



GROWTH INDUSTRY

BUILDING GARDENS IN GP SURGERIES

ALSO INSIDE

05 GP LETTERS
GETTING THEM RIGHT

08 CAREER
GYNAECOLOGY

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Welcome to your GPst

SOCIAL prescribing in general practice seems to come in all varieties now – from Parkrun to bird watching – and the benefits do seem obvious for those who choose to engage. On [page 12](#) we hear about an innovative GP garden project helping patients in Lambeth, south London.

My article on [page 5](#) gives some practical advice on dealing with so-called ‘soul and conscience’ letters for patients wanting to be excused from jury duty or a court appearance as a witness. It’s an area in which GPs should tread carefully.

No one likes to give or receive criticism, but failing to speak up can threaten patient safety. On [page 10](#) senior risk adviser Liz Price offers a constructive approach.

Do you have a special interest in OB/GYN? Dr Roopinder Brar gives her perspective as a portfolio GP with an interest in

the specialty on [page 8](#). And on [page 4](#) we feature an extract from *Tools of the Trade* – a poetry book given free to Scottish medical graduates but also proving popular among doctors of all ages.

Almost every professional can describe feeling like a fraud at work at some point in their career. Allan Gaw offers a helpful way of dealing with ‘imposter syndrome’ on [page 6](#). And on [page 7](#) Liz Price highlights new research suggesting a link between reduced wellbeing of clinicians and patient safety risks in primary care.

Finally, our case study on [page 14](#) involves a dance floor injury that seems minor on first examination but proves less so for the GP involved.

• **Dr Susan Gibson-Smith**
Editor

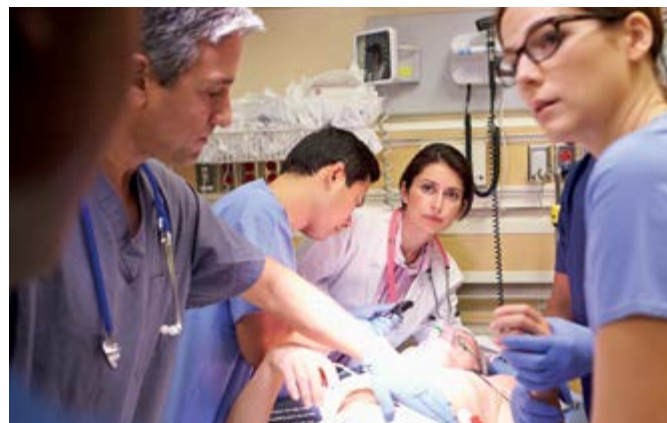
NEW GMC ASSESSMENT CENTRE FOR OVERSEAS DOCTORS

OVERSEAS doctors wanting to practise in the UK will now undergo a “rigorous half-day assessment” of practical skills at a new £2.5m GMC test centre in Manchester.

The centre opened on 6 August and the GMC expected that by the end of the month more than 1,000 doctors would have undertaken the assessment. It is comprised of two practical skills circuits, catering for up to 18 candidates at a time, and features scenarios to test doctors to make sure they are competent and able to treat patients safely.

Jane Durkin, the GMC’s Assistant Director of Registration, said the regulator was committed to supporting overseas doctors through the registration process, adding: “It is also vital that doctors coming to work in the UK meet the high standards we require and that patients rightly expect. This is a series of robust and rigorous tests that assess doctors’ clinical skills.”

Most doctors qualifying outside the European Economic Area are required to pass the two-part Professional and Linguistic Assessments Board (PLAB) exam before they can apply for registration and a licence to practise medicine in the UK.



MAJORITY OF BRITS THINK A&E OVERUSED

MORE than 85 per cent of the UK population believe that A&E services are overused, while just over half agree that it is hard to get a GP appointment.

Figures from the most recent British Social Attitudes Survey reveal a clear majority (86 per cent) of the population think that too many people use A&E services unnecessarily. This increases to 94 per cent for people aged 65 to 74. Just under a third said they had accessed A&E services at least once in the previous 12 months for themselves or others, with the figure rising to 54 per cent among parents with a child under age five.

A surprising proportion (17 per cent) of UK patients prefer A&Es to GP surgeries because they can get tests done quickly, and the figure rises to 29 per cent in the most deprived areas.

In terms of digital resources, 58 per cent of people with internet access said they research health problems online. People aged 18 to 24 are twice as likely (62 per cent) to do so than those aged 75 and over (30 per cent).

Ruth Thorlby, Assistant Director of Policy at the Health Foundation, said: “It is notable that those in the poorest areas report greater problems [in accessing general practice]. Our analysis found that a GP in the most deprived areas will be responsible for 370 more patients than one working in the least deprived.”

She called for a solution that tackles the inequalities in primary care.



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PATIENTS TO BE REFERRED TO PHARMACISTS FOR MINOR CONDITIONS

PATIENTS in England are to be offered same-day pharmacy appointments for minor conditions in order to ease pressure on the wider NHS.

The Department of Health and Social Care has announced that the new NHS Community Pharmacist Consultation Service will offer local pharmacy appointments to anyone calling NHS 111 about minor conditions, such as earache or a sore throat. GPs and A&E could start to refer patients to the service over the next five years if testing is successful.

Patients will still have the option to see their GP or attend A&E, but it is estimated that up to six per cent of all GP consultations could be safely transferred to a community pharmacy, which is the equivalent of 20 million appointments per year.

Pharmacists receive five years of training which provides expert knowledge of medicines and drug interactions, and the NHS says it wants to make better use of these skills. The new service is one of a number of initiatives announced as part of the new five-year Community Pharmacy Contractual Framework, which took effect in October.

The framework focuses on prevention, urgent care and medicines safety to help more

people stay well in their community.

Health and Social Care Secretary Matt Hancock said: "Pharmacists are integral to community health and I want to move towards the French model, where they offer a wider range of services and play a stronger role in the community."

RCGP chair Professor Helen Stokes-Lampard commented: "Whilst this new scheme is welcome... pharmacists - or any other primary care professional - must not be seen as substitutes for GPs." She called on the government to continue its push to recruit and retain more family doctors.



GP ANTIBIOTIC PRESCRIBING REDUCED AND MORE SELECTIVE

ANTIBIOTIC prescribing by general medical practices in England has reduced and become more selective in recent years, according to a study published on *BMJ Open*.

