

Welcome!

Welcome to the 32nd edition of the NASGP newsletter. Richard Sturge proves just how important our basic medical qualifications are when it comes to providing primary care as part of humanitarian aid. Judith Harvey has fallen off her horse, and describes just how it feels to have 12 hours of your life taken from you. Rowena Grenfell is a stalwart newsletter contributor, so we've asked her to tell us more about herself in our Portfolio Lives. More from the MPS about handling informal medical consultations on the school run, and advice on setting yourself up as a partnership in our Money Matters Column. And, the Roundup of Sessional GP Groups apart, have a wonderful Christmas!



Rheume at the Top

So fundamental is the need for basic primary medical care in many parts of the world that rheumatologist Dr Richard Sturge was easily persuaded by his GP locum friend to sign up for an adventure out to the Himalayan foothills of western Nepal with Médecins Sans Frontières (MSF). He reflects on the challenges of providing health care in a very remote area with too few staff, erratic drug supplies and ongoing insecurity.

Recently retired and with a good NHS pension, I felt the time was right to put my medical degree to use in the third world. After speaking to an aid organisation, I was told the best thing to do was to sign up for the three month Tropical Medicine course, either in London or Liverpool. This I did and thoroughly enjoyed, meeting a great bunch of like-minded doctors, and would definitely recommend it. But as a rheumatologist specialising in paediatric rheumatology, how would I cope with not having been a general practitioner in the UK? Fortunately, a good friend of mine is a Freelance GP in Cornwall with quite a bit of experience working in the third world. He easily persuaded me that the need for basic medical care was so fundamental that any medical degree combined with the 3-month tropical medicine course would be ample to prepare me.

Once I'd made contact with MSF, and after being interviewed for the position, all visa arrangements and travel plans were made and off I went!

For 11 years Nepal has been in the grip of a Maoist insurrection, although to the tourist this is barely noticeable. The major urban centres have remained under Government control and trekkers and climbers have free passage through the rural areas - as long as they pay their dues. For the ordinary citizen in the hills and valleys it is a different matter. Maoist rule holds sway, government officials including teachers, police and army have been driven out, administration and development budgets cut

[continued on page 2](#)

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to zero and health services, never strong in isolated rural communities, severely curtailed.

The Kalikot District is in the Himalayan foothills of western Nepal. It has a population of 115,000 and, of the 74 Districts in the country, it is the third lowest

in terms of the Human Development Index. That means it is very poor, with little opportunity for employment and, following two drought stricken harvests, largely dependent on food aid. That is assuming the food can be distributed and not expropriated either by the military or the Maoists.



The administrative centre of the district is the tiny one street town of Manma, perched on the top of a mountain and effectively a fortress surrounded by Maoist territory. Its population is swollen by a heavy police and army presence and by people displaced from their villages, mainly government officials, politicians and their relatives. There are no roads in the entire district, only narrow mountain tracks, and hence no wheeled traffic of any sort. The only way in and out of Manma is by helicopter, though even that is uncertain as the helicopters only fly if they can be guaranteed a full payload. Industrial disputes are common and weather conditions may be unsuitable for days on end. Those who are prepared to risk the journey can make a two day trek to the nearest roadhead; not as yet an opportunity open to MSF.

On a spur of the mountain 200 metres below Manma town lies the District Hospital, upgraded in name only from a health centre early last year. Since September 2005 MSF has been working to make the upgrade a reality and, since February, we have achieved a continuous presence and have managed to refurbish and rainproof most of the buildings and start a comprehensive medical service with facilities for emergency surgery.

All this with, even by MSF standards, a tiny team. The Nepalese Government, initially at any rate, would only allow visas for 2 expats, both medical, so with our Nepalese colleague we have three

doctors, the only ones in the entire District. The rest of the MSF team consists of locally recruited administrators, translators, nurse and health assistant and several auxiliary health workers. We work alongside 20 Ministry of Health staff and here tact and negotiating skills come to the fore. The MOH have no budget for maintenance and little for drugs.

