



# HEALTHCARE

THE FUTURE IS IN THE PALM OF YOUR HAND

ALSO INSIDE

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GPWSI IN MENTAL HEALTH

AN **MDDUS**  
PUBLICATION

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UK INDEMNITY, ADVICE & SUPPORT



## Welcome to your GPst

FUTURE gazing is always a bit of a risk – think of the hoverboard envisaged for 2015 in the film *Back to the Future II*. But much of the technology discussed by digital innovator Dr Keith Grimes in our profile on **page 10** is already in use – the promise lies in applying it to healthcare in clever ways. Who would have thought virtual reality would have a place in the GP surgery?

The technology theme in this issue is continued on **page 12** in Joanne Curran's survey of useful medical apps. Her article also provides advice on quality markers and a few words to the wise before relying on any app.

On **page 4** Dr Greg Dollman offers some helpful insights on reflective practice – what does it entail and how can you ensure it's not just another box-ticking exercise? Not unrelated to this is the need for doctors to monitor their own wellbeing and on **page 5** we highlight a new guide

by the RMBF encouraging GPs to be sensitive to signs of stress and potential burnout.

New revised GMC guidance on confidentiality has recently come into effect and on **page 6** we look at some of the changes, while on **page 7** Dr Gail Gilmartin provides practical advice for doctors called to attend at court or inquests as a factual witness. Our career article on **page 8** looks at opportunities for GPs with a special interest in mental health – an area of growing need with as many as a third of GP consultations now involving a mental health component and 61 million antidepressant prescriptions having been handed out in England in 2015.

And our case study on **page 14** involves some distressing withdrawal symptoms for a patient on opiate patches.

• **Dr Susan Gibson-Smith**  
Editor

## GP TRIAGE SERVICE FOR A&E

NHS England aims to have GP walk-in triage services in all hospital A&Es by next Christmas to address overstretched demand, according to chief executive Simon Stevens.

Funding of £100 million has been made available to support the initiative which was discussed at a recent House of Commons Public Accounts Committee inquiry into GP access.

In the meeting Stevens also stated that by next March it is intended that "half the country" will be covered by GPs "who are able to offer evening and weekend bookable appointments" and this will be expanded to the whole of the country by March 2019.

But Professor Helen Stokes-Lampard, chair of the Royal College of GPs, has warned against imposing services: "We're pleased that Simon Stevens recognises that nearly 90 per cent of GP practices are already offering some form of extended access for patients, as this is often overlooked. However, it remains important that the services we do provide are not imposed, but are based on local need."

"We have a chronic shortage of GPs and if we are siphoned off to do triage in emergency departments or required to keep open our surgeries for longer, it will inevitably have a serious knock-on effect..."

## ADVICE LINE THERE TO BE USED

MDDUS is keen to dispel the myth that contacting its advice line impacts on the subscription rates members pay.

Members are encouraged to seek advice from our team of experienced medico-legal advisers at the earliest opportunity – and are not penalised for doing so.

MDDUS chief executive Chris Kenny said: "As we have repeatedly made clear to the BMA and a number of LMCs who raise this issue, we can give a categorical assurance that the underwriting and pricing decisions of MDDUS are not affected by the number of times members contact the organisation for advice."

"Indeed, MDDUS positively encourages members to make use of the 24-hour advice line that is available to them as a benefit of membership. We believe seeking our advice will assist the member in adopting safer clinical practice and we would never penalise them for contacting us for advice."

Contact MDDUS on 0333 043 4444 or at [advice@mddus.com](mailto:advice@mddus.com)



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## TREAT SEVERE SEPSIS WITHIN ONE HOUR

PATIENTS showing symptoms of severe sepsis should be treated within one hour, according to a new draft quality standard from NICE.

The quality standard highlights areas from NICE's 2016 sepsis guideline and stresses that staff in any setting, from GPs to paramedics, should check patients for specific signs that show symptoms are life-threatening. These include temperature and heart rate, and checking for rashes or skin discolouration.

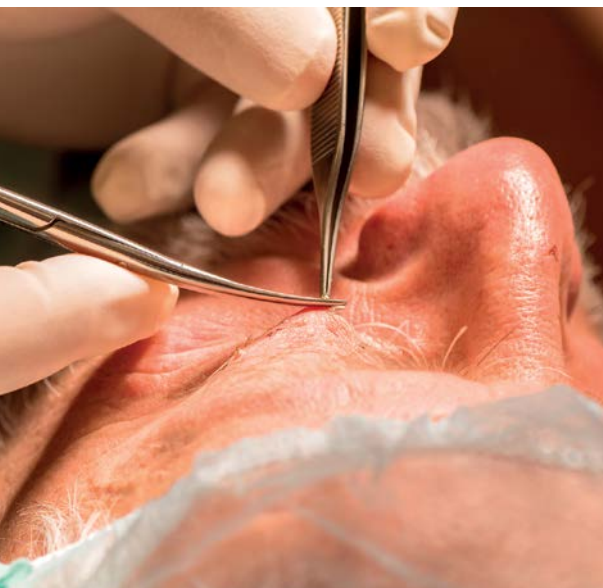
NICE says that high-risk sepsis patients should get antibiotics and IV fluid treatment within the hour. If it will take more than an hour to get someone to hospital, GPs or ambulance staff can also administer antibiotics.

Professor Gillian Leng, NICE deputy chief executive, said: "Severe symptoms can develop in sepsis very quickly. If high-risk patients are not identified and treated promptly, people can be left with debilitating problems. In the worst cases, they may die."

"This quality standard highlights priorities in the continued fight to improve sepsis care. We know from recent case reviews that there are inconsistencies in how people's symptoms are assessed in different settings. More can be done to provide rapid treatment."

Access the new draft sepsis standard at [www.nice.org.uk](http://www.nice.org.uk)





## GPs WORKING IN MINOR SURGERY

MDDUS recognises that GPs may undertake a range of relatively minor invasive procedures, such as contraceptive implant or coil fitting, joint injections, acupuncture or minor surgery for skin lesions and "lumps and bumps". We will extend the benefits of GP membership to include work as described above where it accounts for less than 50 per cent of a member's clinical time and where it is provided to NHS patients.

Members must ensure that they work within the limits of their competence/training, and that the time spent undertaking such work is included within the sessions declared to MDDUS for the purposes of calculating their subscription.

Members undertaking complex/specialist work, treating private patients or exceeding the 50 per cent limit set out above, should contact our Membership Team for a tailored quote.

## VISION FOR "REALISTIC MEDICINE" BY 2025

ALL healthcare professionals in Scotland will be practising "realistic medicine" by 2025 in a bid to increase patient involvement and reduce overtreatment.

