

Welcome!

Noel Thomas gives us another of his stories from rural Africa, whilst Matthew MacGabhann explains how to work a little closer to home in Ireland. Sara Williams from MPS gives us some more risk-management advice, Liz Densley of Honey Barrett advice on finding an accountant and Judith Harvey apposite thoughts on the use of interpreters in consultations.



Lesotho - A Welshman in Africa

Our friend Noel Thomas gives us an account of the remarkable use to which we can put our medical degrees, and general practitioner experience, to help people in desperate need.

"Curiosity killed the cat", our mothers once reminded us. Retired GPs with the Diploma of Tropical Medicine and Health (DTM&H), and delusions of clinical omnipotence, should remember that saying when indulging their wanderlust. New countries bring new experiences, but also risks.

St James Mission Hospital, on a plateau at 6500 feet in the Maluti mountains of Lesotho, rests among surrounding peaks whose slopes support scattered crops of maize, where any depth of soil remains. Young shepherds cajole their cattle, from dawn to dusk, to find whatever sparse grazing remains in a small country whose population of 2 million people long ago outgrew their own food production. Magnificent isolation; no land line nor email, only 'Buddie' mobiles that work occasionally, if you walk half a mile and sit on a large rock.

The Hospital serves 70,000 Basotho people, scattered in villages for 50 miles around, which are connected by rough tracks that become blocked by snow in Winter. Most mountain dwelling Basotho live on the equivalent of less than a dollar a day, and many are without the 10 Maloti (75 pence) to pay for a consultation. They linger and die at home.

They are friendly, proud people with a wry sense of humour, like the Welsh. One is never sure if they are laughing with you, or at you. One evening, walking beside the Mantsonyane river, two tall men approached, in shepherd 'uniform'. Woolly hats, thick blankets covering tattered clothes, rolled down wellies, and heavy sticks. One pointed covetously at my Leki walking stick, put his own baton under his arm, spat on his palms, and strode towards me. A sensible

[continued on page 2](#)

No news is bad news

Our inbox has never been exercised so much as it has this last few months since Medical Reader, the new medical mailing company for GP, Doctor and Pulse, has been instructed not to give regular copies of these newspapers to sessional GPs, instead sending only the left-overs to them as and when they are available. Pulse have gone one step further and have taken GP locums off the books completely.

This all seems terribly short-sighted, and sounds like a misjudged financial decision. As you know, these mags are paid for by advertising - both pharmaceutical and job agencies

[continued on page 3](#)



northwestlocums

The North's premier GP locum agency

- over 30,000 GP locum hours covered in 2006

- **Surgery, OOH and prison work**
- **Exclusive contracts with PCTs and practices**
- **Over 60 GPs and over 100 practices/PCTs across the North of England**

GP locums required in the following areas:

- | | |
|-----------------------------|--------------------------|
| • Greater Manchester | • South Yorkshire |
| • Merseyside | • North Yorkshire |
| • Lancashire | • Nottinghamshire |
| • Cheshire | • Staffordshire |
| • West Yorkshire | • West Midlands |

For more information contact Neil Hutton or Umar Shoab on
0845 257 1666 or
advice@northwest-locums.co.uk

www.northwest-locums.co.uk

continued from page 1

Lesotho - A Welshman in Africa

Englishman would have made for the river: this valleys boyo threw his arms in the air and managed the biggest smile since Wales last won the Triple Crown. Both men fell about laughing, pumped my hand and poured out greetings in Sesotho.

WHO global disease incidence tables for AIDs and TB show Lesotho in third place. HIV testing scarcely exists in rural areas. We saw so many people with advanced disease in clinics and had so many deaths of young adult and child inpatients that the true incidence may be much worse. Death certificates and registration have not arrived. Gaunt adults, with scarcely the strength to stand, children with awful skin lesions, florid TB, broken bones and dreadful dog bites, waited for hours to be seen. And never a tear was shed. The

TB isolation ward housed patients on Streptomycin, with recurrent or unresponsive disease. To get sputum sensitivities carried out in Maseru, the capital, was a forlorn hope. XDR-TB in neighbouring Kwa Zulu Natal is presently untreatable and fatal - a chastening thought as all staff gathered for the daily 8am ward service, held on Thursdays in the isolation ward. The Basotho singing was always a joy, whatever the setting!