Researchers at King's College London analysed antibiotic prescribing at 102 general practices in England that contributed data to the UK Clinical Practice Research Datalink (CPRD) from 2014 to 2017.

They found that total antibiotic prescribing declined from 608 prescriptions per 1,000 person-years in 2014 to 489 per 1,000 person-years in 2017. Broad-spectrum β -lactam

antibiotic prescribing decreased from 221 per 1,000 person-years in 2014 to 163 in 2017.

The decline was similar for men and women but less for patients over the age of 55. Antibiotic prescribing for patients with respiratory infections declined by 9.8 per cent per year and 5.7 per cent for genitourinary infections.

The authors concluded: "Antibiotic prescribing has reduced and become more selective but substantial unnecessary AB use may persist. Improving the quality of diagnostic coding for AB use will help to support antimicrobial stewardship efforts."



CLARITY FOR GPs ON FIREARMS LICENSING

GPs will not be held legally responsible for judging whether someone is suitable to possess a firearm or shotgun certificate, according to proposed new government guidance.

The Home Office has launched a consultation on statutory guidance which makes clear that legal responsibility rests "solely with the police".

Under the guidelines, police in England, Scotland and Wales will be required to check the medical records of every person applying for a firearms licence. The move comes in response to findings by the independent police inspectorate, HMICFRS, that licensing practice across the country was inconsistent and that medical information was not being shared for firearms applications, creating a potential safety risk.

The Home Office has signed an agreement with the British Medical Association (BMA) that aims to improve cooperation between the police and GPs.

GPs are asked to provide information about whether firearms applicants have a history of relevant mental or physical conditions which could affect their safe possession of guns. They are also asked to put a firearms flag on patient records so that police can be alerted if a person develops a relevant medical condition after their licence has been issued.

The Home Office has worked with the medical profession to encourage doctors' use of the firearms flagging system and is looking at ways to widen the use of flags through a national IT system.

Minister for Policing and the Fire Service Nick Hurd said he was confident the proposals would tighten up the system without creating "unreasonable demands".

But the new guidance was described as "disappointing" by the British Association for Shooting and Conservation, who fear gun owners could be left with a £48 million bill for medical reports.

Bill Harriman, Director of Firearms at BASC, said: "The new proposals place no obligation on doctors and leave them to take part or not, to levy unreasonable charges or not, as they wish. There is absolutely no guidance in the consultation on a reasonable charging regime."

He called for a statutory obligation on doctors to participate in the licensing process "in the interests of public safety".

Currently, GPs are not contracted to complete firearms reports and have the right to charge a fee or to refuse to provide the service altogether. Refusal can be on the grounds of conscientious objection or because it falls outside their medical expertise.

TOOLS OF THE TRADE

A new edition of a pocket-sized poetry book that speaks to the experience of being a doctor

WHAT are your essential tools of the trade? People might assume a stethoscope but if you ask most doctors today they would probably reply their smartphone. It's doubtful anyone would say a book of poetry.

And yet this is what was presented to all doctors graduating from medicine this year in Scotland.

Tools of the Trade is a pocket-sized volume of medically-themed poetry first published in 2014 and offered "simply as a compassionate friend" to Scottish medical graduates that year

and in 2015. Now a new edition of the book has been published for doctors graduating in Scotland in 2019, 2020 and 2021 – thanks to the support of both MDDUS and the Royal College of GPs (Scotland).

All the poems speak in some way to the experience of being a doctor, say the editors. Some of the poets featured in the book are or were doctors themselves, including Dannie Abse, Rafael Campo, Glenn Colquhoun, and Martin MacIntyre. Different poems suit different situations and readers but all are intended simply "as tools to help connect with your patients, your colleagues, yourself."

Chris Kenny, Chairman of MDDUS, said: "MDDUS are delighted to provide support for a new edition of *Tools of the Trade*, a resource for doctors to draw on in both the quiet and thoughtful moments of your career and perhaps at its most challenging times as well."

From Tools of the Trade: Poems for New Doctors which is available for sale from the Scottish Poetry Library's online shop at: www.scottishpoetrylibrary.org.uk/shop

Adam, There Are Animals **Chloe Morrish**

There is a small fox
slipping through the fabric of morning,
still coated in a layer of grey dusk

and carefully placing his paws
between what's left of night
in the garden.

There is a monkey,
a stained toy, in your hand
when you arrive at the hospital,

which none of the fussing people
had noticed
and you had clung to.

There are wild-eyed soldiers' horses,
charging at us from the jigsaw pieces
in the waiting room

where we try to sleep
on the table and chairs
and pretend we're not waiting.

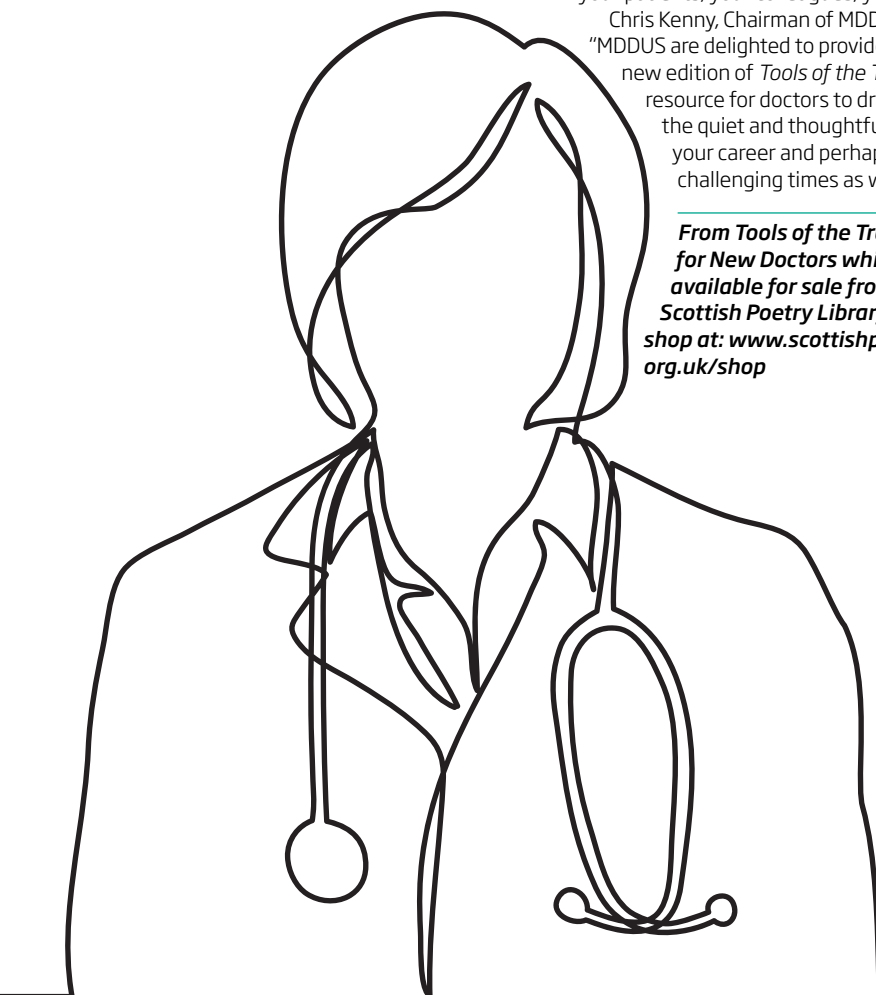
There are several pigeons
on the window ledge, shuffling about
before the steel chimneys and pinkish sky