That is the vision of Scotland's chief medical officer Dr Catherine Calderwood in her latest annual report, *Realising Realistic Medicine*, which builds on proposals set out in her first report published in 2016.

Realistic medicine, the report explains, "puts the person receiving health and care at the centre of decision-making and encourages a personalised approach to their care. Its aims of reducing harm and waste, tackling unwarranted variation in care, managing clinical risk, and innovating to improve, are essential to a well-functioning and sustainable NHS."

Dr Calderwood's 2016 report was broadly welcomed by healthcare professionals and widely shared on social media, reaching almost 10 million Twitter feeds a year after publication.

BMA Scotland chair Dr Peter Bennie welcomed the report but said doctors were concerned they do not have enough time to adopt some of the proposed innovations.

He said: "Doctors want and expect to be innovators and leaders in improving outcomes for patients, however to do this well we need time to learn, teach and reflect. We need to have an honest and open debate with the public and politicians about what the NHS can realistically provide."

Access *Realising Realistic Medicine* at [www.gov.scot/Publications/2017/02/3336](http://www.gov.scot/Publications/2017/02/3336)

## MANDATORY NHS SERVICE PROPOSED

A CONSULTATION from the Department of Health is proposing a requirement for newly trained doctors in England to work a minimum term of possibly over five years in the NHS.

Doctors choosing to leave the NHS before that term to work for a different organisation or overseas could be required to repay the "recoverable elements" of funding invested in their education. It currently costs £230,000 to train a doctor in England and the proposals are to ensure that tax payers "obtain a return on this investment".

The consultation also includes a proposal to expand medical education by training up to 1,500 extra doctors each year in England. Currently more than 6,000 university training places are available and the plan is to increase this each year from September 2018. Medical schools that commit to supporting general practice and providing students more GP placements would be prioritised to receive a greater allocation of these places.

Professor Ian Cumming, Chief Executive of Health Education England, said that the proposals offer a "clear commitment to a sustainable future home-grown medical workforce, making us self-sufficient in doctors for years to come, giving more young people from diverse backgrounds the chance to become a doctor.

"These extra places also give us the opportunity, with partners across health and education, to respond to NHS need, providing doctors in the specialties and places that patients need long into the future."



## WIDESPREAD ILLEGAL ONLINE ANTIBIOTIC PRESCRIBING

A SURVEY of online pharmacies found that 45 per cent offered antibiotics without a prescription.

Researchers from Imperial College London entered the search term "buy antibiotics online" into Google and Yahoo and the 20 pharmacies at the top of the search were analysed. The team discovered that 45 per cent did not require a prescription from the patient and only 30 per cent asked consumers to complete a health questionnaire prior to purchase.

Only 70 per cent of the websites provided information on the safe usage of prescription medications, including potential side-effects or adverse reactions when combined with other drugs.

Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, commented: "It's incredibly concerning to hear that antibiotics are so readily available to patients via some online pharmacies without a prescription. This is against strict GMC guidance on remote prescribing - and it undermines the hard work that GPs are doing to reduce antibiotics prescribing, which saw prescriptions reduce by 2.6m in general practice last year alone."



All doctors have to do it, but what exactly does reflective practice entail?

**Dr Greg Dollman** offers some insight

# THE ART OF REFLECTION

REFLECTIVE practice divides opinion like Marmite: doctors either love it or hate it. Mention reflection, and you're bound to get an emotive response. Some argue it is a box-ticking exercise, that it does not improve patient outcomes and leaves doctors vulnerable to criticism. But it is something we are professionally obliged to engage with. Recently, the argument against this practice was invigorated when a doctor's reflections written in their NHS e-portfolio were used against them in a legal case. This prompted the Academy of Medical Royal Colleges (AoMRC) to issue detailed guidance – more of which later.

## What is it?

Reflection involves carefully considering a personal experience. It goes beyond a description of the incident, rather exploring your actions as well as the circumstances at the time, your thoughts on it with the benefit of hindsight and the comments of others, and what impact it has had on you going forward.

Reflecting is not telling a one-sided story. It is a process of interpreting your, and others', thoughts about an event. It is a critical analysis of your involvement in the scenario and includes an acknowledgement of your feelings, opinions and attitudes as a result.

The GMC reminds doctors, in its *Leadership and management for all doctors* guidance, to reflect regularly on their performance and professional values. This is an essential part of maintaining and improving patient care, as well as helping a clinician's self-development. Doctors are obliged to be reflective, and those who reflect on their everyday practice are considered to be insightful. Medical professionalism requires that doctors learn from their experiences and put patient safety, care and quality improvement first.

## How do I reflect?

There are many different approaches to reflective practice. This article does not aim to summarise these (or propose one over the other); rather it provides a broad overview.

Reflection happens in our everyday practice often without us realising it. By looking back at our actions we can learn from them with the advantage of hindsight. As a starting point, doctors may wish to consider which structured approach they will adopt. If new to reflection, you may find it helpful to try a number of different methods to determine which works best.

First, describe what happened (setting out both the positives and negatives: What went

well or badly?) and why (contributing factors). Then consider how the incident affected you, as well as others. Finally, present a clear action plan (possible only with a good understanding of why the event occurred).

It may be helpful to use established criteria when setting a goal or objective in your action plan. You must be able to outline, for example, what action you will take, who will assist with this, how you will achieve this and assess progress, and in what period of time.

Once the action plan has been put in place, the event (and the associated reflection) should be revisited to ensure learning has taken place, change has occurred and there is improvement as a result. New action plans may then follow such reviews.



Reflection is not a one-off event – it should be seen as a cycle that can be repeated as necessary. A doctor should consider the impact of their frame of reference at the time of the incident and subsequent reflections, what others have said, how their thoughts and emotions have changed as time has passed, and how they would act in a similar circumstance in the future.

These steps should get you on your way:

1. Ask for guidance from a colleague or look at examples of reflective writing.
2. Write about something that stood out in your day.
3. Practice makes perfect.

## Confidentiality

This leads us back to the issue of concerns over doctors' reflections potentially being accessed by a third party and used to criticise them. Under the Data Protection Act 1998 (DPA), a person (or their representative) can make a subject access request to obtain any personally-identifiable information that is held about them. It is advisable that doctors appropriately anonymise their reflections. This will minimise the risk of proper reflection being used to criticise the practitioner.

