



# doctor **di**

WHEN MUSIC MEETS MEDICINE

ALSO INSIDE

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THE RIGHT TIME TO SAY NO

AN MDDUS  
PUBLICATION





## Welcome to your GPst

IN most consultations, we will come to an agreement with our patients about what treatment option is best suited to their needs. But what if you can't agree and the patient insists on a course of action that you feel is inappropriate, whether it's a prescription for antibiotics or a referral for further tests? In his article on [page 12](#), Dr Malcolm Thomas recommends a careful, considered approach when it comes to saying "no".

As patients become increasingly empowered when it comes to their health, a growing number are turning to the internet and smartphone apps to diagnose their symptoms – but with dramatically varied results. And while it may be tempting to dismiss concerns, MDDUS medical adviser Dr Greg Dollman encourages GPs to stop and listen in his article on [page 5](#).

Clinical guidelines are a fact of life for GPs today,

underpinning our decision-making to ensure it is consistent and in patients' best interests. But what about the times when guidance may not be the most appropriate path to follow? Our article on [page 6](#) looks at the need for "logical" justification when deviating from accepted practice.

He is a GP by day and a music producer by night and in our profile on [page 10](#) Dr Thushara Goonewardene talks about his twin passions for medicine and music.

Chronic pain is a major issue for patients and society, with millions of working days lost each year. Find out how GPs with a special interest in pain management can help on [page 8](#). And on [page 14](#), we analyse a case of delayed diagnosis of hip problems in a newborn baby.

• **Dr Susan Gibson-Smith**  
Editor

## TAILOR ADVICE ON SUNLIGHT EXPOSURE, SAYS NICE

NEW NICE guidance on exposure to sunlight highlights the need for balancing risks against benefits when advising patients.

*Sunlight exposure - risks and benefits* acknowledges that communicating this balance poses a challenge to healthcare professionals. Exposure to the sun can boost vitamin D levels but too much time spent in the sun increases the risk of skin cancer.

NICE has made 18 recommendations including the need for professionals to offer one-to-one advice tailored to an individual's level of risk.

Professor Gillian Leng, deputy chief executive and director of health and social care at NICE, said: "How much time we should spend in the sun depends on a number of factors including geographical location, time of day and year, weather conditions and natural skin colour.

"People with lighter skin, people who work outside and those of us who enjoy holidays in sunny countries all have a higher risk of experiencing skin damage and developing skin cancer. On the other hand, people who cover up for cultural reasons, are housebound or otherwise confined indoors for long periods of time are all at higher risk of low vitamin D levels."

Read the guidance at: [www.nice.org.uk/guidance/ng34](http://www.nice.org.uk/guidance/ng34)



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## MAJOR REVIEW OF REVALIDATION

A REVIEW looking at the impact of revalidation and how to improve it has been launched by the General Medical Council.

Three years after the programme was first implemented, the regulator has asked Sir Keith Pearson to assess how effective it has been and produce recommendations for changes to be made in 2017.

Sir Keith, chair of the GMC's Revalidation Advisory Board, will ask doctors about their experiences of revalidation; consider submissions from organisations such as royal colleges, the BMA and NHS England; and analyse statistics and surveys about revalidation, including patient feedback forms.

GMC figures suggest nearly 75 per cent of doctors (150,000) are on track to be revalidated by April 2016.

Sir Keith's report is due to be published by the end of the year. An interim evaluation of revalidation – produced by an independent group of UK researchers known as UMBRELLA – will be published this spring.

## GP LETTERS HELP CUT ANTIBIOTIC PRESCRIBING

WRITING letters to GPs about their antibiotic prescribing rates can bring about a small reduction in scripts handed out, according to a study published in the *Lancet*.

In the trial of 15,000 practices, GPs were sent a letter saying "80 per cent of practices in your local area prescribe fewer antibiotics per head than yours". The letter was supplemented with guidance on ensuring antibiotics prescriptions were necessary.

GPs who received the letter reduced their rate of antibiotic prescriptions to 127 per 1,000 compared to 131 per 1,000 by GPs who did not receive the letter. This amounted to 73,000 fewer prescriptions (a 3.3 per cent reduction) over six months.

The trial also involved a cohort of patients targeted with leaflets and posters about why reducing the use of antibiotics is important but there was no significant difference in the rate of antibiotic prescriptions in this group.

Chief Medical Officer Dame Sally Davies said: "This innovative trial has shown effective and low cost ways to reduce unnecessary prescribing of antibiotics which is essential if we are to preserve these precious medicines and help to save modern medicine as we know it."

## SCREENING MOST EFFECTIVE IN EARLY BOWEL CANCER DETECTION

BOWEL cancer is more likely to be detected early by screening than with GP referral or as an emergency presentation, according to a new study published by Cancer Research UK and Public Health England.

More than one-third (37 per cent) of cases picked up by bowel screening were caught at Stage 1 with eight per cent at Stage 4. This compares to 22 per cent of diagnoses being Stage 4 after referrals from GPs (either routine or urgent) and 40 per cent at Stage 4 on emergency presentation.

The full study considered data from 574,500 cases diagnosed in 2012 and 2013, including bladder, breast, bowel (colorectal), kidney, lung, melanoma, non-Hodgkin lymphoma, ovarian, prostate and uterine cancers.

Screening picked up the highest proportion of early stage cancers – 63 per cent at Stage 1 versus three per cent at Stage 4. Just over a third (34 per cent) of cases diagnosed following a GP referral were Stage 1 compared to just over a fifth (22 per cent) at Stage 4. More than half (58 per cent) of all cancers diagnosed as an emergency were diagnosed at Stage 4 compared to around a tenth (11 per cent) at Stage 1.



## NEW FGM LEARNING RESOURCES

A RANGE of new resources to help healthcare professionals understand the needs of FGM survivors are being launched online as part of a campaign to raise awareness of the issue.

A new training video has been published by NHS Choices to highlight the specific mental health needs of victims of female genital mutilation. And Health Education England are set to launch more e-learning materials looking at the mental health impacts of the practice.

The move follows the recent International Day of Zero Tolerance for FGM, and a "prevention week of action" organised by the Department of Health (DoH).

There are currently 60,000 girls aged 0 to 14 years living in the UK who are potentially at risk of FGM.

