ISLAND ADVENTURES

WITH RURAL GP DAVID HOGG

ALSO INSIDE

04 AN IMPROPER RELATIONSHIP?

12 THE FUTURE OF PRIMARY CARE

AN MDDUS PUBLICATION

Welcome to your GPst

TRUST is an essential element of the doctor-patient relationship, and patients must feel confident their doctor will behave professionally towards them at all times. But what if that relationship changes? Is it ever appropriate to become romantically involved with a patient – past or present? MDDUS medical adviser Dr Susan Gibson-Smith offers advice on this complicated issue in her article on **page 4**.

Ever since Robert Francis QC published his report on the failings at Mid Staffs in 2013, the so-called duty of candour has been much discussed. On **page 6**, MDDUS medical adviser Dr Barry Parker gives an overview of what trainee GPs need to know about the new rules.

Could you tell the difference between the skeleton of a seal's flipper and a human foot? These are just some of the challenges facing rural GP David Hogg on the Scottish isle of Arran. He offers a fascinating glimpse into island life in his article on **page 10.**

Longer patient consultation times, increased funding, multidisciplinary team working, and better use of technology – these are just some of the key elements that the Primary Care Workforce Commission hopes will form the future of general practice. On **page 12** *GPst* associate editor Joanne Curran looks at the commission's new report which predicts what lies ahead for the profession. On **page 8** our career article looks at the work of GPs with an interest in respiratory medicine, and on **page 14** we analyse a case of delayed referral in a patient with testicular torsion.

• **Dr Peter Livingstone**
Editor

PHOTO: PAUL GRAHAM

MDDUS

EDITOR:
Dr Peter Livingstone

CONTENT EDITOR:
Dr Susan Gibson-Smith

ASSOCIATE EDITORS:
Joanne Curran
Jim Killgore

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

PRINT:
Thomson Colour Printers
www.jtcp.co.uk

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

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

recycle
When you have finished with this magazine please recycle it.

GPst is published by The Medical and Dental Defence Union of Scotland, Registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Memorandum and Articles of Association.

NEW SERVICE TO HELP STRESSED GPs

GPs suffering from stress and burnout will be able to access a nationally-specified occupational health service in England from 2016.

The scheme will be supported by specialist services for doctors and build on already successful initiatives such as the London Practitioner Health Programme and House Concern in the Northern region.

NHS England chief executive Simon Stevens announced the move as part of a £5 million drive to improve NHS staff health and reduce sick days.

"At a time when the pressures on GPs have never been greater, we need to extend the local practitioner health programmes that have been shown to help GPs stay healthy and get back to work when sick," he said.

Under the new initiative, NHS staff will also be given the chance to attend fitness classes such as yoga and Zumba, and there will be a clampdown on the amount of junk food served in hospitals.

Health checks will be provided at work for NHS staff aged 40 or over, and there will be access to physiotherapy, mental health talking therapies, smoking cessation and weight management services.

OVERWORKED GPs RISK PATIENT SAFETY

GP fatigue due to overwork threatens patient safety on a "widespread scale", says the RCGP in a new consultation paper.

The College claims that unrelenting and increasing workload pressures are pushing GPs to their limits – having to cope with growing patient numbers and diminishing resources. It says that GPs are working longer days seeing patients, followed by many hours after surgery and at weekends trying to keep up to date with urgent paperwork.

The College acknowledges that safety risks in general practice are inherently lower than those in hospitals but warns that there is considerable potential for patient harm through medication errors, mistaken patient identity and other risks.

GP consultations between 2008/9 and 2013/14 rose by 19 per cent in England alone yet the total number of GPs across the UK grew by just 4.1 per cent in that period. GPs are also seeing an increasing number of patients with multiple and chronic conditions which are more difficult to deal with in a standard 10-minute consultation.

In the consultation paper – *Patient safety implications of general practice workload* – the College offers proposals for protecting the wellbeing of GPs. These include regular, mandatory breaks for staff to minimise the possibility of errors and a mechanism to identify practices under extreme workload pressures – and for measures to be urgently implemented to relieve these pressures.

RCGP Chair Dr Maureen Baker said: "GP fatigue is a clear and present danger to patient safety and we urgently need to find workable solutions that will keep our patients safe now and in the future."

LOW UPTAKE OF ONLINE GP SERVICES

UPTAKE of online GP services in England is low despite efforts to promote their use.

Just six per cent of patients book appointments online while 10 per cent order prescriptions online, according to an analysis by the Citizens Advice Bureau (CAB).

This is despite recent government efforts to encourage digital access. With effect from March 2015, all GP practices in England are required to offer online appointment bookings, repeat prescriptions and access to summary information held in patients' records.

Figures highlighted by the CAB suggest there is a considerable gap between patient preferences and patient behaviour. While more than a third (34 per cent) of patients said they would like to book appointments online, the vast majority (86 per cent) said they do not use any online services.

The CAB analysed results of the *GP Patient Survey* from the past five years, with a particular focus on the most recent data published in July 2015. The survey sees questionnaires sent to 2.6 million people across England, around 33 per cent of whom respond.

The CAB's report blames low uptake on poor patient awareness, with less than a third (27 per cent) aware of online booking services. Technical glitches were also cited as a potential barrier, as was the requirement by some practices to attend in person to collect online login information.

The report encourages practices to raise awareness of digital tools, particularly as research suggests those most likely to use them (patients aged 18-34) were least likely to be aware of them.

NEW YELLOW CARD APP TO REPORT SAFETY ISSUES

DRUG side effects and medical device problems can now be reported electronically using the new Yellow Card app.

