

Welcome!

We've got a great article on working in a village in rural India; Judith tells us about how she once slept with one of her patients and Annmarie tells us how Sessional GPs can work in teams. We're after some more council members and have some new tax-year resolutions for you.



Village health in India

Working as a GP locum in 2006 gave me the flexibility to apply for work abroad so, having worked in rural Malawi during my gap year, I aspired to return to the developing world with the skills and knowledge I had gained through my medical training. Having decided on rural Maharashtra in India, I contacted many recognised international organisations and eventually came across the Institute of Health Management, Pachod, which offers healthcare for women and children, and provides STI/HIV clinics and health education meetings for all village members.

The hardest thing to adapt to was the pace of life. We were the only non-Indians in the village, and we wanted to be involved and contribute immediately, but were advised to "take some time"; although frustrating, it was excellent advice as the society and culture were so radically different to our own. The staff were extremely welcoming and we ate curry with them three times a day. We washed with water from a pump and enjoyed the electricity when it was on.

As many women have to walk for two hours to see a doctor, cultivating their farms or doing housework takes preference over healthcare. In response to this I started running my own female clinics in the villages and, by building on a service that already existed and offering it on their doorsteps, it was much easier to be accepted.

Most of the staff speak some English, although only Marathi is spoken in the villages. I managed to learn some key Marathi phrases, but relied on the rest of my female team - a Christian nurse, Muslim HIV counsellor and Hindu lab technician - for translation.

Women presented with all the typical gynaecological complaints, but all at more highly developed stages: prolapses were more severe; breast lumps had been present for months, and discharge and pelvic pain for years. Advice to leave their village to go to hospital was invariably met with negativity.

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GMC OSCE Assessors

The General Medical Council is organising days in which they give general practitioners knowledge tests and OSCE's to validate and gather reference data for the GMC's Fitness to Practice procedures. They are recruiting volunteers for the week of 21 May 2007 and would like to know if members of NASGP would be interested.

It will involve taking a written test, and a set of clinical skills tests in an OSCE (Objective Structured Clinical Examination) format. The results will be anonymised and volunteers will receive feedback about their own performance in the tests relative to their peers. Volunteers will be paid an honorarium for participation in these days of £350 per day for validator or assessor, or up to £430 per day for locum fees plus travel expenses.

The days will run from 9:45 AM to 4:30 PM and will be held in London. Please contact Joanne Turner for more details at j.turner@medsch.ucl.ac.uk

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The proportion of women who had been reinfected with STIs due to a non-existent partner notification system appalled me. Because of gender inequalities, a lack of education and the rural myths that STIs originate from women, changing this was not a straightforward task. It was incomprehensible that people with an STI could be so asymptomatic!

After a month I had my first success with partner notification. As female doctors cannot treat male patients, we decided that the most effective method for treatment was to pass contact names between the male and female clinics and to supplement this with health education for the index patients in clinic, reinforced by health educators motivating contacts to go for treatment.



Because there seemed little motivation for the males to attend the contact clinic, I could improve the female health through male education by producing a pamphlet about STIs on how a patient could be asymptomatic, with the resulting complications. The language in these leaflets had to be simple and unambiguous, for instance many people could not understand percentages. These were given to patients at clinic, distributed and read out for the illiterate at village health meetings. As a result of this simple idea, there was a steady increase in partner notification and treatment. I was conscious that the health workers should be educated about the need for partner notification and the setting up of systems to monitor treatment that could be continued once I had left.



My work in India benefited me both personally and professionally, reinforcing how communication skills are the core of general practice. I missed the rapport with patients, having to rely on a third party for translation, although this again emphasised the need to ask open questions - meanings get lost in translation and India is a country where people do not like to say no! I learnt to adapt, making the most of the medicines on hand and relying on my clinical skills rather than investigations which were not readily accessible. Ultrasound scans and sometimes swabs were available, but rarely could we afford the cost – and the patients the long journey – of these.



It was an amazing experience to be immersed in another culture. Whether a barefoot child wearing rags, a woman in a brightly coloured sari with nose ring and bangles and pots of water on her head, or men dressed in white sitting drinking chai (sickly sweet milky tea), the villagers greeted us with stares which quickly turned into smiles. We were invited into their two-room homes and given every hospitality. They were all so content, a far cry from the worried well in our society.

Once we had slowed down, we relished our simple lives. It was great to take a break from our hectic materialistic lives in the UK and I feel sure this experience will inspire me throughout my career in general practice.

