

Sessional GP



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This issue:

**What's the buzz about
teamworking?**

Treating non-English speakers

Top ten risks for locums



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Editor's letter

Sessional GPs regularly tell MPS about the unique hurdles that salaried and locum doctors face in daily practice, which GP partners do not

As a medicolegal adviser at MPS and a doctor who previously worked as a GP, I am pleased to have been given the role of editor-in-chief of *Sessional GP*, a new annual magazine for all sessional GPs.

We hope that this magazine will provide you with useful and practical advice on how to avoid the problems commonly encountered by sessional GPs.

Having worked with sessional GPs, we understand how important it is that you understand your legal responsibilities from day one, whether you're salaried or working as a locum. Being familiar with the red flags that co-exist in day-to-day practice is an essential safeguard against possible legal actions.

First impressions

Locum GPs are in a unique position that could possibly expose them to more medicolegal risk than partners. Unlike permanent GPs, locums often only have one opportunity to make a good first impression, and a bad impression can provoke some patients to seek redress, when, in most cases, there has been no human error. MPS's experience is that a breakdown in communication and patients' dissatisfaction with a doctor's manner and attitude frequently give rise to complaints and claims.

Most incidents leading to medicolegal problems fall into one of the

following categories:

- Failure to appreciate legal and professional responsibilities
- Problems in clinical management
- Medication errors
- Administration errors
- Failure of communication, including inadequate medical records.

Vital legal concepts

Although doctors are not expected to be infallible, the law requires that they exercise a reasonable standard of skill and care at all times. It is vital to remember to never undertake a task that is beyond your competence nor without the right equipment; when in doubt, seek help from a more experienced colleague.

In most MPS cases where doctors have unwittingly fallen foul of the law, they were not aware of the legal principles that underpin their practice, or they did not understand the inter-relationship between medical practice and considerations such as consent, confidentiality, record keeping and communication.

Using *Sessional GP*, we've honed in on several of these important medicolegal principles to illustrate what salaried and locum GPs should be familiar with, in order to avoid sticky situations. The magazine is divided into medicolegal features, case studies and practical problems.

The medicolegal features begin with an article on how essential good communication is,

especially for locum GPs. Sara Williams explores how your body language could impact on your clinical practice. Other essential principles are tackled in the following articles on consent and medical records.

Cases form the heart of MPS's signature publication *Casebook*, but we've selected three cases that illustrate the interplay between practices and locums and how things can go wrong.

Practical problems

The last part of the magazine is devoted to tackling the practical reality in which sessional GPs work. Dr Richard Fieldhouse, founder of the NASGP, investigates whether it is a myth that locum GPs are becoming more mobilised and working in organised groups. Sarah Whitehouse and Sara Williams acknowledge that locums can feel excluded from the complaints process, and ask whether the new complaints system will encourage practices to better involve locums.

Locum GP Dr Judith Harvey identifies the top risks for locums in what she describes as the "risk sink" that is the NHS. Sara Williams builds on Dr Harvey's points,

and explores the difficulties of treating non-English speakers in the cultural melting pot that is UK general practice.

Working as a GP your skills may be called upon when you least expect it. I look at medicolegal dilemmas that you may encounter during routine activities like taking the children to school.

Sessional GP ends on the musings of Cumbrian portfolio GP Dr Euan Lawson, who describes locums as the Ray Mears of the GP world, and tackles the peculiarities that this presents.

As this is a new publication, we welcome feedback. If you would like to comment on our choice of articles, or suggest an article for the next issue, contact: sara.williams@mps.org.uk



Dr Richard Stacey
Editor-in-chief

Medicolegal features

**Good communication:
why it's worth it**



Essential guide to consent



Quick guide to medical records



Good communication: why it's worth it

Poor communication is a barrier to the delivery of effective care.
Sara Williams explores how to become a good communicator

Good doctors are good communicators – it's that simple. An Ipsos MORI poll published in November 2005 confirmed that the top characteristic the public wished to comment on in relation to their doctor's performance was their communication skills, followed by their technical ability, how much they involve patients in treatment decisions and whether they show their patients dignity and respect.¹

Understandably patients experience difficulties in assessing the technical competency of a doctor, so will frequently judge the quality of clinical competence by their experience or their interpersonal interactions with a doctor. Developing good communication skills will improve clinical effectiveness and reduce medicolegal risk. Effective interpersonal skills are particularly important for locum GPs because they often have only one chance to make a good impression.

Tips for effective nonverbal communication

- Observe
- Show respect
- Be patient
- Be self-aware (posture, eye contact, first impression)
- Be curious
- Assess patients' moods
- Show empathy.

The GMC's view

Over recent years the doctor–patient relationship has evolved, moving from a paternal to a partnership model. In its most recent edition of *Good Medical Practice*, the GMC says that doctors should “work in partnership with patients” by listening and responding to their concerns and preferences, giving them “the information they want and need in a way they can understand”, respecting their right to be involved in decisions about their treatment and care, and supporting them in their own efforts to “improve and maintain their health”.² The GMC expects doctors to be effective communicators, so what if you are not?

How to communicate effectively

It is often said that body language speaks louder than words. 80% of communication is non-verbal, so it is crucial to the patient encounter. A mismatch between verbal and nonverbal communication can lead to a strained encounter for both doctors and their patients.

Being aware of your own body language is the first step in understanding how your body language is perceived. Maintaining eye contact demonstrates that you are listening and showing an interest; this is particularly important at the beginning and end of a consultation. Turning away and facing

a computer indicates disinterest, so the patient may not give information critical to the consultation.

Interruptions, and cutting off a patient before they have finished, are not effective means of communication. Beckman found that the mean time taken for a doctor to interrupt a patient's opening statement was 18 seconds.³ His research

been met. Although these expectations may be unrealistic, eg, the doctor will have unlimited time and availability, they will solve all the issues at once and all treatments will be 100% effective, these expectations can be addressed if they are identified early on. So, once explored and respectfully corrected through effective communication, the patient



A mismatch between verbal and nonverbal communication can lead to a strained encounter for both doctors and their patients

showed that patients rarely presented problems in order of clinical importance, so allowing patients to complete their opening statement led to a significant reduction in late-arising problems. The longer a doctor waits before interrupting, the more likely the patient will “get to the point” quicker, thus avoiding presenting the key issue at the end of the consultation, where the adherence to time constraints could appear heavy-handed.

Handling patients' expectations

Part of communicating effectively is handling expectations. Patients will be dissatisfied if their expectations have not

will leave content with their treatment and more likely to comply with it.

When things go wrong

Despite the best intentions, some patients will remain dissatisfied and seek redress. In most cases this is not down to human error. MPS's experience is that a breakdown in communication and patients' dissatisfaction with a doctor's manner and attitude frequently give rise to complaints and claims.

Research by Bunting suggests that there are two sets of factors which influence the decision to sue or seek redress:

- **Predisposing factors**
 - rudeness, delays, inattentiveness,



miscommunication, apathy, no communication.

■ Precipitating factors

– adverse outcomes, iatrogenic injury, failure to provide adequate care, mistakes, incorrect care, systems errors.⁴

According to Bunting, precipitating factors are unlikely to lead to litigation in the absence of predisposing factors; yet the media tends to report on the former rather than predisposing factors.

So good communication could save your professional skin; patients who feel informed about their condition and are involved in deciding the appropriate treatment are more likely to comply with it and less likely to complain when things go wrong.

However, should you receive a complaint, it is important to talk to an experienced colleague or your medical defence organisation, and it is vital to try to retain your professionalism. This is particularly pertinent for sessional GPs, so make sure that through the practice you:

- Acknowledge the complaint
- Find out the facts
- Provide an explanation
- Apologise where appropriate
- Identify what can

be done to prevent similar issues arising

- Adopt those lessons into your future practice.

Communicating with colleagues

In today's team-driven environment communication has to extend to a greater number of people, so there are more opportunities for it to fail. Communication between primary, secondary, voluntary and social care should be viewed not as a chain but as a communication net, where all members can contact each other. This requires all members to be aware of who is doing what and understand the part they play. This will inevitably involve sharing patient information, which is entirely appropriate as long as continuity of care is balanced with the need to maintain confidentiality.

In its new confidentiality guidance, the GMC says that most people understand and accept that information must be shared within the healthcare team in order to provide their care.⁵ But it is not always clear how that information will be used. So patients should be informed about disclosures for purposes other than what they

would expect. If a patient objects to the disclosure, you should explain that you cannot refer them or otherwise arrange for their treatment without also disclosing that information.

Working as a locum GP, your colleagues should provide all the relevant details of the patients for whom you are responsible. Practices should have in place protocols for the transfer of relevant information between doctors. However, many do not cater for the nuances of working as a locum, so locums should have in place their own systems to ensure adequate clinical handover.

Overcoming hurdles

Locum GPs, unlike their permanent colleagues, face the unique challenge that they often only get one chance to make a good first impression. Patients will be unfamiliar with a new GP's mannerisms and may be used to a particular GP, so they will be more likely to pick

up on, and make an issue of, poor communication.

A well-organised locum chambers should provide laminated profiles of its members that reassure and inform patients about the GP they're about to see, as well as working with the practices to apply consistent communications systems between its locum GP members and practices.

