can still be made for an additional entry to be made in the records noting the patient's view/disagreement with the contents.

What happens if there is an accidental breach of confidentiality under the Act?

First, clarify what has happened and inform the patient without delay. There should be an apology, an explanation (which may only be possible after further investigation) and prompt action to limit the effects of the breach whenever possible. Breaches that have potentially severe consequences for the patient or involve large numbers of patients or volume of data may require to be reported to the Information Commissioner's Office (ICO).

What are the potential consequences for the data controller following a breach of confidentiality?

Patients may make a local complaint and, if they are dissatisfied with the response, escalate this to the Ombudsman. They may also complain direct to the Information Commissioner who has the power to issue a financial penalty for significant breaches of the Act. They have the option to complain to the General Medical Council if doctors are involved in the breach and they may raise a civil court action for damages. This last option is relatively uncommon and in fact the majority of breaches, if handled sensitively, honestly and efficiently from the outset, can be resolved without escalation.

When is it justifiable to share personal data without consent?

There are circumstances where information must be provided by law, and where disclosure without consent is permissible on a public interest basis. See the GMC's guidance *Confidentiality*.

Further information:

• ICO guidance on the Data Protection Act 1998: <http://tinyurl.com/o9fc7dz>

Dr Barry Parker is a medical adviser at MDDUS

GETTING THE MESSAGE ACROSS

Many patients struggle to understand even basic information – so how can you be sure they have given informed consent?

AFTER years of training, it is no surprise that doctors will often use medical jargon, common clinical expressions and instructions in their everyday working life. So much so that it can be easy to forget the difficulty many patients experience in understanding exactly what their doctor is telling them – even at a basic level.

This mismatch in communication raises serious implications for doctors who rely on patient understanding to obtain informed consent for proposed treatments and procedures.

The notion of shared decision-making between doctor and patient has become central to modern medical practice, but this so-called low "health literacy" presents a major barrier. The term has been coined to describe "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."

Research carried out in 2012 by London South Bank University found a startling 43 per cent of people aged 16 to 65 in England are unable to "effectively understand and use" basic health information. The figure rose to 61 per cent when the information also required maths skills.

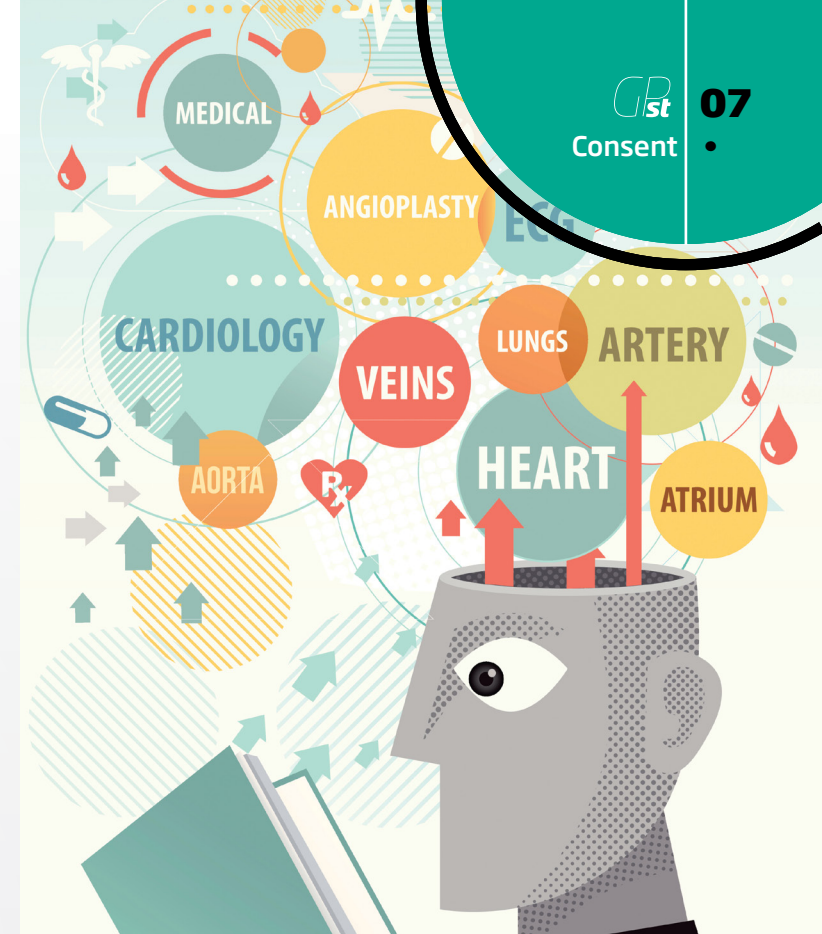
A quick search of MDDUS case files throws up dozens of examples of how a lack of valid informed consent factors in clinical negligence claims. Often, a complaint is made by a patient who had failed to grasp the potential risks of a particular procedure which has then resulted in a poor outcome. It is not uncommon for patients in such cases to comment that, had they fully understood the implications of the proposed treatment, they would not have agreed to it.

