SOMERSET LMC

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THEY HAVEN'T GOT A CLUE

We have railed many times against the right wing press for the cynical and misrepresentative articles about general practice that they so love to publish, and our opinion of the ability of politicians to be objective and sensible about health policy is none too high either, but it is becoming increasingly clear that the real problem – at least for the most part - is not malice, but ignorance. Most people who pronounce loudly about the perceived failings of primary care really don't know what they are talking about, and those that do often seem to forget the volume of work that GPs are undertaking. It is widely quoted that primary care handles 90% of NHS consultations, for 10% (actually now less than 8%) of the budget, but that does not stop even our favourite pundit, Roy Lilley, from suggesting that general practice might be run by acute hospitals. The LMC sees real opportunity in primary and secondary care providers working together to develop new models of care, but we do not believe that the acute sector has either the experience or the mindset to take full responsibility for the huge volume of undifferentiated demand practices deal with every day.

And now NHS England, with strong support from several cancer charities, wants to introduce 60 "cancer self-referral" pilots to address the problem of the late presentation of malignant disease in the UK. The trouble with this, of course, is that cancer symptoms are often non-specific and patients with such symptoms usually have benign disease. We think the experts are looking through the wrong end of the telescope. A cancer specialist commented in a Doctors.net discussion thread "GP triage for cancer misses people who should not be missed - a fact" but that does not acknowledge that only a tiny proportion of people who present to their GP with tiredness, a cough, or even haematuria will prove to have cancer: it is too easy to be wise after the event. We have already learned that introducing formal protocols for "possible cancer" referral generates a great deal of clinical activity – and some harms - with only a small proportion of referrals proving positive, and the current national crisis in dermatology recruitment is sometimes attributed to the huge rise in possible skin cancer referrals overwhelming the ability of the specialty to provide a balanced service. In an ideal world we would, of course, have the resources for everyone with potentially serious conditions to be investigated early, but given all the other pressures on the NHS, would it not be better to at least set a threshold probability of cancer before going down that route just now?

And does this give the right message to the public? Can we persuade people to make healthy lifestyle changes if they think that all they need do is go for a cancer check if they get symptoms? "Whole Body Scans" are fortunately less popular than a few years ago, but your editor recalls one asymptomatic patient whose scan revealed four anomalies, all of which required referral, and all of which proved to be insignificant.

Meanwhile, back in the surgery, in the second week of December Somerset practices offered over 14,000 "same day" appointments, which is about four times the total number of Somerset calls the 111 service handled in the same week. You are doing a grand job, and encouragingly some of the better informed newspapers are beginning to recognise this and are changing their view of general practice. We now need to ensure that GPs have the time and resources to concentrate on early and accurate diagnosis of all significant illness – and that is the challenge for 2015.

PTSD – MAY BE COMMONER IN DOCTORS THAN WE THINK

In December the GMC published the independent report it commissioned into the death by suicide between 2005 and 2013 of 28 doctors under GMC investigation. The report recognises that the impact of the investigation may have contributed to their deaths, and amongst the other very sensible recommendations the author suggests that emotional resilience training should made an integral part of the core medical curriculum. Appearing before the House of Commons Health Committee last month the GMC's new chair Professor Terence Stephenson said "*I've personally been investigated twice by the GMC so I think doctors recognise it is an occupational hazard. Having complaints against you if you have a career of 30 years, seeing 25-30,000 patients over the course of your career - it happens."* He went on to say *"I'm struck by how much the military invests in resilience training, and from talking to them I gather they don't wait until they arrive in Helmand Province, they start in recruitment and training.*"

In modern Britain, formal complaints, solicitors' letters and GMC enquiries are not just to be expected, they are absolutely inevitable, but most of us deal with them very badly. The instant emotional reaction is to catastrophise, and sometimes even before the envelope is opened the GP imagines themselves in jail, their family destitute and certain they will shunned for ever as a medical pariah. Whatever the evidence, many of us will just assume the guilt.

It should be no surprise, then, that when dealing with actual patient events - whether physically traumatic or emotionally disturbing due to a lack of control or capacity – doctors sometimes have an acute maladaptive reaction and develop PTSD with its diagnostic pattern of repeated and unwanted re-experiencing of the event, hyperarousal, emotional numbing, and avoidance of stimuli that could act as reminders of it.

Raj Prasaud puts it thus: (http://careers.bmj.com/careers/advice/bmj.330.7489.s86.xml) *"The worry/rumination thinking style that is present in PTSD leads to constant threat monitoring and avoidant coping (for example, thought suppression). This state is known as "trauma lock." The problem with attentional strategies such as threat monitoring is that they fix attention on threat related information, which leads to a sense of recurrent threat and thereby maintains activation of the anxiety programme and strengthens cognitive strategies of threat detection. The individual becomes a skilled "threat detector," tuning into unlikely threats and failing to retune to the normal threat-free environment."*

As well as the more familiar symptoms such as recurrent nightmares, illusions, hallucinations and flashbacks, intense psychological (or sometimes physiological) distress at exposure to things related to the event, and avoidance behaviour, PTSD can have other manifestations including psychogenic amnesia, feelings of detachment and isolation changes in mood and sleep pattern, increased irritability, progressive withdrawal, or an increase in alcohol or drug misuse.