Be very stringent about documenting any advice given and record all of the patient's concerns. Listen and respond accordingly; body language is key to effective communication – being comfortable in an unfamiliar setting can be challenging for a sessional GP, but don't shy away from moving a computer if it is creating a situation where you are facing away from the patient and remove books that could act as a barrier. Be aware of all these things and communication will no longer be a barrier to effective patient care. **SGP**

1. Ipsos MORI, Health Professional Qualifications poll (November 2005) – www.ipsos-mori.com/researchpublications
2. GMC, *Good Medical Practice* (2006)
3. Beckman, HB, The effect of physician behaviour on the collection of data, *Ann Intern Med* (1984)
4. Bunting, R, et al, Practical risk management principles for physicians, *Journal of Healthcare Risk Management* (1998)
5. GMC, *Confidentiality* (2009) pars 25-29

Essential guide to consent

The GMC's guidance on consent – *Consent: patients and doctors making decisions together* – is the most important document for GPs. Here is a breakdown of the contents

Why obtain consent?

It is not only good practice to be familiar with consent guidance, but the GMC will judge your practice against it, which could have a bearing on your future career. Even the briefest physical examination cannot be performed without consent. No-one has the right to touch anyone else without lawful excuse and if doctors do so it may well undermine patients' trust. If consent is not obtained, a clinical negligence claim, a complaint or even civil or criminal proceedings for assault could follow. Respect for patients' autonomy is expressed in consent law; to impose care or treatment on people without respecting their wishes and right to self-determination is not only unethical, but illegal.

What is consent?

Consent must be freely given by a competent patient voluntarily making an informed decision. Consent is about more than a single decision; rather it is a process to inform the patient of the nature and purpose of their condition and its treatment. Consent must fulfil three conditions to be legally valid. The patient must be:

- capable of giving consent.
- sufficiently informed to make a considered decision
- giving consent voluntarily.

Who should take consent?

If you are providing treatment, it is your responsibility to obtain consent. If you are asked to get consent for a particular treatment you should only do so if you are competent.

Who can give consent?

Patients under the age of 16 may or may not have the capacity to consent to treatment. The test of capacity in children is still whether or not they are Gillick competent. If they are able to understand information about their condition and the implications of either, proceeding with the treatment, or doing nothing, they should be considered competent to provide consent. The capacity to consent depends more on a young person's ability to understand and weigh up options, than on age. When assessing a young person's capacity to consent, you should bear in mind:

- at 16 a young person can be presumed to have the capacity to consent.
- a young person under 16 may have the capacity to consent, depending on their maturity and ability to understand what is involved. If the child or young person withholds consent or is lacking capacity, someone with parental responsibility can consent on their behalf. In cases where a child is likely

to be adversely affected, a parent's refusal to consent in these circumstances can be overruled by the courts.

How should consent be given?

According to the GMC, you must give patients the information they need about:

1. The diagnosis and prognosis
2. Any uncertainties, including options for further investigations
3. Options for treating and managing the condition, including the option not to treat
4. The purpose of proposed treatments and what they will involve
5. The potentials risks, burdens and likelihood of success of each option
6. Whether a treatment is experimental
7. Who is responsible for the treatment and the seniority of those involved, to what extent students will be involved
8. Their right to refuse to take part in research or teaching
9. Their right to seek a second opinion
10. Any bills they will have to pay
11. Any conflicts of interest that you may have
12. Information on any better treatments than the ones offered by you or your organisation.





LA/SCIENCEPHOTOLIBRARY

The exchange of information will vary depending on each patient's experience, but no assumptions should be made about the sort of information they might need. Opportunities should be made available for asking questions, and efforts made to listen to the patient's concerns and views. You should check whether the patient has understood the information and make it clear that they can change their mind about a decision at any time.

What if a patient cannot consent?

Both legislation and the GMC's guidance emphasise that doctors should presume adults have the capacity to consent to or refuse a proposed treatment unless it can be established that they lack that capacity. Each assessment of a person's capacity should relate to a specific decision.

England and Wales, Northern Ireland and Scotland all have different ways of assessing an individual's capacity (See *MPS Guide to Consent* for more details), but underlining all three is that a person's capacity, or lack of it, cannot be judged simply on the basis of age, appearance, condition or any aspect of their behaviour. Even if a patient lacks capacity, the onus upon health professionals is still to involve patients insofar as is possible in decisions that affect their lives. **SGP**

Consent quiz

1. A patient's signature on a consent form automatically means they have given consent.
TRUE / FALSE
2. Consent must be taken by the doctor doing the procedure.
TRUE / FALSE
3. If the patient does not want information about the procedure or the information is likely to make them anxious, you should not mention it.
TRUE / FALSE
4. If information leaflets set out all that the patient needs to know about the procedure, there is no need for the doctor to explain the procedure as well.
TRUE / FALSE
5. When discussing treatments you should describe any serious or frequently occurring risks.
TRUE / FALSE
6. Patients have a right to refuse treatment even if they may die as a result.
TRUE / FALSE
7. A competent patient has the option of nominating a person to make certain decisions for them.
TRUE / FALSE
8. In an emergency, when you cannot obtain consent, you can provide urgent treatment.
TRUE / FALSE
9. Intimate examinations require express consent.
TRUE / FALSE
10. Children under 16 years cannot consent to medical treatment.
TRUE / FALSE
11. Advance directives or living wills are binding on the doctor treating the patient.
TRUE / FALSE
12. A patient can refuse to be tested for HIV.
TRUE / FALSE

Useful links

- Department of Health, *Reference guide to consent for examination or treatment, second edition* (2009)
- DCA, *Mental Capacity Act 2005: Code of Practice* (2007) www.dca.gov.uk
- *Adults with Incapacity (Scotland) Act 2000: Code of Practice* (2002) www.scotland.gov.uk
- GMC, *0-18 Years: Guidance for all Doctors* (2007)
- GMC, *Consent: Patients and Doctors Making Decisions Together* (2008)

This article is intended as a brief summary of consent. For a detailed exploration access the *MPS Guide to Consent in the UK* available in the publications section of the MPS website – www.mps.org.uk. To request a copy contact Vicky Colthart on 0113 241 0530.

Find the answers to these questions on the MPS website – www.mps.org.uk

Quick guide to medical records

Clinical records contain sensitive personal data, contributed to by a number of clinicians over a varying period of time. Keeping them secure from prying eyes or inadvertent disclosure is a legal as well as a professional responsibility

Why keep records?

The GMC expects GPs to keep clear and accurate notes detailing the relevant findings, the decisions made, the information shared, any drugs prescribed and other investigations, at the same time as the events you are recording or as soon as possible afterwards.¹ You are professionally obliged to keep good records.

In the event of a complaint, clinical negligence claim or disciplinary proceedings, the medical record will contain the factual base for your defence. Cases can be difficult to defend if information is missing, inaccurate or indecipherable.

What makes good clinical records?

Good records will contain all the information one clinician will need to take over where another left off; they should be clear, objective, contemporaneous, attributable and original. The mnemonic **SOAP** is a useful reminder of the content that should be included:

- **S**ubjective – what the patient says
- **O**bjective – what you detect – examination and test results
- **A**ssessment – your conclusions – often differential diagnosis
- **P**roblem list and **P**lan – management and follow up. Be wary of using abbreviations that can be misinterpreted. Derogatory

terms and comments have no place in clinical records.

Ways to avoid problems when handling records?

- Obtain a patient's consent and record it, before disclosing information to a third party.
- On rare occasions it may be necessary to disclose information either without consent or if the patient declines their consent. In such circumstances you should be able to justify the disclosure, if called upon to do so.
- Make patients aware that their information will be shared among health professionals on a "need-to-know" basis.
- Ensure that each practice in which you work in has a data controller under the provisions of the DPA (1998).
- Be conscious of inadvertent breaches of confidentiality, eg, talking loudly in a reception area, checking that the information you send by fax will be received in a secure place, etc.
- Do not leave records lying around.

When is disclosure of information acceptable?

- If information is disclosed to insurance companies, employers and people involved in legal proceedings, it must be limited to the authority provided by the patient.
- A doctor must not disclose

personal information to a third party, such as a solicitor, without the patient's express consent. There is also an obligation to inform the patient whose personal information is being sought.

- If a court orders you to disclose health records you should comply with the request; but it would be reasonable to raise objections if the court is seeking to compel the disclosure of irrelevant information.²
- Where GPs have a statutory duty to report certain information, eg, notification of births, deaths, infectious diseases, certain terminations of pregnancy – without obtaining consent.
- The police have no more right to access confidential information than anyone else, except under the following circumstances:
 - Under road traffic legislation, where they may need the name and address of somebody
 - The patient has given consent to release the information
 - In compliance with a court order
 - In a case when consent is not obtainable or declined, the public interest in disclosing the information outweighs the public interest in preserving it. Specifically if it is to protect individuals or society from risks of serious harm.

When is disclosure more complicated?

The GMC recommends obtaining consent before using patients' histories or photographs for education and training, although this is currently undergoing consultation. When it is necessary to use patient identifiable information, or it is not practicable to anonymise it, you should seek patients' consent.

Discussing information with relatives can be problematic. In general, information should be given to the patient who can share it with their family.