Public health minister Jane Ellison said the DoH had taken steps to identify the number of FGM survivors being treated by the NHS, and that training was being provided for thousands of frontline professionals in caring for and protecting girls from FGM.

"The next step is to make sure that survivors are aware of and have access to the right mental health support," she said. "So we are working with professionals, campaigners and survivors to plan how to deliver and embed these services in the health system."

- Watch the NHS Choices video on FGM and mental health: [tinyurl.com/jm5u3u8](https://www.tinyurl.com/jm5u3u8)
- Access DoH resources on FGM prevention, reporting and patient support: [tinyurl.com/na64h4p](https://www.tinyurl.com/na64h4p)

## £20K INCENTIVE TO ATTRACT GP TRAINEES

A ONE-OFF bursary of £20,000 is being offered to GP trainees in a bid to fill vacancies in less popular areas in England.

Health Education England has identified 109 training places in parts of the country in which it has struggled to recruit for the past three years. These include Lincolnshire, East Cumbria, Blackpool, West Lakes, and the Isle of Wight.

The cash is paid to trainees who sign an agreement to complete a three-year placement in one of the hard-to-recruit areas, with no option to relocate. Those who leave the scheme early will have to repay part of the bursary.

Round one applications have closed for the August 2016 intake, but a second round is due to open late summer for the February 2017 intake.

HEE hopes the cash incentive will encourage trainees to consider less

sought after areas.

An FAQs page on the HEE website relating to the "Targeted Enhanced Recruitment Scheme" states: "These areas often have an extremely good track record for education, but are initially less popular simply because of their geographical location. However, those trainees that do come usually stay on after training, as they discover these locations' hidden attractions."

It goes on to say that these often remote areas provide equally high-quality placements which sometimes offer "an increased breadth of training and many more opportunities for diversification."

"Once you get there, you may well find that the lifestyle is much more relaxed than in our big cities," it added.

Find out more on the HEE GP recruitment website at [tinyurl.com/czwgq76](https://www.tinyurl.com/czwgq76)

# SHOW ME THE DATA

With so much scientific research being published, how can trainee GPs critically appraise the evidence available? Dr Allan Gaw offers some practical tips

**A**S DOCTORS, we are constantly reminded of the importance of practising evidence-based medicine, and rightly so, for what is the alternative? But in order to practise the best medicine, we need the best evidence – and we need to understand it. The latest evidence in the medical sciences is presented as a weekly diet of articles in an ever-increasing number of journals. This scientific literature presents the practitioner with two challenges. First there is the volume and then there is the quality.

We have to learn to read efficiently and selectively if we are ever to keep up, but we must also hone our critical faculties and, like all good scientists, take nothing at face value. How then should we read a paper critically?

All scientific papers set out to answer questions. When tackling a paper, your first task is to identify exactly what the authors have set out to do and why. Next, you should find out how they tried to answer their question. In other words, what sort of experiment did they perform? Depending on the topic you are reading about, this might be an experiment done in test tubes on a laboratory bench, a study in mice or rats, or perhaps a clinical trial.

Whatever was done, you should now be asking yourself if the approach was appropriate to the research question. For example, while an animal study might provide invaluable pre-clinical evidence for the effectiveness of a new treatment, it is never going to provide the sole evidence to support the use of a novel drug in your patients.

The design of the study is crucial to its usefulness. The size of the study and its duration will affect how you view it, and what about the study participants – do you recognise them? Are they the same patients you see in terms of age, comorbidity and concomitant therapies? Or are they a cherry-picked group that does not mirror the population you are used to? If so, you may question how generalisable the study findings are to your practice.

Another key consideration in study design is whether the experiment is controlled. If not, the results (whatever they may be) are

meaningless. If there is no control group, we cannot ascribe any change or treatment effect we might have observed to the intervention under study – what we have observed might simply be background noise.

In the paper, the authors will present their findings and from these draw conclusions, but are the conclusions plausible? If a paper reported that smoking does in fact increase your life expectancy, you should pause. Given everything that we already know about this lifestyle risk factor, such a finding would be hard to swallow. Similarly, if the authors of a relatively small, short study claimed that the drug they had studied should now be prescribed to everyone over the age of 35, you should be sceptical. Extraordinary claims require extraordinary levels of evidence. And while consistency between multiple lines of evidence will make the conclusions more credible, disagreement should make us stop and think.

A study may be well designed and executed, and the data credible but the evidence may not support the authors' conclusions. There may be an extrapolation that requires you to take little more than a leap of faith. There may also simply be other explanations of the data. For example, mere associations are often presented as cause and effect, when it is rarely that simple.

Which brings us to our next point – overall, just how good is the evidence? Publication does not alone mean that the evidence is of high quality. The better the journal and the higher its impact factor, the more likely the

paper has been subjected to rigorous peer review. This means that poorly designed and underpowered studies should have been filtered out during the review process, but sometimes poor studies slip through the net, even of the better journals. When it comes to lower tiered journals their nets have bigger holes and you might have to work a bit harder to evaluate the quality of the evidence, because nothing can be taken for granted.

In summary, there are seven questions you should ask of any clinical research paper:

1. What is the research question?
2. How did they answer it?
3. Was their approach appropriate?
4. Was the study controlled?
5. Do you recognise the study population as your patients?
6. Is the answer plausible?
7. Does the evidence support the conclusion?

To answer these you will have to focus on different parts of the paper and you will also have to do some thinking. The study may be published, but that doesn't necessarily mean it's valid or useful, especially to you and your practice. Critical evaluation is about gathering the facts, putting them in context, reflecting upon them and making decisions – decisions that will ultimately guide your practice.

**Dr Allan Gaw is a writer and educator in Glasgow**



# DEVIATING FROM CLINICAL GUIDELINES

No law says you must offer a particular medical treatment – but ensure you have good reasons for departing from accepted clinical guidance

PROFESSIONAL clinical guidelines are a common feature of medical practice today, with GPs responsible for keeping abreast of updated guidance from bodies such as the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN).

The GMC are unequivocal that doctors are personally accountable for their professional practice and must always be prepared to justify their decisions and actions in regard to such guidelines. It goes on to clarify that clinical guidance in itself is not a statutory code and that clinicians must therefore use professional judgment in applying the principles to the various situations they face.

