Somerset LMC Newsletter

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Inside this issue:

WHEN YOUR RISK CALCULATION GOES WRONG: ERROR OR NEGLIGENCE?

It is a truism that doctors are good at managing risk: it is the core of what we do, especially in general practice. We gather the facts about a problem until we feel we have enough data to be able to formulate at least a general diagnosis and plan, and then we move on to the next problem. Some of us need less information to reach a point of diagnostic comfort, others need more – and some are better able to integrate the material to reach a risk management decision.

But inevitably you will sometimes get it wrong – the child with a viral illness will turn out to be developing meningitis, or the barn door case of reflux will go on to complete her infarct in the night. Coping with the consequences of this is what we are paid for, and why we in turn pay our defence organisations, although neither fact will alter the emotional response of guilt and anxiety that such cases generate.

But close analysis of serious adverse incidents shows that relatively few hinge on a simple diagnostic mistake. Many more are about systems and processes, or the accumulation of several things going wrong. And just as sometimes you will throw six sixes in a row, some patients will collect multiple system errors and suffer harm. We can, and must, seek to reduce these, and the main medical indemnity bodies, amongst others, offer helpful risk management and systems analysis training. At the same time we should be aware of and implement recommendations on safety coming from within the NHS, notably from the National Patient Safety Agency. There is a perception that the Agency produces great swathes of instruction, but in fact it issued only 14 Alerts last year, about half of which were relevant to general practice, and these generally are summarised onto a single and easily actioned sheet of recommendations.

The problem is that the "safety culture", which we should in principle applaud, can easily become self obsessed and totally risk avoidant. It can also become unhelpfully confused with the regulatory framework that surrounds us. Anticoagulation, for example, is a high stakes activity with great benefits, but great hazards. It should be undertaken with care and caution. But things can and do go wrong with this complex treatment – for all sorts of reasons from patient behaviour to mis-dosing - and it is simply not possible to eliminate all the risks. How we approach this will depend on how supported practices feel. The list of jeopardies we face after a mistake grows ever longer: patient complaints, legal action, PCT investigations, the GMC, Care Quality Commission, and now the spectre of a medical manslaughter charge is sometimes raised. The judiciary is well aware of the enormous potential impact of this latter on clinical practice and the degree of negligence has to be "gross" (*i.e. showed such disregard for the life and safety of others, as to amount to a crime against the State and conduct deserving punishment)* which needs to be a little more than making a dosing error, but the anxiety generated by a perception that there are people out there just waiting for you to fail will push us into ever more defensive practice, and may cause some to abandon work, such as anticoagulation, for which they feel the risk of blame and punishment after a mishap is just too great.

Medical practice is a bit like being a goalkeeper. In regulatory terms, it is only the ones that get through that count. You may have seen coverage of the RCN conference where a nurse bemoaned the "Holby effect". Patients who judge

their NHS care by the miracles performed on TV medical soaps are apparently increasingly more likely to complain, and the NHS Litigation bill continues to climb steeply, up from £613m in 2006/07 to £803m last year. Ironically, The Independent's website that carried this story is sponsored by a medical malpractice legal firm.

Sooner or later the government of the day is going to have to grasp this nettle, and understand that increasingly powerful and complex treatments offered to increasingly frail and elderly patients are bound to cause some harm, and rather than pointing the finger of blame at the luckless individual holding the pen or the syringe, develop a rational approach to risk management. In the meantime we all need to look carefully at our practice systems and to squeeze out causes of errors and mistakes wherever we can.

MEDICATION FOR PATIENTS WITH A PEG

Links to definitive guidance

With the growing number of patients with permanent gastrostomies for feeding and hydration comes a growing number of problems in ensuring patients with a PEG have their necessary medication in a suitable form. For patients who have an obstruction, - perhaps due to a tumour, - *some* oral medications *may* be safe, but for the majority who have a PEG because of an unsafe swallow all upper GIT absorbed treatment needs to be administered through the gastrostomy tube. We are cautioned against just crushing tablets and squirting them in , not just because of unpredictable absorption and licensing problems, but also because some tablets if crushed can create a sludge in the PEG line leading to blockage, ending up in an emergency trip to the hospital for unblocking - which is the last thing you and your patient need to deal with.

So to begin with, evaluate how important each medication is clinically: a patient with an inoperable mid-oesophageal tumour is unlikely really to need their Adcal. There are then some very helpful sources of advice on how various medications are best administered. The PCT medicines management website has a link to the comprehensive Royal Cornwall Hospital list at http://nww.somersetpct.nhs.uk/pmm/Other%20prescribing%20guidelines/Administration%20of%20drugs%20via%20enteral%20feeding%20tubes%20(RCH%20Feb%202009).pdf which covers nearly all the products you are likely to need, and there is the excellent "Handbook of Drug Administration via Enteral Feeding Tubes" by Rebecca White and Vicky Bradnam (Pharmaceutical Press) though this is rather expensive for non-specialists to have on the shelf.