Free for smartphones and other mobile devices, it allows users to highlight safety issues with healthcare products as well as keeping up-to-date with the latest news.

The launch comes as the Yellow Card scheme celebrates its 50th anniversary.

It is run by the Medicines and Healthcare products Regulatory Agency (MHRA) which collates and reviews reports of suspected adverse drug reactions on all licensed and unlicensed medicines and vaccines. It includes those issued on prescription as well as those bought over the counter from a pharmacist or supermarket.

Yellow Cards are used alongside other scientific safety information to help MHRA make any necessary changes to the warnings given to people taking a medicine or vaccine, or to the way they are used, to minimise potential risks.

The app can be downloaded from the iTunes app store and Google Play for iOS and Android devices.

DISCIPLINARY ACTION FOR OVERPRESCRIBING ANTIBIOTICS "UNHELPFUL"

CALLS for regulators to act against GPs who overprescribe antibiotics are "counterproductive and unhelpful," the Royal College of GPs has said.

The College was commenting on new NICE guidance to help doctors, nurses and pharmacists promote and monitor the sensible use of antimicrobials.

Overall antibiotic prescribing has been steadily increasing over several years. In England over 41 million antibiotic prescriptions were issued in 2013-14 at a cost to the NHS of £192 million. Despite considerable guidance that prescribing rates of antibiotics should be reduced, nine out of 10 GPs say they feel pressured to prescribe antibiotics and 97 per cent of patients who ask for antibiotics are prescribed them.

This has prompted calls for "soft-touch" and "hazardous" doctors to be disciplined for prescribing too many antibiotics.

The NICE guidance highlights the need for local antimicrobial stewardship programmes and recommends setting up multidisciplinary antimicrobial stewardship teams working across all care settings.

Professor Mark Baker, director of the Centre for Clinical Practice at NICE, said: "We need to encourage an open and transparent culture that allows health professionals to question antimicrobial prescribing practices of colleagues when these are not in line with local and national guidelines and no reason is documented."

RCGP vice chair Dr Tim Ballard said the guidance was "sensible" and contained a lot of useful information but he added: "We can come under enormous pressure from patients to prescribe antibiotics. We need a societal change in attitudes towards the use of antibiotics and any suggestion that hard pressed GPs – who are already trying to do their jobs in increasingly difficult circumstances – will be reported to the regulator is counterproductive and unhelpful."

NICE subsequently clarified their position, saying: "Our recommendations are aimed at those who need to change and improve their practice. We want to support, not admonish them and we are clear that our advice on good clinical practice and the professional standards responsibilities of the General Medical Council are distinct and separate."

AN IMPROPER RELATIONSHIP?

Is it ever appropriate to become romantically involved with a patient – past or present? **Dr Susan Gibson-Smith** offers some advice

TRUST is the foundation of the doctor-patient partnership. There is a clear public interest in patients being assured their doctor will behave professionally towards them. While this is a familiar concept for doctors in relation to issues of confidentiality, it is also vital patients can trust doctors will behave professionally during consultations and will not view them as potential sexual partners.

Consider the following scenario:

It was a girls' night out to celebrate our exam success and the end of GP training. After a meal and drinks we headed to the local nightclub – and that's where I met Mark. We got on well and afterwards he said he would find me on Facebook. I thought no more about it until he appeared in my surgery two weeks later with a knee injury from football.

I took a history, examined him and gave him the appropriate advice on rest, ice and elevation and he asked if that meant no more dancing. I said "yes" and he asked if I would have dinner with him instead. I was flustered. I liked him and if he had asked me in the club I would have said yes… but now we had met in the surgery, what was I to do?

The General Medical Council offers guidance on this area in *Good Medical Practice*, as well as its supplementary guidance *Maintaining a professional boundary between you and your patient*, and *Sexual behaviour and your duty to report colleagues*.

The message to doctors is clear: "You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them."

It would be improper, for example, to arrange regular reviews of a child purely to develop a relationship with the parent, or to make a home visit to an elderly man in order to see more of his son. The word "must" is used by the GMC to emphasise an overriding duty and any failure to follow this will result in a doctor's registration being put at risk.

Unwanted attention

It can be difficult when a patient makes unwanted advances and MDDUS has received calls from doctors who have been given letters or gifts or invitations by patients whose motives are not quite clear. It is always good practice to respond politely and considerately and to try to re-establish the professional boundary, explaining it is not appropriate for a doctor to have that type of relationship with a patient. Seeking help from a neutral person such as the practice manager or senior partner can also be useful.

For extra clarity, it may be appropriate to write a letter of response to the patient (with help from MDDUS) gently pointing out that this type of behaviour is not acceptable. In extreme cases, where a doctor feels that trust has completely broken down, then a decision can be taken to end the doctor-patient relationship and remove the patient from your list. If so, you must take care to follow the relevant guidance and it is advisable to discuss the matter first with an MDDUS adviser.

Judgement call

It is clear that pursuing a relationship with a current patient or their relative is not a good idea but what about a former patient, one who has left the list?

The answer is: it depends. And it depends on a combination of factors such as the length of time since the professional relationship ended; the nature of the professional relationship; whether the patient was particularly vulnerable at the time you were seeing them as a doctor; and whether you will be caring for other members of the patient's family.

There is no magic number of days or weeks since a patient left your practice that constitutes an acceptable timescale for you to pursue a relationship. The key factor to consider is whether the relationship you are pursuing is, or can be seen to be, an abuse of power and your position of trust. Common sense would suggest that if you start a relationship with a patient you have seen once, there is far less chance of you being accused of abusing your position than with someone you have seen repeatedly over a period of years.

