



NORTH TO SOUTH

ACCLAIMED WRITER, EXPLORER AND GP
GAVIN FRANCIS ON HIS ARCTIC ADVENTURES

ALSO INSIDE

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IN RECOVERY

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IN ACTION

AN MDDUS
PUBLICATION





Welcome to your GPst

AS doctors, the way we behave both professionally and personally can have a major impact on our careers. Whether we like it or not, we are never really off duty – something we must remember whether we're enjoying a night out or posting comments on social media. MDDUS medical adviser Dr Susan Gibson-Smith offers guidance on [page 12](#).

Dealing with a patient complaint is a daunting prospect for trainees who are often less familiar than senior colleagues with how the process works. MDDUS medical and risk adviser Dr Gail Gilmartin provides practical advice on [page 7](#). Hospital test results are easier to access than ever before, meaning doctors can more quickly advise and reassure patients – but only if they are competent to interpret the findings. MDDUS senior risk

adviser Liz Price highlights this issue on [page 5](#).

It's been 50 years since the thalidomide drug scandal caused disabilities in thousands of UK babies, prompting the creation of the Yellow Card Scheme. MDDUS publications editor Jim Killgore finds out more on [page 6](#).

On [page 10](#), Edinburgh GP and acclaimed writer and polar traveller Gavin Francis talks about his sub-zero adventures working in Antarctica and the Arctic, where he mended broken bones and visited emperor penguins. Our career feature on [page 8](#) looks at how to become a GP with a special interest in substance misuse, helping patients in all areas of their life.

And our case study on [page 14](#) highlights a failure to refer in the case of an enlarged mole.

• Dr Peter Livingstone
Editor

CALLS FOR "PREDATORY" DOCTORS TO BE STRUCK OFF

DOCTORS who abuse their professional position by preying on patients should be struck off, a GMC consultation has heard.

More serious action should be taken to punish predatory behaviour, particularly when it involves vulnerable people.

Doctors should also face more serious consequences if they fail to apologise to patients when things go wrong.

These views emerged in response to a consultation by the regulator on its Indicative Sanctions Guidance for fitness to practise panels of the Medical Practitioners Tribunal Service (MPTS). More than 2,000 people responded to the consultation which ran from August to November last year.

Seventy eight per cent of respondents thought panels should take more serious action in cases involving bullying, sexual harassment and physical violence towards colleagues and where

patients had been put at risk, while 61 per cent wanted stronger action against doctors who discriminated against colleagues or patients.

Results also showed 79 per cent agreed that the stage of a doctor's career should be a mitigating factor when considering what action to take.

GMC chief executive Niall Dickson said the new guidance would include an increased focus on saying sorry.

He said: "In this consultation we asked whether failing to apologise should affect the sanction a doctor faces, and there was strong support for this to be included in new guidance. Until now this has not been highlighted as one of the factors which are likely to affect sanctions - that is now likely to change."

The GMC will publish new guidance for MPTS fitness to practise panels reflecting on the consultation in the summer.



CASH INCENTIVE FOR NEW GPs

NEW doctors are being offered cash rewards if they choose to become GPs, as part of a £10 million campaign to boost numbers in the specialty.

NHS England is implementing a range of measures to make general practice a more attractive career move.

Under the plan, the *Guardian* reports, medical graduates who agree to work for three years as a trainee GP in areas in need of family doctors will receive "additional financial support". They will also be offered an extra year's training in another specialty of their choosing, or help with business skills.

Four new GPs have recently been recruited to Leicester, *Pulse* reported, after being offered a £20,000 incentive for committing to two years' work.

The campaign follows reports in October 2014 that a large number of GP training posts in England remained unfilled. Health Education England (HEE) confirmed an overall vacancy rate of 12.4 per cent, with that figure reaching 30 per cent in some of the worst affected areas.

The RCGP is also taking part in the campaign. Chair Dr Maureen Baker wrote a letter to 20,000 trainee doctors urging them to consider an "exciting" career in general practice, saying the specialty offers "a great deal of flexibility" and its future is "looking bright."

The College also released a three-minute promotional video in which GPs talk about how they find the specialty exciting and varied.



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DESIGN:

CMYK Design
www.cmyk-design.co.uk

PRINT:

Thomson Colour Printers
www.jtcp.co.uk

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COVER PHOTO: DR GAVIN FRANCIS

DRUG DRIVING LAW COMES INTO FORCE

A NEW offence for driving with certain medications over specified blood concentrations came into effect in March.

In July 2014 the Medicines and Healthcare products Regulatory Agency (MHRA) informed doctors of the new offence which is being enforced in England and Wales. It is intended to bring enforcement more in line with that for drink driving and operates in addition to the existing law on drug-impaired driving.

Police will employ roadside tests to check if drivers have taken any of the specified controlled drugs. The type and level of the drugs will then be confirmed by a blood test taken at a police station. The list of controlled drugs falls into two broad groups: so-called "zero tolerance" or commonly abused drugs, such as cannabis or heroin, and mainly licensed medicines though still with significant liability to be abused, such as benzodiazepines and methadone.

The new law sets out a statutory "medical defence" for patients taking medicines in accordance with instructions. Any individual taking a controlled drug from the specified list and in excess of the set limits without a "medical defence" can be prosecuted under road traffic laws.

It is important to stress that under existing legislation it is still against the law to drive if your driving ability is impaired by any medicine.

More information can be found on the MHRA website.

The date of enforcement in Scotland is dependent on approval of regulations by the Scottish Parliament. The introduction of a similar offence in Northern Ireland is under consideration.



WARNING ON WAITING ROOM MUSIC

DOCTORS playing music in their practices must have relevant licences or risk legal proceedings.

MDDUS has received calls from members asking what the licence requirements are for playing music in waiting areas, with reports of a crackdown by royalties companies.

MDDUS Head of Dental Division Aubrey Craig said: "Any business that plays recorded music in public is legally required to have relevant licences - and medical and dental practices are no different.

"Regardless of whether it's the radio, cd, mp3 or other form of music being played, the licences need to be paid to protect the copyright of those who create, produce and publish the music or performances."

Phonographic Performance Limited (PPL) collects and distributes licence fees for the use of recorded music on behalf of record companies and performers, while Performing Right Society (PRS for Music) collects and distributes for the use of musical compositions and lyrics on behalf of songwriters, composers and publishers.