HIV infection through a needle stick injury is always a background concern and a risk that comes with the territory. But, despite all usual precautions injury does occur, with the frightening and sobering realisation of the potential outcomes that were all round us. The only course of action when an injury happened to me - despite double-gloves - was a 4 week course of anti retrovirals, (hoping the cheap generics are the real thing) and another three months' wait for a very reassuring HIV test.

My locum role was made safe by great support from two Congolese colleagues, and from the amazing Dr Elisabeth Hills - a chest physician well past retirement age, with wide experience of working in Africa, and staying on in Mantsonyane for three years to give some continuity to the stretched service. Emergency sections averaged one weekly, in the unventilated theatre, under iv

Ketamine anaesthesia given expertly by a midwife. One hot afternoon, assisting Elisabeth, and trying to divert rivulets of sweat into my boots rather than the patient's abdomen, I mused that we might be worth a mention in the Guinness Book of Records, with combined operating ages of about 135.

The heavy workload, with one week on call in every three, produced novelty and challenge sufficient to make life in NHS practice seem like a carnival of good health. Never have surgeries back in the UK been so relaxing.

Sub Saharan health systems are in a sorry state, so much so that finding short term jobs is made more difficult. No one can bother, nor afford, to advertise them. Search them out, preferably after doing the DTM&H. You cannot help but return with a warmer heart and wiser head, unashamedly shedding more tears in a moment's afterthought for those sad, brave people, than you ever saw shed by them in your time there.



Noel Thomas

nthomas@doctors.org.uk

No news is bad news

continued from page 1

- which arguably are best directed at sessional GPs, who are the ones in the job markets and are much less constrained by restrictive PCO-led prescribing objectives.

Not since locums were barred from contributing to NHS superannuation have we been treated like second class GPs, although this time it's not being reported by the medical media because it is they who are doing it! One would have thought that their first priority would be to distribute these newspapers to the GPs who actually receive the least medical mail rather than those who have to wade through mountains of bumf every day and fill their practices' bins with piles of unopened newspapers. And it's not as if practices seem to pay any attention to recycling either - most of this ends up as landfill!

So, what's being done, and what else can we do?

We've given details to all members via email on how to help reduce this waste by passing on a downloadable letter to any practice manager who has an unopened copy of a medical magazine in their practice. This letter then gets sent on to Medical Reader, who can reduce the number of copies to that practice and thus increase the pool available to sessional GPs.

We've written to every locum agency we can think of telling them of the dire distribution to sessional GPs and asking them to reconsider where they advertise.

Tell any drug reps you see - we doubt that the pharmaceutical companies have the faintest idea that up to 25% of the workforce no longer receive copies, so we need them to exert pressure on the publishers. Some members have already told us that they're boycotting drug-company based talks - but it's only worth doing if you give the drug reps the reason why.

Doctor newspaper has responded by offering to work very closely with the NASGP. They have a limited number of 500 copies each week which they want to distribute direct to NASGP members - see www.nasgp.org.uk/news on how to register - and are starting a regular sessional GP report with us.

Check mate

Every clinician makes mistakes - after all, to err is human, but what if some of these errors were beyond their control, asks Sara Williams, writer for Medical Protection Society.

A core responsibility of a GP is the avoidance of error and the building of safer systems: at the heart of this is the safe practice of individuals. Unsafe practice can jeopardise the skills of colleagues, but identifying your own errors can be harder than it looks.

Last year Brian Toft, Professor of Risk Management at Coventry University, published a paper proposing a new social-psychological phenomenon called involuntary automaticity (IA) to explain one of the root causes of human error.

The Scottish and English Chief Medical Officers called for the paper and it was raised in the House of Commons and at 2005's European Union patient safety summit.

In the paper Toft identified a cognitive mechanism that causes people to miss cues that are right before their eyes, despite double-checking protocols being in place designed to pick up on them. He argues that the problem is not making errors, but missing them.

