GPst

ISSUE 17

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AN MDDUS PUBLICATION

MDDUS
UK INDEMNITY, ADVICE & SUPPORT

Welcome to your GPst

FEW professions out there allow access to the most personal aspects of an individual's life. Doctors are no doubt in a privileged position and therefore turst is the cornerstone of any doctor-patient relationship. Our article on **page 12** looks at maintaining appropriate professional boundaries.

Physician associates are an increasingly common sight in GP practices. While they are well known in the US, they are still a relatively unknown quantity in the UK. Our article on **page 4** takes a closer look at this new medical professional. Another key team member is the locum GP – but what is the job like? Locum GP Surina Chibber shares her insights on **page 8**.

Online prescribing can be a convenient and effective way to provide patient care but there are risks. On **page 5**, MDDUS medical adviser Dr Naeem Nazem highlights issues such as providing prescriptions without a face-to-face examination or full patient information. Computer alerts pop up multiple times a day in practice, but don't be too quick to dismiss them. Senior risk adviser Liz Price explains why on **page 7**.

Would you know what to do if a patient presents with a dental emergency? Risk adviser Lindsey Falconer has practical advice on **page 6**.

When he's not working at a busy practice, GP Rob Ewing imagines himself as a 10-year-old girl on a post-apocalyptic island or perhaps as a Victorian anorexic. On **page 10** he tells *GPST* about his 'other' calling as an award-winning author. Our case study on **page 14** follows a woman presenting with abdominal pain having recently had a positive pregnancy test.

• **Dr Susan Gibson-Smith**
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TWO IN FIVE GPs HAVE A MENTAL HEALTH PROBLEM

FORTY per cent of GPs suffer a mental health problem such as depression, anxiety, post-traumatic stress disorder or bipolar disorder.

A survey of over 1,000 GPs by mental health charity Mind also found that more were likely to look for mental health support from friends and family (84 per cent) or their own doctor (77 per cent), rather than colleagues (45 per cent), practice managers (30 per cent) or professional bodies such as the GMC (one per cent).

Mind is calling on the government and NHS to tackle the work-related causes of stress and poor mental health, such as excessive workload and long hours. It is also calling on clinical commissioning groups (CCGs) and GP practices to ensure the whole primary care workforce (including practice managers, reception staff and practice nurses) receives appropriate support when needed and has workplace policies and procedures in place to better promote staff wellbeing.

RCGP chair Professor Helen Stokes-Lampard added: "More needs to be done to solve the root cause of the untenable workload and pressures that GPs are dealing with, and that means more resources, and more doctors and practice team members working in UK general practice."

EXPANSION OF ELECTRONIC PRESCRIBING IN ENGLAND

ELECTRONIC prescribing in GP surgeries and pharmacies in England is to be expanded, bringing estimated savings of up to £300 million for the NHS by 2021, according to the government.

Use of electronic prescribing by GP surgeries has grown from less than one per cent in June 2010 to 63 per cent in June 2018. More than 6,000 GPs are now able to upload prescriptions electronically, which can be downloaded by a pharmacist, saving time for staff and patients.

Thousands of paper prescriptions are still issued each year but changes to current regulations are to be made later this year to expand electronic prescribing for nearly all prescriptions.

Health and Social Care Secretary, Matt Hancock, said: "We need to harness technology across the NHS to improve care, save time for patients and make the lives of hardworking staff easier."

WALES TO GET NEW GENDER IDENTITY SERVICE

TRANSGENDER patients in Wales will be able to access care services closer to home, health secretary Vaughan Gething has announced.

Currently all patients who present with gender dysphoria are referred to the London Gender Identity Clinic, where they are assessed and provided with a treatment plan.

But from the end of October 2018, a new Welsh Gender Team will begin seeing patients, considerably reducing travel time and costs. In the meantime, a specialist GP will be available from next month to help patients in the Cardiff and Vale area who have experienced difficulty in accessing medicines recommended for them by the London clinic.

Mr Gething said there had been increased demand for transgender health services in Wales in recent years, prompting an annual investment of £500,000 to improve gender identity services in the country.

He said: "This announcement is a positive step towards the fully integrated service I expect to be in place next year."

GMC GUIDANCE ON REFLECTIVE PRACTICE

REFLECTIVE notes do not need to capture full factual details of an experience but should focus on learning or actions taken from a case or situation, says GMC guidance published to reassure registrants in light of the Bawa-Garba case.

The new guidance has been developed jointly by the GMC, the Academy of Medical Royal Colleges (AoMRC), the Conference of Postgraduate Medical Deans (COPMeD) and the Medical Schools Council. It confirms the importance of reflection for personal development and learning and highlights how reflection can help maintain and improve standards of professional practice, helping to drive improvements in patient safety.

Key advice also includes:

- Reflection is personal and there is no one way to reflect.
- Having time to reflect on both positive and negative experiences is important.
- Group reflection often leads to ideas that can improve patient care.
- Tutors, supervisors, appraisers and employers should support individual and group reflection.

The guidance acknowledges that recorded reflections, such as in learning portfolios or for revalidation or continuing professional development purposes, are not subject to legal privilege and disclosure might be requested by a court if considered relevant. But it states that the GMC does not ask a doctor to provide reflective notes in order to investigate concerns, as the focus in fitness to practise investigations is on "facts and evidence relating to a serious allegation".

It adds: "Following a significant event or a serious incident, factual details should not be recorded in reflective discussions but elsewhere, in accordance with each organisation's relevant policies."