Apart from providing an all round medical service, MSF has concentrated on Reproductive Health Care with early treatment of sexually acquired infections, daily antenatal and postnatal clinics, education in safe delivery, and facilities for intervention where necessary. Although there are no reliable statistics for the prevalence of HIV/AIDS it seems rare, though it has the propensity to increase as worsening poverty means more men migrate for seasonal work in India, where it is more common, and bring it home with them. On the other hand two other diseases that need prolonged treatment, TB and leprosy, do pose problems because of difficulties with MOH programmes due to erratic drug supply, difficulties of access to remote hill villages, and lack of staff to ensure compliance with complex treatment regimes. These are areas in which MSF will become increasingly involved, as well as extending primary care services to some of the more remote villages up to several days travel away.

Initially the Government, both nationally and locally, was somewhat suspicious of MSF as they had fallen out with another international NGO the previous year and also doubted our commitment because of the early security-induced absences. But they are now convinced and have supported our application for a much needed logistician to speed the development of the project. Conversely, the Maoists were always enthusiastic, possibly because they felt that any improvement to the healthcare of the population under their control would reflect favourably on them.

In April this year Nepal went through the nearest it has ever been to a revolution, with three weeks of strikes which brought the country to a standstill and threatened all-out civil war, quite apart from cutting our supply chain. Fortunately we had stocked up with food and fuel in readiness for such an eventuality. The strikes and demonstrations ended with the King returning the power, which he had usurped a year earlier, to the Parliament. As a result the Maoists, and then the Government, declared a ceasefire and everybody fervently hopes it will hold. Even if it does, 11 years of chaos does not unravel overnight and much remains to be done for a population afflicted by war, food shortage and economic underdevelopment.



Richard Sturge
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Information about how to volunteer for MSF can be found at <http://www.uk2.msf.org/working4us/index.htm>

'affiliate' Freelance GP Scheme

Where the NASGP's Sessional GP Support Team concept is aimed at creating an environment for Freelance GPs to work together in teams such as partnerships and chambers, our affiliate Freelance GP scheme is for those locums who prefer the idea of a formal relationship between themselves and a GP practice that allows both parties to benefit from each other's skills.

In a nutshell, the aFGP will benefit from the potential of enhanced access to CPD, collecting evidence for revalidation, mentoring, access to audit data, support and the experience of working closely with one practice. And for the 'host practice', it can benefit from having a Freelance GP closely affiliated to it, such as specific clinical skills, mentoring, teaching, leadership and, again, experience.



Negotiating your rates...and salaries

3 years in the making, the NASGP and BMA have now persuaded the Office of Fair Trading to actually allow us to print some advice for Freelance GPs on how best to go about negotiating your rates. As soon as we have the final version back from the graphic designers we'll email the document to all our members. And more good news for salaried GPs – the BMA updated their advice on negotiating salary in September. See our Salaried GP section on the website for more information - www.nasgp.org.uk/salaried

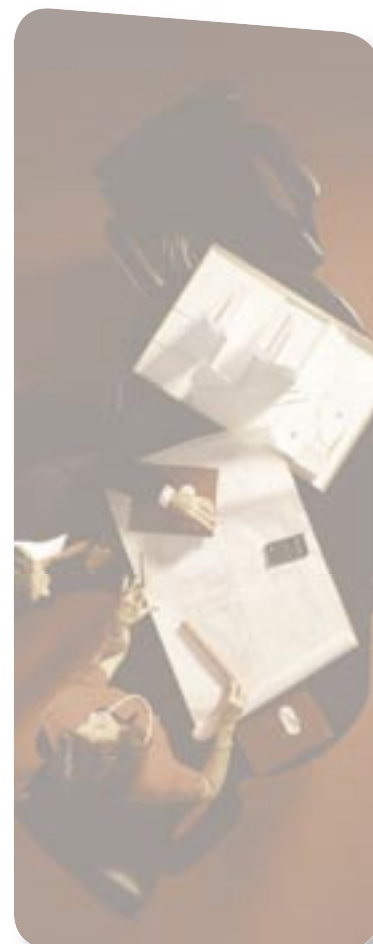
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Sessional GP Roundup

