



# ON POINTE

THE GP WORKING IN THE WORLD OF ELITE BALLET

ALSO INSIDE

**04** DIGNITY IS KEY  
TRANSGENDER CARE

**08** CAREER  
GPWSI IN DEMENTIA

AN MDDUS  
PUBLICATION





## Welcome to your GPst

IN an ideal world, all patients would stick to their treatment plans diligently, carefully following your advice and never missing review appointments. But in the real world this doesn't always happen. While it may be tempting to discontinue treatment for non-compliant patients, the risks of doing so must be carefully considered. My article on [page 12](#) looks at this tricky issue in more detail.

Plans to update healthcare for the 21st century have included much discussion of the importance of so-called "patient-centred" care. But what does this new approach mean for GPs? Our article on [page 5](#) takes a closer look. A growing number of people now identify as transgender or have gender incongruence and have complex healthcare needs. Do you know how best to care for this patient group? MDDUS risk and medical adviser Dr Gail Gilmartin offers

advice on [page 4](#).

The death of a one-year-old child from sepsis has highlighted the need for better recognition of this condition and greater awareness among GPs. Find out more on [page 6](#). No one relishes the idea of receiving a patient complaint, but it's important to respond constructively. On [page 7](#) Dr Gail Gilmartin looks at two types of complaint: those which are "accurate" and those which are not.

Busy GP Chris James talks about caring for elite dancers as company doctor for English National Ballet in our profile on [page 10](#), while our career article on [page 8](#) takes a closer look at the role of GPs with a special interest in dementia. And on [page 14](#), we examine the case of a child presenting with what seems to be a viral infection.

• **Dr Susan Gibson-Smith**  
Editor

## CALL FOR LONGER, FEWER GP CONSULTATIONS

THE BMA is calling for the standard 10-minute GP consultation to be increased to 15 and the total number of consultations per day limited to 25 rather than the 40 or more per GP seen in some surgeries.

These are among proposals published in a BMA report - *Safe Working Levels in General Practice* - which looks at measures to help tackle the "rocketing workload".

To achieve this the report considers the potential impact of 'locality hubs' where demand, patient lists and safe working limits would be managed for a number of local practices with GPs benefiting from greater integration, collaboration and

flexible employment patterns. This hub model was featured in the plans outlined in NHS England's *GP Forward View*, which included £500m of recurrent funding to provide extra primary care capacity and a £171m one-off investment by clinical commissioning groups from 2017/18 for practice transformational support.

BMA GPs committee executive team member Dr Brian Balmer said: "We need a new approach that shakes up the way patients get their care from their local GP practice. [M]ore GPs must be put in front of patients so that the number of consultations per GP a day falls to a sustainable level."



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## MDDUS URGES EARLY REFORM TO REDUCE INDEMNITY COST PRESSURES

MDDUS has urged the government to work towards early implementation of measures to reduce legal costs in clinical negligence cases.

MDDUS chief executive Chris Kenny has written to Minister for NHS Productivity Lord Prior of Brampton, who is responsible for taking the next steps following the government's recent review of GP indemnity. In the letter, Mr Kenny urged the government to push through plans to reduce legal costs in clinical negligence claims as soon as possible.

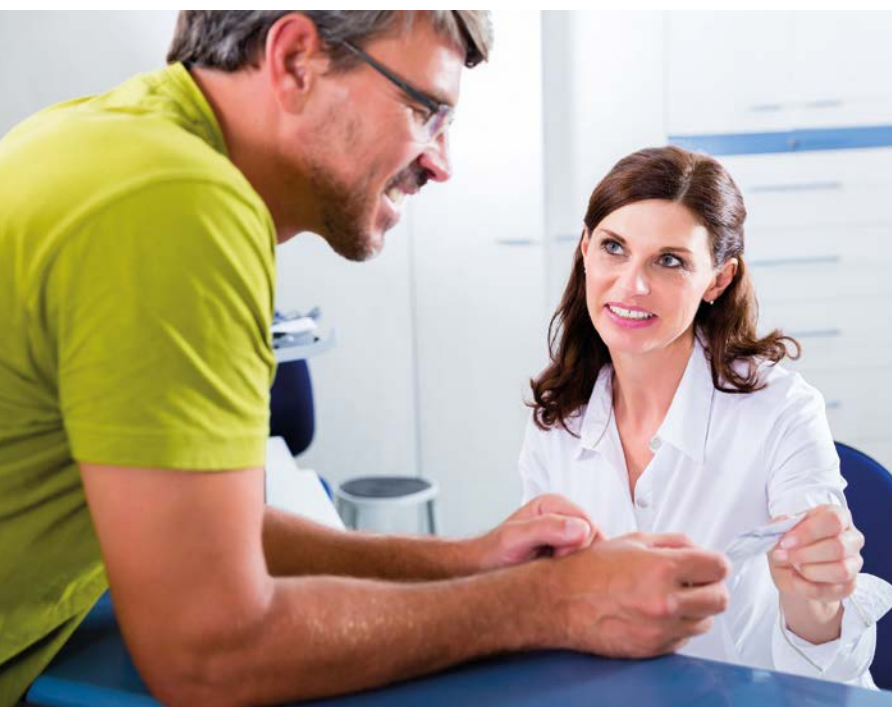
"We welcome the fact that in the recently published *GP Indemnity Review*, the government and NHS England found the indemnity market to be competitive and that the price increases our members face are fundamentally driven by factors beyond our own control," Mr Kenny said.

"The absence of effective controls on the amount of costs which can be recovered in negligence cases is a key driver and substantive action is required on the underlying causes of these increases. The scope for savings are considerable, especially for lower value claims. We have many examples of where the amount paid in legal costs is significantly greater than the compensation payments made to the patient.

"It is for that reason that the idea of a cap to overcome these perverse incentives of the current system is so attractive. Not only will it ensure tighter cost management in individual cases, but it will help ensure the strongest cases are selected and prepared in a cost-effective way."

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## UNHELPFUL RECEPTIONISTS CAN LOWER PATIENT SATISFACTION

UNHELPFUL GP receptionists can lead to lower patient satisfaction scores, according to new research published in the *British Journal of General Practice*.

A study carried out by Loughborough University found that the more patients had to push for effective service when calling GP practices, the less satisfied they were. This so-called "burden" on patients to drive calls forward occurred, researchers found, when receptionists failed to offer alternatives to callers whose initial requests could not be met, or to summarise relevant next actions (for example, appointment, call-back, or other query) at the end of calls.

Researchers noted that: "Survey-based research shows that the helpfulness of the receptionist, along with communication with the doctor, is the most important driver for satisfaction among UK patients."

The team analysed 447 incoming telephone calls to three GP surgeries in England in October 2014.

## GP PRACTICE FINED £40K BY ICO

A GP practice has been fined £40,000 by the Information Commissioner for revealing confidential details about a woman and her family to her estranged ex-partner.