"Both organisations are separate



independent companies and, if you play music in the practice, it is likely you will need both licences," said Craig. "Those who fail to obtain the correct licence face legal proceedings as a result of 'infringing copyright'."

Further details can be found at the PPL and PRS for Music websites.

ONLINE GMC RESOURCE ON DEMENTIA AND MENTAL HEALTH

DEMENTIA and mental health are the subjects of an online resource being promoted by the GMC.

The *Dementia and mental health* website contains a mixture of guidance, case studies, scenarios, articles and tips to prepare doctors for caring for the growing number of older patients.

New updates to the resource include a 'mythbusters' leaflet produced by the GMC from Professor Alistair Burns CBE, NHS England's National Clinical Director for Dementia, which tackles five common myths related to treating patients with dementia, such as "it isn't possible to live well and have a good and rewarding life with dementia".

The resource also contains new opinion pieces from the Alzheimer's Society and the National Dementia Carers Action Network, who provide different perspectives on helping older patients living with dementia and mental health issues.

Access the resource at:

www.gmc-uk.org/guidance/26081.asp

DROP IN GP TRAINING APPLICATIONS

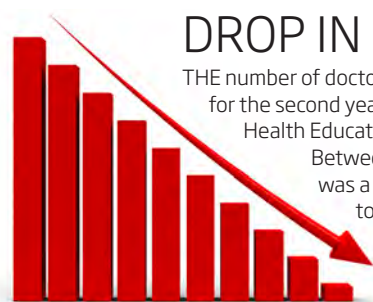
THE number of doctors applying to start GP training has fallen for the second year in a row, according to new figures from Health Education England.

Between November 11 and December 4, there was a drop of 6.2 per cent in UK GP applications to the 2015 programme, with the current total at 5,112. This is a slight improvement on 2014 when HEE reported a sharper fall of 9.7 per

cent in applications to 6,031.

The figures follow reports in October last year highlighting an overall vacancy rate for GP training posts in England of 12.4 per cent with only 2,688 trainees recruited. In some parts of the country vacancies were as high as 30 per cent.

Despite the declining numbers, HEE has insisted it is still "well on course" to meet its government target of having 3,250 GPs in training by August 2016, a deadline which had already been pushed back from August 2015.



SILENT SUFFERING

The recently reported rise in self-harm among children highlights the need for practices to ensure they provide a welcoming place for young people in need of treatment or advice



A RECENT report published by the Health and Social Care Information Centre highlighted that the number of children (10 -14 year olds) being admitted to hospital in England for self-harm is at a five-year high, with admissions of girls increasing by almost 93 per cent and a rise of 45 per cent in boys.

Mental health campaigners believe the figures could be the tip of the iceberg. Boys are often reluctant to admit to self-harming because it is perceived as a largely female behavioural problem and as a result campaigners fear "huge numbers" of children - especially boys - are still "suffering in silence".

Experts say that increases in admissions are partly due to a rise in young people self-harming, but also reflect better recording of data by hospitals. They argue that a 'cultural shift' is needed in society to ensure teachers and parents are not afraid to address the topic of self-harm, particularly among boys.

The report explores further social reasons for the gender discrepancy in young people seeking help, suggesting that because of the way society has constructed the image of self-harming, it makes it easier for girls to speak out about the problem.

Self-harming behaviour of course represents only one reason why a young person may consider approaching their GP for help.

The legal and ethical dilemma here for a health professional is one of competence and when a young person can demonstrate sufficient emotional maturity to make decisions about their own health and wellbeing without the involvement of their parents or other guardians. Fortunately, health regulatory bodies such as the GMC in their *0-18 years* guidance, along with the Caldicott Information Governance Review (tinyurl.com/cuye9b2) and other professional organisations offer plenty of guidance in this area, without providing answers and solutions to situations which are set in tablets of stone.

Even before a young person gets to the stage where they are in a position to have an intelligent one-to-one consultation with their doctor or other health professional, there is another important consideration to consider. Just how young-person-friendly is your training practice?

There are a number of common areas where practices are promoting positive incentives for ease of access, as well as some which are performing less well in this regard.

For example, does your practice actively promote itself to young people? By this I mean through the use of specific literature including, where applicable, web-based info with links. Does this reflect the style of language used to communicate with this age group? Or, conversely, does the information and welcome provided to young people suggest that it is actually discouraged?

Young people should be reassured that the principle of confidentiality extends beyond health professionals to other staff (such as

receptionists), who may live locally and have social relationships with the young person's extended family. The erroneous presumption that confidentiality does not extend to other staff in itself could be a compelling reason for a young person not to consult with their GP.

We have come across instances where written information states that under-16s need to be accompanied by an appropriate adult. This is a capacity and competence issue first and foremost and the young person's ability to make decisions for him/herself should be considered from the outset, before determining how involved parents should be.

Does the reception team at your practice handle calls requesting appointments from a patient who is under 16, and are they aware of the sensitivities around screening reasons for wishing to see the doctor?

The practice can show they understand the particular problems young people can face by publicising in their waiting room examples of why they may wish to see a doctor:

- If you feel down all the time
- Are you being bullied at school?
- If you have a condition you find embarrassing
- If you have unprotected sex, or you wish to discuss contraception
- Are you concerned about your weight?

Another example of proactive policy and practice that we have encountered is where practices address this issue directly with parents, when the young person reaches around 12 years of age. This can take the form of a standard letter informing parents that, as their child matures, they will be increasingly able to make decisions about their own care and treatment. This will mean that individual approaches by the young person will be assessed according to the circumstances, and that parents may not automatically be informed about the contact.

Understandably, practices can be reluctant to address this issue head-on for fear of opening a can of worms, as some parents will be quite forceful in exercising what they see as their legitimate 'parental rights'. However, having the conversation at a stage where there is no ongoing crisis, with the accompanying emotional baggage, can be more beneficial in the long run. At the very least it will have hopefully planted a seed in the parents' mind and allowed them to consider the issue and its implications.

Alan Frame is a risk adviser at MDDUS

BALANCING RISKS AND BENEFITS

Easy access to hospital test results can help GPs reassure worried patients, but only where doctors work within their competence

DIGITAL reporting means it is now easier than ever for GPs to gain quick access to hospital test results. This development undoubtedly brings benefits for patients as doctors are able to make diagnoses and carry out treatment more quickly. But there are also some associated risks.