An abuse of power is more likely to be an issue when the patient is vulnerable. Some patients are more vulnerable than others, particularly patients with mental health problems.

Raising concerns

It is also important to be aware that if a patient discloses to you that a fellow doctor has made inappropriate advances towards them you must promptly report your concerns to the relevant person or organisation who will investigate the allegation. Bear in mind that sexual behaviour does not exclusively involve touching and would include inappropriate sexual comments.

Equally, if you think a sexual assault has taken place then this should be reported to the police. The best approach is to first discuss the matter with the patient and encourage them to disclose the information themselves. If they refuse and you believe there is a public interest in making the disclosure, you should seek their consent to do so. In exceptional cases, where a patient withholds consent but you believe a disclosure should be made to protect other patients/the public from risks of serious harm, this can still be done without permission. In these instances, only the minimum information necessary should be disclosed and the patient should be informed. (See the GMC's *Confidentiality* guidance.)

Trainee dilemma

So what should our GP trainee do about Mark's dinner invitation?

Well the guidance is clear that doctors should not pursue a relationship with a patient, nor should she ask him to leave the list so that she can do so. However, she did meet him first socially, before he became her patient, and she was due to leave her training practice in two weeks' time. Considering these circumstances, she was advised to check how long Mark has been a patient with the practice to make sure he did not register there specifically to make contact with her. She should also check that he is not vulnerable. Assuming both of these factors were in order, she could reasonably accept his dinner invitation after finishing her placement at the practice. She would also have to be clear that she could not see him as a patient again.

Dr Susan Gibson-Smith is a medical adviser at MDDUS

OPEN AND HONEST

MDDUS medical adviser **Dr Barry Parker** highlights what doctors need to know about the duty of candour

IN the wake of Robert Francis QC's report on the failings at the Mid Staffordshire Foundation Trust in 2013, there has been intense focus on the so-called duty of candour when delivering healthcare. Recognising when care has fallen below standard and reporting this to patients and those in charge promptly is seen as integral to avoiding the unfortunate events that have taken place in Mid Staffordshire and elsewhere in recent years.

Francis summarises this duty of candour in the following terms: any patient harmed by the provision of a healthcare service should be informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Recent changes in the law

All doctors have an ethical requirement to be honest when dealing with patients. This is hardly contentious, being one of the basic principles underpinning the practice of medicine, ensuring trust between patients and doctors.

In addition to this ethical requirement, all NHS organisations in England whose services have been commissioned under a post-April 2013 standard NHS contract, with the exception of primary care services, have a contractual duty of candour. This relates to incidents that occur during the provision of care that lead to moderate harm, severe harm (as defined by the National Patient Safety Agency) or death. These must be reported to patients or carers as soon as possible, and at most within 10 days of the incident being reported to local risk management systems.

The most significant change, however, occurred in England in November 2014, when a statutory duty of candour was introduced under the provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 20 initially gave legal force to the duty of candour for NHS bodies as organisations, but not including primary care services. From April 2015, primary care services have also been included.

In Scotland, following a consultation process, similar provisions have been included in the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill which was introduced by the Cabinet Secretary for Health in June 2015. This is still under consideration by the Scottish Government, but it appears likely that some form of statutory requirement will be passed.

Although these statutory provisions relate to organisations rather than individuals, there is of course a clear expectation that individual doctors working for these organisations will co-operate fully with notification requirements so that the organisation complies with the law.

There has been much debate over the need for a statutory duty of candour, with some critics describing it as a "crude tickbox approach" while others predict that legislation will not improve openness and could even "undermine professionalism". Supporters, on the other hand, believe the legislation is long overdue and will play an important role in safeguarding patient safety.

In its information document on Regulation 20, the Care Quality Commission states: "The introduction of a statutory duty of candour is an important step towards ensuring the open, honest and transparent culture that was lacking at Mid Staffordshire NHS Foundation Trust. The failures at Winterbourne View Hospital revealed that there were no levers in the system to hold the 'controlling mind' of organisations to account.

"It is essential that CQC uses this new power to encourage a culture of openness and to hold providers and directors to account."

When to disclose

In relation to primary care services, a notifiable safety incident under the statutory duty of candour means any unintended or unexpected incident that occurred in respect of a service user during the provision of care that, in the reasonable opinion of a healthcare professional:

(a) appears to have resulted in–
i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition
ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days
iii. changes to the structure of the service user's body
iv. the service user experiencing prolonged pain or prolonged psychological harm, (continuous period of 28 days)
v. the shortening of the life expectancy of the service user; or

(b) requires treatment by a healthcare professional in order to prevent–
i. the death of the service user, or
ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in (a) above.

This mirrors the CQC reporting requirements for GP practices in England. NHS bodies have slightly different disclosure requirements under the regulation, which include incidents which could result in, or appear to have resulted in the harms specified. This difference has been the subject of some debate.

Examples of notifiable GP cases are provided by the CQC in a "mythbuster" article on their website at **tinyurl.com/ojm8bmn**

Ultimately, doctors must exercise judgement in terms of when to disclose a particular matter in the light of these requirements.

GMC guidance

The GMC has been issuing specific guidance in relation to being open and honest with patients when things go wrong since 1998, so there is no fundamental change in the regulatory position. However, expanded guidance has recently been produced (available at **tinyurl.com/npxwpz6**) which provides more detail on expected behaviours and the steps doctors should take to honour their professional duty of candour.