Drivers have a legal obligation to inform the DVLA if diagnosed with a medical condition that could impair their fitness to drive. If they refuse, the GMC advises doctors to contact the DVLA and inform the patient that they have done so.³

In circumstances where you think a child is at risk, their best interests are paramount. This may require disclosure to social services or even the police. Consent should be obtained from the parents where possible, except in cases where this would put the child at risk.

¹ GMC, *Good Medical Practice* (2006), para 3f and g

² GMC, *Confidentiality* (2009) para 21–22

³ DVLA, *At a Glance Guide to the Current Medical Standards of Fitness to Drive* (September 2007) – www.dvla.gov.uk/medical/ataglance.aspx

Read MPS Guide to Medical Records, available in Publications on the MPS website.

Case files

More than a headache



Too little, too late



“One last thing...”



Too little, too late

This case serves as a reminder of the importance of taking a detailed history and thoroughly investigating all angles

Mr A, a retired electrician, went to see his GP, Dr F. Recently his cousin had been diagnosed with a rare, inherited haematological condition and he wanted to know if he had it too. As part of the work-up, Dr F requested a full blood count (FBC) and serum ferritin.

The tests showed that Mr A hadn't inherited the condition, but revealed borderline anaemia, with a significantly low serum ferritin. The anaemia was not investigated, nor were arrangements made to follow it up.

Six months later, Mr A had a private medical-screening examination. A further FBC showed persistent anaemia. A faecal occult blood (FOB) test was strongly positive. This information was forwarded to Dr F. She repeated the FBC and haematinics, finding Hb just inside the normal range. Serum ferritin remained grossly depleted. Dr F suspected this was due to a bleeding intestinal polyp and initiated no further investigation.

Two months passed and Mr A saw Dr F again, complaining of epigastric pain, which Dr F attributed to dyspepsia due to stress.

Mr A's pain persisted, so he saw a locum GP, Dr O, who documented that

Mr B's bowel habit wasn't altered. An abdominal examination was recorded as normal. No rectal examination was performed.

Three months after this, Mr A suffered constipation and requested a laxative. A prescription was issued and he was asked to attend the surgery. He saw a partner who, noting a five-month history of abdominal pain and the previous positive FOBs and anaemia, requested an urgent surgical outpatient opinion.

Before he was seen, Mr A was admitted to hospital as an emergency, with intestinal obstruction. He was found to have a large, stenosing adenocarcinoma of the sigmoid-colon, which had metastasised to his liver.

He died within a year of being diagnosed.

A claim alleging negligent investigation of Mr A's test results and clinical complaints by Drs F and O, was brought by Mr A's family.

Expert opinion

Expert GP opinion was critical of Dr F. "The correct response to the blood test results was ... to carry out a detailed history in regard to diet and gastrointestinal complaints, conduct an examination and almost certainly to consider bowel investigation." This was



AJ PHOTO/SCIENCEPHOTO LIBRARY

even clearer when the FOBs became available. Dr O's failure to relate the abdominal pain to the previous laboratory findings was similarly criticised.

Surgical opinion was that had Mr A been diagnosed when he was found to be anaemic, his chances of survival would have been greater, as metastasis was unlikely to have occurred at this stage. The claim was settled.

Further reading

Unexplained iron-deficiency anaemia requires investigation. The British Society of Gastroenterology has published guidelines for the management of iron

deficiency anaemia, which can be found here on their website: www.bsg.org.uk.

NICE has produced referral guidelines for suspected cancer, available on their website: www.nice.org.uk. The guidance is due to be reviewed in June 2010. **SGP**

Case reports

MPS publishes medicolegal reports as an educational aid to members and to act as a risk-management tool. The reports are based on issues arising in MPS cases from around the world. Facts have been altered to preserve confidentiality.

More than a headache

Hearing about others' experiences can provide the inside track on how to perfect your practice. In this case a different approach could have resulted in another outcome



HIDESY/ISTOCKPHOTO.COM

Miss H was 25, had hardly ever been to her GP and was not taking any medication. She was a keen salsa dancer and lived in a flat with two friends.

Miss H had just started working as a qualified accountant. One afternoon, she left work early and went to her GP practice because of a severe headache. She saw Dr S and explained that she was worried because she did not normally get headaches. Dr S established that Miss H did not have any other symptoms and reassured her that this was probably a tension headache. He prescribed paracetamol and advised Miss H to get a good night's sleep.

Miss H missed her dance class that evening and felt too ill to work the following day. She went back to her GP practice, but Dr S had no free appointments so she saw a locum Dr A instead. When Dr A heard that Miss H was now vomiting, he suspected that she was having a migraine. He advised her to go home and rest. Dr A explained to Miss H that her symptoms would probably improve over the next few hours. If not, he advised her to come back to the surgery or go to A&E.

Miss H went home, but

didn't manage to sleep. She wasn't feeling any better by early evening, so she went to her local A&E department. She explained to Dr W, a junior doctor, that she'd already seen two different GPs, but still had a headache. Dr W decided to see how Miss H progressed after more paracetamol and an anti-emetic. By the early hours of the morning, Miss H seemed unchanged. She said her headache wasn't any worse, so Dr W decided to discharge her.

Although she did not feel any better, Miss H struggled downstairs the following morning. She lost consciousness at the breakfast table so her friends rang for an ambulance. At the hospital, a CT scan confirmed that she had had a subarachnoid haemorrhage. Before she could be operated on, she suffered a further haemorrhage.

Miss H was left with neurological disabilities. She initiated a claim against the GPs (both members of the MPS) and the hospital.

Expert opinion

GP experts were supportive of certain aspects of Dr S's care. His suggested

management was reasonable for a short history of headache in a previously healthy young woman.

Dr S did not suspect a subarachnoid haemorrhage and Miss H did not mention that her headache was of sudden onset.

They were also supportive of Dr A, as his assessment was deemed to show reasonable judgment. He advised Miss H what she could expect if she was having a migraine and told her what to do if her condition did not improve as he predicted.

However, the experts were concerned that neither GP had made a note of whether the headache was, or was not, of sudden onset, and had not recorded the intensity.

An expert in emergency medicine was critical of the care given to Miss H at the A&E department. Miss H had had a severe headache for over twenty-four hours by the time she went to hospital. Dr W should have ruled out serious causes of headache, such as subarachnoid haemorrhage. From the A&E records it seemed unlikely that Dr W had asked about the onset and severity of the headache.

The claim was settled by

the hospital, with a small contribution from MPS on behalf of the GPs.

Learning points

- Subarachnoid haemorrhage crops up frequently in MPS case files. Although it is rare, in cases of headache it is important to consider it.
- Patients do not necessarily know what is important about their history, yet most diagnoses are made on history. It is up to the doctor to find out any potentially significant details that a patient does not volunteer. In this case, nobody established whether or not Miss H's headache was either of sudden onset or its true nature. This should be asked and recorded in cases where subarachnoid haemorrhage is a possibility.
- When patients present repeatedly over a short period of time with symptoms that are not improving, it is important to reconsider their diagnosis. Do not assume that relevant questions have already been asked. Eliminate serious possibilities first. **SGP**

“One last thing...”

Poor record keeping and inadequate handovers can have serious consequences for patients. In this case an important diagnosis was not made until it was too late

Mrs F was a married 30-year-old dinner lady with two children. She presented to her GP, Dr L, with symptoms of weight loss, palpitations, increased sweating and general restlessness.

Mrs F had no significant past medical history and, other than the combined oral contraceptive pill, was on no other medications. Dr L took a history and examined her, then arranged for some investigations, including thyroid function tests, which confirmed she had hyperthyroidism.

After assessment by the local endocrinology department Miss F was put on appropriate medication and returned to the care of her GP. She attended the surgery several times over the next two months for further blood tests and follow-up appointments. At these appointments, Dr L discussed Mrs F's condition and the management plan with her. He organised regular monitoring and ensured that she was able to tolerate the treatment that he was prescribing for her.

On two occasions, as Mrs F was leaving the room, she mentioned to Dr L that although she was feeling much better following the treatment for the thyroid problem, she had begun to experience vaginal bleeding after intercourse

with her husband.

Mrs F said she had heard that this could happen sometimes when women took the contraceptive pill, and sought reassurance. Unfortunately, there was no record made of these discussions in her consultation notes and no action was taken to deal with the reported symptoms.

Over the next year, Mrs F's care for the hyperthyroidism was reviewed by a local endocrinologist. Her GP, Dr L, did not see her again until almost 12 months later when Mrs F made an appointment with a locum in the practice, Dr Y. The post-coital bleeding had continued and it had become darker in colour. She was also suffering from intermenstrual bleeding and intermittent discharge.

Dr Y performed a pelvic examination, which was noted in the consultation notes to be “normal” and then made arrangements for Mrs F to return to have a smear test at another appointment with the nurse.

Three weeks later, she was seen at the local emergency department following an episode of heavy vaginal bleeding.

She gave a two-year history of post-coital bleeding and confirmed that she had told her GP, but had been reassured. She was referred to the on-call gynaecologist and investigations including

colposcopy and a CT scan revealed an advanced cervical carcinoma.

Mrs F made a claim against the surgery experts considered the patient's management indefensible and the case was settled.