and a seagull's bark
in the deflated quiet
just after you die.

There is an overfed cat
in the arms of a nurse who smokes
by the automatic doors.

and there are baby rabbits
eating the grass verges
of the hospital car park.

There is our dog
at the door, confused
when we get home without you.



NOT FIT FOR COURT?

Requests for medical exemptions from court require careful consideration

IT'S not uncommon for patients to request letters stating that they are either fit or not fit to undertake a particular activity. For example, a patient with a chronic but treatable cardiac condition may request a statement confirming he is fit to join a gym. A parent may ask for a letter stating that her child is not fit to take part in contact sports, or a pregnant woman may ask for a 'fit to fly' letter for her insurance.

Each request must be considered in line with General Medical Council (GMC) guidance and care taken to ensure appropriate consent is given and the patient is happy with the letter's content before it is sent. Such letters can provide factual medical information but the issue of providing an opinion is more nuanced. You should consider whether you are in a position to provide such an opinion, or if an independent specialist may be better placed.

Letters seeking excusal from jury service or a court appearance as a witness – sometimes known as 'soul and conscience' letters – are slightly different. Certain criteria may allow exemption, such as ill health or physical disability, but this is often not straightforward.

Guidance on applying for jury service excusal in Scotland¹ states: "If you wish to apply for excusal on the basis of ill health or physical disability then you must enclose a medical certificate along with your response. This can normally be obtained free of charge from your GP... If your doctor considers your condition is long term or unlikely to change, please ask your doctor to include this information in your medical certificate."

Similar guidance in England² states that patients must write to the Jury Central Summoning Bureau explaining the reason for excusal including evidence such as "letter from your doctor".

In writing such letters the doctor must be

satisfied that the patient is unable to attend court, bearing in mind the GMC guidance in *Good Medical Practice*: "You must be honest and trustworthy when writing reports and when completing or signing forms reports and other documents." It is often helpful to consider whether you would feel comfortable providing evidence in court regarding your opinion. If not, this could suggest an opinion should not be provided.

Common wording in such letters would be: "I hereby certify on soul and conscience that X is suffering from Y and is therefore medically unfit to attend jury duty and I therefore support X application to be excused on the grounds of ill health."

Consider the following scenario:

A young man, Mr P, attends his GP complaining of extreme anxiety and insomnia. He feels nauseous all the time and describes a tight feeling in his chest with palpitations. His symptoms have been present for several weeks and are getting worse and he now struggles to leave the house. The GP examines Mr P and asks what he thinks is causing the symptoms.

He explains that he recently witnessed an assault outside a pub and gave a police statement. Now he has been called as a witness to attend an attempted murder trial at court. Mr P is having nightmares about the incident and feels unable to attend court. He then says: "My cousin got a letter from her doctor excusing her from jury duty with panic attacks and she suggested I can get a letter from my doctor saying I am not fit to attend court.... can you write that for me?"

The GP is uncertain what to do.

It's important to note here that, while there is a significant difference between a citation for jury duty and a citation to attend as a witness in a criminal trial, the test for the GP remains the same.

In this scenario, the patient has material evidence to give that may be crucial to the trial. Just because he is anxious and worried about attending court does not mean he is medically unfit to attend. However, significant post-

traumatic stress symptoms might mean a patient should not be forced to give evidence, or that protective measures should be put in place.

If there is a medical condition that would limit the ability for a witness to give evidence we would advise writing a report clearly setting out the patient's medical problems and why these would make giving evidence difficult. It would then be a matter for the court to consider whether steps could be taken to assist giving the evidence, for example being behind a screen or remotely by video link. In particularly difficult cases it is often helpful for expert, specialist input to be obtained by the courts. Directing the court down this route can sometimes be the best approach.

These decisions can be difficult to make, so if in doubt phone MDDUS for advice.

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

¹ Scottish Courts and Tribunals Service. *Guide to Jury Service Eligibility and Applying for Excusal*: tinyurl.com/y6mrlm3x

² GOV.UK Jury Service: *Delaying or being excused from jury service*: tinyurl.com/y6j6sxtb



A reflection on imposter syndrome and how to deal with it

LETTERS FOR RAINY DAYS

FOR years, I've kept a file. It's in the bottom drawer and labelled 'letters for rainy days'. In it I keep all the nice ones. The thank you notes, the letters of recommendation, all the ones that start, 'I am pleased to...'. I don't look at it very often but I know it's there. It's the tangible evidence that helps counter all those niggling doubts, the lack of confidence and the feeling that I'm a fraud.

Despite the name it often goes by, the so-called 'imposter syndrome' is not a medical condition. It's not a form of mental illness nor something that needs to be cured. Really, it's just a way of thinking about how we measure up in the world, and it's extremely common.

Ever sat in a meeting, looked around and heard an inner voice say, what are you doing here? You know they're going to find you out, don't you? Ever given a presentation after a poor night's sleep, unable to settle because of the anxiety that they'll all know more than you? Ever got the job and told yourself, they must have been desperate, there must have been a mistake?