These include telling the patient (or where appropriate the patient's advocate, carer or family) when something has gone wrong; apologising to the patient; offering an appropriate remedy or support to put matters right, if possible, and explaining fully to the patient the short- and long-term effects of what has happened.

In summary, for doctors who have already been complying with GMC guidance on what to do when things go wrong, there i s little that has changed. The statutory duty placed on a general practice at an organisational level perhaps brings some clarity to the types of incidents that must be notified, but there remains an element of individual judgement that must be exercised depending on the circumstances of each case. The GMC guidance is more general than the statutory requirements, and simply emphasises that if something has gone wrong, the doctor has a duty to explain and apologise. It also includes guidance on reporting 'near misses' and encouraging a learning culture by reporting errors.

It can only be hoped that this new duty of candour brings positive changes for patient care and that doctors, as the GMC states, receive the support of an "open and honest working environment where they are able to learn from mistakes and feel comfortable reporting incidents that have led to harm."

Dr Barry Parker is a medical adviser at MDDUS

BREATHING EASIER

Respiratory disease costs the NHS billions of pounds a year and kills one in five people in the UK. What better time for GPs to take an interest in this area?

RESPIRATORY conditions account for more than 24 million GP consultations a year and are one of the UK's biggest causes of mortality.

From asthma and pneumonia to tuberculosis and chronic obstructive pulmonary disease (COPD), the range is broad, encompassing both acute and chronic conditions. Other major diseases include cystic fibrosis, lung cancer and sleep apnoea.

Respiratory disease kills one in four people in the UK – even more than heart disease – which is twice the EU average. By 2020, chronic respiratory disease is expected to rank as the fifth leading cause of morbidity.

GPs are at the frontline of care in this field, with respiratory conditions the most common reason for general practice consultation (or emergency medical admission to hospital). Clinicians with an interest in this area are well placed to bring specialist services closer to patients' homes and to help them better manage their conditions.

Entry and training

Training for GPs looking to develop a special interest in respiratory medicine can be gained in a number of ways and should include both practical and theoretical elements. This can vary from work experience and attendance at relevant meetings or lectures, to self-directed learning or recognised university courses.

There is also the option of completing a diploma in primary care respiratory care. One such course is available at the University of Bradford and takes 18 months to complete, combining taught modules and work-based learning.

Assessment for GPwSIs also takes various forms, including case note review, mini clinical examination, logbook and direct observation by a specialist clinician.

The RCGP has a framework setting out the competences required for respiratory GPwSIs, which include:

- Asthma
- Drug therapy for respiratory disease
- Health promotion and prevention
- Respiratory infection
- Allergic disease of the respiratory tract
- Chronic obstructive pulmonary disease (COPD)
- Acute respiratory disease
- Other respiratory disease.

The Primary Care Respiratory Society (PCRS) offers its members advice and training, highlighting best practice in a range of guidance, research and news publications. There are also useful guidelines and resources on the British Thoracic Society website.

The job

The role of a GPwSI in respiratory medicine straddles both primary and secondary care settings. Often GPs will provide care for patients within their normal practice, as well as in a dedicated respiratory clinic (usually alongside a more specialist practitioner), or within a respiratory care specialist service.

Their skills will be used to assess, diagnose and manage patients with defined respiratory problems, for example helping to diagnose and manage care for patients with chronic conditions such as asthma, COPD and allergic disease. GPwSIs should also be able to diagnose and manage acute presentations, such as breathlessness in both children and adults, referring where necessary.

The RCGP lists examples of clinical services that a GPwSI could deliver, including:

- Consultation with patients referred by other practitioners for advice on diagnosis and clinical management for defined respiratory problems
- Diagnosis, e.g. spirometry, skin prick testing
- Disease assessment, e.g. oxygen assessment in COPD
- Pharmacological management
- Non-pharmacological management, e.g. pulmonary rehabilitation in the management of COPD and immunotherapy in the treatment of allergy.

GPwSIs are well placed to offer expertise in prevention, detection and treatment in respiratory care for patients, health professionals and healthcare managers. They may also choose to provide leadership support for the development and implementation of local respiratory services and guidelines.

Whatever responsibilities doctors assume, it is clear that respiratory medicine is an interesting and varied field, and one in which demand for GP skills looks set to increase considerably in the coming years.

Sources/links:

- The Primary Care Respiratory Society – **www.pcrs-uk.org/**
- The Burden of Lung Disease, British Thoracic Society – **tinyurl.com/naarkmy**
- Framework for GPs with a special interest in respiratory medicine – **tinyurl.com/ndx9dtq**

Joanne Curran is an associate editor at MDDUS

Q&A
Dr Steve Holmes, GP with an interest in respiratory medicine

What attracted you to a career as a GPwSI in respiratory medicine?
First and foremost my career has been focused on being a good family doctor/ generalist clinician. The interest in respiratory medicine came after I attended the Primary Care Respiratory Society UK annual conference. The group were enthusiastic and engaging and over several years I have become more involved in respiratory care.

What do you enjoy most about the job?
The job is ongoing, continually changing and involves clinician education, working with charities, patient/professional groups, contributing to guideline development, and influencing senior NHS colleagues and politicians.

Are there any downsides?
My specialist interest involves working with a variety of organisations and supporting my CCG as clinical respiratory lead. I can help change things on a bigger scale through education and policy/ guidance. But as a downside, at times we are slow in the NHS to change. Unfortunately, nearly all my specialist colleagues are still writing in records – the secondary care sector has failed to embrace technology and use it to patient benefit.