Consider the following scenario:

A GP registrar, Dr F, is in consultation with an elderly patient, Mr B. He recently attended the local hospital to undergo a CT brain scan having suffered headaches and a fall in the previous months. Dr F can see how worried Mr B is about his health and she is keen to reassure him. She accesses the results of the CT scan and reads the report. She then informs Mr B that there appear to be "abnormalities", although she admits to being "unqualified to read the report" and feels that specialist input is required to interpret the findings. She advises Mr B that the practice will contact the hospital consultant by letter for more information and get back to him in due course.

Two days later the practice receives a letter of complaint from the patient. Upon leaving the practice after the consultation, Mr B had suffered a panic attack on the way home. After receiving assistance from a neighbour, he was helped by his daughter to contact the hospital later that day. A consultant phoned back and reassured the patient that the result was fine and that the abnormalities reported are nothing to be concerned about.

Mr B is relieved by this but remains very unhappy about the unnecessary stress that Dr F placed on him and wants an apology.

Better and timelier access to information about patient testing and reporting may lead a doctor, with an anxious patient in front of them, to review results which would not previously have been accessible. In many cases, viewing such reports could ease the patient's worry – particularly in areas where discharge information and reporting to the GP practice is routinely slow.

However, in our experience at MDDUS this can sometimes prove counter-productive. As illustrated in the scenario above, highlighting a potential "abnormality" to a patient when you do not have the appropriate knowledge or skills to fully interpret and explain the test results can serve more to increase anxiety rather than reassure.

In such situations, it is important to pause and consider the best course of action to ensure that you work within the limits of your competence. Of course, if you have an anxious patient or one whose condition has significantly deteriorated since they were last seen at hospital, you might judge that action is required.



In its guidance *The Trainee Doctor*, the General Medical Council clearly states: "Trainees must be appropriately supervised according to their experience and competence, and must only undertake appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision. Trainees must never be put in a situation where they are asked to work beyond the limits of their competence without appropriate support and supervision from a clinical supervisor."

In situations where you are dealing with specialist reports it may be more circumspect to inform the patient that you will investigate the matter and agree with them the most appropriate mechanism by which you will get back in touch, once you have further information. This will allow you more time to discuss the matter with a senior colleague or your trainer.

If you feel the patient's symptoms have worsened and you have a higher index of suspicion, consider asking the patient to leave the room before looking online for any available results. This will give you the opportunity to review the report in private, allowing you to manage your uncertainty away from the patient. Taking this time to pause before discussing results with the patient will not trouble them – they will see that you are trying your best to resolve the situation for them and it can allow you to discuss the matter with a senior colleague or your trainer, or with a member of the hospital team if you feel further advice is required.

In summary, the next time you are confronted by a concerned patient awaiting test results, stop to consider the consequences of accessing data which may require specialist interpretation. Consider how the situation might be managed most effectively in relation to both accessing the result and managing the patient's expectations and anxiety. It may be better to await specialist input – either in-house or from the hospital team concerned – before providing specific comment on the results to the patient unless you feel the benefits of this might outweigh the risks.

Liz Price is a senior risk adviser at MDDUS

SEEING YELLOW

Jim Killgore looks at the Yellow Card Scheme – now 50 years old – and its importance in identifying adverse drug reactions

JUST over a half-century ago a 34-year-old research physician named Bill Inman left his job as medical adviser at ICI Pharmaceuticals to join the Department of Health. Britain was then waking up to the full extent of the thalidomide scandal. Thousands of babies had been born with deformed and missing limbs after their mothers had taken the drug, marketed to relieve nausea in pregnancy. A government committee on drug safety was formed to ensure such a disaster was never repeated. Its chair Sir Derrick Dunlop invited Bill Inman to develop an early warning procedure for adverse drug reactions.

Inman knew first-hand what it was like to live with disability. Just after finishing his pre-clinical studies at medical school – age 21 – he contracted polio and spent much of the next two years in an iron lung. Inman resumed his medical training on recovery but had to use a wheelchair for the rest of his life.

Joining the Department of Health in 1964 Inman was charged with developing a scheme that would adhere to key principles defined by Sir Derrick: spontaneity and speed, confidentiality and most importantly a commitment from healthcare professionals to report suspicions in the interest of protecting public health. Inman proposed supplying doctors and pharmacists with distinctive yellow postage-paid cards to report any side-effects occurring in newly licensed medicines. The Yellow Card scheme came fully into effect in 1970 and in the intervening years over 750,000 reports have been processed.

Today the Yellow Card Scheme is run by the Medicines and Healthcare products Regulatory Agency (MHRA) on behalf of the Commission on Human Medicines. Most reports are now made online using the Yellow Card website (www.yellowcard.mhra.gov.uk) or via FREEPOST cards found in the BNF, MIMS and ABPI compendium. The scheme has become a vital tool in monitoring the safety of all healthcare products in the UK. Yellow Cards can be used to report:

- suspected adverse drug reactions
- medical device incidents
- defective medicines
- suspected fake medicines.

Any medicine can cause side-effects or adverse drug reactions (ADRs). An ADR

reported on a Yellow Card will be evaluated along with other sources of information such as clinical trial data, medical literature or data from other regulators. The reports are assessed by doctors, pharmacists and scientists, and the safety profile of the medicine is carefully evaluated including risk-benefit, as well as the side-effects of other medicines used to treat the same condition. Such investigations may result in safety alerts or other actions to protect public health.

Reports can be made for any medication either prescribed or over-the-counter, including vaccines, blood factors and immunoglobulins, herbal medicines and homeopathic remedies. Most of the 25,000 ADR reports received each year are made by doctors, pharmacists or nurses but seven per cent come directly from patients and carers. Yellow Cards should be submitted for:

- ADRs that have caused death or a serious illness
- Any ADR, however minor, if associated with a new medicine or one that is under continued monitoring (highlighted in the British National Formulary with a black triangle)
- Any ADR, however minor, if associated with a child (under 18 years of age) or in pregnancy.

Reports should not include personal information about patients which could be used to identify an individual (such as name or address) but the MHRA does require the age and gender of the person who experienced the suspected ADR in order to investigate contributing factors.

Yellow Cards are processed rapidly, according to tight timelines set out in legislation. Over the last five decades – despite its limitations – the system has established a proven track record in the identification of previously unrecognised safety hazards.