Learning points

- Remember the red flags for referral for gynaecological cancers:
 1. Consider urgent referral for a woman with persistent intermenstrual or post-coital bleeding, even with a normal pelvic examination.
 2. If lesions suspicious of cervical or vaginal cancer are seen on speculum examination a cervical smear result is not needed before referral and a previous negative smear test is not a reason to delay referral. (NICE guidelines).
 3. The first symptoms of gynaecological cancer may be an alteration in the menstrual cycle, intermenstrual, post-coital or post-menopausal bleeding, or vaginal discharge. If a patient reports any of these symptoms the doctor should undertake a full pelvic examination, including speculum examination of the cervix. Review NICE guidelines at www.nice.org.uk.
- When a patient mentions something to you, even in passing or on their way out of your room, you have a duty to take appropriate action. It is useful to remember that the consultation only ends when the patient has left the room. Making a record and asking the patient to make another appointment to discuss the symptoms, in detail, may prevent delays in investigation and diagnosis.
- Be aware of your responsibilities towards ensuring that patients who miss cervical smear tests attend in the future – for example, by asking opportunistically about their missed tests if they attend for other reasons.
- If it is not convenient at that time, then make arrangements for the patient to come back at a later date. A detailed record should be made in the notes. **SGP**



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Practical problems

What's the buzz about teamworking?



What complaint?



Treating non-English speakers



What's the buzz about teamworking?



In the run-up to revalidation, “locum teams” has joined a family of oxymorons such as “open secret” and “found missing”. But are locums really working in well-organised groups, or is it a myth? *Dr Richard Fieldhouse*, founder of the National Association of Sessional GPs (NASGP), investigates

ALLE/STOCKPHOTO.COM

All great solutions descend from a problem. You cannot invent something if there is not a need for it in the first place. The creation and development of our locum chambers not only prove this, but the huge change that it's bringing to locum GPs illustrates the sort of problems faced by locums.

More than “just a locum”

My colleagues and I started working as a team because locuming independently wasn't effective. We ran a local voluntary locum group. This was a reliable way of meeting fellow locums and getting all our practice woes off our chests, but it was hit and miss – attendance was patchy and there was little or no commitment from some members to work more closely. So we put a small business plan together and made a commitment to create a team of like-minded locums to transcend all the misconceptions of being “just a locum”.

The Holy Grail of locuming

To do this, we needed to achieve the ultimate goal of good locuming, which tied in all aspects of clinical governance, booking work and professionalism.

Our basic idea was

to appoint some clinical directors to oversee the running of smaller discrete chambers, each with no more than 12 members and each with a chamber leader. The clinical directors would employ staff to take on all the non-clinical aspects of running each member's day-to-day non-clinical business, such as booking, invoicing, banking, certification, appraisal, information and marketing, etc. This proved successful.



My colleagues and I started working as a team because locuming independently wasn't effective

Now, all new members are interviewed by a clinical director and a chambers lead. If it goes well, and their references are excellent, then they are accepted into one of the chambers, subject to all other members agreeing and a six-month probation period. So teamworking has proved a real benefit for locums, but it is also beneficial for the reasons which I will now discuss.

More consistency

All members – and practices – have to sign up to the chambers terms

and conditions. These conditions are not designed to act as small print to tie members in, but they are a liberating guide to how we can work most effectively in a way that benefits all the members, the practices we work for, and their patients.

For example, all members are asked to use the name badges and door plates provided for them. Apart from the obvious benefit of staff and patients being able to see our names, the removal

network of feedback systems and processes aimed at allowing individuals, separate chambers and practices to monitor all our professional interactions. For conventional independent locums, such monitoring would be hard to achieve and, as loosely-affiliated individuals within a conventional locum group, it would be a complicated spider's web. But as a coherent and highly-organised team, with access to financial and physical resources, our managers and directors facilitate the collection of pertinent information from practice staff, patients, consultants and other team members.

...and have access to more learning

Together with a rolling programme of formal clinical meetings to discuss and plan outcomes from all these sources, not only do we learn more about our personal clinical practice, but we are fully empowered to actually do something to improve it too.

You can spread “best practice”

Periodically, each chamber chooses a practice that it would like to pass on advice to – whether this is regarding the repeat prescribing procedures (or lack of), the heavy-handed

of professional anonymity brings with it a sense of emancipation that focuses our minds as professional GPs in our own right, and gives us an enhanced sense of control over our working environment.

You get more feedback...

How am I doing? What's the rest of my team up to? What do others think of us? What is it that makes our locum team work? Asking questions is a great way of gaining feedback. Cementing our chambers together is a

allocation of visits (we have strict guidelines on this) or the way diabetic care is managed. Equally, we like to let excellent practices know what we think of them too. Working in so many different practices and being exposed to many different systems and processes, there are no professionals better placed than a team of locums to really point out exactly where a practice's strengths and weaknesses lie.

After collecting feedback from members of our team, one of our clinical directors then collates the feedback into a useful format and presents this, with considered advice, to the practice manager.

We have more control over our working environment

Our enhanced reputation as a highly-organised group of professional locums means that many practices prefer to work with our members. They prefer not to risk using a GP they don't know as well, and our chamber managers make the booking process much simpler and safer.

This also puts us in a good

position to lay down the law with a practice that feels it doesn't have to treat locums with any seriousness. Our managers can insist upon the minimum conditions as defined by our team. For example, a practice that did not have a confidential username or password would mean that locums who had previously worked there would not have been properly protected. We would tackle this with a swift call from our managers, to make sure that it didn't happen again.

It is more fun

Although it can be lonely working as a partner, independent locuming can be extremely isolating. But as a team, with its collective financial and organisational resources, and the necessity for obligatory attendance at meetings, isolation is not an option. Members get to know each other well, both socially and professionally, and our team has spawned many firm friendships. Lavish summer parties, and team-building skittles evenings and quiz nights, are blended in with our formal internal chambers meetings

and slightly less formal educational evenings, where all other local sessional GPs are invited too.

It raises standards

Our hard work to improve the working environment for our members has a knock-on effect for local locums who are not members of one of our teams. As well as organising local educational events for other locums – this requires taking on the role of “informal local GP tutor for sessional GPs” – practices are effectively trained to take better care of other independent locums.

It improves workforce planning and recruitment

Geographical areas with groups of locums who work in similar managed teams tend to be more “chaotic”, in terms of how locums are assigned and managed to different practices. In these areas, as it is left much more to chance, practices use alternative methods to cope with a shortfall in GP manpower, using internal cover, a nurse, cancelling appointments or just making do without. Booking a locum can

sometimes be so much hassle that it's simply not worth it. But we're finding that practices seem to be using us more and more, and looking upon using a locum as a positive experience rather than a neutral, or even negative, one.

Looking forward

The ethos of the chambers is to improve our working lives; there's no commercial “tie-in” like a locum agency. In fact, when new members join, we gauge their career aspirations and endeavour to place them in practices that are looking to recruit a new partner or salaried GP.

Working as a GP can be a risky business and we need to be extremely aware of how important it is to practise in a safe environment. A safe environment is one that we have control over. Working as a team creates the domain of possibility for locums to thrive as professional GPs in their own right, which is not only good for us, but for our practices and our patients. **SGP**

Dr Fieldhouse is also clinical director of Pallant Medical Chambers; he regularly appears in the medical press.

What complaint?

Dear Sir,

Locums often feel excluded from the complaints process. *Sarah Whitehouse and Sara Williams* explore whether the new NHS complaints system will encourage practices to better involve locums

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When it comes to responding to complaints, one of the biggest hurdles for locums to clear is actually being told about them, as one locum recently pointed out: “Practices simply don’t tell us that we’ve had a complaint”. This can lead to a situation that leaves not only locums, but patients in the dark.

A new system

The Department of Health has reformed the NHS and social care complaints system so that it is more open and accountable, fair and proportionate and above all patient-focused. A two-tier system was introduced in April 2009, with the Parliamentary and Health Service Ombudsman (PHSO) holding responsibility for handling second-stage complaints. If a patient cannot resolve their complaint locally, they can take it forward to the PHSO.

But will this new system encourage practices to involve locums in handling complaints more frequently? The answer to this question is yes;

complaints against locums should be investigated by the practice and, if they have left the practice, they should be contacted if possible for their comments.

Handling complaints

There is likely to be a new system in place following the government’s changes, so when you start working at a practice you should familiarise yourself with their complaints procedure during your induction. There should now be one person within the practice who administers the procedure for more serious complaints, but minor complaints should be resolved “on the spot” if possible. This might mean offering an immediate apology or explanation in response to a patient’s expression of dissatisfaction and trying to solve the problem with them.

The complaints manager

The complaints manager’s role is to ascertain the facts relating to a complaint, assess the evidence and report the findings. Complaints should:

- normally be acknowledged within three working days
 - be handled flexibly and responsively, in consultation with the complainant if possible
 - investigated and resolved as speedily as possible, giving the complainant a full, clear explanation and, if mistakes have been made, an apology
 - feed into clinical governance and service improvements.
- The complaints manager will prepare a report on the findings. In the document *Listening, responding, improving: a guide to better*

to the DH: “Before the report is finalised everyone involved should be given the chance to give their views on what has been said.”