What do you find most challenging?
There are challenges with trying to find resources, trying to change systems, trying to improve standards – but when there is success the buzz is palpable, and it is possible to see how things have improved in the longer term in many areas.

What about the role has most surprised you?
Most surprising has been the passion from many generalists, nurses, specialist doctors, physiotherapists, and pharmacists to want to make a difference. It is a struggle at times in the NHS but the vast majority of us are trying to improve quality of care.

What is your most memorable experience so far?
I had a patient with severe COPD in her mid-50s. With encouragement she lost two stone, stopped smoking and went from walking 800 yards maximally to walking up Snowdon within around 10 months. She brought me a picture of her at the summit and said she felt so good she walked down rather than catching the train as planned. "I feel better than I have for years, doc" is a significant experience every time it happens.

What advice would you give to a trainee GP considering a career as a GPwSI respiratory medicine?
Enjoy your role as a generalist. Join the Primary Care Respiratory Society UK – go to the conference and get involved. And do enjoyable things that help keep you up-to-date and fit in with your other commitments.

Dr David Hogg offers an insight into the varied life of a rural GP on the Scottish isle of Arran

THE DOCTOR YOU WANT TO BE

RURAL GP: Dr David Hogg, left, assists in a mountain rescue (courtesy of Kirstie Smith)

WHAT'S the difference between the skeleton of a seal's flipper and a human foot? With a new-found respect for the range of anatomy required by vets (not just one species!), this is the question I found myself entering into Google at the end of a busy Saturday on call.

Such is rural practice. We provide a wide spectrum of medical care on Arran. It's hugely stimulating, often challenging and occasionally daunting. The limitations imposed by being the only doctor on-call, or by transport logistics of ferry or helicopter, are relatively blatant. However, our patients tend to be understanding – whether residents or visitors – and an acceptance of the need to find common sensibility in dealing with medical uncertainties can be a helpful element of pragmatism from which to manage patient expectation.

Unusual find

This particular day had been sunny, and that meant people getting out, exploring Arran's many caves, mountains, lochs and bays. These days tend to be enjoyable, the medical variety plentiful. Numerous minor injuries with folk falling off things. The occasional forgotten medication. A cyclist or two with fractured clavicle or similar.

So whilst I was keen to get home, a walk along Kildonan Beach at the end of the day under my role as (deputy) forensic medical examiner wasn't too taxing. It's a role we all share as GPs here. We don't profess to be forensic experts (higher tariff forensic examinations are transferred to those who do it more often) and we are careful to work within our competency. The police had been alerted to a 'human foot' discovery by a passing nurse. Such finds have, I understand, not been too uncommon: Kildonan Beach is in a perfect tidal position for attracting various fishing and yachting paraphernalia - along with the occasional body part (animal or otherwise). However, it's also called 'Seal Shore' for the hundreds of seals who make it home each year.

Thankfully I had been given some intelligence. Since the initial police response, they reckoned the body part belonged to a sadly deceased seal pup. But they wanted 'the doc' to provide official confirmation of this. Google is great for situations like this.

I arrived on site to find a scene similar to those on the TV series *Taggart*. A 200 metre exclusion zone had been set up with police tape to preserve any evidence and an officer escorted me to the offending part. There was the trouser-suited CID detective whose team had come over on the earlier boat. She seemed slightly amused with the incongruity of her attire, having trekked the short distance off the beaten track. The police photographer had at this point changed his focus from capturing the evidence on film to taking some great landscape shots from the beach, presumably for his personal collection.

PHOTO: DR DAVID HOGG

There was relief all round – albeit with an air of respectful sympathy – when I confirmed quite confidently that the article was indeed from a young seal. Likely to have suffered its demise through disease or a fight.

Wide-ranging care

Rural practice is a hugely privileged way in which to stretch yourself across many different medical situations. It is not unusual for a day to involve providing end-of-life care whilst a baby is being delivered upstairs in our community hospital, along with dealing with several minor and perhaps a more major trauma situation. And this after a typical day in general practice, with all the QOF points, ASSIGN scores, ideas, concerns and expectations that it brings.

Rural practice has been described as "being the doctor you wanted to be"; it allows an implicit connection with your community, including an understanding it's fine to be 'normal' and to buy crisps, beer and wine in the local supermarket without fear of criticism, or being seen occasionally looking worse-for-wear after a busy nightshift. Ninety per cent of what we do is the same as any other GP practice, but the other 10 per cent frequently extends into uncharted fringes of general practice that don't easily sit in the MRCGP curriculum.

The flexibility and autonomy that this brings is particularly rewarding. Procedures are done because they make sense, and often when there is no alternative. My first hip block, below-knee backslab, intranasal diamorphine, ultrasound scan and helicopter retrieval escort were all borne through necessity. No one else was around to do them and, helped by a supportive relationship with our mainland A&E and other secondary care colleagues, sometimes you can do good without risking harm. This isn't for the protocol-obsessed nor medical-lawyer-fearing practitioner. We're not cavalier, but we do feel that we can do things because we have a generalist approach which isn't easy to find in centres with wider access to resources. I am the doctor I wanted to be.

Our students and trainees pick up on this too. One recent student had been on placement at Scotland's busiest A&E unit. He commented – admittedly on a particularly demanding afternoon – that our community hospital was the busiest department he had seen in his university experience.