Automaticity is acquired by repeating the same activity. For example, when you first learn to drive you have to concentrate, but once the ritual has been learned, you pay more attention to peripheral stimuli such as other drivers, than to the activity itself; you sail along on auto-pilot. Toft argues that this becomes IA when actions are ritualised and the brain's cognitive checking mechanism takes on a life of its own.

"Instead of paying attention to what you are actually doing, the rules of the action take over and they govern your perception," explains Toft. "I was chatting to a GP about IA and he said when he printed scripts for patients he generally never checked them, as he assumed that the prescription on the screen was for the person sitting in front of him."

Toft says the causes of IA include:

- high workload
- time pressures
- staff shortages
- interruptions

IA is part of the human condition so it can never be completely prevented. The focus should be on reducing the chances of it happening by addressing the triggers above.

Double checking protocols

Clinicians use verbal-response checklists to monitor their actions. Toft says that the response to verbal checklists is similar to a priest

continued on page 5

Sessional GP Roundup

The Liverpool GP Forum

We are a friendly, informal and very international group of sessional GPs, GP principals, registrars and primary care academics. We meet on the last Wednesday of every month at 3345 Parr St Studios, L1 4JN (www.3345parrst.com/3345). Meetings start at 7.30 pm with an educational talk, followed by an opportunity to meet new colleagues in the bar. Talks in July and August will be on Heart Failure by Dr Craig Gillespie, GPwSI in Cardiology, and Expedition Medicine by Dr Alistair Miller, Consultant in Infectious Diseases at the Royal Liverpool University Hospital. All welcome!

Katharine Jones

kats@liv.ac.uk

Manchester Sessional GPs

Current group membership is 33 - mostly Freelance GPs, with the odd Salaried member thrown in too. Meetings are every other month and alternate between straightforward social in a restaurant, and educational - still in a restaurant but with a speaker too (well, you've got to eat haven't you?).

Our £1 per month subscription keeps us ticking over, and members seem to be finding enough work - just about (have other areas of the country found offers of work less abundant than 2 years ago?). If you work in Greater Manchester, feel free to join us.

Tony Webster

tonywebster@btopenworld.com

The Leicestershire Society of Sessional GPs

After various attempts were made to re-establish the success of our predecessor, we have decided to dissolve due to lack of interest. Market conditions have changed dramatically in Leicester, with few local GPs getting involved in locum activities. There is less demand for locums, as most local newly qualified GPs seem to be taking up lower paid salaried jobs. Most locums are supplied by large locum agencies.

I have decided to continue to advocate for non-principal GPs' rights as a Member of the Leicestershire and Rutland Local Medical Committee.

Patrick McSharry

patrick@sosgps.org.uk

West Surrey Sessional GP Group

Our Group continues to meet monthly at Woking Community Hospital on the first Monday of the month, for a sociable buffet supper followed by a talk.

Membership numbers are steady, with 20-30 attending most meetings, but with more than 100 on our circulation list. At our last meeting we had a lively discussion with our local Diabetes Specialist Nurse. Other meetings this year have included talks on Paediatric allergies, Pain management, Family planning, Medicines advice from a PCT Pharmacy Adviser, and the usual resuscitation update. We welcome new members, do join us!

Liz Colyer

davidlizzieburndred@hotmail.com

Leeds Sessional GP Educational Forum

Currently 41 salaried and locum GPs are in contact, mainly in the Leeds area, but a few from other parts of Yorkshire remain on the list. The group meets every six weeks or so, the most recent topics being a "Review of Asthma Diagnosis", and an exchange of ideas regarding work as a sessional GP, discussing some of the clinical problems, medico-legal issues and financial aspects that we face on a daily basis.

We are hoping to hold a training session on CPR in the near future, receive feedback from members working in Ethiopia during the summer, and have a further look at revalidation preparation in the autumn.

Doug Pollock

kdpollock@doctors.org.uk

Newham Sessional GP Group

The salaried/sessional group in Newham meet monthly during a lunchtime - with lunch! The hour-long meeting is divided into an initial educational session with a talk on national and local guidelines around a hot topic, with case discussions. The second half of the meeting is based on support issues and how we can develop ourselves and each other in the local GP community and beyond. We actively encourage all GPs in Newham to take part and have an email list which we use for discussion and to disseminate information.