So if a complaint concerning your practice is being investigated, the complaints manager should seek your views, if possible, whether you are a locum or a partner. This will probably involve being asked to attend a fact-finding interview or writing a witness statement. If you find yourself in this situation stick to the facts and avoid offering opinion, speculation or defensive justifications. You may wish

“A good locum will practise with empathy. Put yourself in the complainant’s shoes, and tailor your responses to their needs

customer care, the DH states that the manager should have an open dialogue with both parties so that their final report does not surprise anyone involved. According

to see a copy of the reply the practice intends to send to check it for factual accuracy.

Complainants now have 12 months from the occurrence giving rise to the complaint

or from the time that they become aware of the matter, to make a complaint. The complaints manager will retain the discretion to investigate complaints brought later than this if there are good reasons for the delay and it is still possible to carry out the investigation.

The locum's role

In *Good Medical Practice*, the GMC says patients "have a right to expect a prompt, open, constructive and honest response, including an explanation and, if appropriate, an apology". Remember, an apology is not an admission of liability so be prepared to meet with the patient, or complainant, and liaise with the complaints manager. See it as an opportunity to listen to the patient, understand the reasons for the complaint and how the relationship can be taken forward and any similar problems avoided in the future.

Most complaints are an opportunity for learning, so good practices will hold a Significant Event Audit (SEA). If you are involved in the complaint, suggest being involved in any subsequent SEA meetings. This will offer a chance to liaise with the practice team and learn from the complaint.

Record keeping

You should always keep good medical records and this is particularly important if a complaint is made as this will help you remember what happened and assist you in providing a clear explanation if asked for your comments. In *Good Medical Practice*, the GMC says Keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients and any drugs prescribed or other investigations or treatment. In addition it is helpful to document any follow-up advice.

Practising empathy

A good locum will practise with empathy. Put yourself in the complainant's shoes, and tailor your responses to their needs. Understand the emotional impact that the events leading up to the complaint may have caused, and be aware that emotions may be highly charged. Keep calm and keep body language neutral during any subsequent complaint meetings. The tone of any responses should be conciliatory and empathic.

Claims

While complaints may occur immediately after an adverse incident, claims often take longer to arise. For this reason it is more likely that, if you are involved in a claim, it will be connected with an incident at a previous practice that you worked at. There are particular reasons to be cautious if this happens.

The first you may know about such a claim might be through contact from a solicitor, and it may not be obvious whether they are acting for the NHS Trust or the patient. It is important to establish this. They may well ask you a series of questions or invite you to make a statement. There are a few points to note:

- Establish the facts – do not be tempted to rely on your memory. Ask to see the medical records, so that you can remind yourself what happened, and write any statement based on these. If you are not able to see them, contact MPS for advice.
- Stick to the facts – you may be invited to give an opinion on particular issues, but this is the role of an independent medical expert. Simply record your involvement in the case, don't speculate about future management or what happened next.



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- Contact MPS – if you feel vulnerable about your involvement, or would like help with writing a report or statement, do not hesitate to contact us.

Future complaints

Only time will tell whether locums feel more involved in complaints handling, but the new system is tighter and less bureaucratic, and the

additional guidance implies that complaints against locums cannot be handled effectively without gathering their input, where possible. One thing that is clear is that where a locum is involved in a complaint in an environment where regulators are pressing hard for increased communication, transparency and more accountability, the locum's viewpoint becomes indispensable. **SGP**

Further reading

It is important that you are familiar with the new complaints procedure; MPS has produced a number of resources, eg, booklets, factsheets, web links, to help you understand the new regulations. They can be assessed at: www.medicalprotection.org/uk/factsheets/complaints

Top ten risks for locum GPs

The risks locum GPs meet day-to-day are different from the risk sink of the NHS – *Dr Judith Harvey* identifies the top ten

Practices have to provide safe working environments for all their staff, but the structures they create are designed with their permanent staff in mind. Locums need to be aware of this and manage their own risks from day one. The top ten risks to be wary of are:

1) Misplaced assumptions

Practices often have unrealistic expectations of locum GPs, and locums can be over-optimistic about how practices will treat them. False assumptions about hours, duties and payment frequently taint the relationship. Practices expect different things from locum GPs, and likewise locum GPs expect certain things from practices.

Solution – Both parties need to work together to foster realistic expectations and develop a shared understanding of how to work together effectively. Realistically, it is up to locums to demonstrate what being professional means. This will require the locum GP in particular to be proactive in ensuring that

a professional approach is followed. For instance, submitting a NASGP booking form outlining the job to be done, insisting on signed contracts with practices and ensuring that the practice has adequate protection to cover your own liabilities.

2) Lack of information

It's amazing how many practices think a locum is born knowing that they hold a venesection session between 2pm and 4pm on alternate Thursdays. Not knowing how to get even simple things done is not just frustrating, it affects the quality of care a locum can deliver. Information about practice-based services and secondary care and support services outside the surgery is essential to deliver the best care.

Solution – A locum information pack. But someone has to create it and keep it up to date. Insist that practices recognise their responsibility to reduce enforced underperformance. Draw their attention to the Standardised Induction Pack developed by MPS and the NASGP. And encourage locum colleagues to help each other by sharing information.

3) Time pressure

Practices want a job done, and rarely allow

locums the extra time they need to practise safely in a strange environment. A doctor under time pressure is more likely to make mistakes.

Solution – Explain the realities of being a locum to the practice manager: a safe locum may need longer to consult than the partners.

4) Professional isolation

Locums spend a lot of time on their own. It is easy to let continued professional development slip. It can be hard to stay in touch with important information, eg, how many locums received the swine flu cascades? Locums can become paranoid about the way colleagues treat them, and have no idea what to do about it.

Solution – There are more than 90 sessional GP support groups, so there should be one near you. Join. Share clinical and practical problems, and gain from the wisdom and backup of doctors who understand what being a locum is all about. And lobby your PCO about their role in supporting locums.

5) Transfers of information and handovers

The next doctor the patient sees will be someone else. And a locum isn't there to check that urgent action has been carried out.

Solution – Good clinical notes are essential for safe handovers and information transfer between GPs. To ensure that urgent cases are reviewed, worrying results followed up, and referrals made, develop a checklist and hand over, not just by word of mouth, but by paper and electronic means. You may take longer to consult new patients than the partners and you may find that you write longer notes, but this will safeguard your practice. Develop your own systems and safety checklist to follow before each handover.

6) New patient, new doctors

To you, every patient is likely to be a new patient, especially when you're called at short notice, eg, when a partner is sick. Receptionists don't know locums either: this could create a situation that does not engender confidence.

Solution – Send, or take a written profile with a picture, containing information on your training, experience and background, to the practice – to introduce yourself.





7) Fitting a square peg into a round hole

Locum GPs do not fit into the traditional partner model. Few practices know how to make the most of them and deliver a good continuity of care. Most practices are not akin to their particular needs.

Solution – Develop realistic expectations by explaining what your job as a locum entails and what you need to do your job well. Cultivating good communication with other GPs and practices will make this easier to achieve.

8) Risky tasks

Practices often expect locum GPs to perform tasks, such as signing repeat prescriptions, which are risky if you don't know the patient.

Solution – Speak to the practice manager. If he or she thinks you are being difficult, explain that repeat prescribing is a common source of medical error, and it's a risk for the patients and the practice. Explain that if you are going to do it, you need more time because you have to check each patient's notes. The practice has to understand this and pay for it. It's in their interest. Before you agree to sign repeats, make sure you know how the practice reviews repeat prescriptions. If the system is unsafe, say no. And consider who needs to know that there is a problem.

9) A clash of beliefs

A locum may hold a conscientious objection to a particular treatment or procedure, eg, abortion. It is important that patients do not get stuck in the middle of a moral debate. Nor should everyone's time be wasted because patients are booked for procedures you aren't qualified to perform.

Solution – Make clear before you start what you will and won't do, and what you can and can't do. Use a NASGP booking form so the practice knows in advance that you don't refer for termination or that you are skilled at injecting joints.

10) Limited practice feedback

"Am I any good?" Every locum wonders this now and again, and appraisal requires an answer.

Solution – Performance feedback is essential for good risk management, and locums should demand it. Working in chambers or through a locum support team makes this easier. Appraisers must take account of a locum GP's working life, and locums' personal development plans (PDP) should reflect this. **SGP**

Do's and don'ts of emailing patients

Electronic communication can provide a useful alternate point of access for patients.

Dr Richard Stacey explores the pros and cons

Do

- ask to have sight of the practice email communication policy
- ensure that the policy incorporates appropriate safeguards in order to preserve patient confidentiality
- confirm that the patient is content to receive a response by way of email
- remember that when corresponding by email, many of the non-verbal clues and nuances, which would be apparent in a face-to-face consultation, or to a lesser extent in a telephone conversation, will not be apparent, and this problem may be amplified because you might have had no previous contact with the patient
- remember to respond in a professional manner and avoid "text-speak"
- respond in a timely way.

Don't

- forget that email exchanges are an important part of a patient's medical records and should be saved therein
- be tempted to use email to respond to complicated or difficult problems; if you feel that a consultation would be more appropriate then make the necessary arrangements to see or telephone the patient
- be afraid to either involve one of the partners or to ask that they respond if you feel uncomfortable responding to the patient's request
- forget that responding to email enquiries may take some considerable time. You should ensure that if you are to be expected to respond to email queries, you should be alerted to this in advance of taking up a locum position and that you should be appropriately remunerated for the same.