Complicating matters is the fact that many doctors may not be aware when a patient does not understand what is being explained to them.

Low health literacy is not just a problem for patients with limited education or reading ability but can also be found in individuals who may be highly literate in other areas but have difficulty understanding medical terminology and jargon. Patients may be embarrassed to admit their lack of understanding and sometimes matters can be further complicated by anxiety or confusion associated with pain or drug treatments.

Struggling patients may feel it is impolite to question their doctor or ask for more information.

The RCGP published a report in June 2014, *Health Literacy*, which suggests "many people engaging both across primary and secondary care may simply not have the assumed levels of healthcare literacy that empowers them to manage their conditions."



It cites research suggesting that "patients typically retain around half of the information they receive in a consultation, and only half of what they do retain is generally correct."

The report goes on to acknowledge the implications on the consenting process, saying: "Low health literacy is a barrier to participating in shared decision-making. This includes the process of informed consent for medical and surgical procedures.

"Patients must be given enough time and understandable information to fully appreciate the implications of their consent."

The report emphasises the importance of good communication skills and for doctors to "tailor information to patient skills as well as clinical need."

General Medical Council (GMC) guidance echoes the RCGP advice by encouraging doctors to share information in a way the patient can make sense of, using written materials, visual or other aids where necessary. The regulator states: "Before accepting a patient's consent, you must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded."

The RCGP says GPs are ideally placed to work with patients and patient advocates to identify barriers in the system and create solutions to assist those with low health literacy. They recommend a "universal precautions" approach to communication by speaking clearly and avoiding jargon with all patients rather than only when health literacy is obviously low.

Joanne Curran is an associate editor of GPST

Below are some useful points to consider to help ensure patients give informed, valid consent:

- Make no assumptions about what a patient may want or need to know.
- Use clear, simple and consistent language when discussing risks with patients.
- Speak slowly and avoid complex terminology or medical jargon.
- Use common analogies – e.g. a patient might better understand a joint problem if compared with a hinge.
- Just because a patient is being agreeable do not assume he or she understands what you are explaining or shares your perception of that information.
- Ask patients to put the information in their own words to check comprehension.
- Consider using patient information leaflets, advocacy services, expert patient programmes or support groups for people with specific conditions but do not assume patients will have read a hand-out or information sheet.
- Go over hand-outs or other written aids with the patient and circle important points.
- Involve other healthcare staff who may have more time, experience and resources to inform the patient.
- Try to foster an open atmosphere where questions are welcome.
- Remember that too much information can be as unhelpful as too little.
- Remember that a patient's ability to process and retain information can be affected by factors such as anxiety, pain or the effects of clinical medication.
- Be mindful of questions of capacity in seeking patient consent.

CARING TO THE END

Dignity and compassion are key for GPs looking to develop a special interest in palliative care

WHAT makes for a “good death”? This question seems to have been up for increased discussion in recent years as the medical profession and its regulators consider issues surrounding end-of-life care more carefully.

Updated guidance from the General Medical Council emphasises the need for high quality treatment, compassion and dignity, while making decisions that are clinically complex and often emotionally distressing. For patients, the ability to control pain, to understand what can be expected and to have a choice over where death occurs have also been identified as important factors.

Palliative medicine specialists play an important role in providing care for patients with complex physical, psychological, social and spiritual support issues. However, the majority of care for those nearing the end of their lives is provided by other clinicians, with 40 per cent of all UK deaths occurring under the care of GPs, at home or in care homes.

A GP with an “average list” of 2,000 patients will have 20 die each year, but that figure rises for practices with a high number of elderly patients. GPs looking after residential and nursing home patients will also be providing palliative care for large numbers of patients in the GP practice setting.

While the number of GPwSIs in palliative care remains relatively small, the field is expanding and opportunities look set to increase.

Entry and training

GPs looking to develop a special interest in palliative care will need to undertake further training, taking into account prior learning and experience. Options include:

- Working under the supervision of a palliative medicine consultant in community/hospice/hospital setting
- Attending recognised meetings and lectures/tutorials
- Undertaking a recognised university course leading to diploma/masters in palliative medicine
- Working in palliative care during a GP vocational training programme.

Most GPwSIs will also undertake accredited communication skills training such as the advanced communication skills training run by the National Cancer Action Team.

The RCGP identifies the skills for a GPwSI palliative care to include:

- Clinical management and symptom control of patients with cancer

and non-cancer end stage illnesses

- Provision and monitoring of drug therapies for symptom control
- Managing emergencies in palliative care
- Care in the dying phase/final days of life
- Communicating with patients nearing the end of life and their carers/families
- Support and bereavement care for carers/families
- Provision of care for the elderly in care homes, including those with cognitive impairment/dementia
- Adequate knowledge of the Mental Capacity Act and other relevant health law
- Knowledge of organisations and access to services related to palliative care in-hours and out-of-hours (OOH)
- Knowledge of strategy, policies and tools related to end-of-life care
- Management, leadership and audit skills.