The GMC recognises that using information about patients is essential for education and training purposes and allows the use of anonymised data in these circumstances. Clearly in some cases the context alone may identify a patient. The AoMRC's new legal guidance on the disclosure of information in e-portfolios to third parties suggests the following:

- Anonymise all patient details as far as possible in reflective writings, including any distinctive medical facts. Healthcare professionals and other parties involved should also not be readily identifiable.
- If a subject access request is made and if it is established that the information within the log is a patient's personal data, a doctor's self-reflective log may not be exempt from disclosure under the DPA.
- In the event of litigation, the doctor could request a court order as their reflective writing contains third party information.

If in doubt, contact MDDUS for more detailed advice.

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





**D**OCTORS make the worst patients, or so the saying goes. Whether they're too embarrassed to admit they need support, worried about stigma, or just plain in denial, seeking help does not seem to come easy.

But as work pressures and stress levels continue to rise, it has never been more important for doctors who are struggling to cope to ask for the assistance they need.

One new initiative hoping to raise awareness of this issue is the *What's Up Doc?* campaign from the Royal Medical Benevolent Fund (RMBF), a registered charity set up to help doctors, medical students and their dependents. They offer financial aid and debt advice, and also provide a befriending service.

### Staying silent

A recent survey carried out by the RMBF as part of *What's Up Doc?* highlighted the overwhelming concern over the state of mental health and wellbeing amongst doctors, largely as a result of working under increasing pressure and scrutiny. It found a massive 82 per cent of doctors knew of other doctors experiencing mental health issues such as depression and anxiety. Despite this, they were unlikely to reach out for fear of discrimination or stigma from colleagues (84 per cent), or were inhibited by their 'high achieving' personality traits (66 per cent).

The survey of hospital doctors, consultants, GPs and charity supporters also revealed 78 per cent of doctors believed medics are so busy looking after others that they neglect to look after themselves, while over 90 per cent believe their working hours put personal relationships under pressure.

Of the key factors contributing to pressure on doctors, 80 per cent blamed patient caseloads and a similar number cited increased regulatory scrutiny, while 76 per cent highlighted working hours.

### Getting help

In a bid to reverse this trend, the RMBF has undertaken a number of initiatives, including hosting a round table debate – sponsored by MDDUS – to explore effective means of support. They have also published free downloadable guides, the most recent of which is *The Vital Signs in Primary Care*, written by Dr Richard Stevens, a coach with the Thames Valley Professional Support Unit.

The guide acknowledges there is "very little support on offer" in the caring professions, adding that doctors "are expected to carry on, and there is even a sense that needing support is a sign of weakness". Many cope, it says, by developing a so-called "survival personality", where they shut off parts of themselves that would otherwise find some aspects of the work unbearable. Other strategies include "medical narcissism", a term used by ethics professor John Banja to describe the attitude adopted by some doctors, especially when things go wrong.

## WHAT'S UP DOC?

As GPs face increasing work pressures, a new campaign aims to reduce stress levels

Key advice points from the guide include:

### Self-awareness

The booklet encourages doctors first to be aware of the signs of stress and to do something to improve the situation. Admittedly this is not always easy. It states: "It is ironic that when we need to do the things that will help deal with a difficult time, it is the most difficult time to do those things."

The guide likens ignoring feelings of stress and burnout to cutting down a tree with an increasingly blunt saw. "Often we continue sawing because we haven't time to stop and sharpen the saw." Developing a good degree of self-awareness is crucial so that help can be sought before any harm is done "clinically, professionally or socially".

### Trigger points

Common factors to keep in mind include:

- Emotional toll of large number of interactions with staff or colleagues
- Long hours/sleep deprivation
- Financial worries
- Lack of support at work
- Understaffing
- Burnout (emotional exhaustion; doubts about personal/professional effectiveness)
- Instability in working arrangements.

### Key signs

The guide outlines a number of key early warning signs to help identify GPs in difficulty. These include:

- Doctors who are often late/absent or not answering bleeps
- A low work rate – slow at carrying out procedures; arriving early and leaving late yet struggling to achieve a reasonable workload
- Bursts of temper/over reaction
- Colleagues find ways to avoid seeking the doctor's opinion or help
- Defensive, unable to accept constructive criticism
- Behaviour changes, such as excess drinking or withdrawal.

### Seeking help

It is crucial to let yourself just be a patient when necessary – seek help early and don't focus on concerns about being judged or stigmatised. If you are keen to avoid the usual healthcare structures, there are a number of programmes available, such as the RMBF, the Sick Doctors Trust and the NHS Practitioner Health Programme in London ([php.nhs.uk](http://php.nhs.uk)). The NHS GP Service has also recently been launched by NHS England ([gphealth.nhs.uk](http://gphealth.nhs.uk)).

Joanne Curran is associate editor of GPST

### Links:

- *The Vital Signs in Primary Care*: [bit.ly/RMBF\\_vitalsigns](http://bit.ly/RMBF_vitalsigns)
- *What's Up Doc?* campaign page: [bit.ly/Whatsupdoc](http://bit.ly/Whatsupdoc)

# ALL THINGS CONFIDENTIAL

New GMC confidentiality guidance goes live in April

It can be easy to forget just how crucial confidentiality is to providing effective healthcare. Patients can divulge the most desperate personal details in seeking help – and without this promised trust more than a few might die simply out of a fear of disclosure. Confidentiality lies at the heart of the doctor-patient relationship, and in an era in which access to personal information is constantly expanding, the requirement to safeguard patient data grows ever more complex.

On 25 April new GMC guidance on all aspects of medical confidentiality will come into effect. *Confidentiality: good practice in handling patient information* reflects an extensive revision of the existing guidance published in 2009. It is intended to address not just new digital challenges but also changing patient expectations, the growing multi-disciplinary and multi-agency nature of healthcare, and an evolving legal and regulatory context.

A detailed review of the core guidance began in 2014 and included seven additional explanatory statements setting out how the principles apply in particularly “difficult” situations, such as reporting gunshot and knife wounds or disclosing information about serious communicable diseases.

Information was gathered from a range of sources, including an analysis of the type of enquiries the GMC receives on confidentiality-related issues and also those arising in the context of fitness to practise cases. In addition, the GMC commissioned surveys and held roundtable events to explore the views and expectations of patients around how and why their personal medical information might be disclosed. Other relevant organisations including the MDDUS were also consulted.

Healthcare law professor at University College London, Jonathan Montgomery, chaired the expert group overseeing the revision. He

commented on the GMC website: “From my point of view, the main challenge for us was building a good understanding of patient expectations when it comes to confidentiality. There are some areas where we found that the health service is already using data in ways that patients are unaware of – and not particularly comfortable with.

