

Time Out in Tasmania

Sitting at the desk of my St Ives surgery in December 2002, after yet another busy and frustrating day, I realised that, at the age of 37, this was not something I wanted to continue for another 25 years. Not even in somewhere as beautiful as Cornwall. My thoughts turned to our recent family holiday in Australia and, in particular, idyllic Tasmania. After discussion with my wife Deb, a community nurse, and my two children Charlie and Rose, then aged 10 and 9, we decided to take the plunge. That was the easy part, telling my partners was more difficult.

Tasmania is a little known island state due south of Melbourne. It is approximately the size of Ireland, with the population of Cornwall (around 450,000) and a similar climate - rolling hills, green and lush. It has

vast World Heritage areas with wild rivers, huge lakes, thick temperate rainforests, glacially carved mountains and tarns, all providing some of the world's best wilderness walking, fishing and rafting. It has a large "Green" active movement to keep the island pristine and unspoilt. Its climate is very English, none of the scorching temperatures of the mainland and no water supply problems. The seafood is spectacular and, being a "cool climate" region, the large numbers of vineyards produce high quality wines on a par with New Zealand.

Finding employment was easy. In 1988, during my elective in Melbourne, I met a Tasmanian whose father was a GP there. I hadn't planned a visit until then, but was immediately taken. My wife and I returned in 1990 on our honeymoon and then

Welcome!

We're really excited this month to let you know about our two new Council members (see page 7). With job opportunities opening up all over Australasia, we have an article on working in Tasmania; Judith tells us about her plans to stop working as a GP for a while; Sara from MPS gives us a rundown on the GMC's plans to lower the standard of proof; Liz Densley tells us how we can claim the use of a room in our house as an office; and we have the usual round-up of sessional GP groups.

again in 2002 with our children. A quick phone call to my old friend, then an email, and I was in contact with the very helpful GP Workforce, the organisation with the role of recruiting GPs to work in Tasmania.

As a UK Graduate, there are restrictions as to where you can work - usually rural or semi-rural areas that sometimes have problems in attracting an Australian graduate. Although Tasmania has its own Medical

[continued on page 2](#)

Cradle Mountain, Tasmania



Tasmania



GENERAL PRACTICE
workforce

12 month positions with 4 weeks leave which include a minimum of return flight to UK, indemnity insurance, visa and associated medical costs, police checks, registration with medical council, costs for obtaining FRACGP (a paper exercise, no exams!).

Depending on the location there may be additional provision of car, accommodation for part/all of time.

Contact Louise Mason

lmason@gpworkforce.com.au

www.gpatlas.org.au

continued from page 1

School, the majority of graduates head to the "brighter lights" on the mainland.

Unlike the mainland, its size means distances comprehensible to Europeans and, as a result, you are rarely isolated in Tasmania. There are three main conurbations (Hobart, Launceston and Burnie) and, wherever you work, you are never more than 40 minutes from a teaching hospital. Sydney and Melbourne are one hour's flight away and the introduction of the budget airlines means the cost is minimal. Similarly classed jobs on the mainland could mean hundreds of kilometres to the nearest referral centre and involve performing procedural work, trauma management and obstetrics.

As a result, the nature of the work here is very similar to my UK experience. Patients and their illnesses are the same the world over. Slightly different drug names, different computer systems etc., to which it is very easy to adjust. GPs here are private practitioners and it is a business. It takes a while to get used to paying patients. Private means no Government interference and being told what to do. You choose how long and hard you work and remuneration is directly related to your workload. Most GPs work on 15 minute appointments. Paperwork is minimal and home visiting rare. Lunch breaks! I regularly go for my daily run during my lunch time. Most positions do involve out of hours work, but all out

of hours calls are triaged by "GP Assist" and the work load isn't onerous. There are some of the issues here with waiting lists and shortages, but not on the scale of the NHS. There is a much bigger reliance on the private sector; a lot of people are privately insured. A huge difference for me has been the easy access to investigations - same day CT scans/US scans really improve the management of your patients. However, the GP system is behind the UK in some areas: practice nurses are not as widely utilised here so, depending on where you work, you may find yourself brushing up on your phlebotomy, PAP smear and ear syringing skills. A lot of patients prefer to see the GP for these. It has actually been nice to be "hands on" again.