Dr Charlotte Macdonald
GP Locum, Yorkshire
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Teamworking and freelance GPs

by Annmarie McTigue, Writer
– Medical Protection Society

Teamwork is among the most popular buzzwords in healthcare at the moment. Providing the best possible outcome for patients by using multidisciplinary teams is the thrust of many a Department of Health policy. But how can a freelance, self-employed locum work effectively in a team and reap the benefits of teamwork?

Safety in numbers

If you are starting out as a locum, or even if you have been freelancing for some time, you could well reap the benefits of joining a local sessional GP group. If there isn't a group in your area, the NASGP offers advice on setting one up. These groups can vary in number and approach, but they provide an invaluable opportunity to network with like-minded GPs in an informal setting, share the latest news from your PCT and provide updates on best practice.

NASGP Chief Executive, Dr Richard Fieldhouse, recognises how his work life has improved thanks to increased teamwork through the groups – whilst still working self-employed.

"When I started off locuming ten years ago I was totally on my own, like many locums. There were few locum groups around the country, but now there are over 80. The group is informal and a good way to unwind and to talk about local primary care developments. It is a very loose arrangement of teamworking, but it's made a difference."

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Elections - We need YOU to represent Sessional GPs

There are two vacancies for NASGP council members, commencing in October 2007 for 3 years. Council members are asked to attend up to 2 midweek meetings in London per year, with travel expenses and honoraria. Other business is generally performed via email.

Any Sessional GP member of the NASGP may propose another Sessional GP member for election to one of these 2 seats. A web-based ballot will take place in June if the number of nominations exceeds the number of seats. The results will be declared in the August-September edition of The Sessional GP.

Nomination forms and further details are available in the 'What's New' section on the NASGP website or by writing to the NASGP. The closing date for applications for nomination is July 15th 2007.

NB: in the event of a ballot, members will be notified by email – if you did not receive an email notification on Thursday 24th May 2007 from the NASGP then please update your email address on the NASGP website.

NCAS join CMO by burying head in sand over locum performance

We mentioned in the previous edition of The Sessional GP how the CMO's "Trust, Assurance & Safety" White Paper was alluding to freelance GPs being regulated through locum agencies. Well, the National Clinical Assessment Service seem to be doing the same! Their latest document "Back on Track" – see www.ncaa.nhs.uk – says "GP locum agencies could be required to take responsibility for managing performance concerns [of GP locums]. This could be achieved through the formal agreement between the locum agency and the PCO or organisation to which the GP locum provides services." It's one of those phrases that the more one reads it, the less sense it makes. Will commercial locum agencies take on GP locum performance issues? So, we're now talking to the NCAS too to find out exactly what they do mean and advise them accordingly.

Sessional GP Roundup

Forth Valley Locum Group

We are a small and very informal group, although quite chaotic at times because we have a very high turnover. We used to have an excellent website set up by a previous member, but have had to stop it recently because someone hacked into it! If you would like to join us please get in touch.

Christine Livingston

christine.livingston@hotmail.co.uk

Maidstone Area Non-Principal Group

We are an active and thriving group who are happy to continue welcoming new members. We meet on a monthly basis at Maidstone Hospital Post-Graduate Centre. Our meetings offer a mix of educational lectures and presentations from external speakers, self-directed learning and mutual support. As we are fortunate enough still to be receiving some funding from the Deanery, a number of our meetings are targeted towards the appraisal process, including audits, analysis of significant events and video consultation analysis. In addition to the educational meetings we have 2-3 purely social gatherings a year.

Julie Morgan

julie@roundelway.wanadoo.co.uk

Chichester Pallant Medical Chambers

With 12 doctors recently applying to join Chambers and a 125% increase in the number of sessions booked in February compared to last year, things continue to go well in Chichester. Our recent Chambers meeting included two Significant Events - one with regards jury duty and the other regards 'on-call'.

The first meeting of our new Southampton 'satellite' is later this month, and over the next few months we'll be setting up several other chambers for locums in the region.

Alan Sim

alan@pallantmedical.co.uk

The Morecambe Bay Non Principals Group

We are a group of Non principals who like to meet up for educational purposes as well as for networking. We generally meet every 2 months and recently held a meeting at Lancaster University at the Health Centre on campus. It is the first time we had met at that venue and it was generally very successful. However there are no computer or projection facilities. Our speaker was a local old age psychiatrist who was able to talk informally without the need for technical backup.