The message, therefore, is that not everything that looks like burnout is burnout, and given that there are remarkably effective interventions available for PTSD, if a GP starts to unravel it is worth gently encouraging your colleague or yourself to get a proper psychological assessment.

The LMC is able to help with this – contact harry.yoxall@somersetlmc.nhs.uk or 07796 267510.

Group A streptococcal infections

Information from Public health England

PHE is continuing to monitor notifications of scarlet fever in England following the substantial elevation in notifications reported last season (2013/14). The early part of the current season continues this with a steep increase being reported in the first few weeks of 2015.

As of end-January 2015, national scarlet fever activity is showing a typical seasonal pattern, gradually increasing from a low level of notifications each week. Most parts of England are reporting elevated levels of scarlet fever compared with previous years. Invasive disease rates remain within the norm for this time of year, although above average activity is being reported in some parts of the country.

See: PHE (February 2015). Group A streptococcal infections: activity during the 2014 to 2015 season.

PRESCRIBING FOR PATIENTS TEMPORARILY IN CARE HOMES

Occasionally a frail older person will be admitted to hospital and then discharged to a care home for a trial period to see if he or she will recover enough to return to their own home or will need longer term residential care. Because of bed pressures it will increasingly be the case that the care home is some distance away, often outside the GP's practice area. As a rule such patients would not be suitable for Out of Area registration, but the majority will be on a number of prescribed medications.

As a general rule, you should assume that you will continue to be responsible for prescribing for at least the first month after discharge, but obviously the care home is responsible for collecting and filling any prescriptions and for arranging temporary registration with a nearby practice.

Some difficulty arises when it is still not clear after that time if the patients is going to be coming back to your practice area. The CCG preference is that the "home" practice should continue to prescribe for up to three months, subject, of course, to an arrangement for the monitoring of any medication (e.g. methotrexate) that requires regular blood or other tests, or the need for other GP interventions.

If the patient's condition requires monitoring by GP home visits and the care home does not have a complex care GP or other suitable arrangement (such as the new Domiciliary Phlebotomy contract) then it is reasonable to recommend that the patient seeks temporary registration and prescribing from a local practice at an early stage.

NEW RISKS OF MEDICATION DIVERSION AND ABUSE

Be especially careful with Oramorph, gabapentin & pregabalin

There has recently been a cluster of alleged cases in Somerset where people purporting to be carers (employed or not) have been ordering and collecting Oramorph prescriptions for elderly or disabled patients and the medicines have then failed to reach the patient.

This is particularly loathsome, for several reasons, and whilst it may be hard to prevent crime completely we can make it harder for prescriptions to be fraudulently obtained.

Firstly, do set a minimum order period for all opiates that is appropriate for the expected use. National guidance post Shipman is that prescription quantities should not exceed 30 days.

Many patients use their Oramorph infrequently, so an apparent increase in requests needs to be noted. You may need to review the patient's pain control, or just reassure yourself that the patient is actually ordering the medication themselves.

It is also good practice to require that people collecting prescriptions for controlled drugs and drugs with known abuse potential identify themselves. Most medication for housebound patients is ordered and delivered via a community pharmacy, so it is relatively unusual for such prescriptions to be picked up at the surgery except after a telephone conversation with the GP. Labelling CD prescriptions (a large red sticker is ideal) to the effect that ID is required is an effective deterrent to this kind of fraud.

There is also a new concern that the GABA agonists, gabapentin and pregabalin are becoming drugs of abuse with a street value for illegal use. Diversion of prescribed medication is a significant risk and if sold on presents a clinical risk for users who may be experimenting for the first time, so do maintain a high level of awareness when prescribing them.

LAUNCH OF NEW LMC WEBSITE 27TH FEBRUARY

The new LMC website will go live on Friday 27th February, this will have a different look and feel than previously and an App will be launched to compliment it very soon. We have been busy posting up information and guidance relevant to Primary Care and will continue to do so over the coming months, so if there are areas lacking please let us know.

It has been designed by Fourteen Fish who many will be familiar with as they designed and host the MSF tool. There will be a facility to book and pay for events online and also if members choose to log in, information can be saved to their own secure area.

We are also working on a new site for the Somerset GP Education trust and this will launch at the end of March.

Dr Whimsy's Casebook: Natural Laws of General Practice

Dr Whimsy has accumulated a glossary of medical axioms and invites further suggestions to: DrWhimsyMD@gmail.com

Patients

1. Patients with the slowest ground speed choose the waiting room chair furthest from your door.
2. Layers of clothing are tightest and most numerous over the part of the body requiring physical examination.
3. With infants in the house, parents who smoke invariably do so outside and in all weathers.[*verification needed*]
4. Patients with urinary symptoms but no sample have just been.
5. A patient signed off work is too busy to request an extension before it becomes urgent.
6. The patient who spends ten minutes discussing an existing condition has actually come to see you about something else.
7. If you visit a housebound patient unannounced they will be out.
8. The frequent attender with trivial problems eventually suffers a serious illness. The only variable is how long it eludes you.
9. A killed vaccine immediately causes what the patient believes to be the symptoms of the infection it will prevent.