Remuneration is less than that of UK GPs, given the recent contract changes but, taking into account the quality of life and the vast improvement in working conditions, this is not an issue. This is equating pounds to dollars, but the cost of living is so much less here - petrol at 45p a litre, housing prices a fraction of the UK. You really can afford to have that big house with as much land as you want.

State and public schooling here is excellent. My children had no problems in adjusting and are thriving. They attend the local Grammar School, the oldest in Australia. The sporting opportunities are huge and the fees are a fraction of the UK equivalent. My wife has been able to pick up nursing work

Wine Glass Bay, Freycinet





Cataract Gorge, Launceston

very easily. Obviously there are times when you miss your family and friends but the world is a very small place nowadays.

Given all the above, we can never envisage returning to the UK.

Any vocationally trained GP with MRCP will have no problems finding work. No more examinations. You need to acquire the FRACGP, but this is a paper exercise and GP Workforce will guide you through this and even pay the fee! It will also help to match you with a suitable practice and guide you through the bureaucracy, which at times can seem daunting. It will pay for all the required medicals, police checks, visa applications,

indemnity insurance, medical council registration and return air flights in return for your agreeing to come and work/live in Tasmania for twelve months. Whether you are looking for a sabbatical or a taste of something different before joining the rat race, I would thoroughly recommend Tasmania.



Dr Andrew Croft
acroft@gpworkforce.com.au

SGP leaders meet to discuss common ground

NASGP Chairman, Dr Mike Uprichard, met last month with his counterpart, Dr Victoria Weeks from the GPC Sessional GPs Sub-committee, to familiarise each other with the work being done on behalf of Sessional GPs by both organisations. Mike highlighted the thrust of the NASGP as a "lobby group" for matters of concern relating to SGPs and also that the work of the association is, in a sense, complementary to that of the BMA - able to channel concerns in a more outspoken way where this was required.

Areas in which both organisations are actively involved are revalidation, how SGPs can be revalidated, and the corresponding collection of evidence. The position of salaried GPs and their representation were discussed, with concerns being expressed on contractual matters which affect particularly those GPs who are contracted to PMS practices. Representation

of members through the respective organisations was outlined, including the changes being made to the NASGP's Memorandum of Association to encourage more direct member participation.

Discussions also addressed briefly the representation of SGPs on LMCs and how effective this is. Once again, salaried GPs potentially could have difficulties in this regard if there were conflicts of interest on a committee made up predominantly of partners in practices. Victoria felt that LMCs, in general, are actually very balanced in this representation and where contractual conflicts could take place these were deferred to BMA agencies for arbitration.

This was an exploratory meeting and it was agreed that more meetings between both parties would be useful in order to champion further the needs of SGPs.



Sessional GP Roundup

THE LIVERPOOL GP FORUM

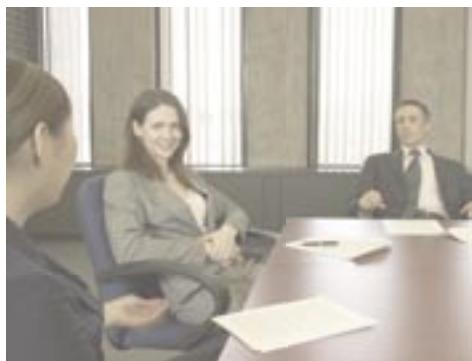
We are a friendly, informal and very international group of sessional GPs, GP principals, registrars and primary care academics. We meet on the last Wednesday of every month at 3345 Parr St Studios, L1 4JN (www.3345parrst.com/3345). Meetings start at 7.30pm with an educational talk, followed by an opportunity to meet new colleagues in the bar. Talks in October and November will be on Palliative Medicine and Headaches in Children by Dr Leslie Allsopp, Consultant in Palliative Medicine at the Marie Curie, and Dr Steve Ryan, Medical Director of the Royal Liverpool Children's Hospital, respectively. All welcome!

Katharine Jones
kats@liv.ac.uk

THE WEST SURREY NON- PRINCIPAL GROUP

Our Group continues to thrive, meeting on the first Monday evening of the month at Woking Community Hospital, with an average turnout of 30 members and a good mix of types of non-principal. We have a sociable networking buffet followed by an educational talk/discussion. We tend to invite local Consultants to speak, although we have had some great meetings with GPs with special interests: next month one of our number who has just done the Dermatology Diploma is going to share some of her wisdom. We have recently had an inspiring talk from Richard Fieldhouse, who enlightened us about the concept of non-principal chambers. New members welcome.