The practice released the information when the patient's ex-partner made a request for the medical records of the former couple's son. Staff at the practice responded with 62 pages of information that included the woman's contact details as well as those of her parents and an older child the man was not related to.

The information was provided despite express warnings from the woman that staff should take particular care to protect her details.

An ICO investigation found

that the GP practice had insufficient systems in place to guard against releasing unauthorised personal data to people who were not entitled to see it. It found that staff had not received adequate guidance or supervision about what could be disclosed or should be withheld.

Steve Eckersley, the ICO's Head of Enforcement, said: "GPs could have protected staff by providing proper support, training and guidance. They did not do this." The ICO says it issued a fine of £40,000 not because the practice's partners would be individually liable, but because of the serious nature of the breach most organisations would expect to receive a much larger fine.



## GPs LACK CONFIDENCE IN NEUROLOGICAL REFERRALS

MORE than half of GPs in England do not feel confident in their ability to make an initial assessment and referral for people presenting with signs and symptoms of multiple sclerosis, and 84 per cent would see benefit in further training on identifying and managing people presenting with neurological conditions.

These are the results of a survey and an expert workshop conducted by the Neurological Alliance.

The *Neurology and Primary Care* report also found that 85 per cent of GPs in England are either "somewhat concerned" or "extremely concerned" about the time taken from referral for patients to see a consultant neurologist. More than half of GPs (59 per cent) believe the local services and systems in their area mean that people with neurological conditions frequently do not receive a timely diagnosis.

The report sets out eight recommendations aimed at improving the primary care pathway for people with neurological conditions, including a call for the development of a pan-neurological "watch list" of the 10 signs and symptoms GPs should be aware of during patient interactions in primary care settings.

## "WORRYING" LEVELS OF STRESS AMONG PRIMARY CARE STAFF

ALMOST 90 per cent of NHS primary care workers find their work life stressful, according to a new survey.

That figure is far higher than the wider UK workforce where 56 per cent of employees reportedly find their jobs stressful.

The findings emerged in a survey of more than 1,000 primary care staff, including GPs, practice nurses, practice managers and their colleagues, by mental health charity Mind.

Almost one in 10 respondents (eight per cent) said workplace stress had led to suicidal thoughts, a fifth (21 per cent) said it had caused them to develop a mental health problem, and 17 per cent said they take medication for a stress-related mental health problem. Two-fifths (43 per cent) said they had resigned or were considering resigning due to work stress.

The poll also found stress impacted more than mental health. Just over 80 per cent said stress affected their ability to sleep, more than half (54 per cent) said it directly impacted their physical health, and 17 per cent have phoned in sick because of it.

A number of employees admitted resorting to unhealthy habits to cope. Two-fifths (42 per cent) drink alcohol at least once a week to cope with stress while eight per cent smoke every day to ease work pressures.

Despite such high stress levels, many staff were reluctant to admit they had a problem. Almost a third said they feared disclosing they were overly stressed would lead to them being perceived as less capable than other colleagues. A fifth (22 per cent) also felt admitting the problem would harm their chances of promotion.

Mind chief executive Paul Farmer said: "We need to make sure that healthcare professionals are well and supported, so they can provide the best care for their patients."

Doctors can feel out of their depth when dealing with patients with complex needs. **Dr Gail Gilmartin** offers some practical advice



# TRANSGENDER HEALTHCARE

**T**RANSGENDER people and those with gender incongruence make up an estimated one per cent of patients. It is well understood that these patients have complex healthcare needs, including a greater incidence of depression and risk of suicide.

Access to appropriate healthcare is compounded by long waiting times to see specialists for gender reassignment treatment.

Indeed, a report from the House of Commons Women and Equalities Committee published at the end of 2015 went so far as to conclude that “the NHS is letting down trans people” who “encounter significant problems in using general NHS services due to the attitude of some clinicians and other staff who lack knowledge and understanding – and in some cases are prejudiced.”

It highlighted how unnecessary treatment delays can occur where GPs have not been trained in trans health issues and do not understand, for example, the new referral pathways in gender identity services. Common misunderstandings, it states, include the belief that local fundings need to be arranged or that a mental health assessment needs to be carried out – “neither of which is true in England since April 2013.”

Personal beliefs have also been found to influence decision-making. The report quotes one remark made to a trans patient by a GP who said: “You’ll be taking money away from more deserving cancer patients”. But the committee agreed with the chair of the NHS National Clinical Reference Group for Gender Identity Services that: “not treating people [for gender dysphoria] is not a neutral act – it will do harm.”

The General Medical Council responded by publishing new advice in March to help doctors support transgender patients. It is based on core guidance from *Good Medical Practice* and is also informed by relevant legislation including the Equality Act 2010.

MDDUS has certainly seen an increase in

calls from members seeking advice and guidance when treating people with gender dysphoria, and they are often concerned about delays in accessing appropriate specialist help.

Many doctors have and will have transgender persons as patients but few are well equipped to deal with the issues that arise. Current medical training does not produce doctors skilled in transgender health.

There are specific risks associated with meeting the healthcare needs of transgender people and two areas where increased risk is clear are:

1. Patients who self-medicate from unregulated sources.
2. Patients who self-harm or consider suicide.

In relation to the first point, patients may seek bridging prescriptions until they can be seen by a specialist. In these circumstances, GPs may feel out of their depth and worry that they risk acting outside their level of competence and expertise.

Regarding the second point, research shows transgender people experience significant isolation, marginalisation and discrimination and are particularly vulnerable to self-harm and suicide. This is often compounded by the effect of delays in accessing appropriate care. The Transgender Equality Network Ireland has reported as many as 83 per cent of trans people have seriously considered ending their life while 44 per cent said they self-harmed. Any patient with significant mental health issues may need referral to appropriate mental health services.

It is helpful that the GMC has entered the discussion at a time when many doctors who are not specialists in this field have questions about their roles and responsibilities. The regulator reminds all doctors that they must provide a good standard of care for their

patients and in relation to transgender patients:

“Do your best to understand your patient’s views and preferences and the adverse outcomes they are most concerned about. It may well be that the risk to your patient of continuing to self-medicate with hormones is greater than the risk to them if you initiate hormone therapy before they’re assessed by a specialist.”

In relation to bridging prescriptions, a matter which generates a significant proportion of calls to MDDUS, the GMC issues specific guidance:

“A GP should only consider issuing a bridging prescription in cases where all the following criteria are met:

- a. the patient is already self-prescribing with hormones obtained from an unregulated source (over the internet or otherwise on the black market)
- b. the bridging prescription is intended to mitigate a risk of self-harm or suicide
- c. the doctor has sought the advice of a gender specialist and prescribes the lowest acceptable dose in the circumstances.”