NICE states that its guidance is designed to help healthcare professionals ensure the care they provide “is of the best possible quality and offers the best value for money”. But it also says that its guidance “does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and/or their guardian/carer”.

One example of a situation where a doctor could justifiably depart from accepted guidelines would be where a patient is likely to suffer a serious adverse reaction to a recommended drug. In these circumstances, it would be appropriate to prescribe an alternative.

Should your routine practice deviate significantly from accepted clinical guidelines this should be reviewed – and if a decision is made to deviate from specific guidance this should be justified in the clinical notes and the patient should be advised of the fact that you hold a different view from that of mainstream practice. Recording your thinking in regard to such a clinical decision may be a crucial factor if challenged at a later time.

A recent MDDUS case highlights the difficulties doctors may encounter in departing from accepted clinical guidelines without adequate reasons for doing so. A 23-year-old female presented initially to her GP with a lump in her right breast of 10 days' history. The GP noted the presence of a small, firm regular lump of 0.5cm diameter in a fibrocystic breast, and asked the patient to return for re-examination during her next menstrual cycle.

The patient was then examined by a second GP who confirmed and noted that the lump

under the two-week urgent referral pathway. Instead the patient was offered a routine appointment at the local breast clinic under a 'choose and book' scheme.

She was seen two months later and on this occasion the breast clinic also provided the patient with a reassuring prognosis and a further delay of several months ensued before the patient was diagnosed with carcinoma of the breast with metastatic disease. Her life expectancy was estimated at two years.

A claim was raised against both the second GP and the local hospital trust. MDDUS obtained an expert GP opinion which was unsupportive of the GP's actions in not referring the patient urgently in the first place. An additional medical report suggested that had the patient been referred at the appropriate time, the cancer should have been detected earlier with curative treatment being possible.

The GP pointed out that she tended to use clinical guidelines in conjunction with additional factors to weigh up her examination findings, such as age, general well-being, family history, history of any pain, discharge and any noted cyclical changes to nipples or skin. Overall the doctor had found the larger picture reassuring and had suggested the 'choose and book' option rather than the urgent referral pathway.

In view of largely unsupportive expert reports which clearly indicated that the two-week urgent referral pathway should have been chosen by the GP, the case was difficult to defend. In this instance the GP did not appear to fully comply with the maxim that when a decision is made not to follow guidelines there should be a logical basis for that decision and the patient should be advised of the fact that the doctor holds a different view.

In summary, it's important to be aware of and be sensitive to relevant guidelines for common conditions and if your practice deviates significantly from these it should be reviewed. Should you decide not to follow accepted clinical guidelines, ensure you provide a logical basis for your decision and record this in the notes. The patient should also be clearly advised why you decided to deviate from accepted practice.



*'If a decision is made to deviate from specific guidance this should be justified in the case notes'*

appeared to be larger, although there were other factors that suggested a benign cause. NHS cancer referral guidelines in place at the time stated that a patient who is under 30 with an enlarging breast lump should be referred

**Alan Frame is a risk adviser at MDDUS**



# FOR INSTANT DIAGNOSIS CLICK HERE

As patients increasingly rely on potentially misleading internet medical advice, **Dr Greg Dollman** advises doctors to be careful not to overlook valid concerns

AS MODERN life gets faster, more and more shortcuts become available to us. Order your coffee via an app on your way to work. Have your groceries delivered to your home any time you want. If only we could get that same instant gratification when we are concerned about our health...

Some believe this is possible. Patients are increasingly relying on the internet to self-diagnose. The reasons seem obvious enough: urgent appointments may not be readily available, the internet has all the answers (doesn't it?), and large sections of the public feel it is a chore to visit a doctor.

## The rise in self-diagnosis

A recent survey by the Astellas Innovation Debate revealed that three-quarters of GPs noticed a marked increase in the number of patients "self-diagnosing" from the internet over the last year. These range from the worried well, to the proactive and genuinely interested, as well as to those seeking a particular quick fix. ("Doctor, I think I have X. Will you write me a prescription for Y?")

Such is the pervasive role of the internet today, it seems inevitable that some people will look up their symptoms online. It can be a fine balancing act for doctors when faced with patients who, prior to the consultation, have already sought a "second opinion" via their health app or a Google search.

Although the internet can be a helpful starting point in some cases, there is also a lot of inaccurate and misleading information online. Patients should nevertheless be encouraged to take an interest in and be responsible for their own health, and discuss any concerns with their doctors. By working in partnership, patients may gain a better understanding of any condition or symptoms. At the same time doctors can improve their

knowledge and gain a greater insight into both their patients' symptoms and the reasons for their presentation.

## Listen

Undoubtedly patients know their bodies far better than a doctor ever could, and it is important for clinicians to listen when they talk about their symptoms, especially in chronic conditions ("Doctor, this feels like an exacerbation of my COPD"). Doctors should acknowledge a patient's central role when formulating diagnoses and making decisions, being careful to remain professional in the care they provide. The GMC's *Good medical practice* reminds doctors that they must adequately assess a patient's condition, taking into account their explanation of symptoms as well as their views and values, before undertaking an appropriate examination.

Doctors may feel uncomfortable, intimidated or even threatened when presented with a dossier of information, complete with diagnosis, sourced from an app or the web. This can be exacerbated where the doctor is unfamiliar with the symptoms or condition described. Furthermore, doctors may feel the consultation loses its usual structure when patients arrive with a diagnosis in mind, and time that should be used to examine the patient may instead be spent looking through a patient's findings. Healthcare professionals, fortunately, are usually skilled in adapting their practice to meet each individual's needs, and resultant discussions can often help to build the doctor-patient relationship.

## Working in partnership

Whatever your views, it is important to acknowledge a patient's research and not be dismissive, even when the proposed diagnosis seems improbable. Patients may feel that a doctor setting aside their concerns is also dismissing them and this can be damaging to your relationship, as well as being a source of complaints.

Patient-initiated research can provide a helpful starting point for investigating concerns and to dismiss it risks overlooking potentially serious health issues. Involving patients in their care is also beneficial for

compliance, as research suggests they are more likely to engage with management plans that they have helped formulate.