“For example, the NHS sometimes uses non-NHS staff to make preparation of letters more efficient. Some of the focus groups we spoke with demonstrated a bit of anxiety about this. Yet, there were other areas where patient expectations run ahead of what the NHS is actually doing. Patients told us they shouldn’t have to keep telling their story to the health service. They expect key information to always be available to the people looking after them.”

Another problematic area for doctors addressed in the new guidance is recognising the significant role that family and carers can play in providing patient support – and how can you have conversations to reassure people their loved one is getting the right care without breaching confidentiality? “We’ve given more advice on how doctors can have these discussions with families without overstepping the mark,” said Montgomery. “What we’re aiming at is that families don’t experience a wall of silence from health professionals, while making sure these conversations don’t rob the patient of their right to privacy.”

The revision group also considered the implications of technological developments – most significantly the shift away from using “physical patient records” controlled by one doctor making individual choices on whether to share that information.

“Now, records are held in IT systems and accessed electronically in many different places by lots of different people who need to contribute to the record, or use that information for a defined purpose. This isn’t new, but the

scale of it has grown,” said Montgomery.

In its scoping and evidence-gathering activities the GMC found that the fundamental principles set out in the existing confidentiality guidance were still sound but more emphasis was needed to ensure that the revised guidance:

- was easier for doctors to refer to and follow
- placed a stronger emphasis on the importance of sharing information for direct care
- distinguished more clearly between direct care and other uses of patient data
- provided more advice on decisions about sharing information with a patient’s friends and relatives
- better addressed considerations that apply to disclosures about adults at risk of harm
- made the legal framework for disclosure more explicit, especially on data protection responsibilities
- clarified advice on public interest justification for disclosure of patient data for secondary uses, such as healthcare service planning and research.

One innovation in the new guidance is a decision-making flowchart to help doctors “ask the right questions, in the right order” to establish the legal basis for any disclosure – and when the guidance comes into effect in April, additional resources and case studies will be published for doctors and patients.

Access the new guidance at [www.gmc-uk.org](http://www.gmc-uk.org).

*Jim Killgore is an editor at MDDUS*

# A DAY IN COURT

Court appearances – be it for an inquest or giving evidence at trial – involve doctors on a regular basis. A few basic tips can help reduce anxiety

A WEEK never goes by without a few calls to the MDDUS advice line from members facing an upcoming court appearance. Such appearances – be it an inquest or giving evidence at trial – are commonplace and involve doctors on a regular basis. Most often these are cases where our members are witnesses, not personally on trial.

Many members are understandably anxious about attending court, probably frightened at the prospect because of the way in which giving evidence is portrayed in TV dramas. This is only natural given the unfamiliarity of the situation and the prospect of having to speak in public – but remember that for lawyers and other staff the court is just a place of work like a hospital or surgery.

If you receive a court summons/citation you must attend. Failure to do so may result in arrest for contempt of court.

One common source of anxiety is how your evidence will be viewed. Will

you be criticised, grilled and left looking foolish? In a worst case scenario will you face some form of censure? These risks are best avoided by adequate preparation.

Remember that you are there to assist the court with information as a factual witness (being instructed as an expert witness is a different role). You are not there to make a decision on behalf of one party or another – that rests with the judge/jury or coroner. You should be objective.

Evidence begins with an affirmation or taking the oath. A witness box is a place of legal privilege and you cannot be accused of a breach of confidentiality when making disclosures in answer to questions put to you.

The natural dynamic in court is relatively slow paced. Lawyers take time to consider their questions; you can take time to consider your answer. There may be pauses between questions and answers, and often pauses after you have answered. If you have said all that you want to say, keep quiet and wait for the lawyer to ask their next question. Do not be tempted to fill the silence!

Always remain polite, answer clearly and ensure your voice can be heard. If you do not understand the question, ask for it to be repeated. Your answers must be truthful – which includes saying “I don’t know” or “I have forgotten”. You can only give evidence that you are directly aware of and within your field of expertise. Good preparation before court includes looking over your notes or reports and being prepared to explain your actions and professional opinion. It does not include

trying to learn all the facts about a particular disease – giving evidence is not a medical test.

Doctors as a group try to be helpful but straying beyond the scope of your knowledge in court is wrong and can lead to difficulties if you are exposed as having gone too far. Be aware of the limits of your knowledge and stick to that. You can quite reasonably say that you can’t answer a question, offering, for example: “... you would need to ask a forensic pathologist”.

If it is pointed out that you may have made a mistake (such as with a date), carefully consider this and if you have made an error, admit this.

The GMC offers guidance as follows:

- The first duty of all witnesses is to the court
- Give evidence that is impartial, honest and not misleading
- Only give testimony and express opinions about issues that are within your professional competence
- Work within the court timescales.

There are a few other ground rules which can help: simple things such as make sure you know where you are expected to attend and when, and leave enough time so that you don’t add to your stress. Take along your court citation. Make sure you dress professionally (like a lawyer but minus the wig!).

You may have to wait in the witness room for some time so take along something to occupy yourself.

Make sure you maintain your focus and attention. If you are very nervous remember that the first evidence you will be asked to give is easy – usually your name and status. Take your time, breathe normally and maintain your composure.

## Action points in court

- Prepare: be familiar with the case and any notes or reports you have made.
- Know where you’re going
- Dress up and speak up
- Answer a question then stop talking
- Call MDDUS for advice if you have any concerns.

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





GPs with a special interest in mental health are ideally placed to provide vital advice and support to meet increasing patient demand

# A HEALTHY M

ONE in four people will experience a mental health problem in any given year, research suggests, with 90 per cent of those making primary care their first port of call for help. It is not surprising, then, that as many as a third of GP consultations involve a mental health component, with 61 million antidepressant prescriptions administered in England in 2015.

The Royal College of GPs advise doctors to consider the mental health of a patient “in every primary care consultation”, and highlight the serious impact of mental health problems in contributing to disability, unemployment and social exclusion.

GPs have a key role in recognising and responding to patients’ mental as well as physical health needs but 2016 figures from the charity Mind show that in England, on average, only 46 per cent of trainee GPs undertook a training placement in a mental health setting. With demand continuing to rise, there is no better time to develop a special interest in this challenging field.

## Entry and training

There are a number of ways to undertake training as a GP with a special interest (GPwSI) in mental health, both practical and theoretical. These are set out in detail in the RCGP’s *Guidance and competences for the provision of services using practitioners with special interests: mental health*.

Examples include:

- Experience of working in relevant departments
- Self-directed learning (with supporting evidence)
- As a GP specialist trainee undertaking a six-month specialist attachment
- Attachment to a mental health provider unit or under the supervision of a specialist practitioner
- As part of a recognised university training course.