If a patient requests treatment for gender dysphoria, the GMC says that “experts agree the best way to meet their needs is to refer them to a gender identity clinic (GIC) or gender specialist without delay.” It adds: “All GPs in England, Northern Ireland and Scotland may refer their patients directly to a GIC and do not need to refer them to a mental health service for assessment beforehand. GPs in England don’t need to seek prior approval from their clinical commissioning group (CCG).”

It is important that all doctors dealing with the health issues of patients with gender dysphoria understand and consider the regulator’s advice. Specific GMC guidance on treatment pathways in trans healthcare can be accessed under the “Good medical practice” section of their website at [tinyurl.com/grugw8z](http://tinyurl.com/grugw8z). The page also has links to useful sites including an e-learning module about gender variance produced by the Royal College of GPs, and the Gender Identity Research and Education Society (GIRES).

**Dr Gail Gilmartin is a medical and risk adviser at MDDUS**

# EMPOWERING PATIENTS

THE idea of putting patients at the heart of healthcare provision is not new, and is one that most doctors would likely agree with. Yet for a wide variety of reasons (political policy, funding and staffing difficulties, “system” inertia, and perhaps some old fashioned paternalism) this approach is still not being fully delivered across the UK.

But momentum now seems to be building behind efforts to change and update patient care for the 21st century. No doubt key factors in this movement include budgetary pressures, increasing patient expectations and an ageing population with rising multimorbidity. An NHS that prioritises truly patient-centred care, it is hoped, could be financially more efficient, reduce workloads and result in happier patients with improved outcomes.

So what exactly is patient-centred (or “person”-centred) care?

According to independent charity The Health Foundation: “In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and healthcare. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect.”

The Royal College of GPs commissioned an independent panel to find “cost-effective solutions to the medical, social and financial challenges posed by rising levels of multimorbidity.”

The panel’s report, *An inquiry into patient-centred care in the 21st century*, concluded that “clinicians must work with patients in a very different way, providing personalised care and empowering patients to play an active role in managing their health.” It called for a major shift in the way general practice is delivered, with practices coming together as federations or networks to work in a coordinated way. In addition, it said more resources should be made available to primary and community-based care, as well as more flexible funding arrangements that would allow providers (particularly GPs and hospital-based doctors) to work more collaboratively.

But a key recommendation was for a “move away from tick box clinical guidelines and performance indicators to an approach that recognises the need for care to be tailored to patients with multiple conditions and rewards professionals for respecting patients’ preferences.” Successful implementation of patient-centred care, the report states, lies in the hands of healthcare providers and their patients. “Critical to this will be embracing the

There has been much discussion recently about the importance of “patient-centred” care. But what exactly does that mean for GPs?

change in the balance of power and responsibility between professionals and patients required by patient-centred care,” it explains. Patients, carers and communities should be seen as “part of the solution, not part of the problem” and their active engagement should be welcomed.

There is an important role for personalised care planning, the report says, particularly for at-risk groups such as those with learning disabilities or multiple conditions. Ideally, patients would be supported to self-manage their long-term conditions, and GPs would be given the time to discuss this fully. Department of Health figures suggest that 90 per cent of people with long-term conditions are interested in being more active self-managers.

GPs are encouraged to support patients to develop health literacy skills, to give them information on positive life choices, how to manage diagnosed conditions and to discuss

care/treatment costs.

This is echoed in a *BMJ* editorial article from February 2015, “Time to deliver patient-centred care”, which said that “care should promote self-management, not dependency”. It urges doctors to offer more tailored support which “reduces dependency and can help the disadvantaged most.” It adds: “We also need to find better ways to listen to patients and ensure their voice is included and heard in medical forums. Better conversations are also core to realising shared decision making based on individual priorities and preferences.”

Scotland’s Chief Medical Officer Dr Catherine Calderwood is also an advocate for this approach. Two main themes in her first report, *Realistic Medicine*, published in January 2016, are shared decision making and personalised care.

One element of care highlighted is the process of informed consent. This, the report says, can often be a “professional-centred process” carried out in a time limited setting, where the patient may not receive sufficient information to reach a decision. This is something that can be exacerbated, it adds, amongst patients with low health literacy (poor understanding, knowledge and skills).

The report proposes one possible alternative approach: “a more person-centred process of ‘request for treatment’” where the patient would be asked to note in their own words why they want a particular treatment, what they expect it to achieve and what their understanding is of the risks and limitations.

Among the benefits promised by patient-centred care are improved patient satisfaction and quality of life, which are closely tied to identifying and respecting patients’ preferences.

Speaking to MDDUS about *Realistic Medicine*, Dr Calderwood highlighted evidence suggesting that doctors don’t always fully understand what patients want – and that sometimes this may be choosing not to undergo a particular treatment.

She said: “Research has shown that doctors assume patients will prioritise living longer over anything else but, when asked, patients say they want two things: to be symptom-free and to spend time with their families.

“If doctors have a full, properly documented discussion with patients and their family about the available options, and then decide not to offer treatment with the patient’s consent, that doesn’t generate complaints, that generates thank you cards.”

## Link

- *An inquiry into patient-centred care in the 21st century*, RCGP – [tinyurl.com/ogrsthph](http://tinyurl.com/ogrsthph)

Joanne Curran is an associate editor of GPST





AN

# URGENT DIAGNOSIS

ONE-YEAR-OLD William had not been well for weeks – suffering from a recurring chest infection with coughing, fever and vomiting. On a Friday his nursery called home to say that he had a persistent temperature despite having been given liquid paracetamol. An emergency appointment was arranged at his GP surgery and William's father took him along.

A GP examined William and found him febrile and congested, a bit quiet but otherwise he was "alert and engaging". The usual safety netting advice was given and when William's father asked at what point the child should be brought back in he was reassured that it was "nothing grisly".

That night William was off his food and the next day he remained unwell and was vomiting. His mother phoned NHS 111 that evening for advice and she later spoke to a doctor on call who took a history over the phone and asked if William's mother would like to bring him in to the out-of-hours clinic. But by this time the boy was sleeping. Asked his professional opinion, the doctor said he thought it best to leave him be for now.

His parents went to bed at 10.30pm that night and William's father recalled him moving around 5am but when his mother went to wake the child at 8.30 she discovered William was not breathing. An ambulance was called but the child was pronounced dead at 8.47am.

An inquest later found that William had died from septicaemia caused by a long-standing chest infection and pneumonia. It emerged that his mother had taken her son to the GP numerous times in the weeks leading up to his death.

A recent NHS England report on William's case has highlighted the need for better

Recent NICE guidance states that patients showing signs of sepsis should be treated with the same urgency as those with suspected heart attacks

recognition of sepsis among healthcare professionals and recent guidance from NICE is now recommending that patients showing signs of sepsis should be treated with the same urgency as those with suspected heart attacks.