There is much to learn as a doctor and it is impossible for us to know it all. So when a patient offers a considered and subjective review of their own symptoms and circumstances, it can be a helpful opportunity for development.

## Work within your competence

MDDUS has handled many cases where patients have requested investigations or treatment as a result of internet research, and it is important that doctors use their professional judgement. The GMC expects doctors to work within the limits of their own knowledge and expertise, and clinicians are not obliged to provide treatment simply because a patient wants it.

GMC guidance *Consent: patients and doctors making decisions together* states: "If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment."

Doctors should then explain to the patient why they don't want to provide the treatment and explain any other options that are available, including the option to seek a second opinion.

In future, patients will likely have more and more information at their fingertips. While some may attend with a plausible diagnosis in mind, doctors are obliged to interpret this information following a focused history and examination, applying their clinical acumen and experience. As technology evolves, so too will the relationship between patients and doctors. Perhaps this is the true partnership that professionalism requires of doctors. For all its advances, however, the digital age cannot offer the skilled unravelling of clinical clues instantly, at the click of a mouse.

**Dr Greg Dollman is a medical adviser at MDDUS**

# DOCTORS ON CALL

## Consulting with patients by telephone has become increasingly popular for GPs, but there are risks

INCREASING patient demand is a source of considerable pressure for GPs, many of whom face the challenges of managing shrinking budgets and growing workloads. Technology is often heralded as the key to greater efficiency and one solution adopted by many practices is telephone triage.

Estimates suggest that as many as 10-20 per cent of daytime contacts between patients and GP surgeries now take place by phone. But questions remain as to how efficient and effective these consultations are, as well as the associated risks.

First contact with GP out-of-hours services is usually by telephone, with a large proportion of encounters being managed entirely over the phone. This is significant as out-of-hours services (usually 6.30pm-8am) cover 70 per cent of the 168 hours in a week.

So do patients approve? Evidence is limited but the answer is probably a qualified 'yes', but only so far as they see a phone discussion as a convenient alternative to a face-to-face consultation and not, as is sometimes perceived, a barrier to accessing services.

In terms of the clinical and medico-legal risks of phone consultations, there is a lack of published studies and case reports addressing this specific area. MDDUS case files and those of the public service ombudsman can provide some insight, but as yet the data is not conclusive.

In our experience at MDDUS, three general themes emerge:

1. Failure to see the patient when it would be appropriate and sensible to do so.
2. Failure to communicate or pass on important information (e.g. a test result).
3. Failure to safety net or provide sufficient advice in the event of deterioration.

There are ways to minimise such risks during telephone consultations. A recognised structure for clinical encounters by telephone is similar to that in face-to-face consultations. The doctor needs to:

- Establish the facts: the relevant history and clinical facts.
- Obtain the patient's perspective about the issues at hand.
- Gather enough or the correct information to be in a position

to make a diagnosis or formulate a plan.

- Reach a decision about what you think is going on and convey this to the patient.
- Come up with a management plan which can be fully understood by the patient.
- Put a safety net in place should things not go as well as expected.
- Document: recording the call, with appropriate data protection protocols, can be of great value and assistance 'when things go wrong'. Be sure to carefully note discussions with the patient in their record.

Of course, both proximity and visual cues are absent during telephone conversations, which means that the doctor needs to compensate. The subtle and more obvious face-to-face cues obtained through non-verbal communication are lost and any incongruity of affect present is more difficult to detect from words and tone of voice alone.

There's an old sales training adage which teaches that it is easier to lie and make up excuses over the telephone. Therefore, the sales person should always endeavour to get in front of a potential customer rather than take the lazy option of calling them up. Could the same dynamics exist in the doctor-patient telephone encounter? What you can't see in a telephone consultation are the obvious and sometimes subtle facial expressions, gestures and postures that often provide evidence as to an individual's true thoughts and state of mind.

So, what's to be done?

- When on the phone it can help to talk more slowly and clearly (the so-called 'telephone voice').
- Ask more questions than you might otherwise in a face-to-face consultation to ascertain and be certain of your facts, and to ensure the patient clearly understands what is being said.
- Ask the patient to repeat back to you what has been discussed and agreed: you might also consider asking the patient to write down the details of any agreed management plan and what to do if things don't go as

expected.

- Adopt a lower decision-making threshold about reverting to a face-to-face consultation: any visible lesion (lumps, bumps, rashes etc) should be examined face-to-face. Be mindful of the potential outcome in any delay getting a patient in front of you. For example, a two-hour gap before examining a patient could be long enough for serious deterioration in certain cases.

Some other practical risk reduction measures to consider include:

- Dedicated and protected telephone consultation times (i.e. no interruptions).
- Enhanced documentation to compensate for the absence of physical examination.
- Standardised protocols for managing the more common conditions, similar to those used by NHS 111 and NHS 24.
- Appropriate training for all staff involved in the telephone consultation process.

Taking all of this into account raises some interesting questions and challenges about why telephone consultations are offered in the first place. I suspect it is often to do with a perception that greater use of the telephone increases efficiency and throughput from the clinician's or service perspective.

However, if a more risk averse approach were adopted through increased scrutiny and enhanced safety netting, then by default a telephone consultation could quite easily take up more time and resources than seeing the patient face-to-face in the first place.

**Alan Frame is a risk adviser at MDDUS**



Living with chronic pain is a hardship endured by over 14 million patients in the UK – and GPs with a special interest in pain management are there to help ease the burden

# PAIN RE

**C**HRONIC pain poses a major burden not only for individual sufferers but for UK society in general. Last year an estimated 10 million working days were lost to back pain alone, according to the UK Statistics Authority. This is equal to £1 billion in lost earnings. Workers aged 50–64 were most affected with around 4.2 million working days lost.

People with chronic pain live not only with the physical pain itself but frequently suffer from depression, anxiety, physical dysfunction and social isolation which can make managing this condition even more complex. It is estimated that approximately one in five of all consultations with GPs are pain-related.

Persistent pain may originate from injury, disease or iatrogenically. It is often believed that its presence relates to ongoing pathology. In certain situations this may be the case (e.g. inflammatory disease), however mostly it is due to maladaptation within the sensory nervous system. Mixed pain states may be a combination of these.