NICE GUIDANCE ON ANTIBIOTIC TREATMENT OF COUGH

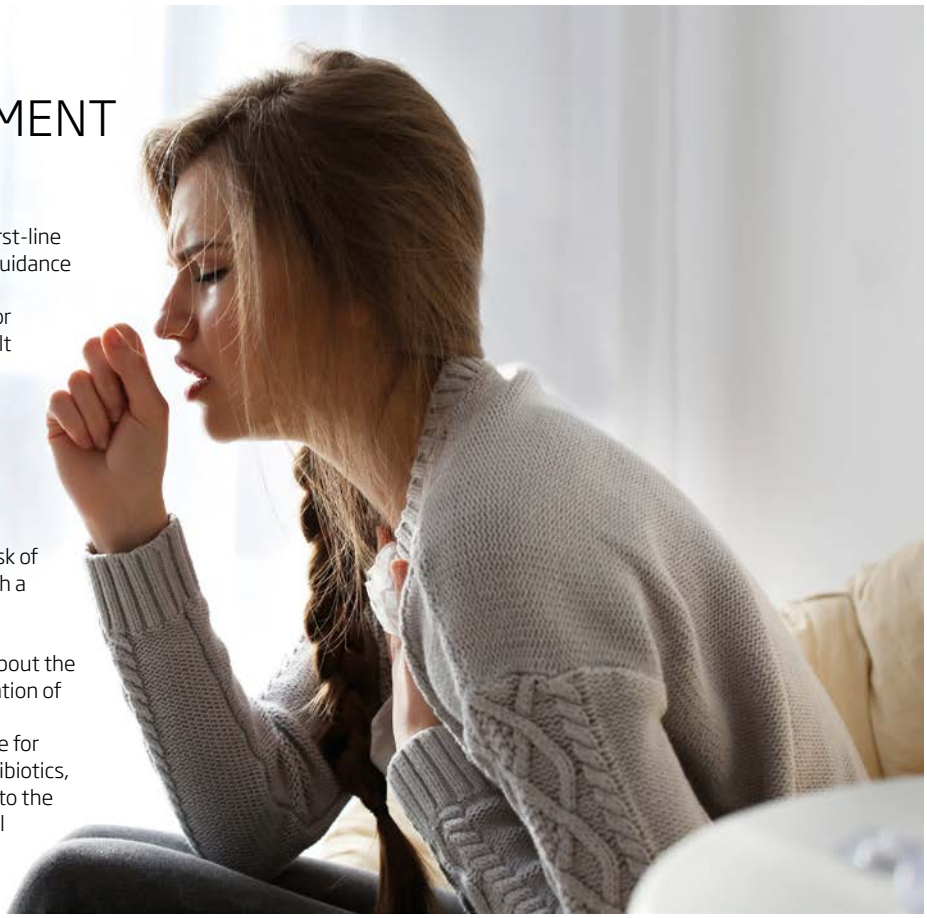
ANTIBIOTICS should not be administered as first-line treatment for cough, according to new draft guidance by NICE and Public Health England.

Patients should be advised to take honey or over-the-counter cough medicines and consult their GP if the cough persists for longer than three weeks. The reasons for not giving an antibiotic should be clearly explained and advice given to the patient on appropriate self-care.

An antibiotic may be necessary for acute cough when a person has been identified as being systematically unwell or if they are at risk of further complications, for example people with a pre-existing condition such as lung disease, immunosuppression or cystic fibrosis.

The draft guidance provides information about the most appropriate choice of antibiotic and duration of the course.

Professor Mark Baker, director of the centre for guidelines at NICE said: "When prescribing antibiotics, it is essential to take into account the benefit to the patient and wider implications of antimicrobial resistance, only offering them to people who really need them."



HELP NOT HINDER

Physician associates are an increasingly common sight in general practice – but who are they and are they a good thing for primary care?

THEY are the new medical professionals on the block and hopes are high that physician associates (PAs) will play a key role in solving the UK's GP recruitment crisis.

But alongside the optimistic narrative of lightening GP workloads and improving continuity of care are fears they could be used as a low-cost replacement for doctors and nurses by employers who are struggling to balance budgets and fill rota gaps.

While PAs are well-established in the US healthcare system, they are still a relatively unknown quantity in the UK, where they are subject to voluntary rather than compulsory regulation.

In 2017 there were less than 600 qualified PAs in the UK, but this is expected to rise as high as 3,200 by 2020. An estimated 350 are currently working in primary and secondary care with another 550 in training. The Department of Health and Social Care (DHSC) and Health Education England (HEE) have said they want to see 1,000 PAs recruited to primary care roles by 2020. In Scotland, a 2013 pilot scheme saw the introduction of PAs into the secondary healthcare system, largely to carry out tasks that junior doctors do.

Who are they?

The Faculty of Physician Associates (FPA) at the Royal College of Physicians describes PAs as a new generalist healthcare professional that is medically trained, working alongside doctors and providing medical care as an integral part of the multidisciplinary team. It adds: "Physician associates are dependent practitioners working with a dedicated medical supervisor, but are able to work autonomously with appropriate support."

In the UK, PAs must complete a two-year postgraduate diploma. They must already have a degree in a life or healthcare science and health service work experience. Students must complete at least 1,600 hours of clinical training across a range of specialties such as community and general medicine, mental health, obstetrics and gynaecology, and paediatric services.

Complementary

One point that is made clear is that PAs are not doctors. Professor Steve Heys, course director of the first Scottish pilot scheme, put it bluntly when he told *BBC Scotland*: "They are not doctors on the cheap." The FPA also stresses that they are "complementary to GPs rather than a substitute."

This notion of debunking PAs as cheap replacements for GPs is highlighted in the FPA's *An employer's guide to physician associates*. In it, the Faculty warns it is "imperative" that PAs are not employed where an alternative healthcare professional such as a GP or practice nurse would be better suited.

The FPA explains: "PAs can fulfil an enabling role in general practice, taking on certain areas of workload, helping to free GPs [and other staff] to focus on the more complex patient cases.

"This does not mitigate the need to address the shortage of GPs or reduce the need for other practice staff. Instead PAs can help to broaden the capacity of the GP role and skill mix within the practice team to deliver patient care."

Clear plan

Another key concern lies in defining PAs' scope of practice. The FPA urges employers to write a clear job plan and says supervision from a GP is crucial, particularly for newly qualified PAs.

As the Faculty says in its guidance, the level of competence at which the PA can work will depend on their skills and experience, and that of their supervising GP. It reassures that "all PAs are trained to be aware of the level of their clinical competence, and to work within their limits accordingly."

The guide details the various jobs that PAs can do. It describes how they can assess, manage and treat patients with a variety of acute and chronic conditions, as well as offering rebooked appointments. PAs can triage patients, carry out telephone consultations, make referrals, and review and act on laboratory results. Many also carry out home visits or visit nursing and residential homes. Some offer specialised clinics following appropriate training, including family planning, baby checks, COPD, asthma, diabetes and anticoagulation. PAs are also able to teach and supervise students.

Registration

While there is still no formal statutory register for PAs, the FPA operates the Physician Associate Managed Voluntary Register (PAMVR). It "strongly encourages" all qualified PAs to join the register and all employing organisations to ensure their PAs are registered.

A registering body has not yet been chosen but both the General Medical Council (GMC) and the Health and Care Professions Council have expressed an interest. The GMC has also said that doctors should not be asked to subsidise the process.

Similarly, the Faculty states that PAs "must take out professional negligence insurance" from a medical defence organisation, or ensure they are covered under a general practice group arrangement.