The NHS England report into William's death concluded that critical opportunities were missed that might have saved his life. It found that GPs had not recorded vital clinical details, the out-of-hours GP service did not have access to William's primary care records and, crucially, the pathway tool used by NHS 111 advisers had been too crude to pick up "red-flag" warnings relating to sepsis.

Sepsis is a clinical syndrome caused by the body's immune and coagulation systems being switched on by an infection and going into overdrive. Sepsis with shock is a life-threatening condition characterised by low blood pressure despite adequate fluid replacement, and organ dysfunction or failure.

The UK Sepsis Trust estimates that there are around 150,000 cases of sepsis in the UK every year and it kills around 44,000 people. Quick identification and early treatment are key to avoid death or lasting morbidity, yet a report published last year revealed that in over a third (36 per cent) of cases there were delays in identifying sepsis. The *National Confidential Enquiry into Patient Outcome and Death* found that many hospitals had no formal protocols in

place to recognise sepsis.

Professor Saul Faust from the University of Southampton, who chaired the group that developed the NICE guidelines, said: "Anyone can succumb to sepsis. It can come on as the result of a minor injury or infection that the body is trying to recover from and the immune system goes into overdrive. Sepsis can be difficult to diagnose with certainty."

Symptoms may vary from person to person with anything from a high temperature to a fast heartbeat to fever or chills. Sepsis is often mistaken for common infections like flu. Doctors are urged to start asking "could this be sepsis" earlier on so they rule it out or get people on treatment as soon as possible.

Professor Mark Baker, director of the NICE Centre for Guidelines, commented: "When hospitals are well prepared, clinicians do better at responding to patients with sepsis."

The new NICE guidance details signs and symptoms clinicians should look out for and describes the tests that should be used to diagnose and monitor patients. Symptoms are broken down by severity and it describes where patients can be best treated.

High-risk patients should be transferred to hospital via ambulance and seen by a senior doctor or nurse immediately so that treatment can be started. Antibiotics should be given to patients who meet the high-risk criteria set out in the guidance.

Check out the new NICE guidance at [www.nice.org.uk/guidance/ng51](http://www.nice.org.uk/guidance/ng51). The UK Sepsis Trust is also working with NICE to update their range of clinical toolkits in response to the guidance. Find out more at [sepsistrust.org](http://sepsistrust.org).

*Jim Killgore is an associate editor of GPST*

Few doctors relish being the subject of a patient complaint but it can be a useful learning experience. **Dr Gail Gilmartin** advises

# A CONSTRUCTIVE RESPONSE

**R**ECEIVING a complaint can sometimes feel like you are being hit with a big stick and your initial reaction is to defend yourself and put up your guard. Who wouldn't try to dodge the blows? However, complaints are part of our professional life. We must respond to them in a constructive way and try to take something positive from them. This is quite a task even for an experienced doctor and can be daunting when you are at the start of your career.

Most clinicians devote enormous time and energy into being "a good doctor" and complaints can feel undermining. So how can they be turned into a positive?

Complaints can be divided in various ways but, put simply, there are those which can be viewed as accurate and those which cannot.

Consider the following scenario. Mrs A brings her seven-year-old son who has been complaining of a sore throat for two days. There are no other symptoms, you check the history carefully, and thoroughly examine the child, who is generally well and cooperative. Apart from a mildly inflamed throat all else is normal.

You advise Mrs A to use simple analgesics and give safety netting advice. You also explain that you are not prescribing antibiotics and why. Overall this was a normal consultation.

The next week the practice receives a complaint from Mrs A alleging that you were very rude, upset the child at examination and scolded her about the child's treatment. You are shocked as this does not accurately describe what happened from your perspective. You are asked to draft a statement to help the practice respond to the complaint.

You may be angry, but remember Mrs A's concerns represent only one side of the story. When drafting your reply keep in mind that you are trying to resolve matters. Also remember that what you write may eventually be seen by a variety of people, for example the health service ombudsman, and it will help them form a view about you.

The first step is to reassure yourself that the letter is not accurate and you can have your say. If necessary wait until you are calm – a letter written when angry may have the wrong tone. Take advice from your trainer and MDDUS – we can discuss your concerns and offer helpful advice.

Try to take an objective view and look carefully at what is being said. It is often best to start with a clear description of what happened, set out chronologically and explained in layman's terms. You do not need to address the complaints yet, that can be done next. Try to avoid negative and inflammatory terms: "I did not raise my voice as you allege" is more



inflammatory than "I spoke to you and said..."

After the factual chronology you can then address specific concerns. Try to respond to each matter clearly and succinctly. Try not to be antagonistic but explain matters, with reference to the chronology if necessary. For example: "I was able to examine Jack and look at his throat because he was cooperative, but I am sorry if in any way this upset him" is better than saying: "I could easily examine Jack, which would not have been the case if your allegations about upsetting him were true."

Reflection is important: stand back from the complaint and look closely at your consultation. Were there issues in communication that you did not pick up? Was the child intimidated and possibly frightened? If you identify areas where you could have done better you should acknowledge this with a suitable apology. If however you find that you cannot identify any issues at the time, and have discussed this with your trainer/ MDDUS adviser, you can only explain what occurred. It is almost always appropriate to say that you are sorry that the person had cause to complain and that they were upset. It can also be useful to confirm that you have reflected carefully on what happened and discussed matters with your trainer.

In our experience, complaints where the doctor feels they have done nothing wrong can be more difficult to reply to than those where they are aware they have made a mistake.

Consider a case where a complaint is received after your consultation with an elderly patient, Mr B.

The records were flagged for a hypertension review as Mr B had missed his last appointment. He has symptoms suggestive of a chest infection and you also ask him about his non-attendance for review. The dynamics of the consultation are difficult – and then you notice you have opened the wrong records.

You immediately apologise and try to clarify your advice about the chest symptoms and that your advice about high BP was misplaced. The patient is a little confused and not impressed.

The complaint letter from Mr B recounts the consultation accurately, explaining he was confused and upset and that he would like confirmation that he had not missed any appointments.

Clearly this complaint is justified and you are likely to be upset and worried. In this type of situation the best approach is to accept your error, sincerely apologise and confirm that you have learned from your mistake. Your response should still aim to resolve matters and be a positive reflection of your practice.

Remember that making concessions, where appropriate, is professional and you should not hesitate to seek help from MDDUS.

**Dr Gail Gilmartin is a medical and risk adviser at MDDUS**

# FORGET ME NOT

Primary care is expected to play a leading role in the growing burden of future dementia care. Could a GP with a special interest in dementia be the role for you?



IT IS estimated that by the year 2025 there will be over one million people living with dementia in the UK and looking forward to 2050 that number will likely exceed two million.