Useful links

- Car, J and Sheikh, A. Email Consultations in Healthcare, *BMJ* (2004) www.bmj.com/cgi/reprint/329/7463/439
- *Guidelines for Clinical Use of Electronic Mail Patients* American Medical Informatics Association (1998) www.amia.org
- *Evaluating Internet Health Information: A Tutorial from the National Library of Medicine* www.nlm.nih.gov

Treating non-English speakers

GPs are at the forefront of the cultural melting pot, treating an increasing number of non-English speakers. *Sara Williams* explores how to overcome the difficulties this presents

The GMC says

In their guide on valuing diversity, the GMC says that: "The Human Rights Act 1998 and other legislative changes such as the Disability Discrimination Act 1995 (as amended) provide a strong case for the provision of effective communications in hospitals, in the community and in GP practices. Wherever possible, communications should be provided in languages and formats appropriate to the patient group."²

The structure and make-up of the UK population is changing, and this brings challenges to the NHS, and can place a strain on GP practices. In 2001, 8% of the UK population were born overseas, and by 2006 this had risen to almost 10%. Practices are at the forefront of this cultural melting pot; serving an increasingly diverse patient population requires practices to keep on their toes to tackle the range of languages and cultures that contribute to the fabric of the country.

These population changes bring real challenges for sessional GPs; if you cannot communicate

effectively with a patient, how can they consent to and receive treatment?

Communication is a core skill in delivering safe healthcare and medicolegally it is arguably the most important area of risk. Every day, MPS deals with cases where a complaint or claim was triggered by a breakdown in communication, even when the care given was sound. These dangers are magnified where those involved in a consultation have different language skills.

This is particularly challenging for locum GPs as they have to tackle the new environment of every practice they work in as well

as communicating with new patients. The first step for locum GPs is to realise that this is a particularly sensitive area and to tread carefully.

Being human

Of course, it is about more than the spoken word. Human interaction is a mixture of different gestures, actions and words. Body language varies from person to person and from culture to culture. Cultural factors may, for instance, strongly influence the expected roles of different members of the family unit. Even when speaking English, patients may have a different understanding of what a "familiar or

colloquial phrase" in English means. Consultations can be complicated by many misunderstandings.

For GPs this is a growing challenge. MPS has received a number of calls from clinicians about these issues. To date the calls have mainly been for advice or following a complaint, and there are no clear cases that have led to direct harm to the patient, and a subsequent claim. In a perfectly resourced world, a professional interpreter would be the ideal solution. Studies have shown that the use of professional interpreters improves care for patients with limited English proficiency. Patients who rate their translator highly are more likely to rate their healthcare highly.

Yet around the UK, the provision of and access to these services is inconsistent. And there are a multitude of different languages to



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translate, so it is difficult to cater for them all. The National Register of Public Service Interpreters provides a quality-assured register of healthcare interpreters, but it does not regulate them.¹ So if an interpreter is not a practical solution option, what are the options available to GPs?

Problem areas

Being aware of the risky areas where there is the potential for problems to arise is a good starting point for GPs, such as:

- **Consent** – Particularly where the information about proposed treatment is complicated, it is important to check the patient's understanding of the risks and benefits.
- **Dual residence** – Patients living in two different countries may be seeing different health professionals. Matching treatments and prescribing options can be difficult.
- **Child protection** – Again, identifying and providing support for vulnerable children is made more difficult by communication problems.
- **Older people and those lacking capacity** – The difficulty of establishing the needs and wishes of those with limited capacity will prove more difficult when there are language and cultural differences. This may be exacerbated if it is difficult to separate the interests of the carer, acting as translator, from those of the patient.

Finding out what resources are available locally to manage language differences will help prepare you for issues which might arise.

However, you may find out that they are limited (your PCT may only fund telephone translation, for example), or inadequate for your patient population. If this does or could compromise patient care, then follow GMC advice

and draw the matter to the attention of your employer or practice manager.

GMC practical pointers

- **Talk to your practice manager** – find out what patient information, ie, leaflets, posters, etc, is available. Check that important signage and announcements are in plain language and are accessible to all the main groups served by the healthcare organisation.
- **Be aware of the communication chain** – non-medical staff, eg, receptionists, are the first people that patients encounter. Communication problems with a busy receptionist can cause distress or discomfort for a range of patients/service users. So non-English patients may be on edge when they walk in to the consultation room.
- **Maintain eye contact** – particularly when working with an interpreter, even if the patient cannot understand you. This can reduce certain anxieties or suspicions from your patient and allows you to monitor body language.
- **Remember that the interpretation process takes time** – suggest that your chambers, agency or personal conditions state that a double-appointment is necessary to allow adequate time to consult effectively.
- **Ensure that background noise is at a minimum** – this should be the case even if an interpreter is not present.
- **Be cautious** – some people who most need information in their own language may not be literate in any language.
- **Be patient** – being sensitive to the needs of non-English speakers by being patient and working with them can safeguard you against complaints. **SGP**



Useful resources

- **NLH Specialist Library for Ethnicity and Health** – Aims to select the best available evidence about management of a healthcare service and specific needs in healthcare for minority ethnic groups. – www.library.nhs.uk/ethnicity
- **Sounds Healthy** – Provides health information in audio and text formats in several languages. – www.soundshealthy.nhs.uk
- **Emergency Multilingual Phrasebook** – The Department of Health website's publication section includes various languages, including Amharic, Bosnian-Bosanski, Farsi, Kurdish, Slovak, Welsh in downloadable PDF files). – www.dh.gov.uk/en/Publicationsandstatistics/Publications
- **Electronic Quality Information for Patients (EQUIP)** – The language has links to a wide range of resources in other languages, including medical factsheets, organisations and translators. – www.equip.nhs.uk

1 National Register of Public Service Interpreters – www.nrpsi.co.uk

2 GMC, *Diversity and equal opportunities – Effective Communication* (resource guide) – www.gmc-uk.org

Learning from mistakes

To err is human unless you are a doctor, is the view held by some, but *Julie Wilson* argues that all doctors make mistakes the key is to learn from them

Ask yourself: "Have you made any mistakes today?" If your immediate thoughts are along the lines of: "Of course not. I'm a good GP and have completed years of training, mistakes are caused by carelessness not by good GPS", then read on.

"The only person who never makes mistakes is the person who never does anything," – Denis Waitley

No-one is a perfect GP; mistakes don't just happen in our everyday lives, they can happen at work. If a plumber put a nail through a pipe, it would cause a mess, but no-one would die. However if a GP makes a mistake, it could result in serious complications.

So think again: "Have you made a mistake recently in your everyday life?"

Ever put unleaded petrol into a diesel-fuelled car? If yes, then you are not alone. In 2006 more than 120,000 people called out a breakdown service after filling up their cars with the wrong type of fuel. Even Wayne Rooney had to be rescued on the motorway when he put the wrong fuel in Colleen's Range Rover, the mistake cost him more than £6,000.

So why do we make these errors?

According to Mike O'Leary ex chief executive of British Airways: "Accidents rarely happen without warning.

The sequence of failure and mistakes that cause an accident may be unique, but the individual failures and mistakes rarely are."

His sentiments are echoed in the work of renowned cognitive psychologist and expert on error Dr James Reason. He began to explore human error after he put cat food in his teapot, while making tea and feeding his cat. The two components got mixed up; both the teapot and the cat's feeding dish afforded the same opportunity - putting stuff in.

Dr Reason created the "Swiss Cheese" model to explain human fallibility, which is made up of two approaches the active (person) and the latent (system).¹

What human factors can lead to mistakes?

- Fatigue (sleep deprivation)
- Hunger – long lapses between food/drink
- Lack of concentration
- Interruptions
- Distractions
- Lack of training
- Lack of information
- Unfamiliar with place of work (different room, new ward, etc)
- Other – illness, under influence of drugs, alcohol, etc

■ **Active failures** are the unsafe acts committed by people who are in direct contact with the patient or system. They take a variety of forms: slips, lapses, fumbles, mistakes, and procedural violations.

■ **Latent conditions** arise from decisions made by management etc and these decisions have the potential for introducing failure into the system. For example these include time pressure, understaffing and inadequate training.