Good communication and the ability to be

empathetic and non-judgemental with patients, carers and colleagues are among the key characteristics for a GPwSI in mental health. Other skills practitioners may have include leadership/coordinating care, managing clozapine in the community, physical health monitoring and understanding the special needs of care relevant to special circumstances and special groups, such as:

- Elderly care and mental health
- Maternal and post-natal care
- Providing care within a custodial setting
- Management of delivery of mental health care
- Mental Health Act (Section 12) approval.

GPwSIs are expected to maintain their competences by keeping a personal development portfolio. It’s also recommended to work regularly within the specialist area to experience a varied case mix, be actively involved in local mental health specialist services, and contribute to local clinical audits.

## The job

GPwSIs in mental health may choose to work in a general practice setting but their skills can be applied further afield, such as in specialist medication clinics, residential care, prison healthcare, elderly care homes and other mental healthcare settings.

The type of care specialists can provide is broad and can include complex therapy for people with mental health problems and those with significant co-morbidities. This may involve areas such as eating disorders, pre and peri-natal mental health, early intervention in psychosis services and medical input to multidisciplinary primary care mental health teams. They may also help those with medically unexplained symptoms, treatment resistant symptoms, long-term medical conditions, and in older people’s mental health. GPwSIs can also provide specific psychological therapeutic interventions such as CBT, systemic or family therapy.

GPs with a special interest are often active





# MIND



## Q&A

Dr Henk Parmentier,  
London-based GP  
with a special  
interest in mental  
health

in leadership and education roles, for example as a mental health champion within their own practice or wider community, and through sharing expertise with other primary care organisations or practitioners.

One of the key messages in the RCGP's 2014 statement, *Care of people with mental health problems*, is that: "An exploration of physical, psychological, social, cultural and spiritual issues should be integrated into both the consultation and the management of illness; cultural issues can impact on how mental health issues present and the acceptability of diagnosis."

*"GPs have a key role in recognising patients' mental as well as physical health needs"*

### The future

Mental healthcare in primary care has been referred to as the "Cinderella of the health system", but the signs suggest that change is afoot. Government policy seems to be placing a greater emphasis on mental healthcare provision, while in 2014 the RCGP made mental health and whole-person care a five-year UK-wide priority. The College says this move is "intended to encourage learning and development in mental health, as well as an environment in which quality improvement in mental health can flourish."

### Sources

- RCGP – *Guidance and competences for the provision of services using practitioners with special interests: mental health*: [tinyurl.com/glbs4fo](http://tinyurl.com/glbs4fo)
- RCGP 2014 statement – *Care of people with mental health problems*: [tinyurl.com/h8ncvk8](http://tinyurl.com/h8ncvk8)
- RCGP mental health resources: [tinyurl.com/n5dgvcu](http://tinyurl.com/n5dgvcu)

#### • What attracted you to mental health as a specialty?

Mental health is the most common "illness" in primary care so if, as a GP, you want to help patients, you need to be aware of mental health. Mental disorders are found in all countries, in women and men, at all stages of life, among the rich and poor, and in both rural and urban settings. Up to 60 per cent of people attending primary care clinics have a diagnosable mental disorder and 90 per cent of all mental health problems are looked after in primary care. Only about 25 per cent of all people with mental health problems receive ongoing treatment and most chronic illnesses are co-morbid with mental health problems like anxiety and depression.

#### • What does your role involve?

Seeing patients who are referred to me by my GP colleagues in the surgery where I work. I also run a specialised mental health/wellness clinic for the local GP federation. I organise educational events and lecture to clinicians about mental health.

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

Seeing my patients and lecturing.

#### • Are there any downsides?

There is a risk of being too much focused on mental health issues.

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

Closing the gap between primary and secondary care is a challenge. Another is reducing the excessive mortality for patients with a mental health illness: people with conditions like schizophrenia, bipolar disorder, and major depression die, on average, 25 years sooner than those without mental health problems.

#### • What about the role has most surprised you?

How with simple advice and interventions you can improve health so much.

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

Seeing how over time a homeless alcoholic person returned to being an independent person with a meaningful job, living by himself.

#### • What advice would you give to a trainee GP thinking about specialising in mental health?

Do it! Primary care mental health is the only "special interest" that will help most of your primary care patients both with physical and mental problems.



# VIRTUAL CARE



PHOTO: TIM DUNK

Self-confessed geek **Dr Keith Grimes** talks about his mission to more fully integrate digital technology into the GP consulting room

His fascination for digital innovation began as a boy while living in the global technology hub of Singapore, now three decades on Dr Keith Grimes has gone from gamer and geek to digital healthcare innovator.

Speaking on his work smartphone – which he uses daily to help treat patients at his East Sussex surgery – it's clear that Dr Grimes has a passion for the digital revolution.

"I was a geek and a gamer long before I was a doctor," he says. "I am always trying to bring it into what I do but I appreciate that if I want to share the positives, I have to do it in the most lightweight way."

"Doctors use the internet, WhatsApp – all those different technologies outside work – yet think that they can't use it in work. There are of course important considerations around data protection and confidentiality, but that doesn't mean that you cannot do it."

## Integrating technology

In demand as a conference speaker at home and abroad, Dr Grimes offers a telling example of how technology can be integrated into general practice to enhance patient care. His smartphone is fast becoming as vital a diagnostic tool as traditional tools like the stethoscope.

The 43-year-old says: "I use my mobile phone for a lot of what I do either for information storage, contacting colleagues or, more recently, as a medical device. I use Cupris, a digital otoscope, to look inside people's ears and take photos and videos that I can share with the patient, which a normal otoscope does not do."

"I can then securely transfer that image on to the clinical system or share to NHS.net or with ENT colleagues. I have even avoided an unnecessary patient hospital admission because I was able to send an image to the ENT doctor for his opinion."

"I also use the CE-marked AliveCor Kardia Mobile ECG machine on my phone (where appropriate) to identify atrial fibrillation (which significantly increases a patient's risk of a stroke) or palpitations."

An active social media user, with his own Twitter account (@keithgrimes), website and blog ([www.drgrimes.co.uk](http://www.drgrimes.co.uk)), Facebook page ([www.facebook.com/groups/vrdocs](https://www.facebook.com/groups/vrdocs)) and a member of numerous WhatsApp groups, Dr Grimes regularly communicates electronically with other GPs and consultants, while some patients choose to consult with him via email and Skype. This easy accessibility can encourage patients who may otherwise have avoided a GP surgery to seek medical attention.