If you recognise any of these scenarios, welcome to the club. And it's a very big club. Well over two-thirds of everyone who has ever achieved anything has thought like this at some point. As a phenomenon, it was formally described in the late 1970s by American clinical psychologists, but of course it's been around a lot longer than that and crops up in unlikely places.

For example, the Academy Award winning actress Meryl Streep is quoted as saying: "You think, 'why would anyone want to see me again in a movie? And I don't know how to act anyway, so why am I doing this?'"

And look at what one scientist had to say about his achievements: "The exaggerated esteem in which my lifework is held makes me very ill at ease. I feel compelled to think of myself as an involuntary swindler." And that was Albert Einstein, the most celebrated physicist of the last 500 years.

So what do these people have in common?

They're all talented, all hard working, but most importantly they are all successful. Real frauds and true incompetents rarely, if ever, feel like imposters. The former don't care enough and the latter achieve nothing to make them feel undeserving.

Why do we do this to ourselves? It stems from the fact that the only mind we can access is our own. We have an internal life – thoughts, feelings and insecurities – that only we can glimpse. Of course, everyone else has exactly the same, but we can only see the surface and often that looks completely at ease with the world. As such, we naturally start to think that it's just us who feel like this, that we are the only ones in the room, or on the ward round or on the shortlist who really shouldn't be there. Everyone else is smart and assured, confident and deserving, but not us.

Although you cannot share other people's insecurities first-hand, what you can do is realise, quite objectively, that they all have them and that they are no different from you. And you can even let some of that awareness temper the self-doubt. You know you're not the best or most talented person in the room but just how good are the rest?

Former First Lady Michelle Obama has admitted to feeling like an imposter. But her concerns were softened when she reflected on her own experiences. "Here is the secret," she

said. "I have been at probably every powerful table that you can think of, I have worked at non-profits, I have been at foundations, I have worked in corporations, served on corporate boards, I have been at G-summits, I have sat in at the UN; they are not that smart." The emperors, as it turns out, really aren't wearing any clothes.

Realising you're not alone in this feeling is a first step, but next time you feel like an imposter, catch yourself and change the narrative. Ask yourself what you did to earn it, whatever the 'it' is. Don't dismiss the hard work that got you there, acknowledge it. And don't put it all down to luck. We all benefit from luck and equally we all suffer because of it, but we probably give it too much credit. It wasn't luck that got you into medical school, or got you that degree. It wasn't luck that helped you get that job or build that reputation or receive that prize. It was a little bit of talent and a lot of hard work.

But there will still be rainy days, and on those you might need to be reminded that you're smarter, more accomplished, more deserving than you allow yourself to imagine. And that's why I have a file. Maybe you should have one too.

Allan Gaw is a writer and educator in Scotland



New research suggests a link between reduced wellbeing of clinicians and patient safety risks in primary care

BURNOUT AND PATIENT SAFETY

ALL members of the healthcare team can experience burnout. This commonly manifests as a feeling of being overwhelmed by the demands of the role, exhaustion and an inability to engage effectively with others. The link between reduced wellbeing of clinicians and negative effects on patient safety and quality of care is of particular interest to MDDUS. There is well-established evidence of a causal relationship within secondary care settings but a recent article published in the *British Journal of General Practice** investigated the phenomenon within primary care.

The study examined whether factors known to contribute to burnout and wellbeing could be associated with patient safety (measured by near misses) in general practice. These factors include increased paperwork and patient demand, and a lack of support.

Further research will be required to define the extent of the causal links, however the findings suggest (similar to secondary care) that a high number of hours spent on administrative work was associated with poorer wellbeing, which in turn was associated with a higher likelihood of being involved in a near miss. The study also found that a lack of adequate support within practices, alongside high patient demand, was associated with higher levels of burnout, exhaustion and lower perceptions of safety. Whether these factors lead to burnout or vice versa, the fact that patient safety can be impacted is legitimate.

In analysing MDDUS medico-legal cases, we find that the most common causes of claims are associated with missed/delayed diagnosis or alleged failures in clinical treatment. Within these categories, common themes include:

- misfiling a result
- failing to follow-up a patient
- forgetting to complete a referral
- failing to document a consultation adequately

- missing an alert from a clinical system
- selecting the wrong item from a drop-down list or ticking/failing to tick a box as part of a process.

These are also common trends within incidents reported as near misses. This is understandable when you consider the 'symptoms' of burnout or reduced wellbeing:

- impaired cognitive function
- decreased recall and attention to detail
- greater susceptibility to alert fatigue and information overload
- poorer interactions with patients and colleagues
- able to cope only with shorter, more specific encounters
- less able to notice changes to a patient's condition
- less likely to be able to provide help or support to colleagues
- increased negative emotions towards patients/colleagues, requiring increased levels of self-management/control
- poor communication with others (patients and colleagues, verbally and in writing) leading to loss of situational awareness.

Clinicians are expected to (and learn to) deal with significant levels of demand, exhaustion and stress throughout their career. However, to avoid future increases in unintentional patient harm (and the impact on clinicians), underlying conditions of work within both primary and secondary care must be examined closely.

Discussions around this issue often focus on the financial costs to the NHS when clinicians leave practice as a result of burnout. But real changes within systems and processes

could mitigate the risks of burnout.

ACTION POINTS

- Consider whether you are experiencing symptoms related to burnout or exhaustion
- Identify a colleague or other with whom you can share your concerns and who can offer support or coaching
- Clinical leads should consult with teams about whether they feel supported and identify ways in which to improve this
- Incident reporting systems should be examined to understand whether they are robust enough to provide early warning signals of increased clinical risk. Evidence indicates that the number of near misses and minor incidents should be around 70 per cent of all incidents reported
- Use of more tangible measures of patient safety is helpful as there is evidence that clinicians experiencing burnout may be more likely to assess patient safety as lower due to their emotional state
- Leads should also review good practice in improving and (where possible) automating workflow within the service, ensuring better system safety netting and a reduced administrative burdens on clinicians
- Investigate and consider implementing the many good examples of organisations refining or simplifying existing processes, and upskilling other members of the healthcare team to share the burden with an eye on risk.