But it's not all like that. Living amongst some stunning scenery is a big draw - we have an adventure playground on our doorstep, with opportunities for sailing, mountain biking, paragliding, canoeing, golfing and more. There is the frustration that sometimes we're looking at this playground whilst tethered to a pager or phone signal - but what a place to be based for this work. We have a good team on Arran, so our on call is "one in eight" and the good links to the mainland allow for a relatively easy escape to the world of enhanced consumerism and the opportunity to buy pitta bread crisps which haven't made it to Brodick Co-op yet.

Continuity

Integration is integral to our work. It's interesting to compare our community hospital interface with that of secondary care. If our GP appointments are not accommodating enough to same-day concerns, patients will end up at A&E - but as we provide that service too, we're quick to feel the brunt of this. Fortunately, the control we have in designing our GP service gives us autonomy to find a decent fix. Similarly, it is not uncommon to discharge our patients (perhaps after cholecystitis, pneumonia, exacerbation of asthma or unstable angina) with a GP appointment to come and see the same admitting doctor a week or so later. It remains normal to witness the trajectory of illness here, for example from home visit, to A&E, to admission, to discharge, to community follow-up. As a teaching resource this is very powerful stuff.

Our patients do receive an excellent service and I suspect that is fuelled perhaps by an increased level of accessible accountability. We're reliant on some of our patients for car mechanics, banking or dentistry, so a reciprocal reliance exists which means that any superficial service is quickly scratched away. Personal experience is that an honest mistake (and a commitment to learn from it) will attract support and understanding of the perils of medical uncertainty, and not (yet) the "no-claim-no-fee" lawyer's letter which threatens to make medicine hugely defensive.

The scope of rural practice is truly rewarding and there are opportunities such as the GP Rural Fellowship scheme which can offer supported and helpful stepping stones from GPST to rural medicine.

The answer, by the way, is that a seal's flipper has interdigital tendons which in the above case confirmed the fact that the body part was not human. Rural practice, in partnership with Google!

Dr David Hogg is a GP principal at Arran Medical Group. Find him on twitter @davidrhogg, and at RuralGP.com

INNOVATION & ASPIRATION

A new report on the future of primary care imagines greater use of technology and GPs assisted by new types of healthcare professional

THERE have been numerous reports in recent years looking ahead to how future UK general practice will operate.

These tend to contain lists of practical predictions and recommendations based on current trends, combined with more aspirational elements of how primary care at its best would work.

Common themes include more efficient use of technology, longer consultation times, increased funding, and multidisciplinary team working.

The Primary Care Workforce Commission (PCWC) is the latest to share its vision in its new report *The future of primary care – creating teams for tomorrow*, commissioned by Health Education England.

Its stated aim is to identify solutions to meet "present and future needs of the NHS" as it faces "increasing and unprecedented pressures". It follows a similar report published by the Royal College of GPs in 2013, *A Vision for General Practice in the future NHS*.

One key consideration in the PCWC report is the way that increasing patient demand has combined with drops in both investment and GP numbers to create major workload issues within primary care. An RCGP poll in June 2014 found that more than 80 per cent of GPs worried about missing a serious condition in a patient because of their heavy workload.

New team members

To address such pressures, the PCWC presents one of its boldest ideas – for practices to employ other health professionals to ease the work burden. This could mean (upon completion of successful pilot schemes) administrative staff such as medical assistants taking over large portions of practice paperwork. GPs spend as much as 11 per cent of their time on administrative tasks, the report states, and if this work was taken on by the likes of medical assistants it would be the equivalent of 1,400 more full-time GPs in England.

Under the plan, wider use would be made of physician associates and healthcare assistants; prescribing pharmacists would help manage people on long-term medication; and paramedics would substitute for GPs in the assessment of urgent requests for home visits.

The proposal has been given a broadly positive reception by the RCGP. Chair Dr Maureen Baker said the College welcomed "any suggestions that will help to ease the unprecedented pressures on GPs and help us to deliver the care our patients need."

She went on: "We would be interested in having community paramedics as part of practice teams". But she emphasised that services provided by additional health staff "must not replace the GP appointment – and paramedics must never be used as a substitute for GPs."

Falling numbers

While these additional staff may indeed help ease practice workload, they would still have to work under GP supervision. The PCWC report acknowledges this, stating: "Unlike the US, physician associates in the UK need authorisation from a doctor when they judge that a patient needs a prescription. Working under the supervision of a GP, they can make a significant contribution to practice workload."

It adds: "While we recognise considerable potential in developing these new roles, the governance of these new staff members will be of critical importance in ensuring the quality and safety of their work."

This again raises the issue of recruitment and the question of whether there would be sufficient GP numbers to provide supervision. In her response to the report, Dr Baker reiterated the College's call for 8,000 more GPs in England to meet increasing demand, but conceded this would take time and that "thousands more GPs could not be delivered overnight even if the funding was in place."

While the report does not address GP shortages in great detail, it does highlight the rather stark fact that between 2003 and 2013 the number of hospital consultants has increased by 48 per cent while GP numbers rose by only 14 per cent. GPs per head of population, it adds, has declined since 2009 "with major problems of recruitment and retention."

Health secretary Jeremy Hunt recently stated that his department would be taking a more "flexible" approach to his pre-election pledge to create an additional 5,000 new GPs by 2020. This number would, according to a *Pulse* news article in June 2015, "include flexibility for other primary care staff, such as practice nurses and physician associates, to boost numbers due to recruitment problems in some parts of England."

Another *Pulse* report the following month suggested as many as half of GP training places could remain unfilled this year in some of the worst-hit areas of England, with vacancies in Scotland of around 20 per cent.