Only recently the Yellow Card scheme was extended to cover medical device adverse incidents. Such incidents could involve anything from contact lenses to condoms, heart valves to hospital beds, resuscitators, radiotherapy machines, surgical instruments, syringes, wheelchairs or walking frames. An ADR involving a medical device could, for example, include faulty brakes on a wheelchair or a batch of test strips for a blood glucose meter giving incorrect readings. Reports are

made in the same way as for medications.

GPs are central to the success of the Yellow Card Scheme and it is part of a doctor's routine duty of care to ensure they report ADRs. In its guidance *Good practice in prescribing and managing medicines and devices* the GMC reminds doctors that they "must" report such adverse incidents.

The guidance states: "Early, routine reporting of adverse reactions, incidents and near misses involving medicines and devices can allow performance and systems issues to be investigated, problems rectified and lessons learned. You must make reports in accordance with your employer or contracting body's local clinical governance procedures."

Jim Killgore is publications editor at MDDUS

Making a report under the Yellow Card Scheme

There are two ways to report to the Yellow Card Scheme:

- The easiest way to report is online at www.yellowcard.mhra.gov.uk
- Complete a paper Yellow Card form which you can post to FREEPOST YELLOW CARD. Yellow Cards can be found in the BNF, MIMS, ABPI Compendium or ordered by calling the Yellow Card Information Service freephone on 0800 731 6789



THE RIGHT RESPONSE

Handling patient complaints can be a daunting prospect for trainee GPs. MDDUS medical and risk adviser **Dr Gail Gilmartin** offers some advice

DOCTORS at any stage in their career can be the subject of a patient complaint. It is an experience no practitioner relishes, but it can prove particularly challenging for doctors in training who are often less aware than senior colleagues of how the process works.

There are many reasons why complaints arise. Often they are a result of care provision going wrong or when patient expectations are not met, while others are based on misunderstanding. They can range from very serious matters to quite trivial issues. At the root of much dissatisfaction are issues of patient communication/rapport. Complaint letters frequently make reference to a doctor's failure to listen or care, with allegations of attitude problems and rudeness. Patient perception is an important factor to remember.

The NHS complaints procedure is formal and is set out in guidance for each of the UK jurisdictions, but all have similar elements. If a complaint comes directly to you, then it should be shared with your supervisor and complaints manager - do not attempt to deal with it alone.

A complaint may be written or verbal and, in the latter case, it should be noted and checked for accuracy with the complainant. The first response should be an acknowledgment by the complaints manager before a full response is provided later.

Complaints may come from the patient themselves or someone appointed by them, usually a close family member. Appropriate consent should be provided by the patient in these circumstances. After-death complaints may also be raised by relatives and consideration should still be given to issues of confidentiality. The GMC's guidance *Confidentiality - Disclosure after a patient's death* is a useful resource.

There are time limits regarding the submission of complaints - usually restricted to within 12 months of the date of incident or date of knowledge of a problem. If you are involved in a complaint you should be advised of this and given the opportunity to respond. The next step is to prepare a written

response, expressed in professional and appropriately conciliatory terms. This is something that can be discussed with your trainer and an MDDUS medical adviser.

Generally, the opening paragraph of any response will be a polite introduction with a suitable expression of regret that the patient had cause to complain. Next, a paragraph summarising how the complaint has been investigated can be helpful. In the body of the letter there should be a factual chronology setting out the sequence of events. This should be supported by the medical records and possibly information from other relevant sources - such as recollections from other staff involved, hospital letters, etc.

The reply must be honest and, where things did not go well or care fell short, this must be acknowledged. The response letter should address the matters of concern raised by the complainant and answer any specific questions.

Conclude the letter with an offer to meet the complainant if that would assist, and provide information about the next stage of the complaints process should they remain dissatisfied. In England, Wales, Scotland and Northern Ireland, the complaint would be escalated to the respective ombudsman for an independent investigation.

There is a role for local health bodies - such as Local Area Teams and health boards - to act as an "honest broker". In addition, NHS England can act as complaint investigator in their jurisdiction. Patients may choose to adopt these routes if they do not wish to write to a practice directly.

In many cases a complaint will be successfully handled within the practice ("local resolution") but sometimes the ombudsman is asked to investigate. All relevant correspondence, including letters sent by the practice, notes of any meetings, etc, will be requested and reviewed - the ombudsman has wide powers to seek documents including medical records.

After review the ombudsman produces a detailed report, stating whether the complaint

is upheld, part upheld or not upheld. In cases where at least part of the complaint is upheld recommendations will be made. These can include offering an apology, carrying out audits, amending processes and in some instances financial withholdings (fines) are made against the practice.

Responsibilities of the trainee and trainer

In Scotland, complaints about trainees must be reported to NES; in other areas there may also be a requirement to inform the relevant deanery/LETB. A trainer would be expected to discuss any complaint with their trainee in an open and supportive way. Any lessons to learn should be highlighted and the trainee given the opportunity to reflect and if necessary improve their practice.

If a meeting is arranged with the complainant and the trainee is present they should be accompanied - usually by their trainer but possibly a fellow doctor in the practice. These meetings aim to resolve matters and need sensitive handling - most trainees would not have sufficient experience and should not be left to deal with matters alone.

If you are named in a complaint always seek assistance about how to respond - this should be from your trainer but MDDUS advisers are also happy to help. We are very experienced in dealing with complaints and can review draft letters of response.

In summary

Even the best doctors can receive a complaint - they are not uncommon and are a part of your professional life that you should be equipped to deal with. Look objectively at what the complaint is about - be honest in any reply, including making appropriate concessions and apologies. And don't forget to seek advice.

Dr Gail Gilmartin is a medical and risk adviser at MDDUS



THE JOURNEY TO RECOVERY

GPs with a special interest in substance misuse look beyond standard clinical recovery to encourage hope and ambition in their patients

RECOVERY is at the heart of the UK government's current drug strategy, encouraging a focus on wellbeing, citizenship and freedom from dependence.

It envisions patients being supported on an "individual, person-centred journey" by a broad range of healthcare staff, emphasising that "no one professional can expect to meet all the recovery needs of any of the people they work with".

Playing a key role within this multidisciplinary team are GPs with a special interest (GPwSI) in substance misuse working collaboratively to build recovery in communities. Their specialist training and additional skills in this field means they are well placed to work with more complex cases.