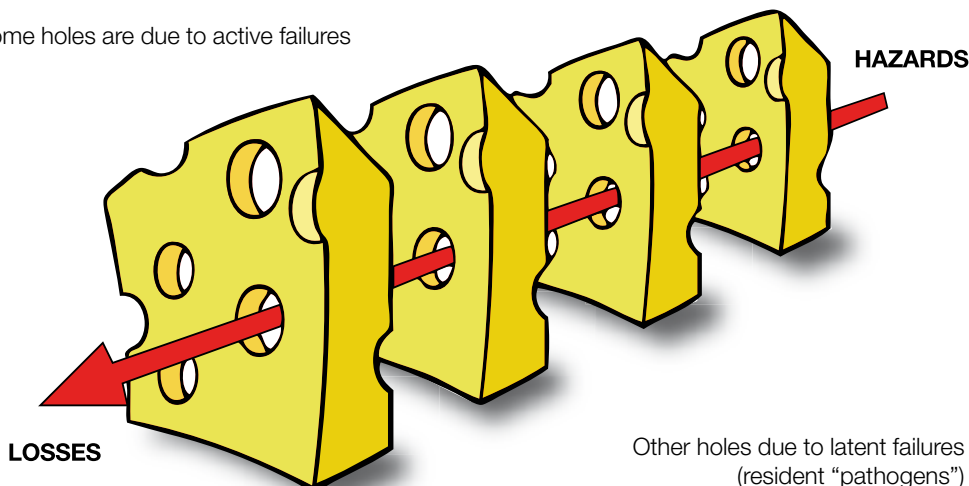
The "Swiss cheese" model illustrates the trajectory of an accident. The holes in the Swiss cheese represent the failures in the system's defences that allow a hazard to pass through. So error is a combination of human and system failures. Even the best of us make mistakes, so it is important that defences are in place to make these mistakes due to human fallibility less likely.

Scenario

It was the day of the baby clinic and the practice nurse was off sick. One of the sessional GPs was asked to undertake the vaccinations, even though

James Reason's famous "Swiss cheese":
Successive layers of defences, barriers and safeguards.

Some holes are due to active failures



Other holes due to latent failures (resident "pathogens")

she had not done any for years. She reluctantly agreed. Unfortunately when she was immunising baby Harry, one of the vaccines she took from the refrigerator was incorrect and she administered Pneumovax instead of Pediacel. What are the “Swiss Cheese” holes in this scenario?

- **Active holes** – tired doctor, pressured, stressed, unfamiliar with vaccination schedule, unfamiliar consulting room, busy surgeries.
- **Latent holes** – boxes of the vaccines, similar names, similar shades of blue and yellow, stored next to each other in the refrigerator, poor organisation of clinics, training issue.

Incident reporting system

Incident reporting has proved to be a useful tool in preventing error in high-risk industries, such as aviation, nuclear and petro-chemical industries. It has increased investment in the development of proactive and reactive safety systems. If an aviation incident occurs

it is reported, investigated and lessons are learnt.

Are you aware of the incident reporting system at each practice you visit? Reporting when things go wrong is essential, as it explores the underlying causes of patient safety incidents. NHS organisations should have a systematic approach where staff know what type of incidents to report, what information is required and how to learn from them. Staff should feel they can report incidents without the fear of personal reprimand. A positive patient safety culture is one that has open communication, mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventative measures.

Learning from patient safety incidents

Patient safety incidents need to be shared to prevent them happening again. The National Patient Safety Agency (NPSA) was set up in 2001 to co-ordinate efforts to report and learn from mistakes. It collects and analyses reports of patient safety incidents received



“The only person who never makes mistakes is the person who never does anything” – Denis Waitley

from NHS staff. As well as making sure errors are reported in the first place, the NPSA is trying to promote an open and fair culture in the NHS, encouraging all healthcare staff and patients to report incidents.

During the last five years, the NPSA has received more than 2.7 million reports of patient safety incidents from primary and secondary care organisations.² The NPSA analyse these reports and create safety alerts actions and Rapid Response reports. An analysis of patient safety incidents reported to the NPSA between April 2008 to March 2009 showed that 2,803 incidents were reported from a general practice setting. This figure represents only 0.30% of the total incidents the NPSA received for that period.³ 24% of the incidents related to medication errors and 12% to documentation.

So what have we learned?

All GPs make mistakes, hopefully minor ones. What's important is being honest, owning up and reporting the mistakes so that lessons can be learnt. The best GPs openly admit to making mistakes and see the process as a learning tool. Prepare yourself by finding out about the reporting system at your practice, and by reading NPSA safety alerts. Patient and staff safety is essential for good quality care; let's not forget that we are all patients too! **SGP**

Julie Wilson is MPS's clinical risk programme manager.

- 1 Reason, J. Human Error: Models and Management, *BMJ*, (2000) 320:768-770
- 2 Department of Health, *Safety First a Report for Patients, Clinicians and Healthcare Managers*, (2006)
- 3 NPSA, *National Reporting and Learning Summary*, (Issue 13, August 2009) – www.npsa.nhs.uk

Dilemmas

Working as a GP your skills may be called upon when you least expect it. *Dr Richard Stacey*, MPS Medicolegal Adviser, gives advice on how to deal with tricky situations

Dilemma 1. Poor-performing colleagues

You've started locuming at a large practice. During afternoon surgery you see a 30-year-old patient who saw their usual GP a fortnight ago. The patient is complaining of the same symptoms she described on her first visit. Upon examination, you make a different, "obvious" diagnosis. Surprised that the other GP missed it, you garble: "Dr Evans should have seen that. I can't believe he missed it". You have criticised your colleague

in front of a patient. Is this ever OK to do?

A medicolegal opinion

MPS commonly sees complaints or claims that have been instigated by a patient only after another clinician made a comment. In most cases, it's not that the doctor has advised the patient to pursue a claim or complaint, but that they have made a comment that has been construed by the patient as criticism, snowballing into an official claim or

complaint. So it is important to be careful with regards to what you say, bear in mind that you were not party to the consultation and the symptoms may have evolved in the intervening period.

The GMC advises:

- When working in a team: you must respect the skills and contributions of your colleagues.
- You must treat your colleagues fairly and with respect, and not unfairly discriminate against them by allowing personal views to affect your professional relationship with them.
- You must not undermine patients' trust in their care, or in the judgment of those treating them, by making unfounded and malicious criticisms.

Raising concerns about a colleague's performance as a locum can be tricky, especially if the doctor in question is employing you. However, the GMC is clear. If you do have serious concerns about a colleague's fitness to practise you should not keep it to yourself, as the safety of patients must come first at all times.

If you have concerns, an honest explanation should be given to your contracting body, or an appropriate person locally – PCT, medical director, responsible officer, etc. These bodies will have procedures in place to deal with accusations of this kind.



Dilemma 2. Medical requests outside the surgery

You're walking your children to the school gates, when Mrs Jones, accompanied by her twin boys Peter and Simon, stop to say hello. You're quite friendly with Mrs Jones and have treated her children over the years while locuming at the local practice. You begin a general conversation with her. She begins discussing her sons and says: "It's quite coincidental that I've seen you actually, because I was going to book an appointment with a doctor as soon as I got home. Will you save me the bother?" She goes on to describe the symptoms of a recurring problem Peter is experiencing. Do you listen attentively and share your medical opinion?

A medicolegal opinion

Initially you may be happy to give someone general advice about a problem; however, it is worth bearing in mind that to do so might engender a claim if something went wrong.

The GMC does not offer advice on dealing with informal consultations. However, there are some general questions to consider:

- Can you deliver good clinical care, by adequately assessing the conditions, examining

the patient and taking account of a full history?

- Can you fully assess a patient in this context, ie, examine them, take a full history, in a public setting?
- Can you arrange further investigations or treatment where necessary?
- Can you refer the patient to another practitioner for follow-up?
- Can you record your findings in the medical records?

Doctor–patient relationships are effective because a professional boundary exists between doctor and patient. Discussing a general problem outside surgery may breach this boundary and undermine the trust that is so crucial to the relationship.

In the case of Mrs Jones, you should adopt an empathic approach and explain why it would be better for her to make that appointment and see a GP at the surgery. Stress that you would not be able to properly diagnose her son's condition without being able to review his medical notes or conduct the necessary examination or tests. If she persists, add that to offer advice with incomplete information may cause a serious problem to be missed.

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Dilemma 3. Requests for references

An acquaintance, who you have also seen as a patient at another surgery, sees you when you're shopping in town. He asks if you could write him a character reference for a new job. Although as an acquaintance you would have no qualms about doing this, as a GP, you are aware of his previous history of depression. What do you do?

A medicolegal opinion

In this dilemma the problems encountered would be similar to those in dilemma 2. How do you manage an informal consultation? You may not see a problem with writing the reference, and may be happy to do it, but if something went wrong you would be liable.

In this dilemma you are in an awkward position. It would be best to explain that, as you have seen him in surgery, you would not be the best person to provide a reference of the type he is requesting.



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Locum workspaces

Locums and practices need to work together, but this doesn't always happen. *Dr Judith Harvey* analyses the particular problems locums face in their working environment



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“I want to see a real doctor” is a typical response to the all too common receptionist’s explanation: “I’m afraid Dr Jones is on holiday; it’s only a locum today”. This is not a great start to any locum’s consultation.

A locum can feel like an oily rag. In an emergency everybody needs one to keep the wheels turning, but then it is forgotten till the next breakdown. Practices don’t get the best out of their investment in locums. Locums may be sitting in a partner’s chair, seeing a partner’s patients; they are not the partner, however, nor are they a second-rate

substitute. They are flexible, highly-trained professionals who can bring special skills and insights to practices which are disposed to take advantage of them. If locum GPs practise in an environment of “enforced underperformance”, they, the practice, and the patients will pay a high price.

The locum in a foreign land

In a consultation it is important that a patient and a doctor have an open mind about each other. It is worth remembering that patients don’t place a high value on continuity; they are happy to see anyone who

is competent. And regular patients can sometimes benefit from a fresh eye which picks up problems that familiarity has rendered invisible. Some locums provide practices with a brief biography so that patients will know a bit about them before their consultation. Practices can promote this: why not ask each locum for a biography with a photograph?