She covered topics around dementia with a summary of services, practical tips on treating dementia, NICE guidelines on anticholinesterases and advice about capacity. One GP, who had not been to one of our meetings before, actually said it was the most useful meeting she had ever attended! The turnout was 10, which is about average for us when a speaker is invited. In-house meetings are less popular. We hope to invite a local neurologist to our next meeting.

Rowena Grenfell

all@thebrownfamily.com

Leeds Sessional GP Educational Forum Meetings

We now number 35 Salaried and Locum GPs. In March we met with two local pharmacists in their shop to look at how their role is changing with MURs, Emergency Contraception and Chlamydia Screening, together with some of the rules governing OTC sales of Prescription medications. Dr. Dinesh Saralaya, consultant in respiratory medicine, gave us a "GP update on COPD" at our last meeting on 29th March, which was held at a restaurant in Leeds and kindly sponsored by GSK.

Our next meeting is with Nicholl Gordon, of the medical accountancy firm Sandison, Easson & Gordon, at the end of May.

Keith Pollock

kdpollock@doctors.org.uk

Newham Sessional GP Group

Our aim is to provide salaried and freelance GPs with support in the Newham area, educational discussions - usually hot topics (no prior reading required!) - and an opportunity to network, find out who are the local sessional GPs in the practice down the road, as well as lunch!

Osman Bhatti

osmanbhatti@doctors.org.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. Talks in May and June will be on The Confidential Enquiry into Maternal Deaths by Prof Jim Nielson from Liverpool Women's Hospital, and Acute Confusional State by Dr Solomon Almond from the Royal Liverpool University Hospital. All welcome!

Katharine Jones

kats@liv.ac.uk

Tower Hamlets Sessional GPs Group

We have now become an independent SDLG, after initial and generous PCT funding helped formation. It is open to all GPs on the THPCT performers' list, with evening meetings held at 7-30 pm on the second Tuesday of every month. We have sandwiches, topical programmes, locally based speakers or group members with specific skills to present or lead. We're mutually supportive, with room for open discussion and a wide variety of GPs to share information and ideas.

Robin Cartwright

robin.cartwright@nhs.net

South West London Locum Group

Welcome to all salaried and locum GPs in the South West London area. We are an educational group which meets about once every 2 months in Clapham. We exchange information on local practices, cover education and appraisal and give each other support. So far attendance has been low with only several members attending reach meeting, but we'd really love more locums to join.

Reggie Sangha

reg_sangha@yahoo.co.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

The new tax year – time for new resolutions?

April saw the issue of tax returns for 2006-07 – don't ignore it until the filing deadline – the longer you leave it the harder it gets to find the information!

Review your records for 2006-07 – how could you have improved on these to make it easier to complete your return?

Spreadsheets recording income and expenses are fine – you don't have to have expensive bookkeeping software.

If you are not comfortable with setting up your own spreadsheets, we can provide some very simple software to our clients to record income and expenditure.

If you send your information to your accountant early in the tax year, chances are it will be dealt with quicker and you will get early warning of the tax that you have to pay in January – which gives you time to save up for it if you haven't done already.

For the current year – keep your records written up as you go – it's so much easier than trying to do it all at once at the end of the year. Set up a folder system to retain receipts, copy invoices, bank statements, interest certificates and dividend vouchers and anything else that is relevant to your tax affairs – and regularly put the paperwork in it!

And the main advantage of all this? Less stress on you (and on your accountant!) and more time to yourself.

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Do your duty

In revising its *Good Medical Practice* last year, the GMC reflected the growth of more multidisciplinary team working in all areas of healthcare. You may feel, as a sessional GP going into different practices all the time, that teamworking is difficult. But the GMC guidelines are there to protect you in practice; they should help you to become more a part of the practice team, particularly if you are there regularly or for a substantial period. The GMC states:

“Working in teams does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you should act as a positive role model and try to motivate and inspire your colleagues. You must:

- Respect the skills and contributions of your colleagues.
- Communicate effectively with colleagues within and outside the team.
- Make sure that your patients and colleagues understand your role and responsibilities in the team, and who is responsible for each aspect of patient care.
- Participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies.
- Support colleagues who have problems with performance, conduct or health.”¹

Ask questions

The RCGP recently published its reflections and recommendations on working in primary care.² It talks about the changes to practice teams and upskilling of nurses and allied health professionals (AHPs) brought about by the 2006 White Paper,

Our Health, Our Care, Our Say.³ Nurses and AHPs taking on roles traditionally performed by a doctor, e.g. a medical care practitioner, can bewilder the unprepared locum GP and lead to mix-ups. Dr Fieldhouse says it is easy to confuse who is responsible for what, especially when health professionals have prescribing or extended care powers.