Recruitment issues extend beyond trainee posts. In Scotland, it was reported recently that a number of GP surgeries were being supported by health boards due to difficulties in service delivery caused by staff shortages.

Hi-tech solutions

But perhaps better use of technology is the answer? This could also help facilitate another of the PCWC's visions – a future where GPs enjoy longer patient consultation times.

The report regards as "outdated" the fact that practices are unable to email/message hospital specialists, adding: "While this may need protected time in the working day, there are significant potential cost savings in terms of reduced referrals to hospital."

The PCWC also believes it will soon "appear outdated" that, unlike countries such as Denmark, doctors and patients do not routinely communicate by email. If five per cent of GP consultations could be dealt with by email, the report says, this would save 17 million face-to-face consultations a year. This in turn could allow for longer consultation times.

The report says: "Care needs to be less episodic and reactive, and focus more on supporting patients to look after their own conditions. This takes time and a 10-minute consultation is inadequate for many of the people attending a general practice."

The PCWC notes that many practices offer 15-minute appointments which "helps them deal with people's problems more effectively."

The report goes on to suggest that: "Alternative approaches that reduce the need for face-to-face consultations should be evaluated, including phone and email consultations with patients." But it concedes: "We do not know to what extent emails from patients would generate additional demand", and again recommends pilot schemes.

Exactly how primary care will look in the future remains to be seen, but the PCWC takes an optimistic view, concluding: "Much of what we recommend can be achieved rapidly, though other changes will take time, especially those that require cultural change and the development of relationships across organisational boundaries.

"However, with a highly skilled workforce, effective multi-disciplinary teams and well-developed IT systems, we believe that the NHS is in an unparalleled position to develop a modern primary healthcare system that is truly world class."

Joanne Curran is an associate editor at MDDUS

DIAGNOSIS

A PAINFUL TWIST

DAY 1

A 29-year-old male – Mr K – awakes on a Sunday morning with mild pain and swelling in his left testicle. An hour later the pain resolves only to recur later that morning, and this pattern is repeated throughout the day. Just before six he calls an out-of-hours service and is asked to attend a local clinic. Here he is seen by an OOH GP – Dr L. The patient describes his symptoms, which also include mild abdominal and back pain. Dr L examines the patient's testicles and finds the left one is slightly swollen and tender, as is the epididymis. Both testes move freely. The scrotum skin is of normal colour with no rash or inflammation. Mr K informs the GP that two years ago he suffered a groin abscess with some swelling. Dr L advises the patient that he has an infection and prescribes co-amoxiclav – but as it is a Sunday he dispenses an immediate dose of amoxicillin. He also advises the patient to attend A&E if the pain/swelling increases and to contact his own GP for follow-up.

DAY 2

Mr K is still experiencing intermittent pain so he makes an emergency appointment with his regular GP. He again describes his symptoms and after another examination the GP refers him immediately to the local hospital with a letter requesting that testicular torsion be ruled out. Mr K drives to the hospital and sees an A&E triage nurse who advises that in view of his symptoms he should be seen by a consultant. He is directed to one of the wards for an ultrasound scan. Waiting over two hours the patient is told there is no staff available to conduct a scan and he is discharged home and told to wait for a phone call to come in when an appointment is available.

DAY 4

Early that morning Mr K awakes in "agony" with constant pain. A flatmate drives him to A&E and he undergoes an emergency scan. Later a consultant urologist informs him that the scan indicates that the blood supply has been cut off to the left testicle. Mr K undergoes emergency surgery but unfortunately the testicle is no longer viable and has to be removed.

OVER a year later Dr L receives a letter of claim from solicitors acting for Mr K. It alleges clinical negligence in the delayed diagnosis of the testicular torsion: this resulting in the loss of the patient's left testicle with risk of fertility problems in future.

In particular the letter states that Dr L failed to refer the patient to A&E immediately on presentation at the OOH clinic. It says intermittent torsion should have been a serious consideration given Mr K's symptoms and that the medical notes indicate the GP had considered the possibility – yet there is no reference to the GP having performed Prehn's test to help determine whether the presenting pain was caused by acute epididymitis or from testicular torsion.

An urgent referral on that day should have led to an ultrasound scan in which the torsion would have been identified. Emergency surgery would then have resulted in the restoration of full blood supply and the testicle could have been saved.

MDDUS commissions a report from a primary care expert who examines the full medical records and various accounts from Dr L and others involved in the patient's care. In his report the expert states that testicular pain is not a rare presentation and is most often due to infection or trauma but testicular torsion would be a routine differential diagnosis. He points out that the cause of testicular pain is not always clear but torsion is an important surgical emergency. The intermittent nature of the pain might have suggested infection was an unlikely cause and the referred abdominal and back pain (unless on micturition) could also have pointed to possible torsion. Reference by the patient to a past infection (i.e. groin abscess with swelling) could not be relied on without full medical records, which were unavailable to Dr L as an OOH doctor.

The expert acknowledges that Prehn's test is not "fool proof" but that it would be reasonable to expect a GP to perform it and record the result. In his view this is the one clear failing in Dr L's assessment of the patient.

On balance the expert concludes that Dr L was not in a position to sufficiently rule out torsion and it would have been prudent to refer the patient to a urologist as an emergency. The failure to do so was therefore negligent. However, he also questions the hospital delays which may have contributed to the poor outcome.

In the end MDDUS judges that the case against our member poses too great a risk to test in court and the decision is made to settle in agreement with the member and without admission of liability.

Key points

- Ensure you employ all routine assessments in consideration of common differential diagnoses.
- Relying on a patient's recollection alone (without medical records) of previous conditions is risky.
- Record your justification for referral decisions.