So while there is much to be hopeful about the use of PAs in general practice, the success of this new healthcare professional will likely depend on whether employers are willing to commit the necessary time and resources to support them.

Sources:

- NHS England case study – **tinyurl.com/yb7tsvyx**
- An employer's guide to physician associates – **tinyurl.com/y96smw64**
- Faculty of Physician Associates – **www.fparcp.co.uk**

Joanne Curran is managing editor of GPST

ONLINE PRESCRIBING RISKS

MDDUS medical adviser **Dr Naeem Nazem** highlights some key risks in prescribing medicines online

PRESCRIBING errors constitute one of the top risk areas for general practice and account for 13 per cent of all GP claims reported to MDDUS. The harm caused by incorrectly prescribed or unmonitored medication can be serious and long lasting.

When it comes to online prescribing, the risks become even greater, especially if GPs don't have a face-to-face consultation prior to issuing the prescription. GPs must therefore be mindful of these additional risks and, where necessary, take measures to ensure patient safety isn't compromised.

A recent report from Care Quality Commission (CQC) inspectors found that 43 per cent of independent online primary care services in England are not providing 'safe' care. Among specific concerns, inspectors found that some online providers were not collecting patient information or sharing information with a patient's NHS GP, who should have an accurate and up-to-date record of their previous and current treatments and health issues. They also found inappropriate prescribing of antibiotics for long-term conditions as well as prescribing high volumes of opioids issued without prior discussion with the patient's registered GP.

Each prescriber takes responsibility for the prescriptions they issue, so doctors must be prepared to explain and justify their decisions and actions when prescribing, administering and managing medicines. When it comes to online prescribing, GPs may not have access to a patient's relevant medical history or usual medications. They may also find it difficult to ensure their involvement in the patient's ongoing medical care is accurately recorded in their usual medical records, significantly increasing the risk of inappropriate prescribing.

In circumstances where the GP hasn't physically seen the patient they need to be alert to the risk of people purporting to be someone they are not. It may be appropriate to undertake additional due diligence in these instances, such as asking the patient additional questions to confirm their identity.

Although it would be prudent to record such questions in your records, it may be more helpful for practices to adopt a policy for online prescribing for practice patients which incorporates these checks and is used as standard. It is worth checking with a senior colleague or practice manager whether your practice has such a policy in place.

Many GPs implement an online prescribing system which asks a checklist of questions before a prescription can be issued. In the event you use such a system, you need to ensure it is appropriate for each medication issued and allows you to ask more questions or speak to the patient in person if required. GPs should consider if they have the same information they would want to be aware of if they were seeing that patient face-to-face.

The GMC underlines this point in its guidance *Prescribing and managing medicines and devices*, saying: "Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent".

Ultimately, the final decision to prescribe should always be a clinical assessment by the doctor rather than relying solely on an online system.

It is worth adding here that nonsurgical cosmetic medicinal products such as Botox, Dysport or Vistabel or other injectable cosmetic medicines cannot be prescribed online. The GMC requires doctors to undertake a physical examination of patients before prescribing these, adding: "You must not therefore prescribe these medicines by telephone, video-link, or online."

There is also a risk that a patient may be seeking online prescriptions from several sources. It is important all doctors prescribing online are alert to these risks, particularly if the medication requested has the potential for abuse or is associated with potentially serious side effects.

Abuse of prescribing is taken very seriously by the GMC. Your practice should have robust systems in place for the issuing and review of prescriptions, particularly for drugs which may be abused. These systems should cover all prescriptions and should include regular tailored audits.

Doctors must provide effective treatments based on the best available evidence. GMC guidance *Good Medical Practice* advises that doctors should: "Prescribe drugs or treatment only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs."

Finally, always communicate your decision to prescribe (or not) effectively to patients to avoid unnecessary complaints. If you do not feel you have the appropriate knowledge and experience to prescribe a particular medicine, you do not have to do so. But you should explain your reasons for declining and explain other available options, including the option to seek a second opinion. As always, these discussions and the justification for your decisions should be clearly noted in the patient record.

If you are considering undertaking work of this nature we would advise you to contact MDDUS, in order to ensure you have appropriate indemnity in place.

Dr Naeem Nazem is a medical adviser at MDDUS

Are doctors taking risks in treating dental emergencies?

DEALING WITH DENTAL EMERGENCIES

MANY general medical practices will be familiar with this scenario. A patient turns up 15 minutes before closing time with a throbbing toothache. You usher her into your consulting room for an examination. Her face and gums are swollen and she has a slight temperature. It is clear this is something that a dentist should be dealing with. You check your watch. Do you signpost her to the appropriate services or do you decide to offer treatment right away?

This can be a challenging situation for a GP and one that is on the rise. Figures cited by the British Medical Association (BMA) suggest a typical general practice can expect to see between 30 and 48 patients with dental problems per year.

There are a number of reasons behind the trend. Anxious patients may delay seeking care for dental issues until they are acutely unwell, at which point they will turn to their GP or even A&E service for help. There may also be a lack of awareness over the availability of urgent dental care services in the local area, difficulty in accessing out-of-hours dental care, or concerns over the potential cost of treatment.

Ethical responsibility

In our scenario above, some practices may be tempted to simply send the patient away, telling them to see their dentist because "we don't treat dental problems". It is true that GPs are not contractually obliged to administer dental care and are also legally restricted (under the Dentists Act 1984) from doing so unless they are dually qualified.

However, they do have an ethical responsibility to offer help in an emergency. This can extend to medical care where the patient requires urgent treatment for pain or an infection.

Always assess

Before making any kind of referral, it is vital to assess the patient to exclude other non-dental conditions. Signposting any patient (particularly one in acute pain or distress) to alternative care services without first evaluating their condition considerably increases the risk of both complaints and negligence claims.

Signpost

Only once you are satisfied the issue is solely dental should you signpost to a dentist, local emergency service or, for serious cases, secondary care. If there is no usual dentist or they are closed, then the local NHS 111 (England), NHS 24 (Scotland), NHS Direct or local dental helplines (Wales) or the Health and Social Care Board (Northern Ireland) should be contacted.

Doctors should also be alert to signs of spreading infection or systemic involvement of a dental infection as this would require an immediate secondary care referral. Signs and symptoms may include diffuse or severe facial swelling, trismus, dysphagia, fever or malaise.

Be mindful of the GMC's *Good Medical Practice* guidance which clearly states you must recognise and work within the limits of your competence.