Supporting people who use drugs or alcohol means looking beyond a simple clinical model by helping patients with a variety of needs in all areas of their life. This is ideally done in a coordinated way and through interventions such as psychosocial approaches, harm reduction, addictions-specific prescribing and medically assisted recovery. With improved mental and physical health and appropriate support, other positive outcomes can often be realised, including employment, living in suitable accommodation, improved personal relationships and reduction in criminal activity.

Entry and training

GPs developing a special interest in any field can acquire training in both practical and theoretical ways. This can include experience of working in relevant departments, self-directed learning, attendance at relevant recognised meetings/lectures/tutorials, vocational training programmes or a recognised university course.

A good way of obtaining structured learning is to complete specialist substance misuse training to certificate or diploma level. And while GPs are already able to prescribe opioid substitution treatment, those developing a special interest in the field of addiction may opt to sit in and shadow an experienced prescriber in order to improve their skill set.

The RCGP's Substance Misuse and Associated Health (SMAH) unit also offers a range of courses, including the Certificate in the Detection, Diagnosis and Management of Hepatitis B and C in Primary Care; the Certificate in the Management of Alcohol Problems in Primary Care (involving an eLearning module and a six-hour training day); and the Certificate in the Management of Drug Misuse. This course is spread over six months (equivalent to nine study days), running annually from February to November.

Other training is offered by Substance Misuse Management in

General Practice (SMMGP), including the Advanced Certificate in Community Management of Alcohol Use Disorders. It is worth checking CPD requirements for GPwSIs in your area as some training may be deemed compulsory.

The job

All doctors should be able to identify patients using drugs and alcohol, carry out a basic assessment and refer where needed. Some will also provide opioid substitution treatment (OST), however GPs with a special interest in substance misuse can offer a greater level of care to patients with more complex needs, often those who have struggled to engage consistently with recovery services. Patients may present with complicating factors such as pregnancy, mental illness, physical health complications (e.g. alcohol-related liver problems) or complicated issues relating to the care of children.

GPwSIs may also manage complex prescribing; work with acute hospital and psychiatric liaison services; help to design new treatment pathways for emerging drugs of misuse; and take part in clinical governance activities, for example GPs participating in an annual audit of uptake of vaccinations for blood-borne viruses.

The framework for the provision of services by GPwSIs in substance misuse lists some of the different types of services they can deliver, including:

- Providing a service to drug users in special circumstances, for example custodial settings, dose assessment services, supervised consumption services
- Facilitating support for secondary care teams managing substance misuse patients during hospital admissions
- Identifying and addressing the needs of vulnerable and disadvantaged groups
- Providing services to substance misusers with special needs, e.g. pregnant women and young people
- Incorporating a significant service development role, e.g. GP lead for substance misuse in a primary care trust
- Advising commissioners and providers on short, medium and long-term planning for prevention, treatment and care for substance misuse
- Input into local substance misuse strategies
- Using skills in a specialist setting working to provide primary care services to drug users, e.g. within a rehabilitation unit.

Helping people who use drugs and alcohol recover presents a continuing, ever-changing challenge. The use of recognised drugs such as heroin and cocaine may be stable or falling, but new drugs such as so-called "legal highs" are rising in popularity while long-term drug and alcohol use amongst older people is on the increase. GPs specialising in substance abuse must find new and innovative ways to support patients on their journey to recovery.

Sources and useful links:

- *Delivering quality care for drug and alcohol users: the roles and competencies of doctors - A guide for commissioners, providers and clinicians*. Royal College of Psychiatrists and RCGP London, 2012 - tinyurl.com/m32o8de
- *Guidance and competences for the provision of services using practitioners with special interests - substance misuse*. RCGP and Royal Pharmaceutical Society tinyurl.com/lc758bm
- Substance Misuse Management in General Practice - www.smmgp.org.uk

Dr Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP. He is also the RCGP regional lead in substance misuse for the West Midlands.



Q&A

Dr Steve Brinksman, GP, clinical lead of SMMGP and RCGP regional lead in substance misuse for the West Midlands

What attracted you to a career as a GPwSI in substance misuse?

I came to realise that this is an area of medicine that not only improves the life of those that I treat but also improves the lives of their family, their community and even wider general society through reduced crime and many other factors. I can't think of another aspect of medicine that has such wide-ranging effects.

What do you enjoy most about the job?

It is very rewarding helping to support someone who is essentially turning their life around. I think in general practice we spend a lot of time managing long term conditions and, whilst this can be a chronic condition, many people do recover either to long-term abstinence or to a state of medical-assisted recovery where they are supported in long-term improvement whilst having a prescription for opioid substitution treatment.

Are there any downsides?

Illicit drug use is a very risky business and a few of the patients I have treated have died. This is always difficult to deal with.

What do you find most challenging?

Sometimes people are either not ready or even unwilling to change which can be frustrating as I am aware of how well patients can do if they engage in the process. To be fair this applies across a lot of general practice and not just to those who use drugs and alcohol. It requires flexibility in trying to find the right approach for each individual.

What about the role has most surprised you?

That despite a plethora of evidence on the value to both the individuals and the health service of treating patients with drug and alcohol dependency, many GPs remain cynical and actively avoid working with this group.

What is your most memorable experience so far?

It is an area of general practice that provides a lot of memorable experiences. I had been treating a heroin user for several years until he moved away. Three years later he wrote to tell me he had stopped using all illicit drugs and was working as a volunteer at the drugs agency near where he now lived. He was kind enough to tell me that he didn't think he would still be alive if he hadn't been in treatment with us and that this then gave him the chance to subsequently make the most of the opportunities that he had.

What advice would you give to a trainee GP considering a career as a GPwSI in substance misuse?

It makes a lot of difference to a range of people so is well worth doing. Use the training opportunities that are available from organisations such as RCGP, SMMGP and others. Make links with more experienced practitioners in the field - finding a mentor to offer advice and support can be a huge help. SMMGP has an online forum at www.smmgp.org.uk that helps connect and support clinicians who work with drug and alcohol users.