Chester Sessional GP Group

We continue to meet every 2 months in the Chester Area. We have around 50 members and approximately 15-20 people attend our meetings. Talks are followed by a meal and social support and are sponsored by drug companies. Recent talks have included an Atrial Fibrillation update and Internet in General Practice. We hope to organise a Resuscitation update in the New Year. New members are always welcome: please contact us via the website, www.chestersgp.org.uk

Alistair Adey

ali_adey@yahoo.com

Swindon Area Locum Group

We have had a number of very well attended and interesting meetings this year. The group seems to be becoming more cohesive and some good friendships are developing through it. I personally feel much more in touch with other local sessional GPs because of these meetings and am looking forward to our next one on cardiology to be held at The Pagoda Palace on 6th December. Swindon PCT now pay me £200, as an Associate GP Tutor, for organising each meeting. Every little helps, eh?!

Alison Brooks

acbrooks@btinternet.com

South Essex Sessional GP Group

We have been active in helping our members with their Appraisals and contracts. We have meetings at least once a month, each with an educational and personal developmental element. Our next meeting will have two speakers - Dr Anjan Bose dealing with definitions in dysglycaemia and Dr P Ambikapathy on Critical Reading.

We recently met with Essex LMC with regard to the devolution of practices and Sessional GP contracts. Our proposed subjects for the future include Locum work and how to make it mutually valuable and interesting, Developing some guiding materials for Sessional GPs and "Enjoying your retirement as a Sessional GP"!

Dr P Ambikapathy

aonedoctor@hotmail.com

Cornwall NP Group

With much effort from the organisers, we have recently restarted our group, organising sponsored educational meetings, the last one being a basic life support teaching session, and with the plan to set 6 dates for next year. We also have a representative on the Cornwall and IoS LMC and are trying to set up a database of Sessional GPs in Cornwall - please email dawn@kernow-lmc.demon.co.uk to register.

Keith Henderson

drhenderson@fridaygirl.com

Lothian Association of Sessional GPs (LASGP)

Our membership is still growing, with nearly 170 members, and we continue to provide ongoing monthly educational meetings. A new committee is in place and there are several local issues that we hope to continue to campaign for. These include improving the uptake of locum packs in practices, pushing for a standard "duty-dr" on-call bag, payment for sessional GPs' appraisals, as well

as continued representation on the LMC. We are planning to carry out a survey of members with the aim of improving both the representation and functions of the group.

Rebecca Sharp

secretary@lasgp.org.uk

Morecambe Bay Non-Principals

We are a group of Non-principals who like to meet up for educational purposes as well as for networking. We generally get together every 2 months and recently held a meeting at the local Education Centre. The group covers a wide area so we tend to alternate venues to even out the travelling for members. This is the first time we met at the Royal Lancaster Infirmary as it is an expensive venue to open in the evening and closes at 9pm. Hence we asked a drug company to sponsor it and we started and finished earlier than usual. The earlier start can be difficult for those who do not finish work in time.

Nevertheless, we had a good turnout for an informative speaker who enlightened us on various lab tests. He gave us some background on where eGFR came from as well as advice on mildly abnormal calcium levels, LFTs and testing for menopause and other gonadotrophins. We only covered half of what was on the list, so maybe we will have to ask him back again. He was a popular speaker and the turnout of 18 was one of our highest.

Our next meeting is planned for January 23 in Kendal and will probably be a journal club.

Rowena Grenfell

all@thebrownfamily.com

County Durham & Darlington Non-Principal Group – GP Choices

GP Choices hosts an educational evening every 2-3 months for Non-principal GPs. Currently we use 2 locations, one centrally in Durham and the other at the Aston Hotel, Coatham Mundeville, Darlington.