GPwSIs must be sensitive to the particular needs of their vulnerable patient group and, as the GMC guidance states, ensure patient dignity is maintained at all times. An ability to work within a multidisciplinary team is also key, as well as tactfulness and a willingness to respond to crises at short notice.

GPwSIs will usually have regular appraisals with a local consultant in palliative medicine, which often includes case note reviews, observed clinical practice, logbooks of patients seen and a portfolio of educational events attended or led.

The job

When it comes to the final days and hours of life (in response to the removal of the Liverpool Care Pathway for the Dying), the Leadership Alliance for the Care of Dying People has identified five key principles for doctors working in palliative medicine:

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the

dying person are actively explored, respected and met as far as possible.

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The majority of GPwSIs in palliative care work in hospices, although some also work in community teams. Hospice work generally involves taking part in the admission and management of hospice inpatients (usually under consultant supervision) and offering advice to medical and nursing staff in hospitals/the community. GPwSIs may also review patients in the day hospice and hospice outpatients as well as during home visits. Some provide care out-of-hours.

GPwSIs may provide direct clinical care to patients and/or offer advice on management and they often work with a number of local primary care teams to deliver palliative care services. They may provide specialist medicines management support for patients and their carers, including end-of-life symptom control. The role often requires liaison with the OOH service, commissioners, cancer networks and other practitioners to ensure best practice is in place on primary care service delivery.

For those interested in becoming a GPwSI, the first step would usually be to meet with their local hospice or hospital palliative medicine consultant and to talk with their CCG/health board end-of-life care lead.

Dr Stephen Barclay is a lecturer at the University of Cambridge's Primary Care Unit

Links:

- The Association for Palliative Medicine of Great Britain and Ireland (APM) - www.apmonline.org
- RCGP's *Guidance and competences for the provision of services using practitioners with a special interest* - Palliative care: <http://tinyurl.com/kw84fp2>
- Leadership Alliance - *One chance to get it right*: <http://tinyurl.com/mad2kql>

Q&A

Dr David Plume, GPwSI palliative care and cancer, and Macmillan GP adviser

What attracted you to a career as a GPwSI palliative care?

During my VTS I was lucky enough to do a six-month palliative care/oncology job, rather than general medicine. I wanted to be a GP and thought this would be a great way to improve my communication and clinical skills. I then secured a “special interest extension” and for a year I split my time between palliative medicine (running clinics, ward rounds, audit and education etc) and a local training practice.

After several years as a full-time GP, I became Macmillan Cancer Support's GP for Central Norfolk. As a GPwSI I work on our local inpatient specialist palliative care team, with local third-sector and educational providers and CCGs. I teach primary healthcare teams, community generalist colleagues and AHPs and run my own palliative care course for GPs.

What do you enjoy most about the job?

Palliative care is a vibrant specialty which shares common underpinning skills with general practice. It feeds my intellectual and social curiosity and requires me to wrestle on a regular basis with complex ethical and legal issues. I work with intelligent, non-hierarchical, caring and supportive colleagues with impeccable communication skills and I feel part of a specialised team where the skills and experience I bring are equally valued. I also get to see people at one of the most difficult and potentially traumatic times in their lives, and hopefully I can do something to improve it.

Are there any downsides?

There can be a sense that one's clinical autonomy is reduced when you are working with a team of training grade colleagues and a consultant. If you only do a limited number of sessions some of your skills can atrophy relatively quickly. It is important to get this role properly appraised annually, which is more paperwork and reflective thinking. It can be difficult to transition from the holistic “as long as it takes” consultations in palliative care, back to the 10 minute GP consultations. Working as a staff grade in palliative care also pays less than a third of what I would earn for a GP session.

What do you find most challenging?

It can be easy to “benchmark” myself against my consultant and FT colleagues, even though they are far more experienced. It can be difficult to see the impact of your decisions if you are only on the ward once a week (and sometimes people can be too nice to tell you that you got it wrong). If you work as a GPwSI in an inpatient unit then having to swap out of on-calls to take a holiday can be a problem.

What about the role has most surprised you?

How genuinely interested palliative care colleagues are to get a GP perspective. How tired I feel after a day of walking around and crouching rather than sitting in my comfortable office chair. How much I continue to learn from my colleagues.

What is your most memorable experience so far?

A man with intractable pain and physical symptoms came in for symptom control and had a “secret” he wouldn't tell us about his home life. His pain was so severe he needed large doses of oxycodone and sedation; he was agitated and distressed and was heading for a potentially horrible death. Eventually he told a colleague that his wife had been having an affair and threatened to leave him if he complained. Once we helped him address this, his pain decreased substantially, his sedatives and anxiolytics were ceased and he had a comfortable week (with his sons around him) before a calm and settled death. This was a really striking example of the impact of spiritual, emotional and psychological distress on pain.

What advice would you give to a trainee GP considering a career as a GPwSI palliative care?