Liz Price is senior risk adviser at MDDUS

* Hall L H, et al. (2019) Association of GP wellbeing and burnout with patient safety in UK primary care: a cross sectional survey. *BJGP* 23/4/19 (Online First)

Are you a GP passionate about women's health? A special interest in gynaecology might be the career for you. **Dr Roopinder Brar** offers a personal perspective

WELL

WOMAN

ADVOCATE



DR Roopinder Brar is a portfolio GP with a special interest in gynaecology. She qualified in 2010 from The University of Newcastle with a merit and gained her DRCOG (Diploma of the Royal College of Obstetrics and Gynaecology) while completing her training in general practice. She also has a Masters in Medical Law and Ethics from the University of Manchester and works as a telephone adviser for MDDUS.

What attracted you to gynaecology?

I have always enjoyed gynaecology and was lucky enough to have very good teachers at medical school who made the subject interesting and easy to understand.

What do you enjoy most about your role?

Seeing women who often feel unable to speak to anyone else about their problems and being able to offer them solutions. It may be changing a method of contraception, treating a sexually transmitted infection, discussing their fertility or talking through HRT options. Exploring their feelings, discussing their options and hopefully being able to manage their symptoms does make the consultation very rewarding.



Are there any downsides?

Trying to do all of this in a 10 minute appointment! It simply isn't enough time and I am constantly apologising to patients for running late. Thankfully, they are very understanding.

What do you find most challenging?

It can be difficult trying to manage

expectations. Some patients are looking for a quick fix to their problem and these expectations can be difficult to manage. For example, when changing a method of contraception I always discuss the bleeding pattern with my patients. Some patients call and return multiple times to discuss this very issue, expecting bleeding to have settled overnight. I do find that giving time to ask questions and explaining things clearly does help ease their mind.

What about the role has most surprised you?

It has to be the sheer demand for gynaecology advice and examinations. I find my appointments are booked up weeks in advance for both advice and assessments. Our patients have been very grateful that we have started a new weekly clinic just for seeing and speaking to patients about these issues and symptoms.

What is your most memorable experience so far?

I saw a lovely patient who did not speak English as her first language. She attended several times and it was clear that she was unable to explain that she needed contraception and something for her menorrhagia. She had four children and was keen to avoid another



Opportunities for GPs in gynaecology

Making the decision to embark on specialist training in general practice can be agonising. Were you as a foundation year doctor passionate about one particular specialism or did you consider yourself a confirmed generalist? For many trainees the answer is rarely clear cut. Fortunately the medical profession has begun to recognise this and it is now becoming increasingly possible to do both.

A well-known GP “super-partnership” recently advertised for a gynaecology GP with an extended role (GPwER) providing sessions within a single practice but also working/training within a busy community gynaecology service. Such opportunities are likely to become more common as the NHS across the UK moves to more integrated primary and community health services.

Gynaecology is certain to be one of the core specialties in the RCGP launch of a new framework for GPwERs, which replaces the current designation of GPs with a special interest (GPwSI). Opportunities for GPs to develop an interest in OB/GYN are numerous, including the option to pursue a diploma from the Royal College of Obstetrics and Gynaecology (DRCOG) which is open to GP registrars in ST1/ST3, especially during O&G placements.

Find out more about the new RCGP framework at tinyurl.com/y5tvamem

pregnancy. Her symptoms were making it difficult for her to go out and care for her children. With the use of an interpreter, we were able to find out what her concerns were – much to her relief. We discussed long-acting contraception, which would also manage her bleeding. I was able to give this patient the coil. It wasn't a difficult consultation by any means. The coil was very easy to insert but the impact this had on her made it a very memorable consultation. She still hugs me every time she sees me.

What are the most common misconceptions about your job or about the specialty itself?

A lot of patients think they need to see a consultant gynaecologist. This is despite me explaining that many gynaecological problems can be managed in primary care without input from our secondary care colleagues.

Describe a typical working week.

Busy. No two weeks are the same. I work four sessions. I am on call on Tuesdays, where anything and everything can walk through the door. I supervise the trainees, which is a great way of keeping up-to-date with all things non-gynaecology. Even though the on-calls are busy, I enjoy being able to see a variety of

patients with different medical complaints, of different ages, and the occasional man at some points! I have one session for routine patients and one session for my well woman clinic. Once a month I have a coil clinic too. I am on hand to advise about any gynaecology-related issues that I am skilled, trained and competent to advise on.

What are the tools and resources that you can't live without in your day-to-day work?

I never start a women's health clinic without my guidelines from the Faculty of Sexual and Reproductive Healthcare (FSRH), female anatomy diagrams, a contraception comparison chart with statistics, speculums of all sizes, gloves and access to a chaperone for intimate examinations.

What qualifications/training/experience are essential to your role?

DRCOG (Diploma of the Royal College of Obstetrics and Gynaecology) and DFSRH (Diploma of the Faculty of Sexual and Reproductive Healthcare) are essential qualifications. Good communication skills and being able to adapt are also essential. Each patient is different and has different needs.

What opportunities are there for a GPwSI/ GPwER working in gynaecology?

I currently work in a GP surgery, where I also have the opportunity to teach other colleagues and trainees. I have colleagues working in hospital clinics as associate specialists in gynaecology and some in GUM (genitourinary medicine). There are plenty of opportunities available to work as a GP with a special interest/extended role in women's health.

Is there any advice you could give to a trainee GP considering a career in gynaecology?

General practice offers the opportunity to not only be a generalist but also, if you choose, to have a special interest. Patients appreciate having special clinics within the primary care setting and it allows GPs to focus on a branch of medicine that they may enjoy. Many practices would welcome a salaried GP/GP partner who is able to bring additional skills and services to their practice. Gynaecology gives the opportunity to develop practical skills too, such as inserting coils and implants. These consultations are rewarding and patients are often very grateful. Having a special interest in women's health allows you to really lead and develop a service for the women of your area.

An illustration on a dark blue background. A large, light blue face with closed eyes is the central focus. A person with brown hair, wearing an orange shirt, is shown in profile, holding a magnifying glass over the face. The magnifying glass's lens is positioned over the mouth area, and a bright white beam of light emanates from it. In the top left corner, there is a teal circular graphic containing the page number '10', the text 'GPst', and '• Risk'. In the bottom right corner, the word 'Let's' is written in a large, bold, teal font.