Dr Sarita Martin-Campbell and Dr Val Pearce, who are both Salaried GPs, organise the events on behalf of GP Choices. To date, we have hosted some very interesting speakers and topics.

The next meeting in the New Year will be to meet the GP Choices team and to give Non-principal GPs the opportunity to learn about the wealth of support that is out there for them in County Durham and Darlington.

If anyone is interested in participating in our Non-principal group, please contact Carol Hartman-Andersen, GP Choices Manager, on 0191 333 3313 or email carol.hartman-andersen@cdd.nhs.uk and we will add your details to our mailing list.

Carol Hartman-Andersen

Carol.Hartman-Andersen@cdd.nhs.uk

Chichester Pallant Medical Chambers

We're a group of sixteen Freelance GPs working in West Sussex and SE Hants. We pay a proportion of our income to employ both me as a clinical director to take on all the responsibilities of clinical governance and CPD, and a business manager who organises all our bookings and payments. We have a series of feedback mechanisms and pathways which we use both for our personal

appraisal and for discussion in our regular 'in-house' chambers meetings. We also organise speaker meetings at a local restaurant that is open to all other local Sessional GPs, with our most recent being a whirlwind roundup of respiratory diseases. Our next 'open' meeting is in January – see our website www.pallantmedical.co.uk for more information.

Louise Taylor

louise@pallantmedical.co.uk

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 7.30pm with an educational talk followed by an opportunity to meet new colleagues in the bar. Future talks on 31st of January and 28th February are entitled "Why a diagnosis of depression can be bad for your health" and "Traditional Chinese Acupuncture" respectively. All welcome!

Katharine Jones

kats@liv.ac.uk

Leeds Non-Principals Group

At our most recent meeting we agreed that our name needs to more accurately reflect our geographical situation and our activities, and so no longer call ourselves the West Yorkshire Non-Principals Group. We currently have 23 members, in contact by e-mail or attending meetings. Topics include educational events/modules, training, appraisal evidence and contractual issues.

More recently, simple but effective audit projects in which Locum GPs could be involved in a practice, to benefit to both parties, were presented.

We aim in future to provide a supportive and inspiring forum to discuss clinical issues and Significant Events. Our next meeting will be on 25th January.

Doug Pollock

kdpollock@doctors.org.uk

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.

Partnerships of Freelance GPs – an alternative to going it alone?

Partnership is the relationship which subsists between persons carrying on business in common with a view of profit (defined in the Partnership Act 1890)

Contrast this with a chambers relationship where effectively a collection of self-employed professionals share premises (where required) and an administration service.

For tax purposes the individual is self-employed, with similar tax reliefs as are available to those practising alone. The real benefit is rather more practical, freeing up time to earn money/practice medicine and improving the likelihood of continuity of work.

In a partnership the profit sharing arrangements can range from each partner keeping their own earnings effectively, to pooling all income and sharing it in defined ratios. In a Chambers arrangement each doctor would normally keep their own income subject to an administration charge.

In either case a formal legal agreement is necessary – using a medical specialist solicitor who will understand what you are trying to achieve.

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.



Medical requests outside the surgery

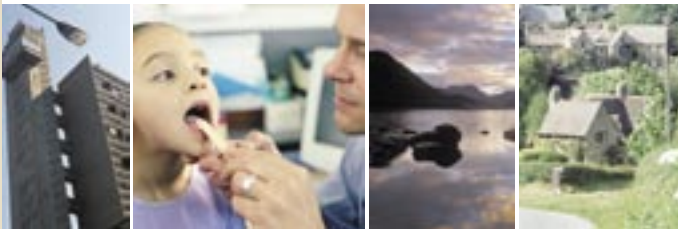
Anmarie McTigue, Writer – Medical Protection Society

What made you decide to work as a sessional GP?