Developing a special interest is a great way of balancing out the stress of primary care, and I believe working as a GPwSI has made me a better and more focused GP. Spend some time with your palliative care colleagues, in an inpatient unit, in the community and in out-patients. Talk to your local team and see what is available. They can also advise about training courses.

GRAPHIC MEDICINE

Adam Campbell meets a GP with a special interest like no other

WHEN I ask GP-cum-debut graphic novelist Dr Ian Williams how his colleagues, friends and family have responded to his new book, *The Bad Doctor*, he says: "I just thought, when the book comes out and they read it, they're going to think I'm completely crackers."

Creative, talented, ambitious even... but crackers? It's not as implausible as it may sound. As a medical student in Cardiff, Ian suffered from obsessive compulsive disorder (OCD) and developed irrational fears which led him to adopt a series of odd rituals, such as avoiding certain "taboo areas" of the city he came to associate with bad luck. He told no one about it – not family, not friends and especially not fellow students – for fear he would be ridiculed and perhaps even turfed out of university.

But nearly three decades later his secret is out. These experiences, combined with those of being a GP in a rural north Wales practice, have helped to inform his highly amusing graphic novel featuring Dr Iwan James, a GP with OCD. And as part of his promotional work for the book Ian has outed himself as a former OCD sufferer – not least in the national press in an article for the Independent newspaper.

"Until I started making comics in 2007, I had never told anybody about having had OCD when I was younger. I hid it the best I could when I was in medical school. You just didn't admit to any illness or failure and you especially didn't admit to any sort of, mental health problems," says the 48-year-old who lives in Brighton, and now splits his time between being a GP and a comic artist.

Well, as he realised some time ago when he sought professional help, crackers he's not – and the response so far to his tale of Iwan's troubled life and times, not to mention those of the community of pensioners, obsessives and gun nuts who attend his surgery, has been

positive all round. "The senior partner where I work said, 'I bought the book and you know I really like it, it's fantastic.'" He laughs as he adds: "That is not to say that there aren't loads of people out there thinking that they would never give me a job in medicine!"

Flaws, failure, illness and self-revelation are all a kind of currency in the indie comics scene, explains Ian, and this was part of the reason he was attracted to the form in the first place. "Although strips or graphic novels may be fictional with an autobiographical streak, comic artists aim for an emotional honesty, basically to tell the truth through story."

Making comics

But there was a good deal of ground to cover – medical, artistic and otherwise – before his eureka moment. His first move was to rural Wales, partly to get away from the urban scene that had featured so prominently in his OCD and partly to pursue his hobbies of climbing and mountain biking – an adrenaline antidote, perhaps, to the disabling cautiousness of OCD. Little did he know that working as a GP there he was starting to store up some of the many tales from the surgery that would later populate his graphic novel.

In the meantime, Ian began to develop his artistic side, pursuing an interest in painting. Before long, he began to exhibit and sell his work and by 1999 he decided to go part-time as a GP and enrol in a postgraduate certificate in Fine Art at Chester. "I built up a sort of side career as a painter and printmaker. I sold work through galleries and actually made a bit of money doing that."

But all the time he was looking for a way to bridge the divide between medicine and art, not wanting to ditch one or the other. "I felt that the two sides of my career were split. So I did a part-time MA in medical humanities in Swansea. While I was doing that I realised that the link for me lay not in painting or



printmaking but in comics. I was reading lots of graphic novels and I found a couple that dealt with illness. Specifically the one that changed it for me was *Mom's Cancer* by Brian Fies. And I realised I wanted to write about illness in graphic novels."

Now he did what "doctors are prone to doing", he says with a laugh. "After I had been writing about it for some time I thought, 'Well I could do that.'" So he created a nom de plume for himself, Thom Ferrier, to maintain some anonymity while still continuing to work part-time as a GP, and began to make comics.

Personal view of illness

The strips he made were blackly humorous and with the air of the confessional. In one, Ferrier admits that as a young boy he used to vandalise his neighbour's house. In another he comes out as having been a "sensitive child" who, later, during his medical training, became a serial fainter in "blood and guts" lectures and practicals.



PHOTOS COURTESY OF DR IAN WILLIAMS

One very detailed strip describes how A&E doctors would "wake up" patients feigning unconsciousness in distinctly unpleasant ways. Underlying the strip is a strong sense of outrage that these supposed "time-waster patients" were being punished for displaying a mental dysfunction, while the dysfunction itself remained unattended.

Immersing himself in the new form, Ian took his comics to fairs in London and began to get a reputation for himself. "I was going down to London every month when I was living in North Wales to meet up with other comic people, to attend comics events, to take part in them, to get to know people in the scene."