Combine this prospect with other factors such as multi-morbidity and polypharmacy and it becomes obvious that the NHS faces significant ongoing challenges in looking after a rapidly ageing population – much of that burden falling on primary care.

Last year the government launched the *Prime Minister's challenge on dementia 2020* which called for GPs to play a “leading role in ensuring coordination and continuity of care for people with dementia”. The Royal College of General Practitioners has also made dementia a clinical priority with an ongoing programme of work aimed at improving the knowledge about, recognition and management of, and commissioning for dementia.

Part of that work has been to develop a framework of guidance and competencies for the provision of service using general practitioners with a special interest (GPwSI) in dementia. It's a role that – among others – will become increasingly important with the burgeoning demands on primary care from a growing elderly population.

## What is dementia?

Dementia is not a single condition but a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. It occurs when the brain is

damaged by diseases such as Alzheimer's, stroke or other neurological conditions such as Parkinson's disease. Around 60-80 per cent of people with dementia have Alzheimer's disease and around 10-20 per cent suffer from vascular dementia, and many have a mixture of the two.

Dementia is incurable and progressive and often compounded by a range of co-morbidities. A survey by the Alzheimer's Society found that 72 per cent of sufferers were living with another medical condition such as arthritis, hearing problems, heart disease or a physical disability.

Early diagnosis of dementia can allow for timely treatment, care, and support (social, emotional/psychological and pharmacological) to enable patients to better manage the condition and its impact. Certainly much can be done to help prevent and ameliorate symptoms such as agitation, confusion and depression. And this is where specialist expertise is important.

A GPwSI in dementia would normally be employed by a local health authority or clinical commissioning group (CCG) based upon the needs of the local populace and as part of a tiered, integrated service delivery. This might involve working within a local “memory service” engaged in diagnosing dementia, or undertaking an enhanced role within care homes. A GPwSI might also provide post-diagnosis support, working with a community mental health team to help dementia sufferers remain at home.

A GPwSI in dementia is also likely to be involved in providing education and support to

primary care organisations, constituent practices and other primary care providers to raise the general standard and consistency of care for people with dementia.

## Required skills

The RCGP guidance framework sets out a list of core enhanced skills required by a GPwSI in dementia including:

- communication with the patients and their family carers
- recognition and management of physical illness, co-existing morbidities and functional/sensory impairments in people with dementia
- assessment and management of behavioural and psychological symptoms of dementia (BPSD), including appropriate use of antipsychotics
- management of drug therapy in dementia patients
- medico-legal issues in dementia care including determining capacity
- carer support
- early intervention/raising awareness of dementia
- community support/post diagnosis care of people with dementia.



*"Much can be done to help prevent symptoms such as agitation, confusion and depression"*

Role-specific enhanced skills include expertise in the timely diagnosis of dementia and managing long-term care of patients in and outside of care homes, including drug and non-drug interventions, nutrition, continence and skin and wound care.

### Training

The RCGP guidance states that a clinician working towards becoming a GPwSI in dementia would be expected to undertake recognised training and education, which may include acknowledgement of prior learning and expertise. Learning can be acquired in several ways and should include a variety of practical and theoretical elements:

- experience (current or previous) of working in relevant departments
- self-directed learning with evidence of the completion of individual tasks
- attendance at recognised meetings/lectures/tutorials on specific relevant topics
- clinical placements agreed locally

- undertaking a course from an accredited learning body (e.g. university, royal college, etc)
- attachment to a dementia unit or under the supervision of a specialist practitioner which may not necessarily be a consultant
- evidence of working under direct supervision with a specialist clinician in relevant clinical areas.

Many universities have developed training modules that include theoretical elements followed by supervised practice and formal competence-based assessments – but work-based experience, accompanied by peer review, may be as acceptable as an academic qualification.

For more information go to the RCGP Dementia web page ([tinyurl.com/zdcpj0s](http://tinyurl.com/zdcpj0s)) where you can access a range of useful resources including the *Guidance and competencies for the provision of service using general practitioners with special interests (GPwSI) in dementia*.



### Q&A

**Dr Louise Robinson,**  
Professor of Primary  
Care and Ageing at  
Newcastle University  
and RCGP National  
Champion for  
Dementia

• **How did you become involved in helping dementia patients?**

Early in my training I met a lady with possible dementia and was amazed to find there was no formal post-diagnostic support or care for her in primary care. This was around the time primary care-led diabetic clinics were being introduced and it seemed odd that we were encouraged to provide structured care for one long-term condition but people with dementia were just ignored.

• **What does your role entail?**

I do not have a formal GPwSI dementia qualification but due to my academic career I have become an 'informal expert' and now provide specialist clinical advice at local and national levels, including the RCGP and Prime Minister's National Dementia Challenge. I was the GP lead on the RCGP working group who developed the GPwSI competencies.

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

The look of relief on people's faces when I explain dementia is not a death sentence but a long-term illness, like depression and diabetes. Although we do not have a cure, we can provide some treatments and support to help people living with the illness have as good a quality of life as possible.

• **Are there any downsides?**

Constant frustration at the geographical inequalities in dementia care support and provision that persist around the UK.

• **What do you find most challenging?**

Changing professional attitudes to having a more positive and confident approach to caring for people with dementia; GP attitudes seem to lag far behind the public and patients.

• **What has most surprised you?**

How surprised families caring for a relative with dementia often are to find a GP who is both knowledgeable and interested in the condition.

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

Being told recently by one of my patients with dementia that they had informed their memory clinic consultant that they did not want to attend any more as they got better care and help from their GP!

• **What advice would you give to a trainee GP thinking about specialising in dementia care?**

Caring for people with dementia is both a privilege and a pleasure. With increasing numbers living with the illness, there needs to be many more of us who have the courage to get more involved.

## KEEPING PATIENTS ON THEIR

# TOES



An interest in sports medicine led **Chris James** to the high-intensity world of ballet. He gives *GPST* an insight into his busy life as company doctor and GP

**A**S Dr Chris James sits in the auditorium of the Royal Albert Hall with his family watching the English National Ballet perform, he is fully aware of what's really going on behind the dancers' professional smiles.

The Southampton GP knows all about the endurance and physical pain they've put themselves through - but it doesn't show on their faces.

Dr James knows because, since 2002, he has been the English National Ballet's company doctor. He started working with the UK's largest touring ballet company almost by chance in the mid-1990s when the ENB were looking for GPs in areas where they were performing. With a keen interest in sport and a hunger for expanding his skills, Dr James applied and was soon treating the dancers visiting his hometown.

Dr James, who qualified in 1985, says: "I guess because I am in a university practice, and therefore have [treated] lots of fairly young people who get hurt, they wrote to our practice and I said 'yeah, I'll do that'.

"So when the company was in Southampton, twice a year for a week, I would call in. It was so accessible - the theatre was just five minutes away. I thoroughly enjoyed it, and got on really well with them."