## Managing risks

As well as benefits, there are of course medico-legal risks to consider and doctors must proceed with caution before using digital technology in healthcare. Key risks relate to data protection, patient confidentiality and informed consent and doctors should be sure to comply with the IT policies of their employing organisation or contracting body, as well as the GMC's *Confidentiality* guidance and the Data Protection Act.

Before sharing any patient information, Dr Grimes secures informed patient consent and shares only anonymised information with colleagues via private messaging groups, across encrypted channels. The GMC advises "recordings made as part of the patient's care form part of the medical record and should be treated in the same way as written material in terms of security and decisions about disclosures." Lost or stolen devices pose a particular risk so it is not advisable to store confidential patient information on personal smartphones/devices.

The doctor, who qualified at the University of Aberdeen, is also quick to advise patients on protecting their private data.

He says: "Patients often take healthcare-related pictures on their phone to show me without realising that many smartphones automatically back up to the Cloud, meaning images may be seen on devices used by other family members. I advise them about ways to do this safely but, while I can guarantee the security of my NHS net email account, I cannot say how secure my patients' emails are."

## Virtual benefits

Looking ahead, Dr Grimes has even bigger ambitions. He plans to make greater use of his "personal favourite technology" – virtual reality (VR).

As unlikely as it sounds, VR is already proving a successful means of reducing pain during procedures such as blood tests, dressing changes and joint injections. One recent patient who was anxious about a dressing change for a back wound agreed to don the VR headset.

"She watched a short video, *An Introduction to VR*, and it was amazing," Dr Grimes says. "She was giggling while the nurse was packing the wound. We asked at the end 'Could you feel it?' and she said she could but it wasn't anywhere near as bad."

VR gives the illusion of being elsewhere which means it not only distracts the patient but can reduce anxiety and heart rate. Anxiety

about pain can exacerbate the sensation so this method helps to reduce the level of pain experienced.

Dr Grimes' practice uses Samsung's Gear VR technology around three times a week and he will soon explore the use of VR in reducing post-operative delirium in ICU as part of an NHS clinical trial.

## Wider adoption

Introducing new systems or technologies can bring extra pressures for already-overworked practices, so how does Dr Grimes propose to convince the unconverted?

"All of this is possible with the technology that you and your patients already have," he says. "I would hate to add something that made a person's life harder, but the fact is that more and more patients will want to use technology and they will want doctors to help them."

Dr Grimes is set to speak at a conference in Hanover about the "gamification of healthcare" and how computer game technology can be used to improve patient outcomes, for example via apps to monitor fitness

or in the self-management of chronic conditions.

He acknowledges that many people may feel games technology has no role to play in healthcare, but he disagrees and believes it will deliver genuine benefits. He adds: "Whether we want it or not as GPs, change is coming and it's important for us to integrate what works, and in a responsible way."

## Looking ahead

Looking to the future, even more sophisticated technologies may be used in healthcare. Dr Grimes will soon virtually visit patients in care homes. And, we could see a reduction in face-to-face doctor/patient consultations as virtual clinics and artificial intelligence (AI) become more widely adopted by healthcare providers.

While doctors should not rely too heavily on virtual consultations due to their limitations, Dr Grimes predicts

virtual clinics will become more widespread and care will soon be managed by "moving the data, rather than the patient."

Longer term, he sees a greater role for AI: "We will be able to access specialised systems supporting the role of the doctor (and the patient) where the expert opinion will come from a machine as opposed to a human."

Some technology proponents believe AI could eventually exceed the ability of a human to diagnose. Dr Grimes predicts that in 20 to 30 years' time, the boundaries between general practice and secondary care will become "blurred", as will those between "human and non-human providers" of that information. "Think chatbots like Apple's Siri and Amazon's Alexa," he says, adding that he hopes the quality of patient care would not be compromised.

Some may find Dr Grimes' predictions daunting, but he says innovation should not be feared. "The optimistic view is that it will massively augment our ability to provide excellent patient care. Yes, we may lose some things, but we will gain more time, something every doctor wishes they had."

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



*"We could see a reduction in face-to-face consultations as virtual clinics become more widely adopted"*



# MEDICINE AT YOUR FINGERTIPS

With so many medical apps on the market, doctors have to be increasingly careful in deciding which ones are worth downloading

**T**HE world of medical apps is an ever-expanding one populated by both the ingeniously innovative and the downright dodgy.

Who knew you could cure acne using the light from a mobile phone or augment breast size by blaring baby cries out of your device 20 times a day? Others claim to allow users to select the sex of their baby by entering certain times, dates and phases of the moon.

While the market is awash with apps making all manner of dubious medical claims, there are many that have proved popular with clinicians. There are tools to assist diagnosis, staging or treatment (such as calculating fluid requirements for burns patients), as well as countless others that can help monitor and promote general health and wellbeing.

## Quality markers

With so much choice, it is important that doctors take a cautious approach, researching as much as possible the app's origins and reliability and looking out for positive/negative reviews by fellow healthcare professionals.

Health secretary Jeremy Hunt recently announced a multi-million pound package of measures to "fast track digital excellence and improve the digital skills of the NHS workforce". As part of this new campaign, NHS England has pledged to launch a library of NHS-assessed apps which aims to make selection easier.

Another helpful guide is to look out for the CE mark, indicating it complies with essential criteria set out under European law. This applies specifically to apps with a medical purpose (i.e. those supporting diagnosis or clinical decisions) which are defined by law as "medical devices" and regulated in the UK by the MHRA.

The first app to be officially registered by the MHRA was Mersey Burns. It is a popular clinical tool for estimating burn area percentages, prescribing fluids using the Parkland formula, and recording patients' details (being mindful of confidentiality). It was developed by plastic surgeons at St Helen's and Knowsley NHS Trust and has won a number of innovation awards as well as favourable reviews.

In its April 2015 guidance *Using apps in clinical practice*, the Royal College of Physicians of London says doctors should not use medical

apps, including web apps, that do not have a CE mark. It is worth ensuring that the specific version of the app you are using is CE marked, rather than relying on the general information in the online app store.

Apps which do not require a CE mark are those which do not use patient-specific information and only perform administrative functions. This might include those offering general guidance or supporting training. While it is a useful indicator, the RCP goes on to state: "Unfortunately, even if an app has a CE mark, that does not mean that it meets best practice, has been tested for accuracy or benefits in clinical use, or is applicable to the patient/decision for which it is being used."

Most importantly, the College adds: "Always exercise professional judgement before relying on information from an app."