Liz Colyer
davidlizzieburndred@hotmail.com



LEEDS SESSIONAL GP EDUCATIONAL FORUM

We are about to have our first meeting since the summer holidays and are planning to discuss "Evidence to collect for Appraisals".

Currently we have two members in Ethiopia, and one member locuming in a Hospice, and are hoping to hear of their experiences.

We are in the process of negotiations with the PCT regarding the issue of receipts for monthly superannuation contributions. We are also organising our own resuscitation training and enquiring about 'flu vaccinations for our members.

Doug Pollock
kdpollock@doctors.org.uk

GLASGOW LOCUM GROUP

We are continuing with our regular diet of self-funded evening educational meetings, which are well attended; recent topics have included employment issues for sessional doctors, locum finances and accountancy issues, and diabetes. The last few months have heralded changes behind the scenes to the group's website, with the use of the on-line Scottish Performers List search: this allows electronic registration for the group which reduces the need for members to send in paper copies of documentation to prove their status as locums. Also, the introduction of an e-mail list for locums has facilitated communication with members.

info@glasgowlocumgroup.org

HAVERSTOCK NON-PRINCIPALS GROUP

The autumn programme has begun, and the meetings are monthly, usually the first Thursday of the month.

Joanna Frank
joanna_frank2000@hotmail.com

BORDERS NP GROUP

Due to small numbers, the Borders locum group no longer meets as a separate group. Instead there is a joint meeting with other non-principals on a monthly basis for educational purposes. Most locum business is now communicated by email, but we have had some short locum meetings before or after the educational session if required. Joe Wilton, the previous co-ordinator of the NP-group, has stepped down. I now co-ordinate locum and practice-based NP information, and Laura Ryan the information for OOH salaried GPs.

Helen Johnson
helenjohnson@doctors.org.uk

THE MORECAMBE BAY NON-PRINCIPALS GROUP

Our informal group continues to meet approximately every 2 months. We alternate meetings between Kendal and Lancaster to cater for the geographic spread of members. I have 62 people on my email list, but attendances are usually somewhere between 5 and 15 at meetings.

We met for the first time since the summer recently and held a significant event analysis. People brought cases to discuss and we could all learn from these. The turnout was small as the date chosen did not suit a lot of people. However, 3 of the 6 attending were new to the group, having just completed their registrar year, so hopefully that bodes well for the future.

We hope to invite a speaker to our next meeting, perhaps a local gastroenterologist.

Rowena Grenfell
all@thebrownefamily.com





PALLANT MEDICAL CHAMBERS CHICHESTER

We're still managing to meet monthly and try to keep our meetings as an even balance of socialising and learning! Our next meeting will be from a paediatric respiratory consultant; she will be speaking on 'Wheezy infants, asthmatic children' and hopefully this will get us all updated on the current best care. Please visit www.pallantmedical.co.uk/cpd for more information about this. If you're in the area we'd be pleased to see you there!

Louise Taylor

louise.taylor@pallantmedical.co.uk

SW WALES SESSIONAL GP GROUP

The Dyfed group now takes in Swansea as well and has become the SW Wales group. We are one of the three which cover the whole of Wales, with each being run by a CPD Co-ordinator. We are lucky enough to have funding from the Department of Postgraduate Education for General Practice, Cardiff University. Meetings are usually held monthly; the next meeting is on Thursday 2nd October, in the Postgraduate Centre, Carmarthen, and is on "Risk Assessment in General Practice". For further details please contact

Dr Margaret Ings

margaret.ings@ukgateway.net

or **Jo Bowsher**

bowshej@cardiff.ac.uk

GP CHOICES - DURHAM & DARLINGTON EDUCATIONAL & PEER SUPPORT GROUP FOR SALARIED & LOCUM GPs

At our meeting on 3rd October 2007, 25 salaried and locum GPs of all nationalities participated in a questions and answers session, "Contraceptive Update". The speaker led a very informative and lively session, and she was impressed with the number of GPs that attended the meeting.

Our meetings are held every 2-3 months on a Tuesday or Wednesday evening in the Boardroom, Appleton House, Lanchester Road, Durham, DH1 5XZ. We provide sandwiches and tea/coffee from 6.15pm, with the speaker following at 6.45pm.