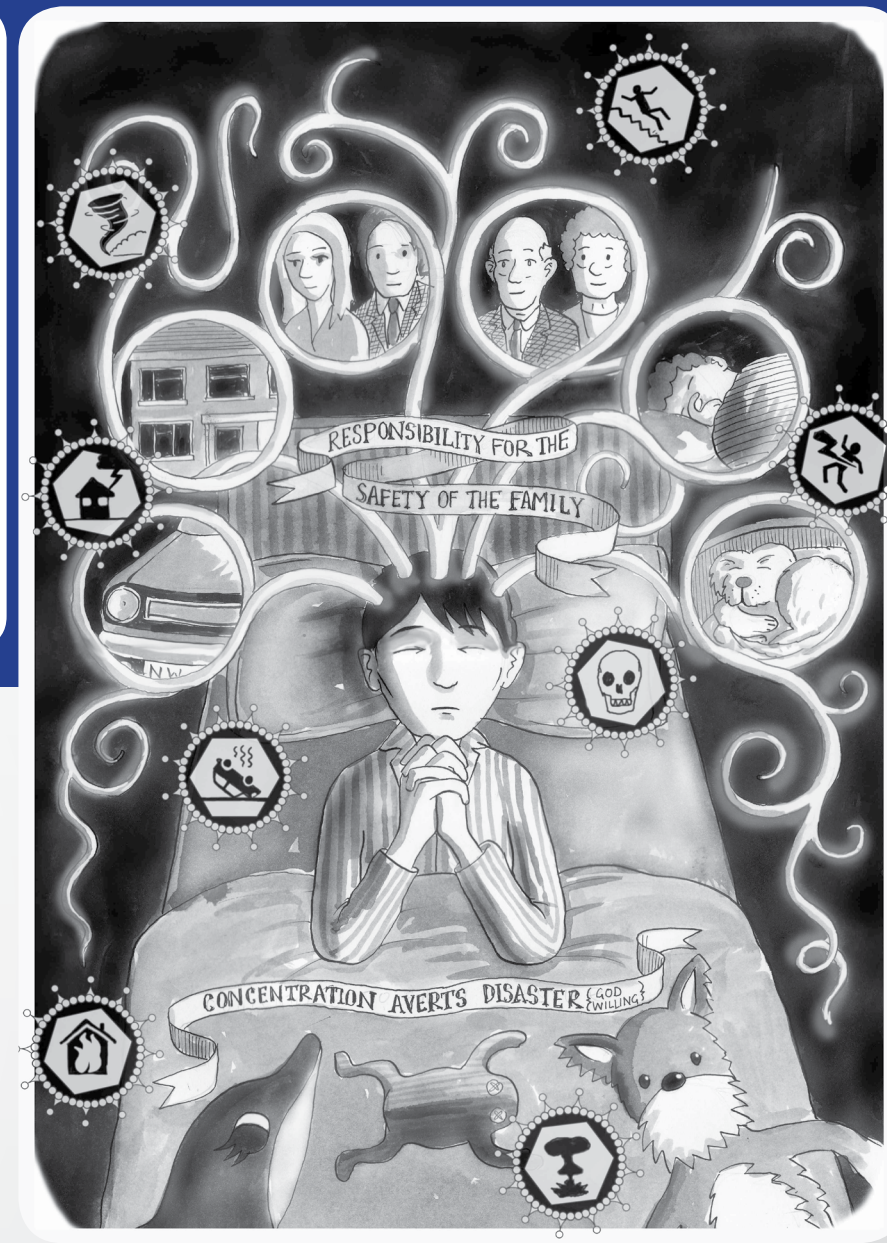
He even started a website, www.graphicmedicine.org, to look at "the area of interaction between comics and medicine". It was then he realised he was not alone. "I thought that I was being pretty clever and there wouldn't be any person interested in this but when I set the website up people started contacting me from all over the world," he says.

The site, which he runs with MK Czerwicz, who makes comics under the sobriquet Comic Nurse, is a hub for this crossover between the medium of comics and the discourse of healthcare and features reviews, podcasts, a blog and more.

Along with others, the pair have run conferences every year since 2010 – with the most recent held at Johns Hopkins Medical School in Baltimore. The events aim to examine the ways in which comics can be used to highlight important ethical issues in healthcare, portraying patient experiences, and even as effective communication and learning tools in medical training.

The conferences have been well received but, Ian admits, this remains a fairly niche subject area.

"If you go in to the dean of your average medical school and say, 'I want to teach your medical students about comics,' they will say, 'What the hell are you talking about?' I've stood



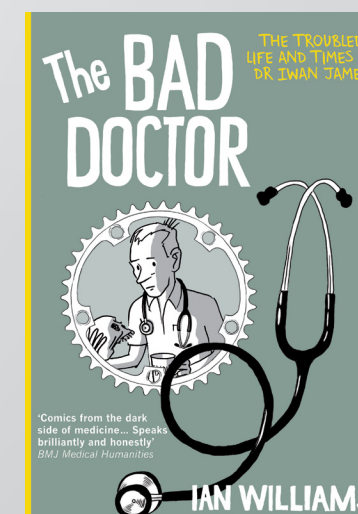
PHOTOS (clockwise from left): GP and graphic novelist Dr Ian Williams; the fictional Dr Iwan James lets off steam in an excerpt from *The Bad Doctor*; Ian illustrates typical thought processes in OCD.

in front of audiences of doctors and told them that they should read graphic novels and they just look at you like a complete idiot."