NORTH TO SOUTH

Adam Campbell meets acclaimed writer and polar traveller Gavin Francis – who also happens to be a GP

DEEP FREEZE: Dr Gavin Francis explores an Antarctic crevasse. (Courtesy of Dr Gavin Francis)

My chat with Gavin Francis begins with a rather blunt admission for a writer. "I hated English at school," he says. "It was all about the themes in *Romeo and Juliet* and *Middlemarch*, and I hated all that."

This comes as something of a surprise to me, and, in truth, slightly derails the line of questioning I've prepared for the Edinburgh-based GP and author of the award-winning *Empire Antarctica*, a highly literary account of his 14 months as a doctor at Halley, the most inaccessible of the British research stations in Antarctica.

Convinced that the 39-year-old would have "always wanted to be a writer", I'd hoped to explore, for example, the way in which the intention of writing a travel book, particularly about somewhere as inhospitable as Antarctica, interacts with and informs the experience itself.

But he's quite clear about that too: "No, no, I didn't set out to write a book about Antarctica at all." What had motivated Gavin up to this point, it turns out, was not the need to write, but the need to travel, coupled with a love of reading – mostly books about travel. The writing (and the awards) came later.

"I think I travel because I want to gather into myself as many experiences that the planet has to offer as I can. And certainly that's what I did when I started out. So after I qualified in medicine – I was about 23 or 24 – I just started travelling straight away. A journey around the Arctic was my first big trip."

That trip saw him travel from the Shetland Isles to the Faroes, Iceland, Greenland, Svalbard and then Lapland, and was part of a pattern of work/travel/work/travel that he adhered to during much of his time as a trainee doctor. Indeed, a career in medicine has been, for him, very much "a passport to travel".

"In those days it was very easy to do six-month stand-alone jobs in medicine," he says. "And these still counted towards my training. It's harder now."

But there was a job that Gavin had set his sights on since he was a student, which would break that on/off pattern and allow him to combine work and travel in a way he hadn't before. He had devoured books about Antarctica and the early expeditions of explorers like Shackleton, Scott and Richard Byrd and had always wanted to go there himself. And he knew that if he could land a position with the British Antarctic Survey, he would finally get the opportunity to 'winter' there, spending a full year.

His CV, littered with travel experiences as well as training in emergency medicine, stood him in good stead – in particular, he says, because it showed he was "clearly happy in his own company", a characteristic that 14 months in Antarctica with only 13 other people would certainly put to the test. The Halley research station on the Caird Coast, where Gavin ended up, is so remote that it is said to be easier to evacuate someone from a space station than to get a person out of Halley in winter.

So the criteria, he says laughing, were less to do with well-honed medical skills, not that he was short of those, and more to do with: "So, how will you cope when, day after day, week after week, month after month, there is nothing for you to do?"

Being 'it' on the ice

He was hired, and there followed six months of training in Plymouth which aimed to plug the gaps, as necessary, in his medical experience. He would be "it" at Halley, which meant doing everything from splinting bones to giving anaesthetics, analysing blood samples, drilling out rotten teeth and, God forbid, dealing with acute appendicitis. Then he was on his way aboard the RRS Ernest Shackleton, named after the explorer who led three British expeditions to the continent in the early 1900s.

To say he had nothing to do is to misunderstand how much there actually is to do on a base station in Antarctica, as Gavin later described in *Empire Antarctica*. There was solitude, of course, and lots of it, but there was also skiing almost every day, riding around on snowmobiles, visiting the emperor penguin colony 20 km (and one ice cliff, down which you had to abseil) away, learning Italian, unblocking the melt tank from which they drew all their water, and digging out a fuel depot, not to mention helping the meteorologists release their weather balloons and monitor cloud formations.

Medically speaking, things were fairly quiet. "I was very lucky. The things I had to do were very minor, just some broken bones, some

"I would do everything from splinting bones to drilling out rotten teeth"



dentistry and some infections that needed treatment with intravenous antibiotics. Some years, there's really severe major trauma – someone falls down a crevasse and ends up with three long bone fractures and you can really be in a lot of difficulty."

But there was a masters research project to carry out concerning the effects of three and a half months' darkness on the body clock. And as the winter wore on, there was some heavy drinking to be done too, with more than a few boozy nights.

There was also, Gavin decided, a book to be written. And though he was practically on top of the South Pole, he chose instead to write one about the other side of the globe. "I decided to write about the journey I had made a year or two earlier around the Arctic. It was the first time in my medical training I actually had time and space from exams to do so."

The result was *True North*, about his travels – and those of others throughout history – in the most northern fringes of Europe. A book had not been his original goal, he says, "But the fact that I loved travel literature so much meant that, for me, it was natural one day to try and write a book that I would most want to read."

It was well enough received for Gavin to want to write another and the next book he wrote, on his return to Scotland from Halley, was *Empire Antarctica*, which was named Scottish Book of the Year in 2013, an award that came with a very handsome £30,000 prize.

Being human

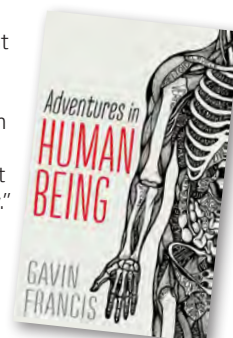
Returning to "civilisation" after a trip like this is not always easy, says Gavin, and after a long period with no one telling you what to do, many people struggle with the loss of autonomy. Gavin's solution? More travel, of course.

"I loved being in the Antarctic, but at the end of a year and a half I very much wanted to be engaged with colour and life. So I came back and did a couple of different jobs, and then I took off around the world on my motorbike with my wife – that was a year and a half in the saddle for both of us."

Since then he and his wife have had three children and Gavin now works as a GP three days a week at a practice where he is a partner. His third book, to be published in May, is *Adventures in Human Being*, described in the advance publicity as "both a user's guide to the body and a celebration of its elegance". It's his first that isn't a travel book, but the apple hasn't fallen too far from the tree. "I really enjoyed writing it because I'm so used to writing travel books and approaching a physical landscape through looking at its history, what it's like to travel there now and the stories of the people that live there – and this book uses the same attitude and approach but turns it on the body."

"It's like a cultural map of the body. Very different for me but ultimately it's just another kind of journey."

For more information on Gavin's books, visit www.gavinfrancis.com. *Adventures in Human Being* is published by Profile Books.