Examination

1. Classical stigmata are manifest only in patients who do not have the classical diagnosis.
2. Morning coffee is delivered to your door the moment you insert the proctoscope.
3. You will discover that you have already used your last speculum only after you put on both gloves.
4. Most rectal lesions are 5mm beyond the tip of your finger.
5. Postural hypotension resolves during the application of a blood pressure cuff. It recurs as soon as the cuff is removed.
6. The Uncertainty Principle: you cannot simultaneously determine the position and velocity of a breast mouse.
7. In palpation of the pregnant abdomen, the baby's rump is its head and *vice versa*.
8. The foetal heartbeat will be detected on the side of the abdomen opposite to where you first place the Sonicaid probe.
9. During examination of the red reflex the surest way to get the baby to open its eyes is to put down the ophthalmoscope.
10. A child subdued by illness retains sufficient movement to prevent a pulse oximeter from working.

Tests and investigations

1. Serum uric acid is normal when gout is indisputable.
2. If a lab retains a blood sample for *n* days after it was taken, the GP will think of another test to add after (*n* + 1) days.
3. The waiting time for an ultrasound scan is a week longer than the maximum acceptable.
4. If you're smug about having obtained a blood sample when a nurse has failed, you will never find that vein again.
5. ESR is raised when you request a CRP, and *vice versa*.
6. The interval between episodes of palpitation is 24 hours longer than the duration of the ambulatory monitor.

Diagnosis

1. Barn door diagnoses are correct only until the results are back.
2. Unstable angina exists solely in patients you don't admit.
3. The more irrational a patient's concern, the more likely they are to be proved right a month after you missed the diagnosis.
4. An elusive diagnosis becomes obvious from the history on the emergency admission discharge report.
5. Guttate psoriasis is pityriasis rosea, and *vice versa*.
6. Pregnancy is the GP's friend: blame it for everything.
7. A child is permitted to catch chickenpox several times.
8. If a child has not trashed your room within 15 seconds it does not have ADHD. Conversely, if it takes longer than a minute there is something seriously wrong with it.
9. In medicine there are absolutely no certainties whatsoever.

Treatment

1. Trimovate® cream cures all rashes except the one you can't identify, but is not available from the manufacturer until your patient is settled on an inadequate alternative.
2. Hyperkalaema and/or hyponatraemia occur mainly in patients who most need diuretics.
3. Your patient will reach the head of the queue for phototherapy one week after their guttate psoriasis has resolved.
4. Inhalers are used incorrectly. This rule has no exceptions.
5. It is not possible to prescribe the correct support stockings.
6. All eardrops are interchangeable, but the ones you just prescribed are not available in any local pharmacy.
7. Prescription doses need adjusting the day after the pharmacy has provided a month of Nomad trays.
8. When you choose an antibiotic for suspected UTI, either the diagnosis or the antibiotic will be wrong. An MSU will determine which of these is the case.

Software

1. In writing up consultations, the longer your entry, the more likely your software is to crash before you've saved it.
2. Programs don't 'hang', they merely pause to work out new ways to annoy you.
3. (a) The most popular medical database is written 'for doctors by doctors' who prefer writing software to seeing patients.
   (b) Once they have entirely forgotten what the rest of us do they issue a major upgrade crippled by redundant alerts. New features fail to compensate for the loss of useful old ones.
4. On average, it takes 15 mouse clicks to rearrange a display in a way that makes any sense. The best arrangement is the only one not offered as the default.
5. When serial blood test results begins to show a trend, the lab will change the code and break the sequence.

Quality & Outcomes Framework and other follies

1. QOF targets are carefully designed to separate GPs from the income they work hard for.
2. Standards for QOF indicators are incremented annually until they are unachievable. If this fails they are discarded.
3. BP is more profitably measured in the debilitated patient.
4. The optimum treatment for a long term condition produces serum levels one decimal point adrift of the QOF target.
5. Intervals between annual checks should not exceed 9 months.
6. QOF standards are chosen so that the patient feels ill from the treatment before maximum points are achieved.
7. Review codes are selected such that they cannot be entered using English, only by knowing the exact 5-digit code.
8. Enhanced Services are designed so that high-achieving practices can barely break even. The rest operate at a loss.
9. When the sublime and the ridiculous are in conflict, either medicolegal expediency or Health & Safety will win.
10. Beware any 'new vision' for the NHS: it's yet more work.

This column is written for humour and does not necessarily represent the views of the author, his/her practice, or the LMC. Apologies and respects to everyone who thought of these first. Doctor Whimsy's Casebook is available on Amazon.

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