Nevertheless, there is a firm place for comics in healthcare, he believes, and his new book stands as one of many that have offered perspectives that might otherwise remain invisible. "I find autobiographical comics in which people are talking about their own experiences fascinating. I am also interested in how authors find ways of representing their illness. The way that we visualise somebody with meningitis or cerebral palsy is traditionally under the control of doctors and medical illustrators. But these comic artists who are drawing themselves, drawing their illness, are having some slight effect on the public consciousness or the way that we visualise disease. I think that's really interesting."

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

The Bad Doctor is published by Myriad Editions.



MDDUS medical adviser
Dr Susan Gibson-Smith
offers advice on raising
concerns about a fellow
doctor's behaviour

SAFETY

REPORTING a colleague that you believe poses a threat to patient safety is difficult for any doctor, but this can be especially daunting for trainees. It is important to remember, however, that you still have a professional duty to take action.

Consider the following scenario:

The tutorial was not going well. My trainer was on holiday and the senior partner, Dr Y, was standing-in.

She seemed distracted and not focussed on the task in hand which was discussing the NICE traffic light management system for children with pyrexia. Her hands were shaking and she dropped her pen on the floor. As we both leaned forward to pick it up I caught a whiff of alcohol on her breath. It was 10am.

We muddled through the next half hour before it was time for my surgery. One patient who usually saw Dr Y came to me for his blood test results, concerned he had been passing blood in his urine and was not any better after antibiotics. His file showed his haemoglobin was 8.9 and his PSA was 18. The comment on both results from Dr Y was for no further action. Concerned, I went to discuss the results with her before advising the patient. I walked into her room rather hurriedly a few seconds after her patient had left and saw her reaching into a paper bag in her bottom drawer. She startled when I came in and shouted: "Can't you knock?! What are you pestering me with now?"

I explained the situation with the patient and as she turned to the computer I could see in the drawer a green necked bottle poking out of the paper bag.

What was I to do? Should I just ignore it? I had only been in this practice for four months and I had two months still to go with another year until the end of my training. Was it really my place to be poking my nose in? After all, I would need a reference in the future. But her management plan for that man was not appropriate and who knows what would have happened if he had not come in to see me? Where could I get advice?

Missing the signs

Sadly the scenario outlined above is not an uncommon occurrence in surgeries and wards across the country. Alcoholism and addiction are significant problems within the medical profession. The British Medical Association estimates that one in 15 healthcare professionals will develop an addiction problem and doctors are three times more likely to develop cirrhosis of the liver than the general population. Whilst this raises concerns about doctors' health, it also raises significant patient safety concerns.

Patient safety has been high on the agenda ever since the 2010 Francis Inquiry into the high number of deaths at Stafford Hospital. An increasing emphasis has been placed on the responsibility of healthcare staff to raise concerns, with health minister Jeremy Hunt calling for a "culture of openness" in the NHS.

The General Medical Council responded by publishing detailed guidance in 2012 on *Raising and Acting on concerns about patient safety*, building on requirements set out in its core guidance *Good Medical Practice*. Whilst their 2012 guidance offers suggestions about what to do and who to approach if a doctor has concerns about a colleague, it is not exhaustive. Doctors must use their judgment to apply the principles to their particular situation.

When to speak out

In the scenario described above, the first thing the trainee should do is to call her defence organisation. MDDUS advisers are happy to talk through issues like these in confidence. While each situation is different, there are some broad principles to consider when raising a concern about a colleague.

The GMC is very clear that: "All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work." Understandably a doctor may be reluctant to report a concern about a colleague for various reasons. The trainee in this scenario has to return to the practice to finish her training and

Clearly our trainee ought to be raising her concern with someone.

Who to tell

It is important to know who to tell about a concern. As a trainee it would be appropriate to approach your trainer in the first instance. If the concern is about your trainer or you feel uncomfortable about discussing the matter with them, your deanery's training programme director would also be appropriate.

In some circumstances it would be appropriate to inform the GMC, such as when the concern relates to the responsible person or body. Otherwise, contact with the GMC is usually made after you have raised the concern through the local channels and you were not satisfied that appropriate action had been taken; or there is an immediate and serious risk to patients and the regulator has the responsibility to act or to intervene. Again, contact an MDDUS adviser for help.

Very rarely is it appropriate to make a concern public but I do not recommend you do this without seeking further advice.

What to say

It is important to be clear, honest and objective about the reason for your concern and be sure to focus on the issue of patient safety. In our scenario above, the trainee may be quite rightly annoyed at the way the senior partner has spoken to her, however she should separate these emotions and any feeling of personal grievance. She should instead focus on the issue of the missed abnormal blood

"Patient safety concerns override a doctor's personal and professional loyalties"

will also require a reference. Raising a concern could affect her relationship with co-workers and she may be worried that a complaint could be made against her.