Osman Bhatti

osmanbhatti@doctors.org.uk

The Morecambe Bay Non Principals Group

Our informal group continues to meet approximately every 2 months. Our last educational session was held in Kendal where the Education Centre at the hospital is free for us to use in the evenings. We try to alternate meeting venues

between Kendal and Lancaster to cater for the wide geographical spread of our membership. On this occasion a local neurologist was able to attend and we had a most informative session looking at GP referral letters and their outcome – anonymised of course.

We have also recently held a summer barbecue at one of our members' houses. This was highly successful, with about 11 people attending; it was a glorious summer evening and we had stunning views across the Kent Estuary to the Lake District hills. Previous social meetings have not been well attended, but this one has led to a call for more in the future.

Anyone is welcome to contact me if they are non principals in the Morecambe Bay area.

Rowena Grenfell

all@thebrownfamily.com

Pallant Medical Chambers Chichester

We've recently had an excellent interactive talk from one of the local consultant haematologists; we all came away with notes scribbled on our handouts, which is always a good sign! We now have 14 members and we meet in alternate months in one member's house for a round-the-table study group and to socialise generally. In the other months we have a speaker. If you are a local sessional GP and would like to attend the speaker meeting please visit www.pallantmedical.co.uk/cpd for information.

Alan Sim

alan@pallantmedical.co.uk

continued from page 3

calling out, and the congregation giving back the answers. A system of verbal double-checking designed to prevent IA would be to:

- examine the patient • determine the problem • determine what treatment is needed • make the prescription • print and give it to the patient • ask the patient to read back the prescription to you

Medical systems

Protocols are ineffective unless the theory behind medical systems is understood by the people who are applying them, argues Toft. He adds that if a manager of a department is warned that a person could be caught by IA and does nothing about it, and a patient safety incident then occurs, it is they, not the doctor, who should be held accountable.

Issues for the future

Sessional GPs may be less susceptible to IA as they change

Money Matters

Liz Densley is medical specialist partner with Sussex Chartered Accountants, Honey Barrett, and is secretary of AISMA (the Association of Independent Specialist Medical Accountants). Contact her on 01424 730345 or at liz.densley@honeybarrett.co.uk

Choosing an accountant...

Do they specialise in dealing with the medical profession?

A wider specialism than just sessional doctors is needed in circumstances where you might want them to review the accounts of a practice that you are considering joining as a partner or where you are looking at wider aspects of business or tax.

Membership of **aisma** (the association of independent specialist medical accountants) means that the individual has shown that they are a specialist.

How many other sessional doctors do they deal with and can they provide references?

Ideally choose someone who comes recommended by a colleague. Do they deal with things promptly? Are they accessible when you want them?

Do they belong to a recognised professional body?

Would you choose an unqualified doctor to operate on you?

Will they quote a fixed fee for specific work?

Knowing exactly what you are going to pay in advance is much better than a low estimate which turns out to be much more expensive when it is finally billed. Remember that you get what you pay for!

Meet them and make sure that you feel comfortable dealing with them.

Do you know who you will be dealing with? There is no point in having an accountant that you don't feel happy ringing up for advice when you need it.

their work patterns on an ongoing basis. However, they are in an ideal position, when working in a practice, to identify dangerous situations where staff are following the ritual of a checking procedure rather than actually doing the checking. However, the theory of involuntary automaticity poses important questions for all health professionals. Following rigid rules may not be enough, as these systems must take into account human weakness.

Sara Williams

sara.williams@mps.org.uk

- Avoid IA by:
- Teaching doctors about systems theory
 - Adapting protocols to generate tactile and oral responses
 - Creating effective relationships
 - Using independent checkers
 - Developing different checklists to keep clinicians alert
 - Involving patients • Minimising stress • Reducing distractions

Locuming in Ireland

In 2006 I decided to return to Southern Ireland to work. I trained as a GP in the UK and worked as a GP locum in Edinburgh and then in Oxford and enjoyed both places, but I missed my family and friends, the Irish way of life and "the craic" (Irish sense of fun).