When the ENB's company doctor left a few years later, Dr James jumped at the chance to take on the role.

The 54-year-old says, smiling: "It wasn't a difficult decision."

### Careful scheduling

However, given that the ENB is London-based and Dr James is around two hours away at the University of Southampton, logistics were a concern and this was a huge challenge for the already-busy GP, a full-time partner at the University Health Service.

Dr James, who is also a member of the clinical commissioning group (CCG) board, says: "I needed to see how I could make it work. I couldn't take a whole day out just to have a half-day in London, I had to work out how I could fit it all in.

"So I start a surgery at 8am and can still make the 11 o'clock train to London. I am with the Company by 1pm, spend a few hours with them, then get the train back and I am home by 6pm. It's like a normal working day, only I get two hours to read the paper in between! And sometimes I wander round the building watching people rehearse. It's great."

He and his family try to catch a performance each season, a particular treat for his daughter who has dabbled in ballet. "The benefits are amazing, especially seeing them perform in grand surroundings like the Royal Albert Hall," he says.

Of all the ballets he has seen, Dr James says his favourite is the *Nutcracker*. "We see it every year either in Southampton, or at the London Coliseum where they perform every winter," he says. "I have seen three or four differently-choreographed versions, and every one of them has been brilliant."

### Sprains and pains

As the ENB's company doctor, Chris carries out primary care treatment, as he would back at his practice in Southampton, and works closely with ENB physiotherapist Jackie Pelly and her team to treat injured dancers. The type of injuries the medical team can be faced with vary from acute sprains, back pains, and stress fractures in the feet and lower leg, right through to sword-fighting injuries.

If a dancer sustains soft tissue damage or a broken bone, they can easily access physiotherapists, MRI scans or orthopaedic surgeons as all ENB dancers are insured (meaning Dr James can refer them for swift



*"Ballet dancers are elite athletes... their ability to endure pain is astonishing"*

PHOTOGRAPHS: ASH



**Main picture:** ENB dancer Crystal Costa stretches her body to the limit  
**Above right:** ENB performing *La Corsaire*  
**Right:** Dr James inspects a dancer's shoulder sprain

specialist treatment).

With 20 years' experience in the specialty, he's noticed it is a much healthier environment for dancers now than it used to be.

He says: "Old-school artistic directors felt pain had to be pushed through, but that thankfully doesn't happen any more. There are still a few dancers who hide the fact they're in so much pain, that they have stress fractures, but now dancers have fitness regimes programmed for them individually by professionals who are looking at strength, endurance and stamina."

But Dr James says there is "still a lot of pain and suffering" in ballet because of the intense stress dancers put their bodies through, adding: "Sometimes it is surprising how graceful and smiley they look knowing what pain they're in."

Sitting in the auditorium watching his patients dance, Dr James can't help but feel a huge swell of pride. He says: "I have first-hand knowledge of the pain, the blood, the sweat and the tears that they gave to make it look so graceful. Ballet dancers are real elite athletes who use and abuse their bodies like no others - their ability to endure pain is astonishing."

### Grabbing opportunities

A self-confessed fitness enthusiast, Dr James has tried most sports but has never been tempted by a pas de deux or entrechat. He laughs: "I have never tried ballet - and even if I had, I'm not sure I would tell you." A keen runner, he has also tried karate, horse riding, scuba diving and skiing, and even swam competitively until 2009 when he took a one-year sabbatical with his family to work in Australia.

Having "had a go at most things" when it comes to sport - it's a similar story when it comes to his medical career. For the father-of-three, who has two sons "doing various things around the world" and a daughter

following in his footsteps and studying medicine, it is important to grab every opportunity.

Variety has been a running theme throughout the medic's 30-year career, from first working in orthopaedics and accident & emergency at the Royal Liverpool Hospital, he spent his GP vocational training in Southport, worked as a rural GP in the Wye Valley in South Wales, and became a GP with special interests (GPwSI) in lower limb orthopaedics.

He says: "I enjoy seeing variety in my career - I know people who have done sports medicine and others who have done political stuff working in the management structures of the various PCGs, PCTs and CCGs."

"I am very lucky to have done all those things (and to do what I do with the ENB) in an era when they were developing, because almost certainly nowadays I would have needed a diploma in sports medicine or post graduate education, but I got where I am by getting experience, making contacts and networking."

To those interested in a career in general practice, he says it is a specialty that offers a lot of freedom in a working week, allowing GPs to "build a portfolio to keep your week varied."

At the moment, Dr James is thoroughly enjoying the challenges of being a busy GP in Southampton and the ENB's company doctor in London. Outside of medicine, his other passion is music - he plays tenor saxophone in a windband (the clarinet "just for fun") and he also plays in a quartet. He even carries out his own instrument repairs.

So, at the age of 54, is he considering slowing down? He laughs: "Retirement is not that far ahead and I might start thinking about changing the way I do things in the next couple of years. I may reduce my hours, I may not, or maybe I will go into saxophone repair full-time!"

**Kristin Ballantyne is a freelance writer based in Glasgow**

# FAILURE TO

What should you do if a patient on a repeat prescription fails to attend for review? Medical adviser **Dr Susan Gibson-Smith** offers some practical advice

**P**ATIENT non-compliance with requests for monitoring can present a difficult dilemma for GPs. Whether it be for INR monitoring, disease-modifying anti-rheumatic drugs (DMARDs) or diabetic reviews, the GP will have to make a decision as to whether to continue to prescribe the medication or not. As a medical adviser I often get telephone calls from our members asking advice as to what to do in these situations.