Prescribing

MDDUS often deals with enquiries from doctors faced with dental issues, many of which relate to prescribing and particularly for pain relief and use of antibiotics. When prescribing for patients with dental issues, it is important to remember that you should not supply an NHS prescription unless you are in a position to accept responsibility for that prescribing decision. This includes ensuring the patient's dentist is aware of the drugs you have prescribed.

Don't be pressured into giving the patient a medication or treatment if you're not sure it is in their best interests. The GMC advises that in providing clinical care: "you must prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs". Your records should show justification for whatever decision you make and should be clear and accurate.

Key points

- Patients presenting with apparent dental issues should always be examined to ensure there is no medical condition requiring treatment.
- Only treat within the limits of your competence.
- Ensure that you and your practice team have the contact details for local emergency dental services, including urgent secondary care referral pathways.

Further information:

- BMA – Patients presenting with possible dental problems **tinyurl.com/hf59898**

Lindsey Falconer is a risk adviser at MDDUS

RED ALERT

Are you tempted to dismiss computer pop-up warnings without reading them? Senior risk adviser **Liz Price** offers a word of caution

DESIGNERS of primary care systems are continually introducing new ways to support GPs and other clinicians in making correct diagnostic, treatment and prescribing decisions.

Many involve digital alerts to support safe clinical decisions as part of remote monitoring device feedback systems or automated triage. Pop-up warnings may also appear when prescribing new drugs for a patient with a known allergy, current prescription or a condition for which a proposed medicine is contraindicated.

Such innovations are designed to assist GPs – and improve patient safety – but the result can sometimes be "information overload" in busy practices. Here we will examine risks associated with prescribing alerts.

A General Medical Council-funded study reported in 2012 that around one in 13 prescribing errors are associated with contraindications or hazardous drug interactions and this is continually replicated in MDDUS' own ongoing analysis of prescribing-related negligence claims.

As a GP you will be confronted with multiple warnings from patient systems about drug interactions – some of them regarding potentially harmful combinations – each time you initiate a new medication. Clinical judgement is required to act upon, override or ignore these alerts. In some situations a patient may have competing comorbidities and there will be no alternative to prescribing a medicine which is contraindicated, in which case you will take note of the alert, prescribe the medicine (having explained the risks) and monitor the patient closely for adverse effects.

Certainly it is most logical for a clinician to take notice and act on alerts within the system at the point of prescribing. However, many GPs admit to feelings of "alert fatigue" . This is defined as "the mental state that is the result of too many alerts consuming time and mental energy, which can cause important alerts to be ignored along with clinically unimportant ones". GPs often report that reading and responding to these can be a challenge – particularly as they can often be irrelevant or redundant. Consider the pop-up "warning, drug with similar name" that offers no indication as to what it might be, or the alert urging doctors to "be cautious in patients under 18" despite the patient in question being aged 60.

A 2013 University of Edinburgh study found that GPs acted on only two per cent of computer prescribing alerts and, while improvements have been made, they are still largely considered more intrusive than helpful. Evidence suggests that each alert takes between seven and 14 seconds to process so it's easy to see how an under-pressure GP whose experience of the alerts has been mostly unhelpful will want to pass through them (perhaps too) quickly.

So how can you achieve safe practice and avoid missing a dangerous drug-drug combination?

The GMC is clear that doctors "must make good use of the resources available" and utilising a combination of resources is often advisable when prescribing new medicines. Although referring to the British National Formulary (BNF) and BNF for Children (BNFC) can take more time, the GMC is clear that you "must be familiar with the guidance".

In addition the GMC advises doctors who are unsure about interactions or other aspects of prescribing and medicines management to seek advice from experienced colleagues including pharmacists, prescribing advisers and clinical pharmacologists. As a GPST, your trainer or fellow practice GPs will be a useful resource, and can at least point you in the right direction where more specialist advice is required.

Up-to-date patient histories, accurate clinical coding and full patient prescribing records are crucial to ensure the relevance of system alerts. Practices must have robust recording processes in place to make sure alerts are raised appropriately, e.g. where a doctor tries to prescribe a beta-blocker for an asthmatic patient.

Documenting hospital-prescribed medicines (e.g. chemotherapy) or over-the-counter medications taken by patients (e.g. antihistamines or low-dose aspirin) in the medical record will avoid serious interactions being missed.

On this, GMC guidance states that: "You must check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving". No system is perfect, so it is important to also ask the patient if they are taking any other medicines.

When prescribing a drug which is contraindicated, be careful to note that you have fully informed the patient of this – including any red flags – and detail what (if any) monitoring will be required. It shouldn't be a surprise to the patient when they are contacted by the team to come in for a blood test or provide a specimen. Practices should have flexible but robust systems to monitor these patients, with alerts generated for those who default from review.

On a final note, it is less common now for GPs to delegate to non-clinical staff the task of adding new drugs to the records and certainly this is something to be avoided. Administrative staff are also likely to override alerts as they will assume you have taken these into consideration before deciding to prescribe.

In conclusion, alerts can be frustrating for you as a GP, particularly as you adjust to using new systems, but they at least offer an opportunity to reduce clinical risk.

Liz Price is senior risk adviser at MDDUS

SUCCEEDING AS A LOCUM

Locum GP **Surina Chibber**, co-founder of MyLocumManager.com, offers practical tips on a successful career

TRANSITIONING into a locum career can be a daunting process whether you are a newly qualified GP looking for variety or a partner changing career direction. There are many reasons why a GP may choose to become a locum, but leaving behind the continuity of one practice and regular paid employment has its challenges.

As I approached the end of my GP training I remember feeling uncomfortable at the thought of walking away from secure employment. However, I wanted to challenge myself by working in different practices. I also wanted to understand how practices adapted to meeting their patients' needs. Working with different patient populations and on different portfolio roles was also important to me. So, when I finished my GP training, I decided to work as a locum GP.

Below are some steps GPs can take to make a successful transition to locum work.

Plan ahead

Towards the end of my training I sent my CV with covering letters to all the local surgeries. (The NHS 'Find GP services' web page is great for finding practices in England or nhs24.scot in Scotland.) I followed up with a phone call and email to their practice managers (PMs) who requested a number of documents before I could start work.

These include:

- Documents confirming entitlement to work in the UK
- Certificate of completion of training
- Performers list confirmation
- GMC certificate
- Medical indemnity certificate
- DBS check
- Immunisation status - Hep B
- Child safeguarding training certificate
- Basic life support training certificate.

I saved all these as a PDF that could be easily emailed but you could also create and share a document from a file sharing site such as Dropbox.