In recent years there have been significant efforts to improve the way the NHS manages pain. A 2013 document co-authored by the Royal College of General Practitioners (RCGP) called for a more integrated and targeted approach to commissioning primary and secondary care pain management services – the aims being to improve quality of life and access to appropriate care, to optimise analgesics and to reduce reliance upon healthcare services.

Practitioners with a special interest (PwSIs) in pain management are an important element in this approach, with the move to bring more complex care out of hospitals and into appropriately skilled community settings. The RCGP and Royal Pharmaceutical Society (RPS) of Great Britain have published guidance and competencies for PwSI in pain management.

## The job

There is no one-size-fits-all description of the role of PwSI in pain management. Commissioners in each CCG or health board identify the specific service requirements, and the competencies required by practitioners can then be agreed. PwSIs may have a broad or narrow competency depending upon what's needed. There is no specific accreditation process for a PwSI in pain management; competency is underpinned by robust governance frameworks, involving mentorship from specialists as appropriate.

Most GPs working in pain clinics offer management of chronic pain, along with an understanding of the underlying neurophysiological mechanisms and the confidence to explain these to patients. PwSIs will usually work in a multidisciplinary team, ideally including psychologists, specialist nurses, physiotherapists, occupational therapists and other pain physicians.

PwSIs may also be in a position to lead local implementation of national frameworks and guidelines in pain management (e.g. British Pain Society recommendations for the use of opioids in the management of chronic non-cancer pain). This can include sharing best practice locally between clinicians, patients and carers.

## Competencies and training

The RCGP/RPS guidance calls for all PwSIs to first demonstrate that they are competent generalists. For GPs this can be assessed in a number of ways including: meeting the competencies set out in the RCGP curriculum ([www.rcgpcurriculum.org.uk](http://www.rcgpcurriculum.org.uk)) together with a holistic understanding of primary care practice; obtaining a pass in the examination of the Royal College of GPs or equivalent and being a member of good standing; evidence of critical appraisal skills and engaging in active clinical work.

Specific competencies for a PwSI in pain management include knowledge and experience in (not necessarily all):

- Comprehensive pain assessment
- Diagnosis and management of persistent pain
- Long-term condition management
- Rehabilitation and multi-disciplinary team working
- Management of drug therapy
- Management of delivery of pain services
- Mental health problems
- Complementary therapies
- Managing pain after trauma
- Welfare system and employment opportunities
- Support of research.

Necessary training for the role of a PwSI in pain management can be acquired in several ways depending upon the scope of the role. There are postgraduate courses available such as the MSc in Pain Management offered by Cardiff University Medical School. GPs can also work under the supervision of a specialist or consultant in pain management or as part of a specialist training programme. Training can also be pursued through self-directed learning; attendance at academic meetings, lectures or tutorials; participation in case conferences and in-depth case reviews.

The RCGP/RPS guidelines state that assessment of individual competencies for

# LIEF

PwSIs in pain management can be undertaken by a combination of the following:

- Observed practice using modified mini clinical examination
- Case note review
- Reports from colleagues in the multi-disciplinary team using 360-degree appraisal tools
- Demonstration of skills under direct observation by a specialist clinician (DOPS)
- Simulated role-play objective structured clinical examination (OSCE)
- Reflective practice and logbook/portfolio of achievement
- Observed communication skills, attitudes

and professional conduct

- Demonstration of knowledge by personal study supported by appraisal (with or without knowledge-based assessment)
- Evidence of knowledge gained via attendance at accredited courses
- Conferences or from online or distance learning courses.

For more information on specialising in pain management contact your local CCG or health board.

## Sources

- *Guidance and competences for the provision of services using practitioners with special interests (PwSIs): Pain Management at [tinyurl.com/h9btnso](https://tinyurl.com/h9btnso)*
- *Pain Management Services: Planning for the Future - Guiding clinicians in their engagement with commissioners at [tinyurl.com/zcj3agv](https://tinyurl.com/zcj3agv)*



## Q&A Dr Chris Barker, GPwSI in pain, and Clinical Director of the Community Pain Service at Southport and Ormskirk Hospital NHS Trust

**What attracted you to pain management as a specialty?**

At first I wanted to carry on with my anaesthetic skills I'd learned as a junior.

The more pain I did, the more I realised interventional practice had a limited place, and good diagnostic skills and consultation technique were more relevant.

**What do you enjoy most about the job?**

I enjoy the endless variability in presentations, applying modern neurophysiology evidence to diagnostics, and having a bit more time than a standard GP consultation to be able to explain, explore and co-create management plans that are as meaningful as possible.

**Are there any downsides?**

Politics. Pain is "owned" by anaesthesia with little recognition for other clinicians who can often offer great expertise and unlimited motivation to collaborate meaningfully with those professionals who provide the bulk of care for this patient group. This is slowly changing but it needs to move quicker to keep up with modern commissioning.

**What do you find most challenging?**

Working with managers to identify and measure meaningful quality KPIs [key performance indicators]. Also changing long-established care pathways that promote dependence on clinicians and reduce patient confidence to self-manage.

**What about the role has surprised you most?**

How it cuts across most aspects of medicine. I don't think there is a specialty that's not represented in my clinic. Also how it's really useful to have a deeper understanding of pain - especially in medically unexplained situations.

**What is your most memorable experience so far?**

The new patient consultation when I didn't say anything for 27 minutes, and spent the final three being told how wonderful the management plan was!

**What advice would you give to a trainee GP thinking about specialising in pain management?**

Be open-minded. Consider the patient as an expert too.

# INFECTIOUS BEATS

GP Thushara Goonewardene talks about balancing his love for medicine with his passion for music

AT THE end of a busy day in practice, GP Thushara Goonewardene swaps his stethoscope for headphones to make dance tracks in his role as a successful London music producer.

So far it's been a well-kept secret, with most of his patients unaware of their doctor's talents behind the decks. The former Saturday night radio DJ, who goes by the artist name of Fushara, first discovered his love of music at school and quickly became immersed in 1990s dance music culture.

He said: "I kind of fell into it because my friends were doing it. They would show me their DJ equipment and mix records at each other's houses. It seemed fun so I got involved and I kept doing it when I went to university because it is infectious. There wasn't really an agenda, to begin with, but in my twenties I wanted to take it a bit more seriously."