## Consider the following scenario:

*The repeat prescription request for warfarin caught my eye as I*

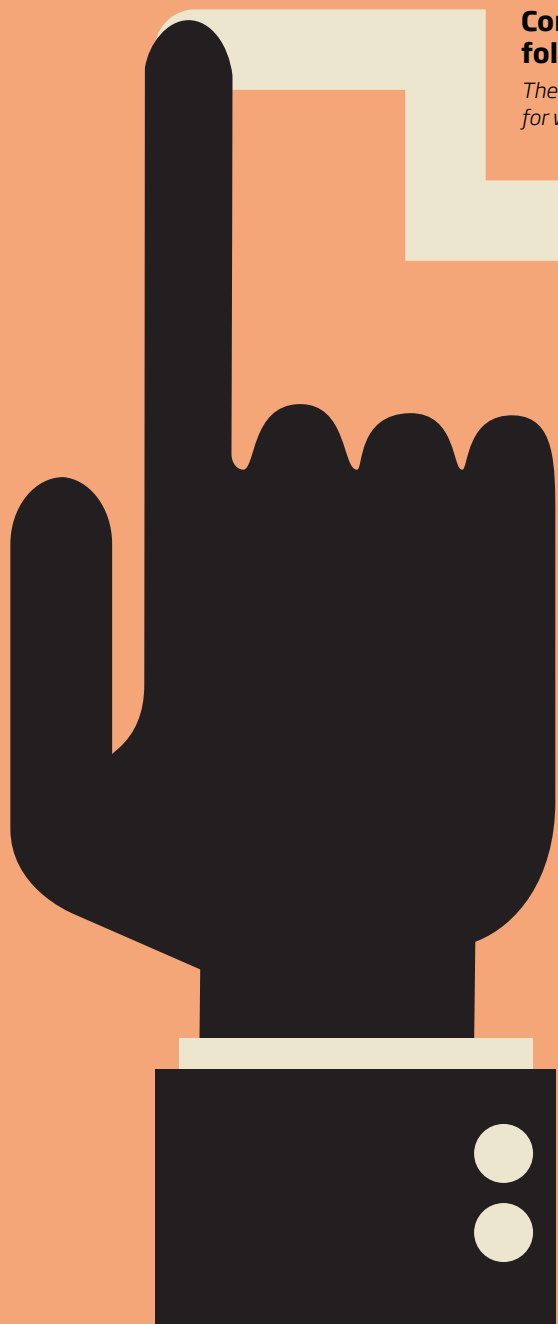
*was going through the bundle. Review overdue. I opened up the record to check out the details: 56-year-old man, five years post-op, mitral valve replacement, on warfarin. I reviewed the blood test results: not had INR checked for five months... five months! There were three letters on the file asking him to come in for blood test monitoring but he had not been seen in the surgery for nine months. He clearly needs the medication to keep his valve functioning but what if his blood is too thin and he has a bleed because he has not come in for monitoring? What should I do?*

## Responsibility

The first thing to be aware of is the GMC's supplementary guidance *Good practice in prescribing and managing medicines and devices*. I would recommend a review of the whole document but the following paragraphs are particularly pertinent here.

*"You are responsible for the prescriptions*

*"Don't set out to frighten the patient, but it is important to make them aware of the dangers involved and potential risk they are exposing themselves to by not attending"*



# COMPLY

you sign for and your decisions and actions when you supply and administer medicines and devices or authorise or instruct others to do so. You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicine.” (paragraph 3)

This applies even if you are simply signing a repeat prescription that you did not initiate:

“You are responsible for any prescriptions you sign including repeat prescriptions initiated by colleagues so you must make sure that any repeat prescription you sign is safe and appropriate.” (para 55)

Therefore, should any medical mishap arise out of a side effect from a medication and you signed the prescription, you would be held to be at the very least partly responsible:

“Whether you prescribe with repeats or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring follow-up and review, taking account of the patient’s needs and any risk arising from the medicine.” (para 51)

Suitable call-recall arrangements should be standard practice in all GP practices. It is therefore very important when signing repeat prescriptions that you are aware of your practice’s review procedures and make sure that you are following them.

The first thing I would advise would be to check the patient’s contact details and then send a letter asking them to attend for monitoring. Most practices have a standard template letter for this purpose. It is also advisable to set an alert to remind you to check whether they have attended or not.

If the first routine letter does not work then send a second. If that does not work then I would advise sending a personal letter from the GP inviting the patient to attend an appointment to discuss their medication and its

continued supply. The time between each letter will depend on the risks involved. It may also be appropriate to contact the patient by telephone.

It is not enough, however, to simply say: “I sent a letter and the patient did not attend”. The guidance states you must take account of the patient’s needs and any risks arising from the medicine.

## The patient’s needs

Often the most efficient and best way to fully understand the patient’s needs is to speak directly to them to try to understand their reluctance to attend for the monitoring. For example, if the patient works 9-5 it is not helpful to invite them for review appointments during those hours: an early morning appointment might be more helpful. If it is difficult for the patient to travel, it may be appropriate to arrange near-patient testing or a home visit review. Perhaps the patient simply does not understand the significance and importance of the monitoring and a conversation outlining the risks involved in continuing to prescribe the medication would be helpful. Whilst you shouldn’t set out to frighten the patient, it is important to make them aware of the dangers involved and potential risk they are exposing themselves to by not attending.

It is also important to clearly document in the patient’s records the steps you have taken to contact and invite them for monitoring. Should they attend the surgery for another matter, the clinician seeing them will be alerted to the need to discuss these issues.

## Stopping medication

If the patient still refuses to attend then the next step would be to write to them, clearly outlining the risks of continued prescribing in the absence of monitoring. You can also consider issuing shorter prescriptions that they will be forced to collect, or advise them that, due to the risks involved, you will have no choice but to discontinue the medication

should they fail to attend for review within a given time limit.

This last option is rarely necessary as most patients by this point do realise it is in their interests to comply with your request. However on the rare occasions it does occur it would be advisable to involve your secondary care colleagues in this decision and have a case conference to discuss the pros and cons of continuing/discontinuing the medication. It is very important to also involve the patient in this decision-making process and make sure they have the capacity to understand, weigh and retain the consequences of their decision to refuse monitoring. If a competent patient understands the risks of refusing to attend for monitoring it is for the doctor to decide whether continuing to prescribe poses more risk to the patient than not prescribing.

## Here is how our earlier scenario resolved:

*Having checked with my trainer he suggested that, given the passage of time without review, it would be most appropriate to call the patient. Fortunately I managed to speak to him. He had been working abroad but was home that week and agreed to come in for the blood test the next day. His INRs had always been stable and he had not seen the significance of continuing to regularly attend. His INR was within the therapeutic range and a plan was made with him to ensure that his INR could be monitored monthly whether he was abroad or not and this arrangement was recorded in his records.*

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



## DIAGNOSIS

## SICKLY CHILD

## DAY ONE

A seven-year-old girl – Emma – is brought into the GP surgery by her mother for an emergency appointment. The child has been sick four times since the previous evening and had a high temperature, though this reduced subsequent to a dose of paracetamol. Emma has been taking plenty of fluids but is off her food. The GP – Dr K – examines the child and finds her well hydrated and alert. Her temperature is normal and the doctor can hear no abnormal chest sounds. The abdomen is soft and not distended and the GP also records: *No neck stiffness/other meningeal symptoms*. He advises that Emma has a viral infection and should continue symptomatic treatment with paracetamol and plenty of fluids. He warns Emma's mother about "red flag" symptoms and to return if the child's condition does not improve or worsens, or take her straight to A&E.



## DAY TWO

Emma's parents bring her to A&E late the following evening with a high temperature and more vomiting. An upper viral respiratory tract infection is diagnosed by emergency staff and she is given more paracetamol. The child is later discharged home after a few hours of observation.