Let's

No one likes to give or receive criticism, but failing to speak up can threaten patient safety. Senior risk adviser **Liz Price** offers advice

MOST of us don't like to be criticised or challenged about our performance or behaviours. Despite our best intentions, such encounters can quickly disintegrate into defensive and unhelpful interactions. While avoiding potentially awkward discussions with colleagues might seem like a good idea, failing to speak up can harm patient care.

Evidence suggests that in teams where regular positive and negative feedback is given across the group:

- difficult issues are addressed earlier
- individuals are more likely to disclose problems and receive swift help
- people are less afraid to challenge
- effective relationships are built up more quickly.

These are important factors in delivering safer patient care.

Doctors have a responsibility to raise concerns if patient safety is at risk. Whilst it can be difficult, most clinicians find the courage to challenge colleagues when there is an imminent clinical error. Behaviours that are most difficult to address are often those which are less immediate, but more pervasive in terms of their effect on you, the team, or patients. This article will explore how to plan your approach to maximise the chance of a successful outcome. It will also look at how best to deliver feedback as a GP trainee, including the tricky dynamic of raising issues with your trainer, and also other clinical and administrative colleagues in the practice.

Assessing risk

During your training, you will have received feedback about your performance, and perhaps been challenged about your behaviours: "you were too abrupt with that patient" or "you didn't provide worsening advice to the patient". Consider how the feedback was given – was it valid? Just? Constructive? What were your emotional and cognitive responses – did it make you feel uncomfortable, or even angry? Did you leave the encounter understanding what was expected of you? It's likely that not all of your feedback experiences will have been pleasant.

To decide on whether or how to address issues, ask yourself these questions:

- How much do you want to tell the person about your concerns? Is the issue making you unhappy or causing you/others to underperform? If it is not important in

relation to patient care, is it your responsibility to raise the issue? If it's not, decide whether the risk of a negative response is worth taking.

- Is there a culture of providing feedback within the team or do individuals tend to avoid challenging each other, meaning your feedback is then more likely to cause surprise? Providing regular praise has been shown to make it easier to accept criticism. Has your trainer or other colleague asked for feedback in the past? Ideally, clinical leads or trainers would give trainees a safe space or "permission" to offer feedback. If they have at least mentioned it, they are likely to understand the value of receiving feedback from a trainee – even if they find it hard to swallow in the moment.
- What is your level of trust with the individual? If high, it is more likely that feedback will be valued and responded to positively – even if only after they have time to reflect.
- Do they seem like the type of person who would retaliate if they don't like what you have to say? Maintaining a good working relationship is important. You may have observed that they are happy to receive feedback on some areas of work/behaviour but not others. Concern about this is not a valid reason to avoid challenging your colleague but it's crucial to do it carefully.

Constructing feedback

What we might classify as "constructive feedback" can still be hurtful to someone who feels they are trying their best while working under pressure. It is essential to "construct" a feedback encounter with care. You should:

- Think about when and where you will have the conversation. As soon as possible after an incident or issue arises is good practice. Ensure it is done privately and when the person is less likely to be distracted or exhausted.
- Start by asking if it would be okay to share some thoughts or insights with them. Alternatively, you could say that you would like to have a chat about something, and ask if you can schedule a time to talk.
- Find a way to acknowledge the positive aspects of your relationship or normal behaviours.
- Avoid subjective feedback and

generalisations. Do you have specific evidence or recent examples to back up your position?

- Resist spontaneity unless a positive feedback culture is already in place or there is a high level of trust between you. Choose your words carefully and focus on the specific evidence, aspect of the task, or behaviour that is causing the problem. Focus on the future, not the past. It can be useful to write down and rehearse in advance what you plan to say.
- Be selective in what you choose to raise and stick to the issue(s) that matter. If a feedback culture is in place there's more likely to be only one thing that is being raised. This can be less threatening – particularly against lots of positive feedback encounters.
- Focus on problem solving and actions. Use "I" statements such as "I would appreciate more support in...." or "When you are telling me about X, could you also include Y details, as this would stop me having to bother you with minor questions".
- Encourage the person to articulate any points of disagreement with the feedback. It may not be obvious how much pressure or other issues they are experiencing.
- Highlight a potential personal benefit for the colleague in changing behaviour if you can. For example, a change by them might prompt a change in others' responses to them, or their ability to perform more effectively, which will make their own life easier.
- Stick to your script. Allow the other person to process what you're saying but try to politely bring them back round to the issue at hand before the encounter ends.

Learning to give feedback is an important aspect of developing your skills as a doctor. Carefully considering the nature of your feedback as well as how, where and when it is delivered using the suggestions above will help. You may not always get the response you would have liked in the moment, but you will perhaps get the person thinking and possibly open an ongoing dialogue. This will help the personal development of all parties, fostering a better working relationship, and potentially improving patient care.

Liz Price is senior risk adviser at MDDUS

be honest

Sowing the seeds for good health

An innovative project building gardens in GP practices is transforming patient care

CROWING vegetables is not the usual scope of practice for a GP, so when NHS educator Ed Rosen approached a group of clinicians with his 'gardening for health' idea, he was met with some scepticism.

However, six years (and one Royal visit) later, his ground-breaking food co-operative project is flourishing.

Today, 15 gardens have been created in the grounds of doctors' surgeries across the South London borough of Lambeth, growing everything from beetroot and mushrooms to herbs and potatoes. In these green spaces, patients and healthcare teams come together to cultivate crops as well as relationships.

Alongside the more obvious practical lessons on gardening and healthy eating, the project has provided a lifeline for those affected by loneliness, depression, anxiety and chronic conditions such as diabetes and arthritis.

Ed, a self-confessed "novice gardener", is the director and driving force behind the Lambeth GP Food Co-op (LGPFC). So far the project has engaged with more than 400 patients, many of whom suffer from multiple long-term conditions and who live in high-rise tower blocks with no access to green spaces.

Health boost

The gardens are an ideal, informal setting for healthcare teams – including dietitians – to highlight the importance of eating well and to offer nutritional advice.

Over the years a number of patients have shared their stories on the co-op's website, describing how it has benefited them. One patient in Vauxhall who was struggling with his weight and a long-term health condition was inspired to transform his eating habits and is now the proud owner of a window sill herb garden at home.