Dr Rupert Sells, a Taunton GP, has a lot of experience with PEGs and is happy to offer help if you want general clinical guidance (Rupert.Sells@lyngfordparksurgery.nhs.uk), and, of course, medicines management at the PCT is able to give authoritative pharmaceutical advice, including dose equivalence when switching between drugs in a particular class.

It should very rarely be necessary to get "specials" made up – in this context, that means liquid or suspension medication made up on a one off basis. They are extremely expensive, usually take some time to obtain, and maintaining supply can be a problem. If you are interested in this see http://nww.somersetpct.nhs.uk/pmm/Other%20prescribing%20guidelines/NHS%20East%20of%20England%20%20-%20Pharmaceutical%20Specials%20Guidance.pdf but in practice it is best to speak to Shaun Green or one of his colleagues at the PCT before going down this route.

PLANNING TO RETIRE?

Make sure you give 3 months notice

Please make sure that if you intend to leave the NHS Pension scheme, whether through permanent or "24 hour" retirement, you let Patient & Practitioner services at the PCT know three months in advance. They have to send you an AW8 form to update something called the NHSPA POL to make sure you can draw your pension on time. This is separate to any notification the practice gives to Primary Care Contracting about a change of provider. Meanwhile, the rest of us will just dream on.

COMMUNITY HOSPITAL SURVEY & GP PROVISION OF MEDICAL COVER

Many thanks to the practices that replied to our brief survey. 14 practices currently providing daytime medical cover for their community hospital replied, 13 of which had "Bed Fund" employment contracts. Only one of these was supported by current written documentation! Most practices were enthusiastic or supportive of continuing to look after inpatients, but for the majority this work is a minor contributor to practice income. Discussions continue between the LMC and Somerset Community Health on the replacement of the Bed Fund contract with one that better reflects current clinical practice and service needs.

Dear Editor
I was interested in the newsletter article on chaperones. We have discussed the issue at one of the regular meetings we hold between Brendon Hills, Porlock and Dunster practices – three nearly single handed male GPs - as we believe the issue is magnified in smaller practices where we lack handy alternatives to doing an intimate exam oneself, and also have fewer staff to nab as chaperones.

We are all starting both to routinely offer chaperones and also to document the patients' responses, as well as specifically coding the procedure (e.g. a vaginal examination) in the electronic record The point of this, should it need to be demonstrated, is that we are aware of the importance of the matter and can point to the systematic recording of both the examination and the offer of a chaperone. The other message, of course, is that an abusing individual would be unlikely to do the same.

David Davies, Dunster Surgery

Dear Editor
I wonder whether you would alert GP colleagues in Somerset who are members of the RCGP to the national election of RCGP council members. This is the central decision making body of the RCGP and thankfully has developed a good working relationship with the GPC. I currently represent the Severn RCGP Faculty on council for an area that covers Bristol, Bath, Gloucester and Somerset. I am delighted that we have another Somerset GP, Dr Bill Irish, standing for Council through the national election process - and would encourage all RCGP members to take the opportunity to vote in the election. Bill is a local GP of many years standing in Coleford (Mendips) and is involved in GP education as Head of the Primary Care School in the Severn Deanery. Bill's practice has been involved in the Federation and Wyvern work and he has always been very positive to raise awareness of GP training and education, along with rural GP issues / dispensing and many of the issues dear to our hearts in Somerset. Every vote will be important (well, perhaps more so than the national elections) so please take a couple of minutes to vote on line. There are many very good candidates nationally and I am sure the voting will be tight.

Steve Holmes, Park Medical Practice Shepton Mallet

SMALL ADS SMALL ADS SMALL ADS .....

SALARIED GP: WINCANTON HEALTH CENTRE Maternity locum required starting from July 2010. Friendly, four partner, 7,900 patient, GMS practice. Full time (9 sessions) or part time combinations. Salary negotiable according to experience. Informal visits welcome. Please contact Janet Loe on 01963 435703 or email janet.loe@wincantonhc.nhs.uk. For more details visit www.wincantonhealth.co.uk.

SALARIED GP: FROME MEDICAL PRACTICE Full-time GP (8 sessions per week). Offering a competitive salary. Please apply with CV and covering letter to Tracey McCulloch, Frome Medical Practice, Park Road, Frome, Somerset BA11 1EZ or by email to tracey.mcculloch@fromemedicalpractice.nhs.uk by 28th May 2010.
www.fromemedicalpractice.co.uk

SALARIED GP: VICTORIA PARK MEDICAL CENTRE, BRIDGWATER For maternity cover up to 5 sessions per week from September 2010 for approximately one year. Informal visits and discussions welcomed. For more information and information pack contact Paul Cawkwell, Practice Manager. Closing date 28th May 2010. Drs Lewis and Hawkes, Victoria Park Medical Centre, Victoria Park Drive, BRIDGWATER, TA6 7AS Tel 01278 437100.