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



A HIGHER STANDARD

The way doctors behave in their personal lives can have a serious impact on their fitness to practise. MDDUS medical adviser **Susan Gibson-Smith** offers some advice

WHETHER we are on duty or making the most of our free time, doctors are expected to act in a professional way. It is fair to say that we are never really off duty and the way we behave is held up to closer scrutiny than members of the general public. Indeed, failure to act in an appropriate way can have serious consequences for our careers.

Consider the following scenario:

It was not a serious incident really. We were celebrating passing the CSA and as it was a warm sunny night we had taken a few beers to the park. Unfortunately there was a rather unruly crowd nearby and some of us were caught up in the ensuing melee. The police came and I was charged with breach of the peace alongside some of my friends. Rather than go to court, and to avoid any hassle, I accepted a higher-tier fixed penalty notice and thought that would be the end of the matter. I was shocked to receive a letter from the General Medical Council stating that they had received information about me which may call my fitness to practise into question. It said they had reason to believe my conduct may have brought the profession into disrepute and my registration may therefore be at risk. My heart turned cold. I was at the start of my career – could it be over so soon?

A matter of trust

Some may wonder exactly why it should matter to the GMC if a doctor is given a fixed penalty notice at the higher tier. And why is it that doctors are subject to higher expectations of behaviour than the general population?

The GMC's 2013 guidance *Good Medical Practice* goes some way to explaining this when it states: "You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."

The need for patient trust is quite straightforward. Doctors are allowed to access sensitive personal information, they perform intimate examinations and do at times hold the power of life and death in their hands.

With such privilege comes responsibility and the incumbent duty to be a good doctor. The GMC defines this as someone who makes "the care of their patients their first concern, they are competent, keep their knowledge and skills up to date ...and act with integrity and within the law."

In the above scenario the GP trainee has clearly fallen on the wrong side of the law and her behaviour could jeopardise the trust patients have in her as an individual. But equally importantly, and what many young

doctors fail to understand, is that the actions of an individual may also serve to undermine the public's trust in the medical profession as a whole.

The GMC as regulator has three main roles: to maintain the register; to protect patients; and to protect the reputation of the profession.

Professionalism in action

A 2005 report by the Royal College of Physicians, *Doctors in Society: Medical Professionalism in a Changing World*, defined medical professionalism as: "A set of values, behaviours, and relationships that underpins the trust the public has in doctors."

As a doctor you are not just part of society you are a member of the profession of medicine. A doctor does not hang up her stethoscope at the end of a shift and go home a member of the general public. Whether at work or at home, on social media or at the gym, at the conference or at the pub, doctors at all times wear the mantle of the profession with all the duties and responsibilities that brings.

These professional duties are described in detail in *Good Medical Practice* which states clearly that: "Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human

practise, you must demonstrate, through the revalidation process, that you work in line with the principles and values set out in this guidance. Serious or persistent failure to follow this guidance will put your registration at risk."

Reporting criminal matters

So what about our trainee with the letter from the GMC? The reason she is in trouble is not only for the offence she has admitted to committing but also because she has failed to inform the GMC of the charge as per the guidance in *Good Medical Practice* at paragraph 75 which says:

"You must tell us without delay if anywhere in the world:

- You have accepted a caution from the police or been criticised by an official inquiry
- You have been charged with or found guilty of a criminal offence."

The GMC's supplementary guidance *Reporting criminal and regulatory proceedings within and outside the UK* provides further detailed information on what must be reported to the GMC.

"Whether at the gym or on social media, doctors must always behave professionally"

life and make sure your practice meets the standards expected of you."

These standards are divided into four "domains", covering: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust. It is this fourth domain that is most relevant here, with its three main points:

- Be honest and open and act with integrity
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession.

The guidance goes on to inform doctors that they are personally accountable for their professional practice and they must always be prepared to justify their decisions and actions. It adds: "To maintain your licence to

The trainees' failure to inform the GMC at the time has resulted in an investigation into her probity. It is alleged that she acted dishonestly and tried to hide the matter from the regulator in addition to the investigation into her disorderly conduct.

Fortunately the trainee contacted a medical adviser at MDDUS who was able to provide advice on how to respond to the GMC.

The GMC concluded the case by issuing her with a warning over her conduct which was to be published publicly on the regulator's website for five years. It is likely that if she had reported the charge to the GMC at the time the case may have been resolved with a simple letter of advice.

If you are in any doubt as to whether you ought to report a matter to the GMC please do pick up the phone and either myself or one of my colleagues will be very happy to advise you.

Dr Susan Gibson-Smith is a medical adviser at MDDUS

DIAGNOSIS

SUSPICIOUS MOLE

DAY ONE

A 37-year-old woman – Ms J – makes an appointment at her GP surgery concerned about a mole on the back of her calf. It has been present for a number of years but Ms J suspects it has become slightly bigger over the last two years. She is seen by Dr M who examines the lesion and records that it has a smooth outline, is reddish in colour and slightly dry on top. Ms J also reports some associated itchiness. Dr M assures the patient that the mole appears benign and prescribes Daktacort cream (cream containing an antifungal agent and a mild steroid). Follow-up is arranged for four weeks.

WEEK FOUR

Ms J is seen again by Dr M who records that the mole appears lighter in colour but is otherwise unchanged. He reassures the patient that the lesion appears benign but that Ms J should re-attend if she notices any change in appearance.

MONTH 13

The patient attends the surgery and is seen by a different GP – Dr W. She notes that the lesion now has a black central aspect with signs of minor bleeding. The GP arranges for an urgent referral under the two-week rule to the dermatology clinic at the local hospital.

ONE WEEK LATER

Ms J is examined by a consultant dermatologist. He notes a 20mm lesion on the left calf with a 5mm dark irregularly coloured and crusted centre showing evidence of bleeding. Ms J says that the mole had developed the crust about a month ago and had only just begun to bleed. An incisional biopsy is performed and a diagnosis of malignant melanoma is confirmed.

**MONTH 19**

Ms J is seen by a consultant plastic surgeon, and hospital notes indicate there is no evidence of local, regional or systemic recurrence of the melanoma. In the meantime the patient suffers the effects of lymphoedema in her upper legs, with pain and swelling. She also undergoes treatment for depression.

MONTH 14

A wider excision of the lesion is performed along with a lymph node biopsy in which deposits of melanoma are found and Ms J is referred for further dissection of the right inguinal lymph nodes. CT scans of her chest, abdomen and pelvis are clear and the patient later undergoes a groin dissection in which over 20 lymph nodes are removed, all of which show no evidence of metastatic disease. Ms J suffers a post-operative infection which is slow to clear with IV antibiotics, extending her stay in hospital.