## DAY THREE

Another emergency appointment at the GP surgery is made for Emma early the next morning and her mother reports that she is not feeling any better. The child complains of severe headache and has been "vomiting all night". Dr K examines Emma and finds she is afebrile but dehydrated (dry tongue) and lethargic. He also observes that she is wobbly and unsteady on her feet and displays neck stiffness. The GP arranges for a 999 ambulance admission from the surgery. Emma is admitted to hospital and later diagnosed with pneumococcal meningitis. Her condition further deteriorates and she is transferred to ICU and requires ventilation. Her conscious level fluctuates but she eventually responds to treatment.

MMA makes a slow recovery but is left with some hearing loss and cognitive impairment. A year later Dr K receives a letter of claim alleging clinical negligence in failing to diagnose and refer Emma after her first consultation at the surgery. In her account of events Emma's mother states that the child first complained of severe headache and intolerance of light – both of which are signs of possible meningitis. It is alleged that Dr K's failure to arrange for emergency admission after this initial consultation led to a crucial delay in treatment, resulting in a protracted recovery and life-changing complications.

An expert in acute primary care provides an opinion on the case for MDDUS. He agrees that headache, vomiting and photophobia are all typical symptoms of meningitis but in examining the notes from the first consultation he finds no reference to frontal headache or light intolerance by Dr K. The notes indicate the

GP examined Emma and found she was well hydrated and did not have an elevated temperature. He also recorded there were no "meningeal signs" though no specific mention was made of examination for neck stiffness. The consultation finished with "safety netting" advice: return to the surgery or go straight to A&E if the condition worsens.

The expert concludes that in his opinion Dr K's findings were "typical of viral illness" and that his history, examination and follow-up advice were adequate and appropriate – even if it is accepted that headache and photophobia were mentioned in the first consultation. It is also noted that the medical records show Emma was up-to-date with all her immunisations including meningitis C and pneumococcal infection. Emma's subsequent discharge from A&E on the following night also supports the uncertain nature of her symptoms.

Regarding the second consultation the

expert states that he does not question Dr K's decision to arrange immediate transfer to hospital given the finding of neck stiffness and other changes in Emma's clinical condition from his previous examination of the child.

MDDUS responds to the letter of claim on behalf of Dr K restating the expert findings. The case is later discontinued.

## Key points

- Ensure that you consider the possibility of meningitis or septicaemia in children with non-specific illness featuring fever, vomiting and muscle aches.
- Record your findings negative or otherwise.
- Ensure that you are familiar with recent clinical guidelines including red flag symptoms.

# 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...

● **CONSULTATION SECRETS** How long do you let your patient speak before you feel compelled to butt in? Apparently US researchers found that patients were only allowed to finish their opening statement in less than a quarter of consultations, and that many doctors interrupted after around 18 seconds. A more recent study of UK GP consultations paints a more encouraging picture with those in their first two years of GP training interrupting after around 36 seconds. Experienced GPs seemingly hold out even longer, until around 51 seconds. London GP Dr Graham Easton ponders these issues and more in his new book *The Appointment: What Your Doctor Really Thinks During Your Ten-Minute Consultation*. He also shares his tips for signalling when it's an appropriate time for the patient to leave. Techniques include breaking eye contact ("that's easy, just look at the computer"), and altering your body position away from the patient (both of which risk irritating patients). Alternatively, he says doctors can try speaking faster and louder than the patient, sitting up straighter, handing over a prescription or patient information leaflet, or picking up the patient's bag or walking stick for them. Finally, he adds, "there is the nuclear option: stand up and go and open the door. I've been known to use that."

● **HOPING TO NEVER RETURN** Diary has heard many tales in recent years of brave souls who have posted "hilarious" out-of-office email messages, but has never dared stray beyond a safe, functional alert. We could only dream of equalling the boldness of some of the employees whose comedy gold has featured in the internet's summer news feeds. The ill-advised notices include: "On holiday. Hoping to win the lottery and never return" and "I am away from the office right now. Unfortunately I will be back tomorrow." The love-my-job theme continues with "I've run away to join a different circus", while another cynic offers: "I am out of the office from dd/mm to dd/mm and will not be checking email. It's likely your note will be swallowed in a sea of inbox banality, never to be seen again. If you require a response, please re-send your email after dd/mm." And finally, winning the award for "most likely to backfire" must surely be: "I am currently out at a job interview and will reply to you if I fail to get the position."

● **BASH BACK** GP bashing has long been a cherished sport among certain tabloid and broadsheet newspapers - not to mention names (...Daily Mail). But recent statistics released by insurers 1st Central reveal that doctors do a fair bit of bashing on their own, albeit of a different kind. Analysis of

accident claims in 2015 ranks doctors at number three on the list of worst drivers by profession - just behind solicitors and accountants. No doubt it's with all that racing about in expensive high-powered cars bought with outrageous salaries...or so the trope goes, as opposed to doctors driving home while exhausted from overwork. So who are the safest drivers according to the analysis? Roofers top the list followed by farm workers and builders. Perhaps most worrying - number 10 on the worst list was train driver.

● **WINTER IS COMING** Rural Scotland needs GPs and the government has shown it is willing to pay. One hundred new GP training places were recently advertised and some with a £20,000 "Golden hello". The one-off bursary will be paid for posts that have "not been filled recently" - many of these in isolated rural communities. Diary suggests that NHS Scotland could also enhance the offering with a bumper supply of vitamin D. Recently the Scientific Advisory Committee on Nutrition (SACN) recommended that everyone in the UK take 10 mg daily supplements in autumn and winter to protect bone, teeth and muscle health. Given that in mid-winter the sun barely breaks the horizon in some northern parts we feel it only fair to equip eager recruits. Sadly whisky is no substitute.

● **CHEWING KALE** Health experts have railed against the Department of Health's "watered down" obesity strategy which asks the food and drinks industry to "work towards" lower sugar content in products. Hence the burden remains on healthcare professionals to encourage healthy eating among patients - including advice on avoiding fad diets. To this end the British Dietetic Association (BDA) compiles a yearly five worst celeb diets of 2016. Trim Secrets (5): buy offers a pocket countdown of 2016. Trim Secrets (5): buy capsules to take three-times daily along with a 1,500 calorie diet and regular exercise (or skip the pills and lose weight anyway). Super Elixir (4): powder bought at £96 per month to regulate your body's acidity levels (or you could just eat a balanced diet with fruit and veg and trust your body to regulate acid balance naturally). Bulletproof diet (3): drink daily 'Bulletproof coffee', essentially black coffee with some added butter and MCT (medium-chain triglycerides) oil. Foods are classified in three categories - bulletproof, suspect or kryptonite - with rules on timing of meals. All-kale and chewing gum diet (2): that's it really; just eat kale and chewing gum (and be in close proximity of a toilet). No sugar diet (1): tall order unless this means processed sugar (not fructose, lactose, etc). BDA says: "It's not about a single food or nutrient, we advocate a whole diet approach." So forget the Donut Diet.





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