And Thushara, 35, could not have predicted where his early introduction to London's famous electronic music scene would lead.

## Musical release

Before long, like many other successful music producers, Thushara was laying down his own drum'n'bass and techno tracks in his bedroom and later, as Fushara, went on to release music on various electronic labels. He has worked with acts such as Subject 13, and even collaborated with Justice and Metro, the duo behind the music label MJAZZ who were part of the early 1990s drum and bass revolution.

Coming from a hardworking Asian family, Thushara was expected to follow in the footsteps of his mother (a former ENT doctor) – and he did – but DJ-ing was also calling him. At medical school, he had to be very disciplined to balance studying with spinning.

The DJ admits his family "thought it was a fad" but says: "As the years went by, I was still doing it. My parents were very encouraging and they gave me my space to do it, because they saw how much I really enjoyed it."

"It was a bit intense at med school; there was a three-year period when I became quite regimental about it: I would go to uni, finish work, do music. I would dedicate a Wednesday afternoon and a Saturday afternoon to producing music."

Music was a release for Thushara but he did face criticism that at one point made him consider (reluctantly) giving up his passion.

"I didn't get a lot of understanding at university because that kind of hobby wasn't

well accepted at the university I went to. It wasn't easy so I had to find my own way with that." Despite the negativity, he continued to follow his path.

## Finding balance

Content with being a doctor-by-day and DJ-by-night, Thushara's working hours of 8am until 6pm in general practice means he has the work/life balance just right.

But reaching this point hasn't always been easy and the doctor-cum-producer admits he initially found it tough and struggled to balance the two roles.

Three years ago he moved from London to Derbyshire, leaving behind the capital's vibrant music scene, his family, friends and girlfriend, to complete his GP training at a medical practice in the Peak District.

During this time away from home Thushara began to feel isolated and he started to question his career choice and how it balanced out with his passion for music.

"In the last couple of years, I was finding it more difficult to continue doing both. The more responsibility I took on at work and the harder the exams got, I started feeling a lot of pressure."

"I was trying to assess my future – music started off as an absolute passion, then I thought 'actually, could I make a career out of this?', but there was no guarantee to make money from it."

"Becoming a GP was a serious step and it meant I couldn't make as much music, so I asked myself 'am I becoming more of a career man now? Is music something I have to do less of?'"

"My motivation and inspiration were lacking and I felt my identity was slipping away."

Thushara found solace in the Lone Foundation, his own record label for releasing collaborations and projects which he set up with support from his video artist and graphic designer friends. The self-funded project paid off. Not only did it allow the London DJ/producer to regain his motivation, it also inspired him to release his own album *A Wasteland of Memories*, a selection of down tempo and techno-influenced tracks, in 2015.

## Forging a path

Now nearing the end of his three-year stint in Derbyshire, the medic is making plans to move back home to

be nearer his two loves – his girlfriend and the London music scene: "I am looking forward to going back home. My patients are unaware of my music career. When I qualify and go back to London I will have to think about that!"

Credibility and your standing in the community in which you treat patients is hugely important for any GP, so is Dr Goonewardene concerned about this, especially given his issues at medical school?

"I don't think my credibility will be questioned as I am not a different person," he says. "I am the same person as a GP as I am when I am not a GP. If I bumped into a patient out of work at a bar or a club, I would be totally happy to talk to them about it."

Thushara feels that being a successful DJ and producer has, in many ways, benefited his career in medicine because of the transferrable skills he has built up and the relationships he has forged with people from all walks of life.

"I have made my best and most varied friends through music and medical school. The music scene is like a movement and, because you're in a relaxed environment, you learn things about people that they wouldn't normally tell you. They express themselves genuinely and I have a lot of experience meeting lots of different people that way."

"In a consultation, I try to draw on that to communicate with people in that way. I definitely think it has made me better with people as a GP, there's no doubt about that."

**Laura Coventry is a freelance writer based in Glasgow**

● Find out more about Thushara's music at: [www.lonefoundation.bandcamp.com](http://www.lonefoundation.bandcamp.com)



# SAYING

Patients can't always get exactly what they want. Here **Dr Malcolm Thomas** offers some advice on holding your professional ground

**M**R MCKAY sees you in a booked-on-the-day appointment. He opens with: "Doctor, this won't take long. I've had a cough for a few days, but the cough's getting worse and it's keeping me up. So I've just come for a few of those antibiotics like Dr Smith usually gives me."

Mr Jamieson has managed to get one of the urgent appointments. He looks a bit furtive, and his opening remarks are: "Doc, sorry to bother you. My mum tipped my tablets down the toilet when she was cleaning. I just need a few of me mazzies to tide me over. Thirty should be more than enough."

Mrs Wallace has booked a routine appointment to see you. She says: "I'm glad to be able to speak to a sensible doctor. I was at the out-of-hours with my sciatica and just got fobbed off with tablets. This pain isn't getting any better. I've been googling it, and it's clear I need a scan. So that's about it really."

## The dilemma

General practice seems to attract doctors who like people – and who want to be liked themselves. Fortunately, in many of our consultations we can happily say "yes" to our patients' own ideas about how they should be treated. The right thing tends to be the popular option.

But what happens when there is a good professional reason to decline a patient's expressed request?

It is tempting to resolve this by convincing ourselves that the situation isn't as it seems: e.g. "your spit has been green, so I'm happy to give you an antibiotic". (Read the NICE guideline if you don't know why this may be wrong.)

Assuming our clinical assessment backs up the initial judgement, we then face the dilemma of meekly acceding to our patient's request or holding our ground. A recent finding that patient satisfaction scores often correlate with increased antibiotic prescribing (at the practice level) has only intensified the dilemma.

We can't get off the medico-legal hook just by saying "Yes" all the time, however. We can be sued for prescribing an unnecessary antibiotic if the patient develops side-effects. Or we can be sued by benzodiazepine users, for example, who may allege that they weren't properly counselled about the risks of addiction.

The ethical dilemma here is to balance the principle of supporting patient autonomy versus non-maleficence (do no harm) and/or distributive justice (being thoughtful with NHS money or bearing down on the risk of antibiotic resistance to the population).

## Some guiding principles

Below are some principles to guide our consultation behaviour when faced with patient demands.