Whilst recognising this difficulty, the GMC reminds doctors that the duty to act to protect patients overrides a doctor's personal and professional loyalties. The law does provide protection against victimisation or dismissal for individuals who reveal information in raising genuine concerns and exposing malpractice. Furthermore, you do not need to wait for proof. *Raising and acting on concerns* states clearly that you will be able to justify speaking out if you do so honestly on the basis of reasonable belief and through the appropriate channels, even if you are mistaken.

results, the smell of alcohol on the breath and the bottle in the drawer. It is also important to keep a record of your concern and the steps that you have taken to deal with it.

What happened?

In the scenario above the trainee phoned MDDUS for advice. As her trainer was still on leave, she was advised to discuss the issue with the deputy trainer or phone the deanery. She spoke to the deputy trainer who reassured her that the matter would be dealt with. The deputy trainer then spoke to Dr Y who agreed to take a period of leave from the practice to seek help. It transpired that Dr Y was known to have an alcohol problem and her condition had relapsed. She had been working under conditions imposed by the GMC following previous concerns about her fitness to practise. The regulator was informed of the relapse and took appropriate action to ensure patient safety until such time as she was fit to be working again.

Dr Susan Gibson-Smith is a medical adviser at MDDUS and content editor of GPST

FIRST

DIAGNOSIS

GUT PAIN



DAY ONE

Mr T – a 48-year-old plumber – phones an out-of-hours service on a Sunday afternoon complaining of diarrhoea and vomiting along with colicky pain in his abdomen. He speaks to a triage nurse who advises the patient that he is most likely suffering from viral gastroenteritis. She advises him to take paracetamol for the pain and to phone back later in the day if the symptoms worsen.

DAY TWO

Mr T attends his GP surgery for an emergency appointment as his symptoms have not improved. He sees Dr K who confirms a history of vomiting and diarrhoea but with no blood in the stools. He examines the patient and notes a temperature of 36.1 and a soft tender abdomen on palpation with no guarding or rebound. The GP offers a diagnosis of gastroenteritis and advises the patient to drink plenty of clear fluids and take co-codamol for the pain. Mr T is told to call back or return to the surgery if the symptoms do not improve or grow worse – or if there are any red flag symptoms such as high fever, blood in vomit or stools or worsening/severe abdominal pain.

DAY EIGHT

Mr T attends for another emergency appointment and this time sees a different GP. He is suffering severe abdominal pain and reports vomiting black bile and passing black stools. The GP immediately has the patient admitted to hospital. Mr T is found to have maximal tenderness and guarding in the right iliac fossa. An X-ray is taken revealing small bowel dilatation. This is followed-up with a CT scan which shows a large pelvic abscess secondary to appendicitis. He undergoes an emergency laparotomy, appendicectomy and a section of small bowel is resected. A loop ileostomy is performed. Mr T slowly improves over the next weeks but has problems coming to terms with his need for a stoma.



Four months later the practice is notified of a negligence claim against Dr K for not diagnosing appendicitis timeously and referring Mr T to hospital at a stage when the subsequent complications could have been avoided – preventing the need for an ileostomy. Dr K contacts MDDUS and various expert reports are commissioned including one from an experienced primary care physician. Copies of the patient notes and detailed statements by Dr K and the patient are assessed.

The expert notes that in his statement Dr K contends that the main purpose of his examination of Mr T on Day 2 was to exclude a diagnosis of appendicitis. He states that the common presentation of appendicitis is central abdominal pain spreading down the right-hand side. His standard practice is to examine for evidence of rebound tenderness and guarding which would be indicative of an inflamed appendix. A rigid abdomen suggests a ruptured appendix. His examination of Mr T on Day 2

revealed neither of these findings. Given the patient was complaining of diarrhoea and vomiting of less than 24 hours his diagnosis was gastroenteritis.

Mr T claims that he was “doubled over with pain” on attending the surgery that morning. He states that when the doctor palpated his lower right abdomen he “nearly hit the ceiling”. He further states that he asked Dr K specifically if it could be appendicitis but was told it was “only a tummy bug”. He denies having his temperature taken or being asked about blood in his stools, nor being told to come back if his symptoms worsened or if there were any “red flags”.

In addressing the conflicting claims between doctor and patient the primary care expert refers to the patient records. Here he finds contemporaneous and well set-out notes by Dr K detailing the nature of the history taken and the examination conducted. The doctor specifically records “safety net” advice given.

This, and the precise note of the temperature taken, suggests that Mr T’s recall of the consultation may be flawed.

The expert concludes that in hindsight it is clear Mr T was in the early stages of appendicitis on Day 2 and had he been referred to hospital at this point he would likely have avoided the subsequent complications. But it is also his view that Dr K provided a reasonable standard of care in his encounter with the patient.

MDDUS lawyers offer a firm rebuttal of the claim and it is eventually dropped.