Locum work certainly offers some advantages compared to being settled in just one practice. It offers experience in a variety of practices – from rural to inner city, dispensing to single-handed – without the tie of a permanent contract.

For the majority, though, it's the flexibility of freelancing that appeals. It gives you a chance to sample and develop other interests, medical or otherwise, and consider other career opportunities. Also useful is the flexibility for GPs who are parents. Locum work gives you the chance to do the school run and attend parent evenings without the guilt of relying on the goodwill of partners.

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MEDICAL PROTECTION SOCIETY

However, it is the very nature of this flexibility, and choosing work in the area that you live, that may lead you to another medicolegal pitfall – the off-the-cuff consultation.

Scenarios

1. You're walking your children to the school gates, when Mrs Smith with little Jordan and Peter stops to say hello. You're quite friendly with Mrs Smith and have treated her children over the years when locuming at the local practice. Following a general conversation, she says: "I'm so glad to see you, as I was going to book to see the doctor, but this will save me the bother." She goes on to describe the symptoms of a recurring problem. What do you do?
2. An acquaintance, whom 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?

You may not see a problem with giving somebody some general advice about an illness or writing that reference, and may be happy to do it. Both these scenarios, however, could lead to a complaint or claim if something went wrong.

1. GMC recommendations

The GMC's Good Medical Practice¹ does not offer specific advice on dealing with informal consultations. However, there are some general points to follow that should help you make a judgment.

Providing good clinical care

"Good clinical care must include:

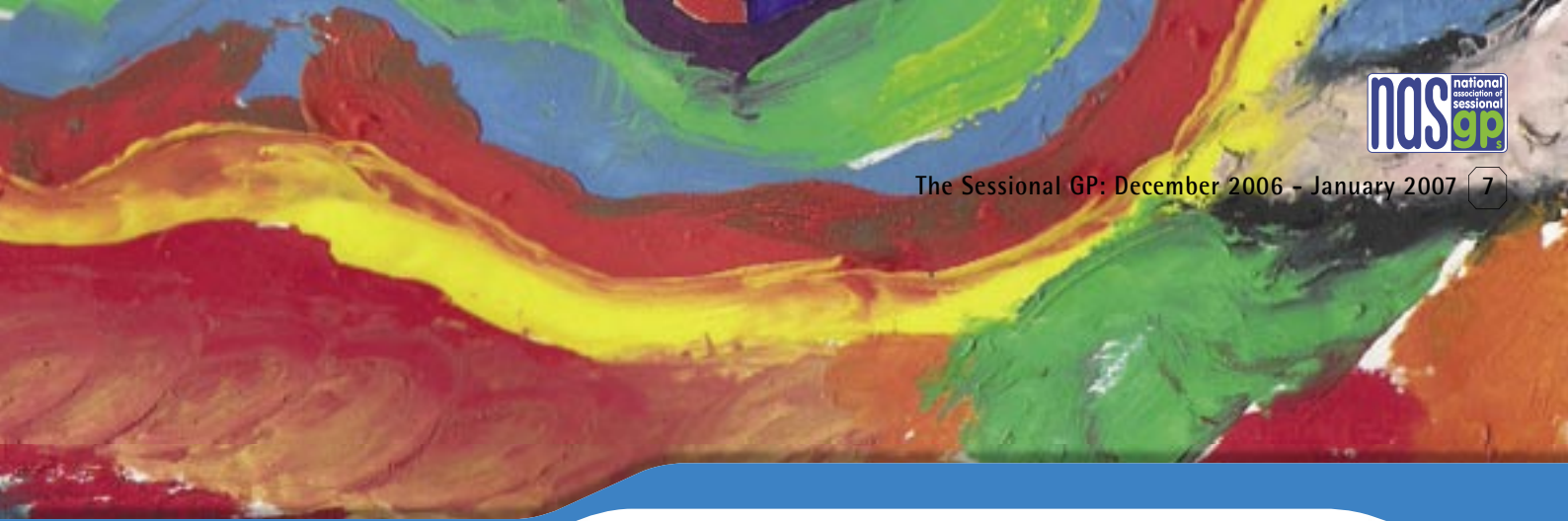
- adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient
- providing or arranging advice, investigations or treatment where necessary
- referring a patient to another practitioner, when this is in the patient's best interests."