If you are a salaried GP or self-employed locum, working in County Durham and Darlington, and feel you are working in isolation please come along to join us. You can discuss any issues or significant events within a confidential, supportive environment.

Carol Hartman-Andersen

carol.hartman-andersen@cdd.nhs.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

USE OF HOME AS OFFICE

Where you are conducting a business from home, you may deduct some of your home costs against your business income. The problem is – how much?

If you designate a room 100% for business use, then there could be a capital gains tax liability on that share of the house on the subsequent sale. In reality however, it is very unlikely that a room will be used 100% for business in a normal family home. At some stage the room will be used for personal phone calls/paying bills at the very least.

Therefore, it is usually better to use a proportion of a room – and in this case there should be no capital gains tax problem.

In simple terms look at the total running costs of the house first. Then look at the area used by the business as a proportion of the total. Then apply this fraction to the total costs.

For example if one room is used for 2 hours a day, out of 6 rooms, then 2/24ths of 1/6th of the total property costs might be claimed. If this works out to a small figure, it might be worth just making a small 'study allowance' claim, adjusted by inflation each year.

The Revenue have recently issued some good guidance on this subject with examples.

<http://www.hmrc.gov.uk/manuals/bimmanual/bim47825.htm>

A Question of Proof

The GMC's proposal to lower the standard of proof will affect all GPs. So what can sessional GPs do to protect themselves in the face of these changes? Sara Williams explores the issues.

Concern has been raised by medical organisations across the UK that new GMC standards will lead to an increase in the number of doctors found to have their fitness to practise impaired.

From 2008 the civil standard of proof (balance of probabilities) will replace the criminal standard (beyond reasonable doubt).

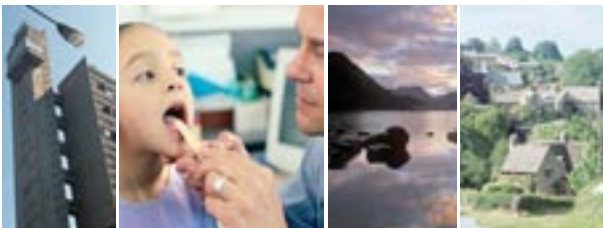
■ **Beyond reasonable doubt** – a decision will be based on whether the panel is sure beyond reasonable doubt that something has happened.

■ **The balance of probabilities** – a decision will be based on whether it is more likely than not to have happened.

Echoing the concerns raised by MPS, the BMA says that: "It cannot be right, when a doctor's entire means of earning is at



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.

stake, to rely upon a balance of probabilities rather than proof beyond reasonable doubt."

MPS Medical Director Priya Singh says "All GPs can find themselves the subject of a complaint to the GMC, and MPS is vigorously opposed to the adoption of a lower standard of proof. This brings a very real risk that there will be miscarriages of justice, and sanctions placed on a doctor's registration when it is inappropriate.

Sessional GPs and locums often work in challenging circumstances. They have to adapt to unfamiliar working environments on a regular basis and to find out about local policies and procedures specific to the practices in which they work.

Sessional/locum work can also be more challenging because you do not have an established working relationship with patients nor any prior knowledge of them, other than that which can be gleaned from clinical records; this may not include valuable non-clinical background information."

What can you do?

Doing the groundwork before setting foot in a practice is invaluable. Ringing to find out if they have a practice pack that will contain existing practice protocols will better prepare you (see www.nasgp.org.uk/spip for the NASGP pack), as will spending time with the practice manager upon arrival. Practice managers are a valuable resource because they know where the equipment is, the referral routes, the practice pitfalls and, most importantly, how to access the computer systems.

the risk of dissatisfaction and conflict presented by the nature of their work by focusing on their communication skills - being satisfied that they have established a rapport with their patients and that there is mutual understanding. By doing this, they could avoid the chances of misunderstanding a subsequent complaint. In the same vein, patients will be less likely to complain if they feel that they have been listened to and understood. The GMC has launched a consultation on how the change to the civil standard of proof can be implemented. It runs from 20 August to the end of October 2007. The proposals were first outlined in a White Paper published in February. The changes will come into force in April 2008, and will form one of the provisions of the Health and Social Care Bill.

Useful practice points:-

- 1 Awareness of guidelines and local protocols.
- 2 Being flexible and receptive improves team working.
3. Good record keeping reflects good care.
4. Good handover reduces the risk of mistakes.
5. Remember the importance of setting up a chaperone when conducting intimate examinations.