- **Acknowledgement response.** Consider early deployment of the



"acknowledgement response". This is a statement that combines a comment showing we have understood the request with a signpost that we need to do some clinical work before coming to a decision.

***"So your cough is keeping you up, and you were thinking some antibiotics might sort it out."***

*"That's right doc."*

***"Ok, so let me find out a bit more about the cough, and then I'll check your chest, and then we'll see what's what".***

*"Can't you just write out the script, like Dr Smith used to do?"*

***"I'd prefer to find out what's actually going on. It won't take long, and then we'll know what we are dealing with."***

*"Fair enough doc."*

- **Explore the thinking behind the patient's request.** For example: *"You've asked me about a scan, and that sounds very important to you. Would you be able to tell me what you are hoping a scan will show?"*
- **Perform a thorough examination (if relevant).** Examine the relevant part or system thoroughly. This works for the antibiotic and "scan" examples above but is not so relevant to the benzodiazepine case. You can then refer to the exam when attempting to reach common ground with the patient. For example: *"I've had a thorough*



*listen to your chest, and I am pleased to say there are no signs of infection in your lungs just now."*

- **Educate the patient about the clinical rationale/current practice.** A good example here is with MRI scans. Few patients will have a detailed understanding of exactly when such a test is clinically indicated, and how it depends on the severity of their symptoms, the length of time they have been present, and so on. The mindset is: "Surely it will show up on a scan". They are unlikely to appreciate that a scan can show up an "incidentaloma" i.e. a finding that is hard to ignore, but of no clinical significance. This reasoning is reflected in policies and guidelines for GPs (e.g. those issued by the Royal College of Radiologists) - which most patients will not have read. The trick is to explain this to the patient in a way they will easily understand.

*"MRI scans can be a good test, but right now that would not be the best way of treating you."*

*"How so, doctor?"*

*"An MRI (of your back) is going to show up some wear and tear in any patient over 25 years old. Our guidelines are based on research from patients like you. If there is no evidence of nerve damage, as in your case, the best outcomes come from getting mobile, and seeing how it goes. We will re-examine you in six*

*weeks if it isn't settling, or sooner if it gets worse."*

*"Does that mean I'll not get a scan?"*

*"I expect you will not need one. But if things drag on or get worse, then an MRI could be a good idea, and if so, of course we'll arrange it".*

- **Use "not" instead of "no".** When explaining your thinking, it will usually be profitable not to sound totally inflexible. The use of the word "not" in your explanation can help.

*"A scan can be a good idea in backache with sciatica. Based on what you've told me and my careful examination, I am sure we are not at that stage yet."*

*"What makes you so sure doctor?"*

*"Let me explain my thinking..."*

- **When you can't reach common ground.** There are times when reason doesn't get us to common ground - and not just with benzodiazepine addicts. The conversation seems to be a broken record. In essence, the consultation is over. There is nothing we can say or do that will make this patient happy. One approach is to point this out to the patient.

*"So it looks like you won't be happy if you don't get a scan, and as I've mentioned, it is my opinion that this is not an appropriate investigation for you at the minute."*

*"Yeah. So what now?"*

*"Well that was what I was going to ask you. Can you see any value in carrying on this conversation?"*

*"So you're not going to send me for a scan?"*

*"Not just now"*

*"Well that's been a waste of time. I'm off. I'm not happy you know doctor".*

## Documentation

Careful documentation has two important benefits. First, the patient may go on to consult with a colleague and if we have documented carefully that colleague can back us up (if appropriate, as it will usually be). Second, in the event of a letter of complaint or from a solicitor we have evidence to refute any alleged substandard practice.

Important things to document include:

- Patient's specific request.
- Findings from the thorough examination which led to our clinical opinion.
- Why we came to the conclusion that we reached.
- What we told the patient.
- Details of the safety netting discussion.

## Sum up

I am a GP appraiser and if a practising GP has not declared any complaints in the last five years, I gently enquire: "Why not?"

The GP's job is to give patients our opinions. In most consultations these are agreeable to the patient. Sometimes they are not. On those occasions, we have a duty to prioritise doing the right thing over doing the popular thing.

**Dr Malcolm Thomas is a GP and medical director of Effective Professional Interactions, specialising in training for consultation effectiveness and professional skills for doctors**

## DIAGNOSIS

## TELLTALE LIMP

## DAY 1

Ms T has just given birth to a baby girl – Kirsty – and attends her GP surgery for the standard newborn check at three days. Dr N gives Kirsty a full examination, including heart and chest sounds, skin, genitalia and hips. In the medical notes for each element of the examination Dr N uses the notation NAD to indicate 'no abnormality detected'. Ms T says she has no particular concerns and a follow-up check is agreed for six weeks.

## DAY 45

Ms T brings Kirsty to the surgery for her six-week child health surveillance check. Dr N again exams the baby fully from head to toe, checking the hips and recording NAD in the notes. She reassures Ms T that Kirsty is well and developing normally.



## 16 MONTHS LATER

Ms T attends with Kirsty at a local orthopaedic outpatient clinic. The specialist registrar notes she has a shortened left leg with an obvious limp and asymmetrical skin folds. An X-ray confirms a high dislocation of the left hip with significant dysplasia. Kirsty is later seen by a consultant who says she will require reduction surgery with recovery in a hip cast. The prognosis is uncertain.

## 15 MONTHS LATER

Kirsty attends the surgery with her mother and father. They have noticed that, having started walking, Kirsty has developed a limp on the left side with an out-toeing gait. Dr N examines the child and notes a possible discrepancy in limb length with shortening on the left side. She also finds asymmetrical skin creases on the left thigh. The GP informs Kirsty's parents that she requires an orthopaedic referral for further assessment. A referral letter is sent the next day.

A LETTER of claim for damages is received by Dr N a year later from solicitors acting on behalf of Kirsty. It is alleged that the GP was negligent in failing on two occasions to detect the child's left-sided hip dysplasia. In particular Dr N is claimed to have failed to provide a detailed record of the signs and observations noted during the two routine health assessments – the only reference to the hip examination being "Hips: NAD". No record can be found in the patient notes of specific tests carried out to assess the hips.