Ed says: "Dietitians and nutritionists from St Thomas' Hospital and Kings have come out, rolled their sleeves up and planted alongside patients. In doing so, they have spoken to patients about the nutritional value of what they are planting. They are low-key health conversations whilst they are collaborating in planting courgettes or pumpkins.

"It does improve the quality of life for some of the most vulnerable people in society."

Another patient who attended the food co-op describes how it has benefited her

mental health, saying: "As a person with depression and anxiety problems, I find the project a good way to meet people and combat a sense of isolation I often feel. It has also motivated me to utilise my balcony space to grow food and has reignited my love of cooking."

Pioneering work

Lambeth food co-operative is something of a pioneer in the movement towards more widespread 'social prescribing' (where clinicians direct patients to a variety of cultural and community activities to improve quality of life). The initiative was established well before the UK government unveiled its "loneliness strategy" in 2018, which called on GPs to engage in more social prescribing.

NHS national clinical lead for social prescribing Dr Michael Dixon has praised their work as "a model of social prescribing in action". At the same time, in February 2019, the food co-op received Royal recognition when Camilla, Duchess of Cornwall, visited the LGPFC garden at Swan Mews in Lambeth for their sixth anniversary.

And as Lambeth's co-op goes from strength to strength, other healthcare providers are taking note. A food garden has been built at the

Pulross Centre in Brixton, a 20-bed unit which cares for patients with MS and who have suffered from stroke and other conditions.

Ed says: "The OTs and physiotherapists are planting and growing vegetables with patients, many of whom have lost limbs and are in wheelchairs. That is a really important model as we continue our journey in the acute sector and the community centre."

Ed has ambitious plans for the longer term, including building gardens on hospital roofs and other unused spaces in the community. He also hopes to work with NHS catering companies so that the food grown in the grounds of local surgeries by local patients can be served in local hospitals, like Kings.

However, at present, the volumes required to make this happen are just too high, as Ed explains: "If we were able to grow one tonne of





PHOTOGRAPHS: JIM WINSLET/LAMBETH GP FOOD CO-OP

ABOVE: Patients planting at Jennie Lee garden.
LEFT: Camilla meets volunteers with project director Ed Rosen to celebrate the sixth birthday of Lambeth GP Food Co-op

"Dieticians and nutritionists from St Thomas Hospital and Kings have come out, rolled their sleeves up and planted alongside patients"

Ed Rosen

mushrooms they would buy the whole crop and make mushroom soup for staff and patients. It's not that far down the line but it requires a slightly different model of growing compared to what we have at the moment. I can't ask people who are not well to work their socks off, but we are looking at new technology for growing at scale. I think over the next five years, if we get the investment, we can do this.

"In terms of what we are doing just now, it is very timely and very relevant."

The Lambeth co-op has also published its first recipe book (available via its website for £7), with a second due to be published in time for Christmas. It features a selection of healthy recipes submitted by patients, GPs and nurses, including red onion marmalade, spring green miso noodle soup and roasted butternut squash.

Model for success

It all seems a far cry from that initial scepticism Ed faced in 2013, and is testament to his determination to make the project a success. He is magnanimous and clearly passionate when asked what he would say to all those who doubted the garden project would ever succeed.

He says: "I would say to them 'would you like to make a financial contribution?! No, seriously, I would invite them along. We have demonstrated that the concerns, reservations and anxieties were not grounded in the reality of developing the project. It is possible to do it and it works. It may not cure cancers but it improves the lives of some of the most vulnerable people in our communities."

Support for the food co-op comes from many different areas and is increasingly high

profile. GP and media doctor Jonty Heaversedge, London regional medical director for primary care and digital transformation, has spoken of the positive impact the project is having on patients. He says: "The Lambeth GP gardens help people feel less isolated and improve the health of local people living with long term conditions across the borough."

Aidan Cleasby, Trust community facilities lead for Guy's and St Thomas' adds his support, saying: "Patients can get outside, particularly in the spring and summer months, to plant, water and prune the plants, which is much more stimulating than sitting on a hospital ward. This complements their recovery process and enhances their wellbeing."

"Once the planters are in place it's just a case of refreshing the area every year with top soil, plants and seeds. There is very little impact upon the environmental footprint and the benefits to our patients are huge. We are very proud of that."

- Find out more at www.lambethgpfoodcoop.org.uk or follow the project on Twitter @GPFoodCoop

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MISSED DIAGNOSIS

DANCE FLOOR MISHAP

DAY ONE

Mr G, 56, presents at a minor injuries unit with a painful ankle and is seen by a triage nurse. He says he had been dancing at a wedding four days previous and woke the next morning with pain and swelling. On examination swelling is noted to the lateral malleolus but no bruising, erythema or deformity is evident. Pain is noted on palpation of the posterior talofibular ligament and Achilles tendon. Mr G demonstrates a full range of movement in his ankle/foot and can weight-bear with a limp. The nurse diagnoses ankle sprain and advises rest and joint elevation with ice packs. Mr G is advised to return for review or to see his GP.

SIX MONTHS LATER

Mr G is still suffering with pain and difficulty walking. There is still a step in the tendon with grossly reduced plantar flexion, and he cannot weight-bear on his toes. He undergoes surgery and is found to have a total rupture with a 2cm gap. Surgical reconstruction is undertaken using a flexor hallucis longus tendon transfer and the patient endures lengthy rehabilitation.

DAY 37

An orthopaedic registrar examines Mr G and confirms the diagnosis. On advice the patient opts for non-surgical treatment with a "moon boot" and periodic review.

DAY SEVEN

Mr G attends his GP practice and is seen by Dr P. He complains of a painful ankle and in particular his Achilles tendon. The GP notes swelling and some minor bruising in the lateral aspect of the foot. He records that on examination there is tenderness in the Achilles region but no "step" in the tendon. He prescribes an NSAID with PPI cover and recommends Mr G to persevere with the ice and joint elevation. He recommends a physio who provides telephone advice on gentle exercises and pain management.

DAY 36

Mr G returns to the practice and is seen by another GP – Dr J – who specialises in sports injuries. The GP records that the patient has experienced ankle pain for the last five weeks since an injury while dancing on a slippery floor. The patient recalls feeling a "sudden snap" with sharp pain. Examination reveals a negative Thompson's sign and a "step" in the Achilles tendon. Dr J diagnoses a ruptured Achilles tendon and refers the patient to the local orthopaedic clinic.