SIX months later solicitors acting for Ms J send a letter of claim alleging clinical negligence against Dr M in his failure to refer the patient for dermatological assessment after the initial and subsequent consultations concerning the mole on her calf. More specifically it is alleged the GP failed to take account of the recent increase in size of the lesion and did not record its shape and dimensions. The letter also claims that Dr M erroneously diagnosed the lesion as benign and offered inappropriate treatment, and then failed to keep the patient under adequate review. Failure to refer the patient led to otherwise unnecessary surgery and the subsequent complications.

MDDUS acting on behalf of Dr M commissions a primary care expert to comment

on the case. In addressing the allegations the expert finds no fault in the GP's overall review of the patient – seeing her three times in an eight week period and advising her to be vigilant for any changes in the mole. But he does identify some failings – most significantly that Dr M did not measure and record the size and shape of the lesion at the initial consultation nor at subsequent review. The expert also questions the decision not to refer when there was a reported history of growth in size and a persistent itch. Prescription of the antifungal steroid cream was in any case inappropriate.

The expert acknowledges the difficulty in judging when it is appropriate to refer pigmented lesions, with too cautious an approach leading to over-referrals. Diagnosis of

melanoma can be difficult even for dermatologists, with signs easily missed.

Given the risks involved in taking the case to court it is decided (in consultation with the GP) to settle the case with no admission of liability.

KEY POINTS

- Follow published guidelines on referrals for skin lesions with high index of suspicion in any reported changes in size or shape.
- Measure and photograph suspicious moles to compare in subsequent reviews.
- Record in the patient notes specific advice on being vigilant for change in the appearance of a mole.

Diary

ALL those who accuse the NHS of offering poor value for money should be silenced by the latest research uncovered by Diary. Who knew rabbits were so expensive to look after?...



● **CHEAPER BY THE BUNNY** The Health and Social Care Information Centre recently published figures on GP funding in England revealing that the cost of primary care was on average £136 per registered patient. *Pulse* reporting on the announcement helpfully pointed out that this amounted to less than an annual Sky TV subscription which costs £238 per year. The magazine noted that £136 also can't get you the yearly rise in the price of a season train ticket from Guildford to London, a trip to the cinema every fortnight, one haircut per month or a daily Mars bar. An anonymous reader on the *Pulse* website further commented: "Just got a quote from PetPlan for a year's health insurance for a rabbit; £175.80. No cover for the first 14 days and £65 excess per new illness."

● **WAITING ROOM SCIENCE** Diary abhors thievery of any kind - even when it might serve a public service. Researchers from New Zealand have recently reported on the findings of an ambitious study designed to shine a light on the murky world of waiting room magazine theft. In the study, 87 magazines were placed in the waiting room of a general practice in Auckland. Titles ranged from high-minded magazines such as *The Economist* and *National Geographic* to 'gossipy' entertainment publications defined as having five or more photos of celebrities on the cover. Twice a week the researchers checked back and within a month nearly half had disappeared including all but one of the 27 "gossipy magazines" - yet all 15 copies of *The Economist* remained. Research team leader Professor Bruce Arroll commented: "Quantification of this phenomena was urgently needed... Future research in waiting room science would include identifying who or what is responsible for the removal of magazines."

● **THE SECRET IN THEIR EYES** Caucasian women with blue or green eyes are apparently better at tolerating pain and distress than their brown eyed counterparts. A study by scientists at the University of Pittsburgh on 58 pregnant women found those with light coloured eyes seemed to experience less pain when giving birth. Light-eyed women also experienced less post-birth distress. The reason for the discrepancy is thought to be genetic. Genes determining eye colour are also linked to other features such as levels of melanin - the pigment that makes eyes darker - which has been connected to pain. Melanin might also make brown-eyed people more susceptible to alcohol than those with light eyes. It's not all bad news, however, as increased melanin means brown eyed people have quicker reaction times and are therefore better at throwing a Frisbee at a target.

● **SAVED BY SULPHIDE** You may think it a rather whiffy inconvenience, but the smell of flatulence could help stave off serious illnesses like cancer according to some unlikely new

research published in *Medicinal Chemistry Communications*. A team at Exeter University found that hydrogen sulphide - produced by bacteria as it breaks down food in the gut - plays a key role in protecting cells and fighting illness. They noticed how cells stressed by disease try to draw in enzymes to generate their own tiny quantities of the chemical which helps to preserve mitochondria and prevent the cell from dying. The researchers have now created a compound called AP39 designed to help the body produce just the right amount of hydrogen sulphide in the hope it could be used to treat illnesses like stroke, heart failure and diabetes. Now, where did I put that tin of beans?...

● **GOLDEN HELLOS** Fresh from telling NHS staff they should lose weight and get fit, NHS England chief executive Simon Stevens has also recently been endearing himself to GPs. In a speech to the RCGP conference he suggested GPs stop complaining so much as they are putting off potential trainees. "There's a balancing act to be struck here - a conundrum. Quite rightly you are telling it as it is in general practice at the moment... but the danger is that wake-up call sounds like a proposition to young doctors, that you want to steer clear of general practice." The recently announced move by NHS England to offer "golden hellos" to new GPs might go some way to making the specialty more attractive. Indeed, Leicester City Council's health and wellbeing board is already offering £20,000 cash incentives to attract new GPs to the city. Similar schemes in Essex have been using funding from Health Education England to offer golden hellos worth £10,000 and one practice in Doncaster is putting up £20,000 of its own budget to fill a long-vacant partner post. Sadly Diary is more familiar with the golden goodbye.

● **TOO TIRED FOR ETHICS** It seems there are more reasons to be wary of those relentlessly cheerful early risers who leap out of bed at the crack of dawn to hit the gym or get a head start on their emails. So-called "larks" become less honest as the day goes on, according to research by Georgetown University in the US. By the evening, they are more likely to act unethically than those who enjoy a bit of a lie-in. In a study of 200 students given problem solving tests and games, early risers were more likely to cheat and inflate their scores in the evening. Night owls can't claim too much moral superiority, however, as they tended to tell lies earlier in the day when they were still tired. The study noted that "ethical behaviour arises when people 'match' their situations".

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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