Dr Singh says that sessional GPs can help to minimise

**Sara Williams, Writer
Medical Protection Society**

The NASGP Standardised Practice Induction Pack allows individual practices to efficiently and effectively inform all GPs of the 200 essential non-clinical items of information that are specific to the provision of care to their patients.

- **Reduces the risk of enforced underperformance by new or temporary GPs working in an unfamiliar environment.**
- **For Freelance GPs, new principals, assistants, retainers, registrars.**

Ensure every practice in your area has taken all appropriate measures to reduce the risk of under provision and underperformance by GPs unfamiliar with their surroundings.




www.nasgp.org.uk/spip

standardised PRACTICE induction PACK

NASGP Discussion Forum

Our forum has been up and running for 2 years now and, despite the odd few quiet moments, is the liveliest it's ever been, with 307 postings (at the last count) and new members joining every week.

Only paid-up members can join, so if you're not yet a member just log on to the NASGP website and you can start tapping into lots of member-friendly advice.

New NASGP Council members

We're delighted to introduce two new members to NASGP council – Dr Tony Webster and Dr. Stephen Bassett. Tony is chairman of the Manchester Sessional GP Group and has been a regular contributor to the NASGP Newsletter's

Sessional GP Group round-up. Stephen is from Swansea and has a wide experience of working with OOH services, is an ex-partner, an academic barrister specialising in medical regulatory law and a professional negotiator.



Artwork by Toby Fieldhouse



NASGP • PO Box 188

Chichester • West Sussex • PO19 1FP

Fax/answerphone 01243 536428

Email info@nasgp.org.uk

www.nasgp.org.uk

Council Members

Chairman	Michael Uprichard
Secretary	Bashir Qureshi
Treasurer	Peter Taylor
Council Members	Stephen Bassett
	Judith Harvey
	Mark Selman
	Tony Webster
CEO / Editor	Richard Fieldhouse
RCGP Observer	Jean Ker

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

Free to members of
NASGP or £5 per copy
to nonmembers.

Giving up . . . or stopping?

When I first became a GP, there was a problem with easing octogenarians out of the practices they had served for more than half a century. Then came Mrs Thatcher's purchaser-provider split and a new GP contract. Suddenly grey-haired GPs became an endangered species and no-one wanted to go into general practice. Now in 2007 there are not enough openings to go round for newly trained GPs, and their older colleagues seem to be finding more options for the last years of their working lives.

NASGP's membership includes doctors of all ages. There are will-be partners, have-been partners, may-be partners and won't-be partners. I fall into the second category and, like many colleagues, have found that flexibility as a sessional or freelance GP has returned to me control over my work and my life, and restored my enjoyment in seeing patients. It has been a great six years.

Now I am about to give up. "NO!" said a friend who has

already done so, "We are not giving up, we are stopping." We doctors have a strong tendency to do guilt, and if you were lucky enough to secure a place to train as a mature student, as I was, you have even more to beat yourself up over. But we should not apologise when we recognise that it is time to move on.

GPs are used to change. After all, each working day we start again every ten minutes. And we are constantly learning to keep up with new drugs, techniques, new ways of doing things. Change keeps you flexible, keeps you young. Until it wears you out. It's not what you do; that changes slowly. It's not patients who change. Their problems and worries have as much to do with the human condition – unchanging – as with disease, and even disease doesn't change that much. It's not what you do, it's how you do it that changes. At the moment it seems to change monthly. DESs and LISs are commissioned and we struggle to remember what codes we are to use, then they

are decommissioned and that doesn't count any more. Every time there is a reorganisation some doctors, usually those towards the end of their careers, will call it a day. Been there, done that twenty years ago and it didn't work then. When you have got to the stage in life where one new fact inserted into the brain pushes one old fact out, you quickly feel overloaded. When I give up — sorry, stop — I look forward to getting my brain back. I think of all that space which will be available for all the things that over the years have been stuffed into the cramped corners of my cerebrum.

Will I miss it? Yes, of course. The multitude of human contacts, the fascination of the glimpse into other people's lives, the intellectual stimulation are addictive. But there are other things to do and new pleasures to be found.

I'm not giving up. I'm stopping. And starting again.

Judith Harvey
judith.harvey@btclick.com