The GP setup in Ireland is a bit different to the UK: patients who are entitled to the GMS (General Medical Scheme) – about 30% of the population - have free GP visits and free prescriptions. Everyone else must pay. This is probably the biggest difference between working in the NHS and Southern Ireland and it took some getting used to - especially when I told the patients that the cough and sore throat was "just a viral illness" and then charged them! I see a lot more of the "good stuff" that has been allocated to nurses in the UK. For example, amongst the morning surgery might be one or two ante-natals, a six-week baby check, some minor suturing. It's much more fun than some of the monotonous mornings in Edinburgh when I would often see one depressed patient after another.

The work in Ireland is far more varied and sometimes more challenging, but the doctor is still treated in a semi reverential manner, especially in more rural areas. I was even tipped once or twice when out on house calls! In my MRCGP oral I gave the standard response about the issues surrounding monetary tips, but in Ireland to refuse them is gravely insulting! And it was a great excuse to buy everyone a round of drinks in the pub!

Obtaining work here was easy (see below for how to register in Eire). Initially I went through Locumotion, a locum agency: I told them my availability and they organised everything else. After a while I was able to arrange all my own work by using a locum text-messaging service called IrishLocum.ie, and also by word of mouth. The pay is probably slightly less than in the UK, but the rates I charge are up to me.

There is a shortage of GPs in Ireland, so there is plenty of locum and permanent work. However, the system is very different to the NHS, with the mixture of private and public treatment. There is little standardisation in medical care across the country – medical services can be excellent or shocking - so you have to be flexible and able to handle anything that comes your way. The lack of bureaucracy can be both refreshing and infuriating, but once you accept the Irish way of doing things, work is very rewarding and loads of fun.

It is great being back in "The Land of Father Ted". People are certainly more laid back here – they only expect you to do your best - and everything is "grand". This does not mean things will get done, it just means that there is no point in worrying about them! Sport is religion - there is always something on and it is always the hot topic of conversation. I can't wait until October to see Ireland win the Rugby World Cup! Until then there is plenty of horse racing, Gaelic football, hurling and fishing to keep me busy!

Matthew Macgabhann

There are a few official steps to take in order to be able to locum in Eire:

- You must have full registration with the Irish Medical Council. Details on how to obtain registration are available on the website - www.medicalcouncil.ie. Anyone who is registered with the GMC should be able to register with the Irish Medical Council.
- It is not necessary to have vocational training to work as a GP locum. In Ireland a lot of hospital doctors do GP locum work in the weekends and in their holidays.
- It is necessary to have professional indemnity. In Ireland the medical indemnifiers are the same as in the UK, so contact your own one and there should be no problem in getting cover.
- You must be an EU citizen or have a work permit.
- There is no performers list in Ireland. Medicine is much less regulated than in the UK. Vocational training is needed to apply for a list of patients on the GMS, but you have to be established for a few years before applying for a GMS list.

Other useful websites and contacts are:

- Irish College of General Practice – www.icgp.ie
- There is an Irish branch of the Royal College of General Practitioners. Their email address is roi@rcgp.org.uk. They have a good information pack for GPs moving from the UK to work in Ireland.
- Matthew is happy to be contacted for any help or advice on working in Eire.

matthewmacgabhann@hotmail.com

The spirit catches you and you fall down

During its war in Vietnam, the USA fought a secret action against the communists in Laos. The CIA recruited the aid of the Hmong, one of Indochina's hill tribes with little love for the Pathet Lao. Their participation cost the Hmong their lands and livelihoods, and many took advantage of American promises of reward in the USA. Few found their dreams fulfilled. The Lee family were one such. They were settled in Merced, a small city in California, with poor accommodation and few prospects.

Their daughter Lia developed intractable epilepsy. The account of their engagement with the US health services is compelling.*

Every A&E department has its heartsink patients; Lia, taken to the emergency room countless times in status epilepticus, was Merced hospital's heartsink. Hmong shamans rationalise epilepsy as what happens when the soul flies from the body: the spirit catches you and you fall down. Her parents were desperate to reunite their daughter's body and soul; her doctors were equally anxious to control her seizures. Lia's tragedy was that, try though they might, they could not find a way to do so.

[continued on page 8](#)



Different place, different practice,
same protection



No-one is going to pretend that the life of a Sessional GP is easy... though it can take you to some pretty interesting places.