Diary

SO MUCH absurdity, so few column inches. Welcome back to Diary where we ask for interesting and entertaining medical anecdotes from our readers, get nothing in reply and so make up our own. But let us not be bitter...

● **STAR-CROSSED CARE** Could the answer to the overuse of antibiotics lie in the ancient practice of astrology? Conservative MP for Bosworth David Tredinnick seems to think so. A supporter of complementary and alternative therapies, he was quoted in *Pulse* suggesting it could "certainly" be useful to GPs and could also help reduce the cost of the NHS as a whole. A keen student of the stars himself, the MP said it could be used by GPs to help patients understand which pending health issues they should look out for. The signs of the Zodiac, he explained, have been associated with different ailments – Capricorn with knee issues, Aries the head and Pisces the feet. "Some people because of their astrological make-up would be more susceptible to some ailments than others," he said. "It has been used for 3,000 years... and we need to be a bit more broadminded."

● **EXTREME MEASURES Diary isn't certain whether a topless shot of health minister and GP Dan Poulter will help or hinder efforts to boost exercise uptake among the general population, but we can only applaud his bravery. Earlier this year he announced that he (and two fellow MPs) had accepted an eight-week fitness challenge from *Men's Health* magazine in a bid to prove even busy people have time to exercise. Two months of calorie controls and work with a personal trainer left the Tory politician 2.5kg lighter while his body fat dropped from 24 per cent to 18 per cent. Dr Poulter and his colleagues showed off the results of their labour with topless before and after shots in the magazine, whose editorial declared: "If they can juggle work and fitness, you sure as hell can too."**

● **LIVERPOOL, KNOW THYSELF** GPs practising in Liverpool may be delighted to know that the city appears to lead the country in online self-diagnosis. Video service Push Doctor accessed data from 61 million UK internet searches for 160 leading health issues. It found that the trend for self-diagnosis has risen 19 per cent over the last year (with an average of an extra 848,000 searches each month). The share of health searches was highest in Liverpool (5.99 per cent), Cardiff (5.86 per cent) and Surrey (5.74 per cent). Least curious about medical issues were Hertfordshire (0.94 per cent), Milton Keynes (0.72 per cent) and York (0.64 per cent). Among other curious trends was that back pain and depression were the most searched-for topics in Liverpool whereas in Shropshire it was diarrhoea.

● **RE: YOUR CANCER Some GPs can be reluctant to break bad news to patients – but in Oxford it may be far better for all to grasp the nettle. John Radcliffe Hospital is reported to be introducing a strategy where hospital administrators will inform patients they may have cancer if GPs have been less than explicit when using the two-week urgent referral pathway. This is to prevent patients from cancelling appointments or investigations for "trivial" reasons such as going on holiday. Oxfordshire LMCs' chief executive Dr Paul Roblin said it is "variable" whether GPs do it at present and that is the reason the hospital has taken that stand. "I do sympathise with both sides, GPs need to play their part in informing patients, but the John Radcliffe has to deal with patients in a sensitive way. Especially if it's administrative staff offering the appointments, they're not clinically proficient and they have to have the clinical skills to deliver that news in the right way."**

● **TOP BEACH, NO GP** There has been no shortage of dire news when it comes to GP recruitment. A report in the *Herald* recently highlighted the failure of a Scottish health board to attract even a single applicant for a GP job despite offering a salary over £80,000 per year plus a golden hello and relocation package. The job is based in the town of Durness in Sutherland which has "a beach which is rated one of the best in Scotland". A *BBC Scotland* investigation recently reported that health boards have had to step in to run 42 GP practices and only 240 of the 305 GP training places on offer in this year's recruitment round have been filled.

● **WALK, SIT, CONSULT ON WATER Diary has noted that the dwindling supply of willing GP trainees has lately been matched by ever more creative means to attract candidates. Forget sober adverts in the back of the *BMJ* – you need a You Tube video with a James Bond sound track and action shots (Arran) or a consciously (let's hope) cringe-worthy musical number on the attractions of primary care (West Sussex CCG). East Cumbria GP Training Programme has launched #GreatBritishConsultations as a way of getting noticed on social media with a series of eye catching photographs to attract attention – this one rather Messianic. Good luck we say.**

Source: Steve Razzetti (www.razzetti.com) steve@razzetti.com

● **MEDICAL EMERGENCY WITH A VIEW** NHS Highland recently conducted a workshop considering innovative solutions to improve out-of-hours care in rural areas. The current service was judged to be too fragmented and lacking in flexibility to cross cover, as well as being "extremely expensive". One solution floated was the use of "telebooths" which would allow patients to talk to GPs from remote locations. Diary was immediately put in mind of the lone red phone box in the film *Local Hero* – perched on the stone quay of the fictional Scottish village of Ferness. Maybe you could enjoy a lucky glimpse of the northern lights as you await the EMRS helicopter.

DON'T MISS OUT!

CHECK OUT THE MANY BENEFITS OF MDDUS MEMBERSHIP

MDDUS members are entitled to exclusive discounts on a range of medical books and journals.

DISCOUNTS INCLUDE:

- 15% off at Cambridge University Press
- 15% off at Manson Publishing
- 15% off at Dundee University Press
- 15% off all titles at Oxford University Press
- 15% off books and journals at Elsevier
- 15% off at Radcliffe Press
- 20% off at Hodder Education
- 20% off at Scion Publishing

For further information contact our Membership Services Department on

0845 270 2038

www.mddus.com