Avoid treating those close to you

"Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship." (the GMC does not specify what constitutes a close relationship.)

Doctor-patient relationship

"In most successful doctor-patient relationships a professional boundary exists between doctor and patient. If this boundary is breached, this can undermine the patient's trust in their doctor, as well as the public's trust in the medical profession."



Portfolio Lives



Rowena Grenfell

Rowena Grenfell is one of our regular contributors to the Sessional GP Group 'Roundup', and here she tells us about her life as a Sessional GP

Can you tell us something about your home life?

I live in an immediately post war house which still has much work needed on it, but we are also hoping to build on adjacent land. Planning permission problems have postponed that idea at the moment. We have a ½ acre garden, which the kids love, but it provides lots of lawn to mow. My husband is really useful to have around as he works with computers. I have 2 girls, aged 11 and 10, who are the reason I became a Sessional GP in the first place

What medical organisations have you been associated with?

Apart from the Morecambe Bay Non-Principals, I have been the local association secretary of the Medical Women's Federation for 12 years. I feel that the Federation has achieved a lot for women doctors over the years and, although there are far more women in medicine than ever before, the glass ceiling is still very apparent in that women are not proportionally represented at higher levels in medicine.

Describe your GP career so far.

I trained at Sheffield University and went out to New Zealand - initially for a year but I ended up staying for four! It is a wonderful country for the outdoors. I did hospital work to start with, but then had a major accident, fracturing my femur in the wilds of Fiordland. Instead of returning to the UK at that point as I had planned, I went on to do GP training for a year. Soon after, I returned to the UK and completed UK GP training. Next I opted for a partnership in Kirkham - it was the ideal partnership with which I stayed with for ten years. Part way through

I moved to Lancaster so that the children could attend a Steiner Kindergarten, which involved a 28 mile commute each way each day. When a salaried job came up in Lancaster I was able to negotiate favourable working hours and felt it was too good an opportunity to miss as it would give me more time with the family and less time on the road.

What floats your boat about general practice?

For me, the important things about General Practice are the relationship with patients and continuity of care over a period of time. We are very privileged to share intimate aspects of people's lives. It also provides great variety, which keeps it interesting as well as giving flexibility, especially for Sessional GPs.

How do these passions influence the way you work as a GP?

Changing to a Sessional GP role has provided much greater flexibility, as I have been able to arrange to have time off in most school holidays and collect the kids from school most days, whereas in a small practice with just four partners, we were restricted to having only one person off at a time.

However, the current practice has much less of the continuity which I value, due to a high proportion of university students and young people for whom it is not so important.

What are your passions outside general practice?

I love orienteering, which I have done for many years at a very mediocre level. Being a Sessional GP has enabled me to become fitter, as I have much more time for training and so I gain more satisfaction from the sport. I have also branched out into mountain marathons which provide a greater challenge and are a tremendous satisfaction to complete. I have recently taken up the flute at the centre where the kids do much of their music and where adults are encouraged to join in.

2. BMA guidance on treating family or friends

The BMA advises that treating family and friends should generally be avoided, except in emergencies. It states that in such cases a GP "may fail to notice symptoms that a dispassionate observer would note" and if seeing somebody outside the surgery, they "may not be able to carry out all the tests that would be done in a formal consultation".

Getting out of a tricky situation

So what would you do in the above scenarios?

In the first case, MPS would advise adopting an empathetic approach to Mrs Smith and explain that it would be better for her to see her usual GP. Explain that you would not be able to properly diagnose any condition without being able to review her medical

history/notes or conduct the necessary examination or tests. Add that if you were to offer a diagnosis or advice now on the basis of incomplete information, problems could arise for both if you if a different, even serious, condition came to light in the future.