## Popular apps

So what are some of the commonly used apps for doctors on the market? Those listed below have received positive reviews but doctors are advised to carefully consider any app used in clinical practice. And if you access a smartphone app in front of a patient, it may be worthwhile quickly acknowledging this - MDDUS has dealt with a number of complaints from patients who wrongly assumed their doctor was rudely texting mid-consultation.

The following are in no particular order (and MDDUS doesn't endorse or approve any app):

# OUR FINGERTIPS

## **NICE (National Institute for Health and Care Excellence)**

*FREE; for Apple and Android devices*

Access all NICE guidance on a variety of conditions and diseases as well as on public health topics such as smoking cessation and diabetes prevention. Browse by topic or type of guidance, search for keywords, or revisit bookmarked pages. Specific chapters or an entire guideline can be easily shared by users via email.

## **NICE BNF**

*FREE; Apple and Android*

Available to NHS staff in England, Scotland and Wales, this offers a useful offline reference for the *British National Formulary*. There is up-to-date practical information on prescribing, dispensing and administering medicines that can be easily searched or browsed. An NHS Athens account is required to activate the app. Described as useful by many, although some recent reviews have complained of technical glitches/crashing.

## **My GMP**

*FREE; Apple and Android*

This new app from the General Medical Council offers easy access to core guidance *Good Medical Practice*. It has a quick search function and users can favourite paragraphs, get alerts on monthly "hot topics" and link to online case studies to help apply GMC guidance in practice.

## **MIMS (Monthly Index of Medical Specialties)**

*£9.99 for a 12-month subscription to content updates; Apple and Android*

MIMS is described as the essential prescribing and drug reference guide. For over 50 years it has provided medical professionals with information on UK-licensed medicines, including drug dosages, warnings, contraindications and adverse events. It is said to be accessed over 450,000 times every month by UK GPs. The app downloads the whole database to your device (no internet access required) which can be easily searched from anywhere in the app.

## **SIGN (Scottish Intercollegiate Guidelines Network)**

*FREE; Apple and Android*

This app was downloaded more than 8,000 times in its first two months of release. It features Quick Reference Guides (QRGs) on a selection of SIGN guidelines, including those for the management of atopic eczema, rheumatoid arthritis, venous thromboembolism, and psoriatic arthritis in adults. The QRG content is enhanced with material from the main guideline and online resources, linked to the SIGN website. Each new SIGN QRG will be added as an update as it is published, building into a complete library. The app also features keyword search, bookmarking and in-app access to the SIGN website.

## **Patient.co.uk**

*FREE; Apple and Android*

Search their database of more than 900 patient information leaflets on health, conditions and diseases and quickly locate health services in your area (England only). Browse by category and bookmark and share concise summaries/diagrams useful for explaining conditions in plain English.

## **GPnotebook**

*One-off payment of £27.99; Apple*

This "online encyclopaedia of medicine" offers quick access to a database holding more than 26,000 pages of information. Users can make annotations and search the resource by keyword or browse by topics such as "cardiovascular" or "chest medicine". GPnotebook account holders can synchronise annotations and other personal data held in the app with their online account.

## **Cancer Referral Guidelines - Quick Reference Guide**

*FREE; Apple and Android*

This aims to help doctors make referrals for patients with a suspected cancer. The guidelines are searchable and grouped by cancer type. The app is based on the Scottish Referral Guidelines for Suspected Cancer.

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*Joanne Curran is an associate editor of GPST*

## TREATMENT

ONE **PATCH** TOO MANY**DAY ONE**

Ms P is 45 years old and has suffered with osteoarthritis for a number of years. She attends a new GP – Dr T – complaining of depression and tiredness in addition to pain in multiple joints. Recent blood tests to check for inflammatory joint disease proved normal. The GP notes fibromyalgia as a possible diagnosis and modifies the patient's existing pain relief from co-codamol to tramadol, following NICE guidelines. A further review is arranged.

**WEEK TWO**

Ms P returns to the surgery and reports "feeling weepy all the time with weakness and pain". Dr T increases the tramadol dose, along with adjuvant analgesia amitriptyline to be taken at night. Ms P is referred to the local rheumatology department.

**WEEK FIVE**

A consultant rheumatologist supports the diagnosis of osteoarthritis with fibromyalgia and arranges a bone scan. He discusses with Ms P lifestyle issues including weight reduction and gentle exercise – and also use of BuTrans (buprenorphine) opiate patches. She is commenced on the patches, 5ug/hour, replaced every 72 hours.

**MONTH EIGHT**

Dr T is on holiday so Ms P is seen by a GPST – Dr N. The patient complains the new patches are not working and her pain is worse. Dr N reviews the history and increases the dose to 50ug fentanyl. He then arranges for Ms P to re-attend for review. Two weeks later she sees Dr T again and reports that although there is still some pain she is now coping.

**MONTH SIX**

Ms P attends Dr T twice in the intervening period and reports the patches are helping with the pain but the GP notes that the patient has developed a skin rash. Suspecting an allergic reaction she changes the prescription from BuTrans to fentanyl patches at a dose of 25ug per hour and this is later adjusted to 37ug per hour.

**MONTH 15**

In the intervening period Ms P visits the surgery once and consults with Dr N in regard to a throat infection but there is no discussion of her ongoing pain. Later she consults again with Dr T and reports having lost some weight and other symptoms, including insomnia, "restless legs" and difficulty concentrating at work. Having researched these online, Ms P has concluded she is suffering from opiate withdrawal – and as such she has been changing her patches every 48 instead of 72 hours. Dr N refers Ms P to a pain management clinic but in the meantime ups the dose of fentanyl to 75ug every 72 hours. Five days later Ms P attends the pain clinic and it is confirmed she is suffering from opiate withdrawal.

**MONTH 19**

Discussing her situation with a nurse consultant in pain management Ms P decides to go "cold turkey" and ceases using the fentanyl patches. She suffers withdrawal symptoms over three weeks, including sweats, shivers, vomiting and hypersensitivity. The pain clinic advises a range of non-opiate treatments, including cognitive behaviour therapy, and Ms P gradually improves and is better able to manage her pain.

A LETTER of claim arrives at the surgery from lawyers acting on behalf of Ms P alleging clinical negligence against Dr T and Dr N in failing properly to review her opiate medication and make a timeous referral to a pain clinic. The claim contends this led to opiate dependency and severe withdrawal symptoms.

MDDUS represents the GPST – Dr N – and an expert in primary care is instructed to provide an opinion. In regard to Dr N's decision to increase the dosage to 50ug the expert observes that the patient had already been established on opiate treatment following clear diagnosis by a consultant rheumatologist. His view is that Ms P was in effect undergoing an "up titration" of dosage in line with BNF recommendations.