Wherever your profession takes you, there's one thing that should always go with you – the protection and support of MPS membership.

Why not call us now... and find out why so many Sessional GPs rely on MPS.

0845 718 7187

Visit www.mps.org.uk

or Email member.help@mps.org.uk

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

Variety is the Spice of Life

With locum assignments in RN, RAF & Army bases, Prisons and community practices from Cornwall to Scotland, we offer exceptional choice, excellent pay and a superb and friendly support package.

tel 01792 580580
email info@med-co.com
www.med-co.com



NHS PASA & MOD NATIONAL CONTRACT HOLDERS

med-co
europe

We'll take the time to
make a difference for you

NASGP News

We're constantly updating the website – for the latest, go to www.nasgp.org.uk/news. There's even a facility there to receive an email every time news is added.



Artwork by Mr Toby Fieldhouse, age 12



NASGP • PO Box 188
Chichester • West Sussex • PO19 1FP
Fax/answerphone 01243 536428
Email info@nasgp.org.uk
www.nasgp.org.uk

Council Members

<u>Chairman</u>	<u>Michael Uprichard</u>
<u>Secretary</u>	<u>Bashir Qureshi</u>
<u>Treasurer</u>	<u>Peter Taylor</u>
<u>Council Members</u>	<u>Judith Harvey</u>
	<u>Mark Selman</u>
<u>CEO / Editor</u>	<u>Richard Fieldhouse</u>
<u>RCGP Observer</u>	<u>Jean Ker</u>

Registered in England
No. 3861212
Six Cawley Road
Chichester
West Sussex
PO19 1UZ

Free to members of
NASGP or £5 per copy
to non-members.

The spirit catches you

continued from page 7

The family wanted the help of conventional medicine. The paediatricians – an idealistic husband and wife team - were immensely caring and tried their best. But different social customs, lack of understanding, lack of a shared language, poor education, inflexibility — all contributed to a gap through which Lia fell.

The core of the problem — or perhaps what we would regard as the core of the problem — was Lia's medication. Lia's doctors did not want her to have second-rate treatment simply because she was from a disadvantaged immigrant community so they strove to develop a perfect regime. The trouble was that the family could not understand the complex and continually changing medication schedule, and all they saw was that the medicines were making their daughter ill. Finally, Lia was fit-free, but at a terrible cost.

Could it happen here? Lia's doctors saw second-best as a form of prejudice. In the underfunded NHS we are used to muddle and compromise. We accept that people may be illiterate; that they may not know their date of birth or immunisation status, and that their family structures are different from ours. British GP training is about understanding the patient's point of view and negotiating a mutually acceptable management plan.

But we should not feel smug. Last week I saw a middle aged Somali woman, looking twenty years older than the age on the computer. She had consulted many

times about her pain, often as an emergency with no interpreter. Many things had been suggested and tried. She was no better, her daughter told me while her mother leaned back in the chair, her eyes closed, groaning and rubbing her side. Her mother felt that we didn't care. I suspect my patient's views and those of Lia's parents would have been similar, and that my frustration would have echoed that felt by the doctors in Merced.

It has recently been suggested that the NHS should stop funding interpreters on the grounds that immigrants would then be forced to learn English. The idea that axing interpreter services will encourage integration seems ludicrous. It would remove a crucial channel of communication. Once you are over the age of ten, it takes quite a time to become fluent enough in a language to negotiate another country's bureaucracy. If you are elderly it usually takes more effort than you are able to make — ask the Brits who retire to the Costa del Sol. Without interpreters social equity is impossible. They are essential, not just to the provision of decent health care, but to education. Unless someone explains, how can you understand the practice's appointment system? Or the NHS referral system — something that does not exist in countries where direct access to specialists is the norm? How can you understand about pills and potions and side effects? And how can I understand what you are feeling, and how you interpret your symptoms and what you fear? I suspect that the kindness of doctors is for many immigrants their first encounter with humanity in the UK. We have a crucial role in helping people feel that Britain is a good place to be and we need to make the most of it.

*The spirit catches you and you fall down, Anne Fadiman
Publ. Farrar, Straus and Giroux 1998 ISBN 0-374-52564-1*