I prefer to liaise directly with practices but the alternative is to use agencies/third parties to source work. This comes with its own challenges. You may find that after the initial introduction to practices you'd rather work without a middleman, but it's important to be aware of the terms and conditions. Often you will be prohibited from working directly with practices if the work is sourced via a third party.

Be responsive

PMs tend to have lists of locums with whom they communicate regularly, while others may use a Whatsapp group to post upcoming sessions. Once you are added to these lists, you will begin to receive work offers. You should respond promptly as it is often allocated on a first come, first served basis. I find the best approach is to contact practices directly and build up a portfolio of workplaces where you are familiar with local policies and pathways and can provide good patient care.

Admin

Be sure to keep a diary of all your booked sessions. This may sound obvious but double booking can happen and makes everyone's life difficult. Using scheduling software like My Locum Manager can simplify the process.

Additionally, have a system to create invoices, log expenses, track mileage, monitor the number of sessions you are working in line with your indemnity and collect all work data for your accountant. You may have additional portfolio jobs which contribute to your income. You can do this manually, on Excel, or with a bespoke locum business toolkit like My Locum Manager. Ensure you have found a good medical accountant who can advise whether to set up as a sole trader or limited company.

Set terms

It is important that both you and the practice understand what work will be undertaken. When I first started as a locum I put together a contract setting out my terms and sent this to PMs. This stated the amount I expected to be paid and included the number of patients I expected to see in a routine surgery, how I wanted my surgery arranged regarding breaks and catch-ups, and the number of telephone calls and home visits included in my fee.

I also included a clause regarding cancelling work and the amount of notice I would give/expect to be given by practices. These terms and conditions help to protect me and the practice and ensure each party's expectations are clear.

When it comes to agreeing a fee, I often ask practices what rate they usually pay and negotiate from there. Ensure you clarify if this rate is inclusive of your pension contribution.

On the day

Locum work in unfamiliar practices comes with its own risks. Ensure you arrive early to get set up in your room. Introduce yourself to key staff and get their extension numbers so you can access their advice quickly. If it has not already been sent to you, ask for the locum pack which will have key information, from login details to local prescribing protocols and referral pathways. Note down who you can speak to during clinic should you need a second opinion or other advice.

Useful questions to ask include:

- What is the extension number for reception?
- Where is the panic button?
- How do I call patients in?
- How do I request blood tests and where are these done (on site or local hospital)?
- How do I order X-rays and ultrasounds?
- How do I refer for physiotherapy and counselling?
- Where are MED3, MATB1 and maternity exemption forms kept?
- Do I dictate or type referrals?

Mutual support

The patients you see as a locum are your patients and you have a duty of care to them and your colleagues. Do not be tempted to "pass the buck", even if you won't be working at the practice again. Clear documentation when arranging investigations and reviewing test results are extremely important from both a clinical and medico-legal point of view. Before starting your clinic, confirm who in the practice can act as a chaperone if needed, noting their full name and title.

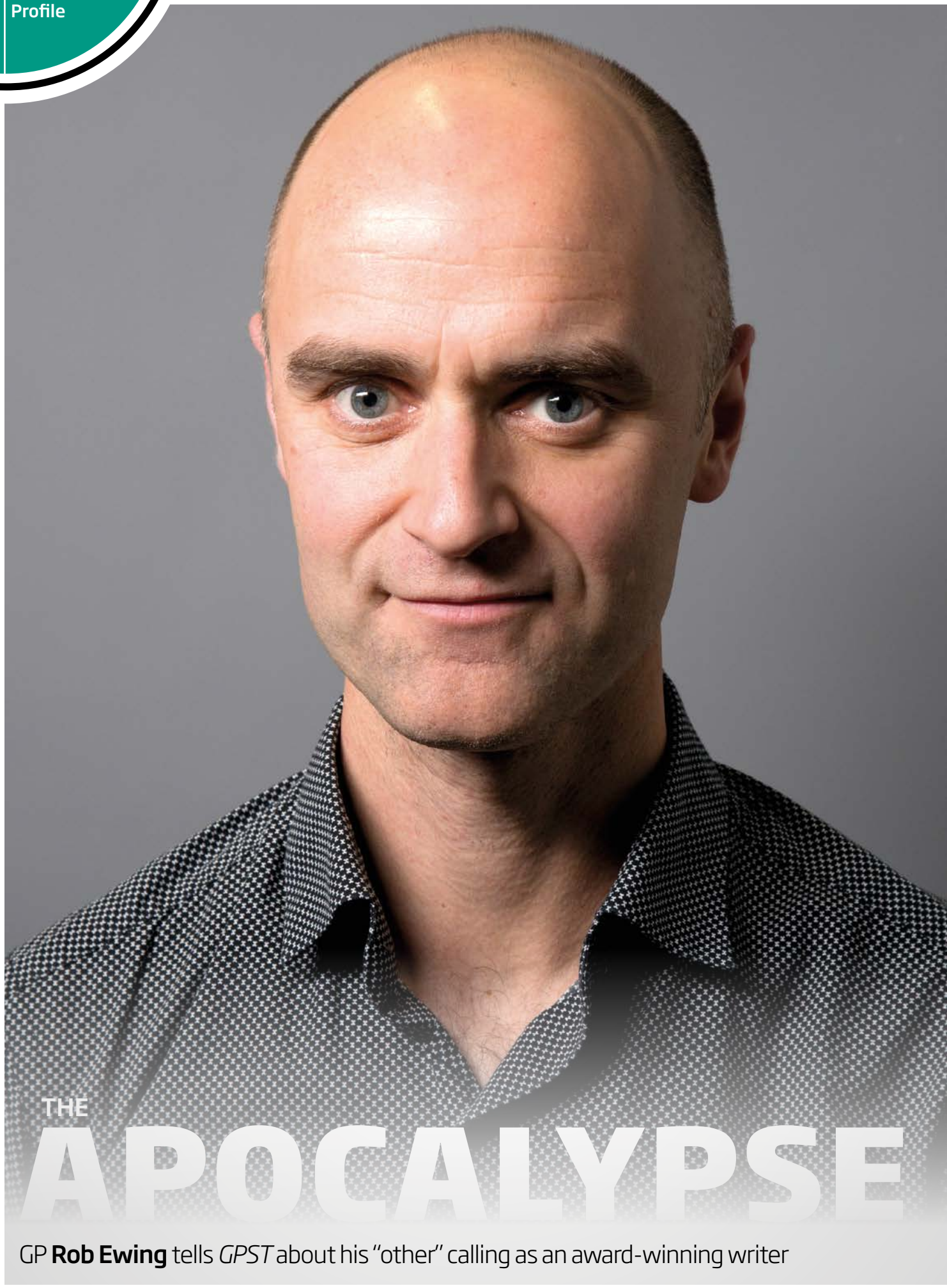
Working across a regular group of practices can make continuity of care and patient review easier. But if you are changing practices regularly and won't have the chance to follow-up a patient, don't forget to do a comprehensive handover to your colleagues. You should also note down a clear plan so the patient's regular doctor has all the relevant information they may need. Clearly document red flags, safety-netting advice and follow-up arrangements discussed with your patients. Try to keep up-to-date about prescribing polices and referral guidelines. One useful free online resource is the Red Whale GP Update Locum Essentials Guide.