Most practices claim to have a locum induction pack. Efforts are made to keep the pack up-to-date, but I’ve visited practices where the information covering the hospital pathology services over the festive period was two years out-of-date. Practices should provide the local information that doctors need to do their job. Locums can help their fellow locums by contributing additional notes.

If the practice system is accessed using a Smart Card, unless a locum has this card he/she will have to practise without patient records and write paper notes. It is helpful if practices have someone on hand who can get the locum up and running without delay.

The locum computer techie

When a locum starts they immediately need to ask, and practices need to tell them, what clinical software

system the practice uses. Experienced locums will be familiar with widely-used systems and new locums can familiarise themselves with the most common systems, but a practice with a homespun, off-brand system will be difficult to navigate even for the most IT-literate visitor.

Gone are the days when organising a referral just meant dictating a letter. Care pathways and clinical referral systems vary widely. Partners only need to know one system on a day-to-day basis. In the course of a month’s work, locums may be dealing with 4 PCOs and 24 secondary care trusts. Telling a locum that all the information and forms are “on the computer” is unhelpful. If a locum has to run searches to find documents, which can be shrouded under an uninformative alias, their time will be directed away from seeing patients.

Similarly, while any good locum will endeavour to support the practice’s work on the QOF, enhanced services and local incentive schemes, they will not always know the computer codes. Templates incorporated into the clinical software make it much easier for doctors new to a practice to contribute to practice targets – and, hopefully, to patient health.

Some practices still log in



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all locums as “Dr Locum”. This is unacceptable. It is a legal requirement that every consulter have his or her own username and password, so that a proper audit trail exists and no-one can falsify another doctor’s notes.

The locum archaeologist

A typical GP’s consultation room is a monument to their individuality. But this can be difficult for a locum who has to search through a desk full of papers, knick-knacks and family photos, or drawers crammed with drug company freebies, spare spectacles and stale biscuits, to find a peak-flow meter or medical certificates. Unearthing the tools of the trade can be an exercise in office archaeology. Untidiness is hard to cure, but it helps to establish a common system for where equipment and forms are kept. Providing a box of essential bits and pieces specifically for locums is very handy. In turn, locums should leave a consultation room in the state they found it; everything should be left as it was.

The locum mind-reader

GPs who know their patients very well (likely in single-handed practices) may carry a lot of information in their heads. A locum will not know if Mrs Jones usually looks that funny colour, or what “white pills” she was prescribed last week. Adequate notes are essential to maximise patient safety. All doctors need to write notes with the assumption that the patient may be a stranger to the next doctor who sees them.

The locum prescriber

Repeat prescriptions are a daily practice chore. They are also a common cause of complaints. For locums, signing repeat prescriptions is a particularly

high-risk activity and some organisations advise that they should not do so. In the real world, both sides need to minimise the risks. For the locum that means checking the patients’ notes before signing for practices that means allowing the locum time to do so, and accepting that any locum is justified in refusing to sign some prescriptions. Patients on anti-hypertensive or asthma medication, who haven’t been reviewed for years, repeats for benzodiazepines, anti-rheumatoid drugs where no evidence can be found of monitoring, can all present difficulties for the locum.

The locum visitor

In a practice it is inevitable that occasionally someone will take the opportunity to scump an unattended Apple iPhone. However careful they are, locums are vulnerable to casual theft. You can’t lock your belongings in a drawer if the drawer is already locked and the key is on the partner’s keyring. You can’t lock the consultation room door while you go and hunt for the Sonicaid if no-one knows where the spare key is. It does not foster a good relationship between a locum and practice if a locum discovers that the small print of a practice insurance policy excludes cover for their belongings. Locums and practices need to consider whether their property is protected, and indeed whether they would have cover if they were the victim of an assault.

The locum management consultant

Locums are a fresh pair of eyes, not only for the patient but for the practice. They see almost every aspect of the practice and can spot the things that go unnoticed: out-of-date test strips, a wobbly stool, outdated TFTs – any of these are a significant



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event waiting to happen. Most practice managers and partners will be glad to have problems brought clearly, but diplomatically, to their attention, and will let the locum know what they have changed as a result.

The locum and the practice

Partners work in the same place, using the same systems, every day. Locums walk into an unfamiliar building to meet a team of strangers with their own way of doing things, knowing that every patient will be a “new” patient. This requires not only the standard clinical

skills, but a special degree of flexibility and an ability to judge and manage risk. Locums can only be as good as their skills and abilities, but unfortunately all too often they are not given a chance to practise at their best.

Practices owe it to their locums, and their patients, not to put locums in a position of enforced underperformance, and locums can help themselves, their colleagues, and their patients, by using their unique position to support practices. **SGP**

Dr Judith Harvey is a council member of the NASGP, and a recently-retired locum.

Further information

- National Association of Sessional GPs – www.nasgp.org.uk
- Haynes, K, et al *Clinical Risk Management in Primary Care*. Radcliffe Publishing ISBN 1-85775-869-2 (2005).

Final thought...

Dr Euan Lawson, a portfolio locum GP from Kendal, steps out of the surgery and into the wild to explore the peculiarities of locum craft

I like to think of locums as the Ray Mears of the GP world. All GPs will use a wide variety of skills each day, but locums need to be resourceful and determined to survive and thrive in the primary care jungle. Never trust a rich GP or a thin survivalist and Ray is a well-fed fellow who looks like he has mastered his art. Wholly attuned to a hostile yet beautiful environment, Ray declares that bush craft is “the art of the possible”; a useful approach for doctors developing their own locum craft in the modern NHS.

You have to be prepared to rough it a little as a locum. There are some practices where I’ve worked in every single room in the building and I’ve been shunted around like an ugly, unloved occasional table. I once ran a clinic in a toilet block in Bosnia and that was more salubrious than some of the consulting rooms to which I’ve been banished. Locums have to be hardened to the often disturbing insight into the psyche of the GP on whose territory they are squatting. Foraging is a key skill in locum craft and the ability to track down a microbiology form in teetering tower of QOF paperwork is not something that can be learned in a clinical skills lab. The top drawer of a GP’s desk is a source of rich pickings for essential forms and usually reveals the obligatory packet of tramadol amongst the yellowing vintage sick notes from the 1980s.

There is no doubt that a little resourcefulness goes a long way. Many GPs wonder how locums can manage patients without detailed prior knowledge of their old problems. I won’t dispute the clear advantages of continuity of care, but I think the answer lies in a little used arcane technique deployed by locums known as... history taking. As essential as an antler-handled knife to Ray, your history-taking skills should be honed to perfection if you want to achieve mastery of the art of locum craft. A locum examining a patient should be reminiscent of a tracker stooped over fresh rhino spoor, but personally I recommend drawing the line at stool inspection in the surgery.

It is worth bearing in mind with locum craft that there are many predators and the natives need to be handled with care. I’ve been winched into a Borneo jungle, but it wasn’t as unnerving as being metaphorically parachuted into a failing practice. The receptionists lurched around like hungry bears rudely woken from hibernation and the patients were practically baying at the door. Even in good practices patients seem to be worryingly prepared to badmouth their own GP to a locum. My preferred technique is to nod empathetically while simultaneously wobbling and tilting my head in a non-committal fashion. I



DELHAYATI/STOCKPHOTO.COM

often try to throw in a little “it’s a rum do” grimace to emphasise my solidarity.

In locum craft there are subtle warning signs of impending danger that should be studied and learned. Some of these will be familiar to all GPs: patients with lists, or anybody on diazepam who attends late on a Friday afternoon. Occasionally, the storm will strike a locum without warning. This week a patient came into my room with the not uncommon opening gambit of “but you’re not my usual GP” and I feared the worst. I sat quietly and tried manfully to exude empathy as I passed the tissues. Her face crumpled and after a minute or two of repressed sobs she got up and left. I felt like I had just been caught out in the open in a sudden and unexpected deluge. I paused and reflected for a moment. What would Ray do? What is needed is an early warning system and all practices have them. In fact, they usually have several and the simple act of treating them like human beings will be enough to activate the defence. Making tea for reception staff can even result in adoption as the unofficial practice mascot or introductions

to eligible daughters.

So Ray may suggest that “knowledge doesn’t weigh anything” but he has obviously never considered the ultimate survival resource for locums – the senior receptionist. I would guess that neither has he tried carrying the complete collection of Oxford Handbooks around every practice in the county. There’s still room in my bag for a gadget or two and although a satnav may be a touch more Bear Grylls than Mears, I would wager that Ray has never had to juggle an EMIS printout and a dog-eared map as he toured the local council estate in a downpour on a late visit.

Ultimately, any GP can turn up and see a waiting room full of patients, but there is a crucial ecological niche for savvy locums in the general practice wilderness. There will be scant appreciation on the patient satisfaction surveys to show for your locum craft, but it is possible to do much more than just survive the experience. And as Ray almost said: “the great thing about locum craft is that wherever you go, the skills go with you”. **SGP**

Dr Lawson is a portfolio GP working in Cumbria and North Lancashire.

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VOLUME 1, 2009

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