A LETTER of claim for damages is sent to Dr P alleging clinical negligence in the delayed diagnosis and referral of Mr G for a ruptured Achilles tendon. The letter cites a specific failure to adequately examine him and perform a Thompson or tiptoe test. This led to delayed treatment necessitating secondary reconstruction using tendon transfer, with additional pain, reduced range of movement and restricted mobility in the big toe.

MDDUS commissions a GP expert whose analysis of the case file notes that in the letter of claim Mr G insists he described a sudden sharp pain or "snap" in his ankle while dancing, but in the notes from the triage nurse and Dr P there is no specific mention of the point of injury – only a brief description of "ankle pain/swelling".

The expert also observes that Mr G's

examination did focus in part on the Achilles tendon but that "no step" was noted. But in his view there is some legal "vulnerability" in not having also asked Mr G to "stand on his tiptoes" with follow-up employing the Thompson test. This would have been crucial if Mr G had mentioned acute pain on injury. The factual dispute is a matter for the court but a negative Thompson should have prompted referral.

A consultant orthopaedic surgeon is asked to comment on causation (consequences of any breach of duty of care). He opines that an urgent referral after Dr P's consultation would have led to a prompt diagnosis of Achilles tendon rupture and direct primary repair – generally indicated within four weeks of injury. This would have prevented the need for the later more extensive surgical reconstruction with subsequent pain,

recovery and loss of mobility in the big toe.

Given doubt over the reported nature of the patient's injury, the factual dispute and Dr P having not conducted further tests other than palpation of the Achilles tendon, MDDUS seeks to settle the case with no admission of liability.

KEY POINTS

- Ensure notes record the specific mechanism of injury and nature of pain.
- If a specific injury is part of the differential diagnosis list, ensure that specific examination is undertaken in an attempt to investigate this potential.
- Justify clinical decisions in the notes even if that includes taking no action.

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...

● JAB! SLICE! SUCK! DRILL!

Maybe best to skip the sound effects – but it's been found that a comic-book approach to getting informed surgical consent can improve comprehension and reduce anxiety in patients facing complicated procedures. Researchers in Berlin developed a 15-page comic-style booklet to help inform patients undergoing cardiac catheterisation and stent insertion. A total of 121 patients were then recruited with some undergoing standard consent only and the rest being additionally provided with the 'comic'. The researchers found that the latter scored better on a short recall test and also reported feeling less anxious and better prepared for cardiac catheterisation. Dr Anna Brand, one of the lead investigators, said: "We want to use future research to test whether similar positive effects can be achieved in patients undergoing other medical procedures." Source: OnMedica

● KEEP YOUR GERMS TO YOURSELF

The idea came to GP Dr Robin Kerr of Teviot Medical Practice when he was lying in bed wondering which of his patients had given him the flu. "I was thinking how could I have stopped this. By the time the patient comes in for an appointment with a cold or flu the time has passed – it's no good saying 'next time you have a cold, consider self-care'." His idea was a telephone recording – before talking to a receptionist – signposting appropriate patients with cold symptoms in the direction of a community pharmacy to basically tough it out. Research conducted by Dr Kerr and colleagues found that the approach led to a 5.5 per cent reduction in calls continuing through to reception in a period when the incidence of the common cold was at its highest, and a 21 per cent reduction in the mean waiting time to the third available routine appointment. Voltaire did say: "The art of medicine consists in amusing the patient while nature affects the cure." Source: GPonline

● VICTORY...ALBEIT BELATED

It only took 150 years but seven female Edinburgh University students have finally been awarded their medical degrees. In 1869, Sophia Jex Baxter and six other women were allowed to enrol in medicine at the university but had to endure fierce hostility, not only from the public but from fellow male students, culminating in the Surgeon's Hall Riot in November 1870 when they arrived to take an anatomy exam facing a mob and were pelted with mud and worst. Later the so-called Edinburgh Seven were refused graduation and forced to study elsewhere in Europe. This summer seven current female medical students at Edinburgh University accepted degree certificates on behalf of these pioneering women. Better late...

● ICE LOLLY, STAT!

Summer may be long forgotten but ice lollies are still on the menu at the ICU at University College London Hospitals foundation trust. A common complaint among patients after major surgery is thirst. "And that's not just feeling a little bit thirsty and dry; it's intractable thirst..." says professor of perioperative care, David Walker. Yet these unnecessary fluid into circulation. His solution is to give patients an ice lolly to suck on. "We want patients out of bed, sitting in a chair, and eating and drinking as early as they are able." Source: BMJ



● AMAZING DOCTOR AMAZON

Diary has special pity for anyone this century with the misfortune to be named Alexa. Imagine the constant quips: Alexa, where's my stuff? Alexa, play Rick Astley. Alexa, have you ever had sex? Add now to that requests for health advice. The NHS has announced plans to team up with Amazon to provide voice-assisted technology employing algorithms that tap into information from the NHS website to provide answers to questions such as: Alexa, how do I treat a migraine? or Alexa, what are the symptoms of flu? The aim is to help patients, especially the elderly, blind and those who cannot access the internet through traditional means, to get professional, NHS-verified health information using simple voice commands. The Government says: "It is hoped the technology will reduce pressure on the NHS and GPs by providing information for common illnesses." Just remember to shut the windows at night to keep out the surgical cyberspiders.

● WEAPONISED TICKS

It may sound like the ultimate fantasist "told you so" but the US House of Representatives has ordered the Pentagon to conduct a review of whether the defence department experimented with using ticks and other insects as biological weapons. The review was demanded by New Jersey Republican Chris Smith and prompted by "books and articles" exploring research carried out at a biological research unit on Plum Island, which lies across a narrow stretch of water from the community of Lyme, Connecticut. Here in 1975 a cluster of paediatric arthritic illness was later associated with infection by the spirochete *Borrelia burgdorferi* and thereafter commonly referred to as Lyme disease. Smith wants to know if medical entomologist (and *B. burgdorferi* namesake) Wilhelm Burgdorfer may have worked for the US Government, breeding ticks and injecting them with various pathogens. Nice. Source: BMJ





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