This second case puts you 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. If he persists in his request, explain that you would be able to write something in the form of a medical report, which would need to include reference to any relevant past medical history, adding that he would need to see and consent to it being sent.

If you find yourself in a grey area between professionalism and your social life, contact your protection organisation for advice.

Artwork by Toby Fieldhouse



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NASGP council member Judith Harvey...

If you had asked me about concussion a couple of months ago, I would probably have scratched my head and muttered about headaches. Now I am living with it, but I still find it hard to describe.

What led up to the concussion? I am dependent on the observations of others, because in effect I wasn't there. I remember riding up a leafy lane leading onto Dartmoor on a lovely late-September day. The next thing I recall is lying on a hospital trolley feeling a hard collar with holes in it around my neck, and being told that I had fallen off the horse and injured my head six hours ago; that I'd had a normal CTS, but was going to be kept in hospital overnight for observation. I recall the regular disturbance to have my BP taken and a light shone in my eyes, the kind efficiency of the A & E staff, the NHS toast and tea next morning.

As we drove home, my husband told me what had happened. Nothing impressive: we had left the lane and were up on the moor, my horse was restive and started to canter, I lost a stirrup and slipped off. Not onto granite, onto a gorse bush. No obvious head injury, and yes, I was wearing a helmet, but there must have been enough of a

wallop for me to be unconscious for several minutes and to have no memory of the fall (just as well if I were ever going to get on a horse again). I have no picture of being in the Land Rover, the drive over the moor to the cottage hospital, the ambulance trip to Exeter and the CT scan. During that time I had tried persistently to understand what had happened – asking endlessly where I was and why I was there. For a while I thought John Major was the Prime Minister, but by the time I reached the cottage hospital I am told I was able to recall the names of my current colleagues, though still persevering with a litany of repetitive questions as I tried to anchor events in time and space.

For the first few days I couldn't read comfortably, or use a computer, and I couldn't bear music playing – it overloaded my brain. I didn't know that I try to deconstruct Bach fugues when I listen, but apparently so. I just slept. After a few days I picked up 'A Short History of Tractors in the Ukraine'. Taken in short doses, just the thing for the bruised brain to practise on (those of you who haven't read it will be very puzzled).

After a couple of weeks I went back to practice for two days a week. I was safe enough – so much of what we do is embedded so deep that the blow had not shaken it out, and there are always people around should I get stuck. But for a while I was clumsy on the computer, and I am still slow. After a couple of sessions in which I ran 40 minutes late, I now have 20 minute appointments, a luxury

both I and the patients will find it hard to relinquish.

Though the old knowledge is still intact and accessible, newer information tends to bob out of reach when I try to grasp it. Irregular Spanish subjunctives and QOF codes for example. And I haven't gone to any educational events; there doesn't seem any point in going through the ritual. Mental multitasking is still difficult, too. I am not up to driving round Camden on a wet, dark evening looking for blocks of flats. Could I cope if a patient were collapsed, or psychotic or waving a knife at me? And I still tire easily and sleep badly – apparently a not uncommon sequel to a head injury.

Speaking to a neurologist was reassuring – six hours of amnesia is quite a long time compared with most knocks on the head, and, as they say in Cornwall, 'the age is there', so I can expect it to take three months for my mental processing to return to its normal speed and complexity. And if I do too much I will only set myself back. I am learning that 'doing nothing' does not mean picking up the newspaper or fiddling on the computer. It means sitting with my eyes shut, doing . . . nothing.

I am told that during the hours of amnesia, I kept asking 'Is this real?'. For me, of course, it still isn't. No images have ever come back to fill in the black hole. I suppose I realised that I was not forming memories. Neurologically, what processes were involved? When I am recovered I shall try and find out.

Judith Harvey