In regard to Dr N's failure to refer on two occasions, the expert can see no valid reason to have involved a pain clinic in the patient's care. A referral might be appropriate near the top end of opiate dosage scales but Ms P's fentanyl use was in the mid to low range. Nor could the case be considered so particularly complex as to require specialist care.

Further expert opinion is supportive of both GPs in the case. Ms P was encouraged to attend for regular review and adjustment of her pain control. The only possible criticism is a lack of documented evidence of discussion of the potential hazards associated with opiate use, including addiction risk.

MDDUS drafts a letter of response to the claimant solicitors and the case against Dr N is dropped. A small settlement is agreed in Dr T's case.

**Key points**

- Make patients aware of the risks involved in long-term opiate treatment.
- Ensure there is a record of such discussions.
- Have systems in place for regular medication review.



# 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...

● **HISTORICAL DIAGNOSIS** Eighteenth century medicine is not known for its sophistication (the stethoscope was only invented in 1816), but it seems one clinician was ahead of his time. Doctors from London's Royal Marsden Hospital recently reviewed patient samples and case notes left by Scotsman John Hunter, one of medicine's most influential surgeons. Hunter had treated a patient in 1786 who had a "tumour as hard as bone", a diagnosis (of osteosarcoma) confirmed by the Royal Marsden team. Indeed, they said they were "amazed" at Hunter's insight and told BBC News: "I think his diagnosis is really impressive and in fact his management of the patient followed similar principles to what we would have done in the modern day." Mr Hunter amputated the man's leg but he died seven weeks later. The autopsy showed bony tumours had spread to his lungs, the lining of the heart and on the ribs. There are plans to review more of Hunter's historical samples which are preserved at the museum named after him - the Hunterian in London.

● **DOG DOSH** A dog owner is pursuing her dream career in medicine after training her husky to pose for pictures. Grumpy Anuko's fur pattern gives him a natural steely glare and he has taken social media by storm, notching up almost 40,000 Instagram followers and millions of YouTube views. The three-year-old has been showered with gifts and is even in demand for modelling jobs. Owner and budding doctor Jasmine Milton, 21, of Shropshire, has so far coined in £20,000, which she is using to fund a place at medical school.

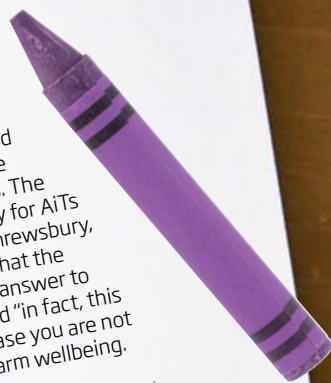
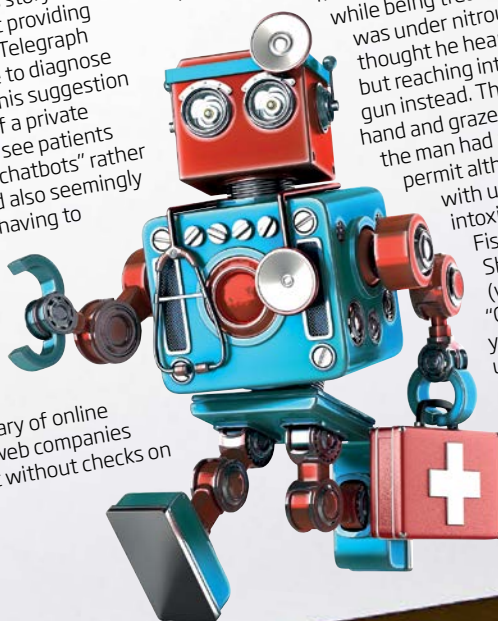
● **ROBOT WARS** Another day, another news story suggesting technology will soon be better at providing healthcare than actual human doctors. The Telegraph reports claims that robots will "soon be able to diagnose more accurately than almost any doctor". This suggestion comes (unsurprisingly) from the founder of a private company bidding for contracts that would see patients encouraged to seek medical advice from "chatbots" rather than a living person. Full diagnoses would also seemingly be offered via smartphone without ever having to see a GP. Patients could key in their symptoms and artificial intelligence would assess the urgency of each case, deciding whether users should be sent to A&E, a pharmacy or just rest at home. The Care Quality Commission has waded into the debate by urging consumers to be wary of online services after an inspection of two web companies found drugs were being handed out without checks on patient identities or side effects.

● **DOC DRIVERS** Doctors are apparently the third worst drivers by profession, according to a recent report. Insurers 1st Central analysed claims in 2015 and found medics were amongst the most accident-prone, just behind solicitors and accountants. Financial advisers, letting agents and train drivers were also amongst the top 10 professions most likely to have an accident.

● **PASS THE PURPLE CRAYON** Looking for realistic solutions to the problem of low GP morale and burnout? Not long ago it was revealed that the RCGP is considering issuing members with "wellbeing" packs including a bag of chocolate coins, some teabags, a "mindfulness colouring book" and a "gratitude journal" for noting down all the things GPs can be grateful for in their lives. The packs are purported to be intended mainly for AITs (Associates in Training) and Dr Duncan Shrewsbury, chair of the RCGP's AIT Committee, said that the college is aware that this is not the only answer to the problems facing general practice and "in fact, this is clearly stated in the packs" - just in case you are not immediately swept away in a tide of warm wellbeing.

● **EMAIL MELTDOWN** Cringeworthy though the recent Oscar envelope gaffe might be - pity the poor health worker who last November accidentally sent a test email to all 840,000 NHS staff, thus paralysing the system. A spokesman explained that the disruption was "due to an NHS Mail user setting up an email distribution list which inadvertently included everyone on the NHS Mail system". The problem was further exacerbated by some recipients clicking "Reply all" and further choking up the system.

● **ROOTIN' TOOTIN' SHOOTIN'** Providing healthcare in the UK does come with its risks but thankfully these do not include patients packing loaded pistols. A 72-year-old man in Ohio is reported to have shot himself while being treated in a dental chair. He was under nitrous oxide sedation and thought he heard his mobile phone ring but reaching into his pocket grabbed his gun instead. The bullet went through his hand and grazed his stomach. Amazingly the man had a legal concealed carry permit although he may be charged with using a weapon while intoxicated. Sgt. Christina Evans-Fisher with the Clark County Sheriff's Office commented (without discernible irony): "Going to a doctor's office where you might possibly be placed under some kind of medication that may alter your mental status at that point, you might not want to carry a weapon in there at that time."







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