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 will there be a clampdown on the amount of junk food served in hospitals. Health checks will be provided for NHS staff aged 40 or over, and there will be access to physiotherapy, mental health, 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 with data and urgent paperwork.

The College acknowledges that safety risks in general practice are inherently lower than in many other 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.

The College claims that the pressures on GPs have never been greater, and that extending the local practitioner health programmes that have been shown to help GPs stay healthy and get back to work when sick is necessary.

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 as a tool to raise awareness among doctors, nurses and pharmacists of new or revised information about medicines. They are shared with prescribers, patients and carers and can be used to help make 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.
Is it ever appropriate to become romantically involved with a patient – past or present? Dr Susan Gibson-Smith offers some advice

An Improper Relationship?

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

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.

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 or the public from risks of serious harm, this can still be done without permission. In these instances, the only 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 had 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
Define/I Bill which was introduced by the Cabinet Secretary for Health in June 2013. 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" whereas 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:

1. appears to have resulted in—
   i. the death of the service user; or
   ii. any injury to the service user which, if left untreated, would lead to one of the harms specified in (a) above.

2. implies a failure in the care provided to the service user which is of such a nature and magnitude that it appears the doctor has a duty to explain and apologise. It also includes guidance on what to do when things go wrong, there is 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
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 and health.

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. GPs can, with an interest, in this area as 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 the option of completing a diploma in primary care respiratory care. One such course is available at the University of Bradford and takes all 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, guidance, research and news publications.

• The Primary Care Respiratory Society
• Acute respiratory disease
• Chronic obstructive pulmonary disease (COPD)
• Other respiratory disease.

The role of a GPwSI in respiratory medicine

Whatever responsibilities doctors assume, they are well placed to offer expertise 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.

What about the role has most surprised you?

What do you find most challenging?

What advice would you give to a trainee considering a career as a GPwSI in respiratory medicine?

Joanne Currin is an associate editor at MDDUS.
Dr David Hogg offers an insight into the varied life of a rural GP on the Scottish island of Arran

Wide-ranging care
Rural practice is a hugely diversified 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 major trauma situation. And this after a typical day in general practice, with all the QOF points, AHSN 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 “homely” and “fishy” critics, 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 MRCP 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 amputation, intracranial diamphine, ultrasound scan and helicopter retrieval were all done though necessity. No one else was around to do them and, helped by a supportive relationship with the TV series ‘Borgen’ and the local police, sometimes you can do good without risking harm. This isn’t for the protocol-obssesed no 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.

The scope of rural practice is truly limited only by the needs of our patients for care, mechanics, banking or dentistry, so a reciprocal reliance exists which means that any superficial service is quickly stretched 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-feee” lawyer’s letter which threatens to make medicine hugely defensive.

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 illnesses like, for example, from home visit to hospital was the busiest department he had ever seen on a 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 cool draw; we have an adventure playground on our doorstep, opportunities for sailing, mountain biking, paragliding, canoeing, golfing and more. There is the frustration that sometimes we’re looking at this playground whilst beholding 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 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.
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 the problem of 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 how to deal with the increase in workload pressure on GPs. It states that a “significant proportion of work is currently not fit for purpose” and that “there is a need for more effective oversight and prioritisation of patient care.”

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.”

Joanne Curran is an associate editor at MDDUS.
DAY 1

A 29-year-old male – Mr K. – awakes on a Sunday morning with pain and swelling in his left testicle. An hour later the pain resolves only to recur later that morning, and this pattern is repeated for most of the day. Just before 6:00, 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 testicles move freely. The scrotum skin is of normal colour with no rash or inflammation. Dr L 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 ultrasound scanning, 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 3

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.

VER a year later Dr L receives a letter of claim from solicitors acting for Mr K. and it is clear that Mr K. had considered the GP’s diagnosis of testicular torsion. However, there was no evidence of testicular torsion or its causal relationship to his presenting symptoms. Mr K. had presented with intermittent pain and swelling in his left testicle. Dr L concludes that the torsion would have been identified. Emergency led to an ultrasound scan in which the torsion was evident, and that the medical notes indicate the GP had pointed to possible torsion. Reference by others involved in the patient’s care. In his report, Dr L points out that the cause of testicular pain is not a rare presentation and is most often due to infection or trauma but testicular torsion is not a “fool proof” but that it would be reasonable to expect a GP to perform it and 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.

Diary

S MUCH abnormally, too few columns inches. Welcome back to Diary where we ask interesting and entertaining medical experts from our tenders, get them in a room in a pub and make up our own. But it is not their business.

0.0 STAR-CHASING CARE

Could the answer to the overuse of antibiotics lie in the empiricism of astrology? Conservative MP for Bournemouth East, Dr Andrew Rosindell, seems to think so. In a supporter of complementary and alternative therapists, he has placed in Positive Thinking Tom’s campaign to “buy to save” and who could also help reduce the cost of the NHS. Despite a keen interest in alternatives, the GP is not a believer that the signs of the Zodiak, the star sign that rules the patient’s date of birth, would be more likely to be the cause of the patient’s symptoms. He is not “fool proof” but that it would be reasonable to expect a GP to perform it and 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.
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