I often discuss any queries I have with the practice's regular doctors and make a point of submitting any referrals before I leave for the day.

Returning to practices

The key to locum success is being invited back by practices. It pays to be flexible in helping to meet the surgery's needs, be punctual, organised, and be equipped with the necessary equipment. Developing a good working relationship with practices will help you access regular work, support and continuity and become a valued member of the wider team.

Dr Surina Chibber is co-founder of MyLocumManager.com – the cloud-based locum business toolkit



THE APOCALYPSE

GP **Rob Ewing** tells *GPST* about his "other" calling as an award-winning writer

WHEN Dr Rob Ewing is not working as a GP in Edinburgh he's imagining himself as a 10-year-old girl on a post-apocalyptic island, an anorexic woman in Victorian-era London, or perhaps as a terminally ill patient attending a pantomime. That's because outside medicine, he takes on a different role, as an author.

It was when the award-winning writer, who won third prize in the Costa Short Story Award 2016 for *The Persistence of Memory*, was studying medicine at university that he began to write, and found his "other" calling.

At one point the father-of-three, who is originally from Falkirk, considered giving up medicine for writing, but decided he could successfully combine both.

"Medicine allows you a lot of latitude in terms of what you can go on to do," he says. "In general practice I like people and the communication side of it, plus you never know what you are going to get from one day to the next."

In fact his chosen vocation has been a source of inspiration.

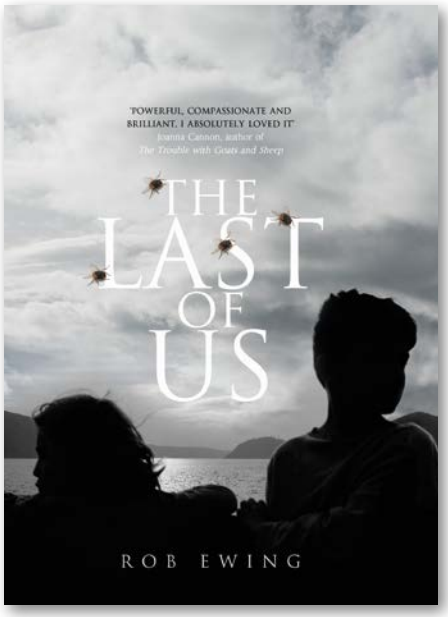
He says: "A couple of my stories were loosely based on patients I'd met (anonymised, of course). The first novel I ever wrote, for instance, was about a young woman called Euphemia (the Victorian-era anorexic), who travels from Scotland to see Professor Gull in London, one of the first to describe anorexia."

Breakthrough

As his interest in writing grew he switched from full to part time GP, working six sessions a week to free up more writing time. And in 2016 his third novel, *The Last of Us*, was published by Borough Press. It follows the story of a group of five young children on a remote Scottish island who are the sole survivors of a pandemic. Combining elements of *Lord of the Flies* and *Station Eleven*, it has been described as "bleak, beautiful and gripping" by bestselling author Ian Rankin.

The inspiration for this dark tale came from a two-year stint living and working on the island of Barra in the Outer Hebrides (population c1,200) with his GP wife Karin, and their three children during the 2009 swine flu outbreak.

"The place is so empty, you forget other people are there," he says. "One day my kids and I were out walking and they were way ahead on their own. I thought to myself, 'what would happen if they were left on their own?' and 'how would they cope?' It wasn't until a year later when we left the island and came back to Edinburgh I began writing the novel."



The Last of Us sold well – a few thousand copies – but Rob is keen for his next book to be a much bigger success. He is currently awaiting feedback from his agent on a novel he finished earlier this year which he describes as "the type of book I wanted to write".

"For my second book, I have got to have a success," he says. "It's about a drug that cures people who are psychopaths, which instead turns them hyper-empathic – they care too much, and they feel other people's pain. I have got into the heads of four people: four quite extreme characters.

"It might not see the end of the day, so I have already started on to my next book. Part of the enjoyment for me is the process, so I am pretty happy."

Learning the craft

As a creative child with aspirations of becoming a comic strip artist, it was perhaps a surprise to his family when Rob decided to pursue a medical career.

He explains: "I recently read an article about the 'reparative urge' (when illnesses occur in a close family member and influences a person's career decision) – but that wasn't the case with me. My mate Jamie went to medical school and had a great laugh, so I basically did what he did."

It was equally surprising when it came to chasing a book deal and becoming a published author, as Rob did not come from a family of avid book-readers and admits to being "a very bad writer for a long time".

He says: "It took me a long time to get good at writing. Early on, I had no insight into how bad I was but the resounding silence that came back when I sent out short stories kind of told me.

"It took me a while to become readable, never mind publishable. I am not sure I am even there yet; there are still some things in fiction that I struggle with."

On average, Rob takes around a year to complete a novel and then another to edit it. He says he loves to "get inside" his characters' heads, rather than write dispassionately in the third person as the narrator.

"The further it takes me from my own life the better," he says. "I would struggle to write about a forty-something-year-old man: but give me the character of a 10-year-old kid, or a woman, and I can ventriloquise."

Now an urban GP with a special interest in dermatology, his day-to-day duties are in stark contrast to the varied and often unpredictable work in rural Barra.

He says: "There, we had an A&E and we saw a lot of people out of hours, there was more obstetrics too. You have a 24/7 responsibility, unlike the cooperatives operating in cities like Edinburgh and Glasgow. It's all-consuming, but the flipside is that it is less busy, and I really liked it. You experience everything from road traffic accidents to someone phoning your home number at 3am to say they can't sleep."

Pushing ahead

In between striving towards his writing goal of getting published for a second time, he is also planning on going back to being an A&E doctor, something he enjoyed on Barra, and something he considers a "great anecdote generator".