“As a locum you find yourself in a different practice all the time,” he says, “and you don’t have access to information about who is qualified to do what. For doctors and patients, there isn’t anything to distinguish between nurses, therapists and nurse prescribers.”

So, whenever possible, ask the practice to send you information about how its team is made up. Ask for an introductory meeting with as many of the team as possible on your first morning: this will be particularly useful if you are going to be there for a few weeks or more.

The NASGP has produced a practice induction pack (available to order online) to help locum GPs to settle and perform effectively in a new environment. Ask your practice manager to complete one for you, with further information about advanced care practitioners where relevant.

Be a team player

You may be self-employed, but you don’t need to work in isolation. General practice now focuses on patient-led care, multidisciplinary patient management and interaction with community services. The RCGP acknowledges that this has “reduced the emphasis on the individual GP providing

isolated care, necessitating a team approach and the employment of greater skill mix". An unpublished RCGP report – *What Sort of General Practice* – provides a standard for successful teamworking, which applies to all GPs. Its topics include clinical governance, team values, CPD, and patient and public involvement.⁴

Sessional GPs now have the opportunity to enjoy the best of both worlds – marrying the support of a local team with the freedom of the locum life.

Teamwork: Medicolegal requirements of a doctor

Sections to refresh your memory from the GMC's *Good Medical Practice* (2006):-

- Duties of a Doctor – page 2
 - Good Doctors – paragraph 1
 - Good Clinical Care – paragraphs 2c, 3f, 3h and 3i
 - Teaching and Training, Appraising and Assessing – paragraphs 15 and 17
 - Working with colleagues – paragraphs 41-42
 - Arranging cover – paragraph 48
 - Sharing information with colleagues – paragraphs 50-53
 - Delegation and referral – paragraphs 54-55
1. "Conduct and Performance of Colleagues"; *Good Medical Practice* (2006): GMC, London
 2. *The Primary Care Practice and Its Team*; RCGP, February 2007
 3. *Our Health, Our Care, Our Say*; Department of Health (January 2006): London
 4. Schofield T, *What Sort of General Practice*; RCGP (2006).

Different place, different practice, same protection



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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 Toby Fieldhouse, age 11



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Me & Mrs M

Improper relationships with patients are in the news.

Mrs M was the patient. She might or might not have been dementing, but she seemed confused and was certainly prone to wandering. She might or might not have been in severe pain from her arthritis, but she certainly had a flail leg after failed surgery. All of which made it difficult for her to live in her isolated cottage with its steep narrow staircase. Somehow her medication had reached alarming levels and might or might not have been making things worse. She was in the cottage hospital for evaluation. Essentially this meant taking her off her psychotropics and titrating her pain relief. After several days no-one was sure what was going on. Does paracetamol take effect within half a minute? Was she skipping down the corridor when she thought no-one was watching? Was she attention-seeking? She was certainly much more peaceful when someone spent time with her.

I was a registrar, and on call. The previous evening the cottage hospital had not been busy and the nursing staff had popped in regularly to see Mrs M. Everyone had had a quiet night. Tonight the staff were occupied with a dying patient. At intervals through the evening they rang to say that Mrs M kept struggling out of bed and falling, and asking what could be done. In line with the agreed plan, I authorised further doses of major tranquilliser as I went from visit to visit.

At 1am things quietened down and I went to the cottage hospital to see how they were getting on. Badly. Mrs M was still creating problems the staff could not manage. I had no confidence that yet more medication would help. I could see no hope of going home to an undisturbed night. Mrs M was the only patient in a double-bedded room. After some thought, I asked the nurses to move her bed against the wall, and then we pushed the second bed alongside it. I got in and put my arm around Mrs M. There we lay until dawn, in uneasy repose. Every so often she would make a play for escape off the end of the bed and I would persuade her to lie down again.

Next afternoon, the psychogeriatrician came to assess her. Standing on the steps of the cottage hospital chatting to a colleague before going in to hear his verdict, I noticed the door being pushed open. A familiar figure sidled around it, coat over her nightdress and slippers on her feet. I steered her back inside. "It's all very well for you; you can escape", she muttered. I could; she, on the other hand, disappeared into the psychogeriatric unit and from my life.

So I have spent a night in bed with a patient. It was unorthodox but not improper, and it solved the problem. Even with the hindsight of 18 years' more experience I don't have an alternative strategy.

Judith Harvey

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