KEY POINTS

- Good medical records are the best defence in negligence claims – especially with conflicting accounts.
- Comprehensive and contemporaneous notes will outweigh recall as evidence in almost every case.

Diary

WHAT more could you need to enjoy your tea break than another serving of dramatic headlines and outlandish claims, involving impending doom, the Magic Circle... and Justin Bieber.



practice. Ten years of unfruitful negotiation with representatives of his LMC and former PCT drove him to this final desperate act. Dr Cormack-the-Family-Doctor-who-works-for-the-NHS-for-free is now in the process of registering his change of name with the GMC and Mid Essex CCG.

- **TRAIN THREATENS FUTURE OF MEDICINE** While environmental campaigners protest over the potential threat to the countryside, the RCGP has lodged its own rather dramatic objection to the proposed High Speed 2 rail link. The College fears the £50 billion scheme could have “a detrimental impact for the future delivery of general practice and primary care throughout the UK”. The source of their concern is the potential noise and disturbance from construction work that will take place near their new Euston HQ where GP trainees currently enjoy peace and quiet during exams. “Were the examinations not able to run due to the disturbance caused by HS2 this would mean that the UK would be deprived of thousands of new GPs each year,” treasurer Dr Helen Stokes-Lampard told Pulse. She also fears the College could be evicted from the newly refurbished building unless “adequate compensation and mitigation measures” are put in place.

- **GOOGLE SAVED MY LIFE** Who needs GPs when you have the world’s favourite internet search engine to rely on? A recent report in (where else but) the *Daily Mail* told the story of two women who claimed the web had saved their lives in the face of alleged indifference from their doctors. One patient’s symptoms research helped her reach a breast cancer diagnosis while the other discovered she had oral cancer after trawling the web. The report went on to quote a UK survey from earlier this year suggesting 21 per cent of patients trusted Google above their GP while 27 per cent said they relied “entirely on Google for a diagnosis”. Well at least that solves the GP recruitment crisis...

- **JUSTIN BIEBER SAVED MY LIFE** The headlines just get increasingly unlikely... He may not be much of a role model for young drivers, but Canadian pop star Justin Bieber is being credited with helping to bring down skin cancer rates. It seems many of his millions of fans have been emulating their idol by growing a fringe. The hairstyle has been particularly popular amongst pale-skinned youngsters who were found to have fewer forehead freckles. US dermatologists say the hirsute covering shields the skin, reducing potential sun damage.

- **WHAT’S IN A NAME?** Ten years’ worth of frustration to one angry doctor. An Essex GP recently applied to change his name by deed poll to Dr John Cormack-the-Family-Doctor-who-works-for-the-NHS-for-free. This was done in protest at the serious underfunding from his local CCG. The GP who runs a practice of 4,000 patients has been reduced to paying his staff – four nurses and a part-time locum – from his own pension fund and claims that in 2011/12 the cleaner earned more than he did from the

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

- **SHAPE UP, DOC** Overweight doctors and nurses should be told to slim down to set a good example to patients. That’s the view of NHS England chief executive Simon Stevens who said NHS staff should “get our act together” before offering healthy living advice to patients. Suggestions for achieving the goal include encouraging healthcare professionals to take part in weight loss competitions and building more gyms. A newspaper report suggests as many as 700,000 of the 1.3 million health service staff are either overweight or obese.

- **RISK ON THE ROAD** Healthcare workers are apparently among the most accident-prone motorists on the road. Research from gocompare.com has found that GPs made proportionately more car insurance claims than many other professions last year. Figures show 28.6 per cent of GPs had at least one claim in 2013. Professor Andrew Smith from Cardiff University’s school of psychology believes the stress of the job could be making them absent-minded and distracted, adding: “You might even find that [stress makes you] become especially clumsy at times.” Health visitors and community nurses were also in the top 10 list of claims. Gocompare.com recommends stressed-out drivers are encouraged to take time to calm down before getting behind the wheel. Sage advice, although there doesn’t seem to be any data on the relationship between GP car insurance claims and the number of home visits doctors make to those less salubrious areas.

- **NOW YOU SEE HIM...** Most retiring GPs slip quietly away with a few buns at coffee time or maybe staff drinks at the local pub. Patients are often none the wiser. Not so with Dr Richard Hughes who retired in April at age 60 from Hanway Medical Practice in Portsmouth. Patients queued for four hours to thank the GP in person for his 32 years’ of service. Practice manager Denise Fenton said that Dr Hughes was so dedicated that he would sometimes call worried patients at 10pm to give them test results. “He knew most patients by name, made them feel valued and treated them as individuals.” A much splashier exit was planned by Dr Ajay Vora for his retirement from Barnetby Medical Centre after 25 years. Dr Vora put on a show at Grimsby Auditorium for over 1,000 of his patients with magic, music and dance. The doctor, who is member of the Magic Circle, performed along with his wife and practice nurse Angela. Dr Vora said: “We wanted to let everyone have an invitation to thank them personally and wave goodbye from the stage.” Diary prefers buns.

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