For would-be writers, he says: "If you enjoy writing and it doesn't matter if you get published or not, do it. Do it for the love, not the money."

• Find out more about Rob and his work at: www.robewing.co.uk

Kristin Ballantyne is a freelance writer based in Glasgow

and other tales

A STEP TOO FAR?

Maintaining appropriate boundaries with patients is key for doctors – but sometimes the right course of action is not so clear. **Dr Naeem Nazem** offers some advice

DOCTORS should all be aware of their privileged position in society. There are few professions in which you can question an individual on the most personal aspects of their life, let alone examine them or perform invasive procedures. People, or more specifically patients, allow their doctors this liberty in order to receive appropriate treatment. In return they trust doctors not to abuse their position. And therein lies the cornerstone of any doctor-patient relationship: trust.

A friend in need

Any doctor would help a stranger on the street suffering a medical emergency and MDDUS provides access to indemnity for such "good Samaritan acts". However, what do you do when the situation is not as clear?

Consider the scenario. A friend meets you as your Friday night shift is ending. They are going on holiday on Monday and forgot to pick up a repeat prescription for their thyroxine medication, which will now run out during the trip. Their practice is closed for the weekend so they ask you to write a prescription to cover them. What should you do?

The GMC states you should, wherever possible, avoid providing medical care to someone close to you unless in an emergency. But does this scenario qualify as an emergency? After all, your friend is unable to collect their prescription before going on holiday so it is an urgent situation for them. Or perhaps you could argue that they are just a friend and not "someone close to you"? If you are going to prescribe how would you do it – can you use the practice's prescription pad?

Although one or more of the arguments above may seem persuasive, the GMC's guidance does start by saying "wherever possible", implying that you need to exclude all the other possibilities before you make a decision to treat or prescribe. In this case there are lots of other options available. For example, your friend could attend one of the many walk-in centres in the UK that open at weekends. Or they could see a doctor in the country they are visiting and obtain a local prescription. By prescribing, in this case, you are likely not only to fall foul of the GMC's guidance, but also your own Trust/health board's prescribing policy and the restrictions within it.

A friend request

When it comes to maintaining boundaries, another common risk area is social media. Patients can often form close bonds with their doctor and many are tempted to look them up on Facebook and may even send a friend request. So what do you do if you receive one from a patient? Is it okay to accept? Or should you decline and potentially face awkward moments as you continue to manage their care?

If you feel declining a friend request may be awkward, imagine how you would feel knowing they had seen your personal photos and details of your friends and family. Or that they had read personal comments you had written or received. Would you feel as able to discuss treatment plans or difficult decisions with them? Do you think it would impact the level of professional trust between you?

The GMC's guidance *Doctors' use of social media* advises that using social media creates risks, "particularly where social and professional boundaries become unclear." It goes on: "If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile."

In the case described here, MDDUS would recommend that you decline the friend request and, if the matter is raised by your patient, politely explain the importance of maintaining a professional relationship. If they persist in seeking to engage with you through social media it may be helpful to get the support of your senior colleagues. As with nearly all difficult situations, it is also essential you keep a clear record of everything that is happening at the time it happens.

There are steps you can take to minimise the chances of patients contacting you via social media. Take a good look at your privacy settings to make your profile as secure as possible, and try to keep a clear line between your professional and personal pages.

"Is it ever appropriate to become romantically involved with a patient, either past or present?"

More than a friend

Another common dilemma is whether it is ever appropriate to become romantically involved with a patient, either past or present.

As highlighted at the outset, trust is the foundation of any doctor-patient relationship. The GMC is clear that a personal relationship with a current patient is never acceptable. Doctors must never use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. Their guidance *Maintaining a professional boundary between you and your patient* also states you must not end your professional relationship with a patient solely to pursue a personal relationship with them.

But is it ever appropriate to become involved with former patients? There are no answers or set time limits in such situations and doctors must always exercise their judgement. The GMC explains that the more recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate. The duration of the professional relationship may also be relevant. For example, a relationship with a former patient you treated over a number of years is more likely to be inappropriate than a relationship with a patient with whom you had a single consultation. Much also depends on whether there could be any perceived abuse of position. Factors which you would need to consider include the amount of time since you last saw the patient in a consultation, whether they are vulnerable, and whether you are still treating their family members.

It may be helpful to take a step back and think of how someone looking at your situation for the first time would judge it. If you think they may frown upon your actions, or you find yourself acting in a manner to conceal them, it may be time to take a second look.

Dr Naeem Nazem is a medical adviser at MDDUS

REFERRAL

PAINFUL PREGNANCY

DAY ONE
Ms G is a 28-year-old web designer and attends her GP – Dr L – complaining of sharp intermittent (three to four times per week) abdominal pain in the right iliac fossa. Four months ago she came off the pill hoping to conceive with her partner. Dr L records: *Examination and swab for HVS* [high vaginal swab]. He then advises Ms G to keep a diary of symptoms and return in a few weeks.

DAY FIVE
Results from the HVS are negative for infection and this is communicated to Ms G.

DAY 25
Ms G returns to the surgery and advises Dr L that a recent home pregnancy test was positive and her last period was six weeks ago. She still has intermittent pain and some brown spotting. Dr L examines her and asks about the nature of the pain which she characterises as "shooting" from the epigastrium to the lower abdomen – and unlike normal period cramps. Dr L refers the patient to the midwife for antenatal care and advises her to return if there is increased bleeding and/or abdominal pain, in which case an ultrasound will be arranged.

Later that afternoon
Ms G experiences severe abdominal pain and passes brownish vaginal discharge. She is taken by ambulance to A&E with a suspected ectopic pregnancy. A scan reveals a large amount of free fluid in the pelvis and Ms G is taken to theatre. A laparoscopy reveals a ruptured left tubal ectopic pregnancy with significant blood loss. A left salpingectomy is performed and she makes a good recovery and is discharged a week later.

DAY 41
Ms G makes an emergency appointment at the surgery. She is concerned that there is still bleeding and also her cramps have returned. Dr L examines her and records: *Not unwell; abdo non-tender. Refer to EPAU* [early pregnancy assessment unit] *tomorrow am.*

A LETTER of claim is received from solicitors acting on behalf of Ms G alleging clinical negligence against Dr L. It states that the patient had informed the GP of her positive pregnancy test in the first consultation and that he failed to ask about the date of her last menstrual period (LMP) and order a further pregnancy test. This would have resulted in referral to an early pregnancy assessment unit and diagnosis, avoiding the later need for surgical intervention.