SESSIONAL SURGEON/GP: EAST QUAY HEALTH LTD, EAST QUAY MEDICAL CENTRE, BRIDGWATER Required for an established not-for-profit company offering extended minor surgery. working on a self-employed basis, remuneration is based on a fee per procedure (but this is negotiable). 2 sessions per week and can accommodate preferences in the timing of the sessions – including evenings and weekends. For more information call Rachel Stark on 01278 440400.

CLINICAL PERFORMANCE MANAGER: WARWICK HOUSE MEDICAL CENTRE We need someone with a clinical background or knowledge of QOF with excellent IT skills and performance management experience, to support our high-performing practice in meeting its QOF targets. 10 hours a week. Job description and further information at www.warwickhouse.org.uk. For an informal chat: Joanna Haxby 01823 447373 or Sam Sweeting 01823 282147. Closing date May 25th 2010.

DR WHIMSY'S CASEBOOK

Life: a Pathological Pre-Death Syndrome

A recent editorial in the British Medical Journal (BMJ 2010;340:c1168) previewed the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), due for publication in 2013. DSM-IV (published in 1994) has, with encouragement from drug companies, been associated with three diagnosis epidemics (as distinct from real epidemics) of psychiatric conditions: Autistic Disorder, ADHD and Childhood Bipolar Disorder. That's according to DSM-IV's own author, who warns that DSM-V is likely to contribute a further eight epidemics by introducing new categories (such as Binge Eating and Temper Dysregulation) and lowering the threshold for diagnosing existing ones.

Reading this, I asked myself, "Are they determined to medicalise *everything*?" Then I reviewed my previous, unremarkable, working day and was shocked to discover that these diagnostic categories actually don't go far enough:

Woke up at 5:30 a.m. as usual. I wish I didn't, but I have CHEWS: Chronic Habitual Early Waking Syndrome. After the usual ablutions, precariously performed in a Twilight Incapacitative Torpor (TWIT), I tried to have some breakfast, but because of my Post-somnolent Orientation Disorder (POD) I poured orange juice on my cornflakes. So I gave up on the cereal and had a cup of tea over the latest BMJ, pandering to my Compulsive-Obsessive Revalidation Neurosis (CORN).

As always, my computer at work took ages to boot and triggered the Software-Oriented Dyspatience Irritability Trait (SODIT) that I share with a number of other sufferers. Over the morning post my colleagues and I unwisely joked about this and succumbed to a cluster of Paroxysmal Risibility Attacks (PRATs).

I had an enjoyable morning surgery. I say "enjoyable", but I'm really referring to a subcategory of the Premorbid Universal Subclinical *Status Euphoricus* group of disorders (PUSSE) which are diagnosed retrospectively: it turned out to be Pre-Irascibility Meta-Psychosis (PIMP) because, just as I was going upstairs to a meeting, a walk-in patient demanded a prescription for diazepam. I treated her courteously, as befits Acute Suppressed Intolerance Disorder (ASID), but I was late for the meeting and suffered a relapse of Recurrent Idiopathic Punctuality Perturbation Anxiety (RIPPA). Before embarking on house calls after the meeting we had a 5-minute break, spoiled only by the guilt from Periodic Occupational Latent Inactivity Paranoia (POLIP).

Afternoon surgery was fine and therefore defies diagnosis, then I had three hours of paperwork and a severe episode of Recurrent Parchment Dysphoria (RPD).

Got home late and fell asleep in front of the TV, overcome by Post-Occupational Ortho-Psychotic Enervation Disorder (POOPED). Went to bed and had a pretty good night's sleep, otherwise known as Chronic Recurrent Episodic Diurnal Undiagnosed Latent Oenophiliac Utilisation Somnolence, which the American Psychiatric Association should recognise as CREDULOUS.

Just an ordinary day, really, so I was lucky to get through it alive. Thank goodness for PsychoFix™ (olanzasulpilithifaxazepine).

This article is based on a letter published last month as a rapid response on the BMJ website.

FIFTY YEARS AGO

The Somerset County Gazette of 29th April 1950 covered a meeting of the Somerset Executive Committee of the National Health Service – the forerunner of the current Primary Care Trust. The Committee received a circular from the Ministry announcing a cut in the gross wholesale profit for pharmacists from 33% to 16% and a reduction of 10% in fees for NHS dentistry.

An un-named doctor was to be fined £65 for not returning the notes of 321 patients after as many as 7 requests. The Committee recommended a reduction in the penalty to £25 on the grounds that the doctor was overworked, having more than the permitted maximum number of patients (3,500!) to manage on his own. The Chairman noted that *"These cards do contain the clinical records of patients and I think we should assume that they are of some value"* whilst a GP member responded *"That is a matter of very great doubt. Doctors with two or three surgeries cannot carry these cards around with them, and they are a curse from start to finish… with 90% of them you cannot read a word... information on the record card should be cut even more than it is now".* Another GP commented "*today the tendency seems to be to regard offences against the state and bureaucracy as very much more serious than offences against individuals".* A sentiment present day GPs might share.

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