In regard to causation it is further alleged that the delay in detecting Kirsty's hip abnormality has necessitated more extensive treatment with significant pain and suffering and an uncertain prognosis. Diagnosis before six months would have allowed treatment with a Pavlik harness to allow normal hip development.

MDDUS undertakes an examination of the case and commissions an expert in primary

care to assess the allegations.

In regard to Dr N's note keeping the expert finds these are of a standard expected of any reasonably competent GP. Dr N detailed the systems examined with regard to the specific and essential elements of both the neonatal and six-week check, indicating that all the observations were normal. The expert states that it is common practice for a GP having examined a system to use the notation NAD. Further, it would be uncommon for a GP to record each test (namely the Ortolani and Barlow manoeuvres) used in a health assessment. All in all he finds the records clear, extensive and clinically appropriate.

In regard to the failure to detect left-sided hip dysplasia the expert questions whether it was present at the time of Dr N's examination of Kirsty. Developmental dysplasia of the hip (DDH) is commonly present at birth but can also develop later in the first year. The medical notes suggest that the abnormality only

became apparent in the months after Kirsty's six-week check.

MDDUS solicitors send a letter of response to the claim against Dr N denying breach of duty in her treatment of Kirsty. It cites the expert report on the adequacy of the clinical examination as recorded in the medical notes. Causation is thus also denied.

Four months later a letter from the claimant solicitors says the case has been discontinued.

## Key points

- Record normal findings (at minimum) for all systems examined in neonatal and six-week checks.
- DDH affects 1-3 per cent of newborns and thus requires a high index of suspicion.
- Be aware of early signs of DDH in babies such as uneven skin folds on the thigh, or limping or toe walking in toddlers.

# Diary

**S** O 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...

● **SCIENTIFIC GUESSING** Statistics from the non-profit Perinatal Institute have shown how wildly inaccurate due dates are. It seems babies are born on their predicted date just four per cent of the time, rising slightly to 4.4 per cent if you exclude premature births and pregnancies with complications. While this may leave some would-be parents scratching their heads and wondering if they'd be better off asking Mystic Meg when their bundle of joy will arrive, the Institute was quick to highlight the value of these predictions. Professor Jason Gardosi told BBC News that while it may be helpful for parents to get an idea of when their child will arrive, the main purpose of the due date is to "define a metric for the care" of the mother during pregnancy. "So, for example, to interpret early pregnancy blood tests for the risk of congenital anomalies, it's important to know how far gone the pregnancy is." He went on to say that the advice to expectant mothers is that the baby is likely to come any time between 37 weeks (259 days) and 42 weeks (294 days), a period referred to as "term", when the baby has reached full maturity. The prof has suggested the phrase "due date" is misleading and that "estimated date" would be more realistic.

● **EAR NO MORE** Doctors have one man's shyness to thank for the invention of the stethoscope. In 1816, when confronted with an overweight female patient complaining of heart problems, conservative French physician René Laënnec felt the usual practice of pressing one's ear against the patient's chest was not appropriate. A keen flute player, the idea came to him to roll up a piece of paper into a tube and press it against her chest. In a research paper published in 1819, he described how he was "not a little surprised and pleased to find that I could thereby perceive the action of the heart in a manner much more clear and distinct than I had ever been able to do by the immediate application of my ear." His early hollow wooden prototypes were eventually improved upon in the 1850s into a design very similar to that used today. The pioneering Laënnec, who died of tuberculosis aged just 45, was celebrated in a recent Google doodle on what would have been his 235th birthday.

● **PRE-MORTEM** Diary recently had a nightmare that we consulted the Ubbly UK Longevity Explorer only to discover we are already dead. How welcome it was to awake Scrooge-like and realise there is still time to make a change. This apparently is a key motivation behind the development of the online tool which uses self-reported information to generate a score that predicts the risk of death within the next five years for UK people aged 40 and 70. It is based on research from the Karolinska Institutet utilising health

data from nearly half a million adults held in the UK Biobank. Researcher Dr Andrea Ganna said: "Of course, the score has a degree of uncertainty and shouldn't be seen as a deterministic prediction. For most people, a high risk of dying in the next five years can be reduced by increased physical activity, smoking cessation, and a healthy diet." Diary will honour these resolutions in our heart and try to keep them all the year!

● **BEASTLY REMEDIES** Hearing loss is a common complaint in general practice and it is a problem that apparently was treated as far back as 1550 BC in Ancient Egypt. A recent article on [historytoday.com](http://historytoday.com) by Sheffield University researcher Alison Atkin examined the Ebers Papyrus medical texts from the time which suggest some alarming early remedies for "Ear-That-Hears-Badly". Highlights include injecting red lead, ant eggs, bat wings and goat urine into the ears. The earliest mention of the creation of a hearing aid comes in the *Magiae Naturalis* science writings from 1588 which references the use of horns shaped like the ears of animals known to have excellent hearing. But things didn't seem to improve much for hard-of-hearing patients for a while longer until the first ear trumpets were developed in the 1610s.



● **FREE-FALL BURDEN** Diary has learned that the recent HEE recruitment campaign featuring a GP filling out a sky-diving consent form for a patient has sparked reports from dozens of surgeries overrun with parachutists. One PM said: "Just last week our waiting room was stowed out. They turn up in their orange suits and demand emergency appointments. My staff can no longer cope." Another GP commented: "Sure. It's exciting for them but an administrative nightmare for us. No doubt there will soon be calls for a seven-day parachutist consent service."

● **JUST NOT SORRY** If you're struggling to get ahead in your career, then it may be your choice of words in emails are to blame. Including phrases like "I'm just writing to say...", "I'm no expert but...", "does that make sense?", or apologising too much could be causing colleagues to lose respect for you and undermining your authority at work. According to the *Daily Mail*, the habit has prompted New York-based entrepreneur Tami Reiss and the tech team at Cyrus Innovations to create the web browser plug-in Just Not Sorry. It acts like a kind of spell-check in flagging up self-demeaning language to encourage you to eliminate it. Tami advises email writers to "be nice, be polite and be direct. Be clear, honest and open - and that's true if you're asking someone to do something or if you're responding to a request for something." She says we should stop saying sorry but also be careful not to come across as too negative or aggressive... Sorry, but does all of that make sense?



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