It is further alleged that Dr L failed to adequately examine the patient in the second consultation, including taking blood pressure and pulse readings to establish whether she was haemodynamically stable. Referral for an ultrasound scan should also have been undertaken and failure to do so constituted a breach of duty.

The letter also alleges that at the third consultation Dr L again failed to assess if the patient was haemodynamically stable and arrange an immediate referral to an on-call gynaecologist, given the persistent spotting and cramps at eight weeks pregnancy.

ANALYSIS/OUTCOME

MDDUS commissions a report from a primary care expert regarding the alleged breach of duty of care. The expert points out that given the patient's dates it would be very unlikely that Dr L had been informed of a positive pregnancy test at the first consultation. Most over-the-counter tests will only detect a pregnancy four to six days prior to the next expected period. A further pregnancy test would not have been indicated at this stage. However, the expert is critical of Dr L's failure to record a detailed gynaecological history (including LMP) and examination findings.

In regard to the second consultation the expert is again critical of Dr L's failure to record detailed examination findings and he questions whether such findings might have proved significant in deciding whether Ms G needed an urgent referral, although it is unlikely that the patient would have displayed any clinically significant signs of blood loss at this time. Regarding the third consultation and the need for referral to an on-call gynaecologist (rather than waiting for an EPAU assessment the next morning) the expert notes that Ms G did not appear acutely unwell so an urgent (same-day) referral might not have been warranted.

An expert report is also commissioned from an obstetrics and gynaecology consultant in regard to causation (consequences of the breach of duty). He states that had an early referral been made an ultrasound would have revealed an empty uterus and a suboptimal rise in serum beta HCG levels, leading to an eventual diagnosis of ectopic pregnancy. This would have prompted treatment with either methotrexate or laparoscopy prior to the tubal rupture.

Given these vulnerabilities in the legal defence, an offer of settlement is made by MDDUS on Dr L's behalf.

KEY POINTS

- Record menstrual history (if relevant) in all gynaecological conditions.
- Do not discount pregnancy, no matter how unlikely.
- Do not neglect to record findings.

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...

● **SORRY (NOT SORRY)** GPs are no strangers to the game of email ping-pong and the delights of finding increasingly imaginative ways to politely chase someone for information for the umpteenth time. But it turns out all the favourite phrases that we think sound pleasantly professional are really fooling no one. A survey by software company Adobe of 1,000 US workers found that the most-hated lines were those that tacitly imply the recipient has not yet responded to a previous email. Giving off more than a whiff of passive-aggression is that classic opener: "Not sure if you saw my last email" (most hated by a quarter of survey respondents), followed by the abrupt "per my last email" and "per our conversation" (hated by 13 per cent and 11 per cent respectively). While maybe sounding innocent enough, "Any updates on this?" and "Sorry for the double email" also caused irritation. And let's not forget the quiet persistence of those who are "re-attaching for your convenience" in the hope of receiving a reply sometime this millennium. Adobe's director of email solutions Kristen Naragon says that, despite its speed and efficiency, expressing oneself clearly and politely via email can be tricky. "Emotion and intent are sometimes hard to convey via email, so [some phrases] can negatively impact productivity and culture," she tells CNBC. "Your colleagues could choose not to respond out of frustration," she continues. "This can damage relationships and ultimately, morale." Diary advises all readers to approach their emails with caution.

● **BRAINY BANDAGE** A new "smart" bandage with an in-built processor could help treat non-healing chronic wounds from the likes of burns and diabetes. It can check for infection and inflammation by tracking pH and temperature then administer the correct dose of antibiotics when needed throughout the day. Normal healing wounds fall within the range of pH 5.5 to 6.5, whereas non-healing infected wounds can have a pH level well above 6.5. Inflammation is tracked via sensors monitoring temperature and specific bio-markers. A microprocessor – which can be reused – reads the data from these sensors and releases antibiotics on-demand from its carriers. The innovation is thanks to the emergence of 'flexible electronics' which have made many wearable medical devices possible. Pre-clinical studies are now said to be underway.

● **ROCKY ROAD** Whoever said that progress runs smoothly? Looking only to advance human wellbeing, lifestyle brand Goop (founded by Gwyneth Paltrow) has faced its share of setbacks. Coming hot on the tail of recent criticism over its DIY coffee enema kit, sceptics are now questioning the efficacy of its vaginal eggs. The jade (£51) or rose quartz (£42) stone eggs are claimed to boost sexual energy while balancing hormones, regulating periods and improving bladder control. The company has agreed to pay a $145,000 settlement over alleged unscientific claims about the eggs and a herbal essence said to help tackle depression and has also agreed to refund customers. In July, Paltrow announced that Goop had hired an in-house fact checker for its website. Not an enviable task.

● **BRAIN ROT** No doubt the GMC is still assessing the long-term implications on the profession of Dr Alex George's turn on *Love Island* – "perfect gentleman" though he was. More serious are comments by NHS England chief executive Simon Stevens regarding "explicit" adverts for cosmetic breast enlargements targeting young women watching the hugely popular reality show. "That is all playing in to a set of pressures around body image that are showing up... The time has come to think long and hard about whether we should be exposing young people to those kinds of pressures." Talk is of a ban similar to that proposed for adverts promoting sugary products.

● **GENDER CONTROL** And so to Japan where women account for over 40 per cent of the workforce but this year's 18 per cent pass rate for women taking the entrance exam to Tokyo Medical University proved something of a mystery. Was there a subtle cultural/gender bias at play? Not at all – a local newspaper found that administrators were simply marking down exam results by up to 10 per cent to keep the female student population down. This was deemed necessary (media reports have alleged) to prevent women undertaking medical training only to later quit in order to raise children. Head of the Japan Medical Women's Association, Yoshiko Maeda, was astonished. "Instead of worrying about women quitting jobs, they should do more to create an environment where women can keep working."

● **FAMOUS FINGERS** Prostate Cancer Canada has come up with a novel campaign to encourage men to undergo digital exams and other checks to test for the disease. "Famous Fingers" features 13 model hands wearing latex gloves – index fingers raised – inspired by historical and fictional figures including Sherlock Holmes, Abraham Lincoln, Winston Churchill and King Tut. "It's about normalizing the conversation around prostate exams and stressing the importance of detecting prostate cancer early," said Peter Coleridge, President and CEO of Prostate Cancer Canada. "Any alternative to being examined by your doctor is quite absurd, which the campaign captures perfectly. Would you prefer to have your prostate checked by your doctor, or by Big Foot? We'll let you decide." Er... doctor please.
www.famousfingers.ca

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