Missed melanoma
LEARNING FROM MISSED DIAGNOSIS
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LEARNING AND DEVELOPMENT SPECIAL EDITION

Setting up a peer support group
Reflective learning
Revalidation Q&A
WHERE THE RISKS LIE

MPS General Practice Conference 2012

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MPS’s 2012 annual general practice conference will explore where the real risks lie in primary care and take an in-depth view of some specific areas of risk. Delegates will experience a combination of plenary sessions, Q&A panels and streamed workshops exploring different aspects of medicolegal risk and ethical challenges arising from clinical practice in primary care.

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- Workshops on: Medicolegal Hot Topics, Employment Law in Practice, Defusing a Difficult Complaint and Acting as an Expert Witness.

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Welcome

Dr Richard Stacey – Editor-in-chief
MPS Medicolegal Adviser

The world is not static – new medical developments emerge every day. Change provides GPs with the impetus to stretch their knowledge and stay up-to-date, which in turn adds credibility and drives up standards of care. This is a learning and development special edition of Sessonal GP honing in on how sessional GPs can improve their continued education.

We kick the issue off with Dr Paul Nisselle’s eye-opening feature “Missed melanoma”. In the UK about 60% of all claims lodged against GPs involve an allegation of delayed or missed diagnosis. Some of these claims fail because while in hindsight it may be obvious that the doctor missed a diagnosis or made an incorrect one, being wrong is not the same as being negligent. Dr Nisselle, who has dedicated his life to improving patient safety, uses his feature to highlight what GPs can learn from missed diagnosis and their subsequent adverse outcomes.

MPS’s Dr Zaid Al-Najjar also encourages GPs to learn from other’s mistakes in his Hot Topic, where he encourages GPs to think before you print.

Isolation is widely regarded as a problem for sessional GPs. Dr Arthur Hibble, Dr Kamilla Porter and Dr Clare Taylor all draw on different learning initiatives that bring sessional GPs together, such as peer support groups and the RCGP’s First5 initiative.

I hope you enjoy this special edition of Sessonal GP. We welcome any feedback you have or suggestions for themes for future issues.

Richard Stacey

Inside this issue of Sessional GP...

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In the UK about 60% of all claims lodged against GP MPS members involve an allegation of delayed or missed diagnosis. Claims arising from just one area, the missed or delayed diagnosis of bacterial meningitis in children, represent less than 1% of all GP claims, but incur about 30% of the total cost of all GP claims.

About 35% of this class of claims involve a missed or delayed diagnosis of cancer. However, all the hardy perennials turn up from time to time – coronary ischaemia, subarachnoid haemorrhage, torsion of a testis, temporal arteritis, cauda equina lesions, ectopic pregnancy, congenital dislocated hip, slipped femoral epiphysis, appendicitis, scaphoid fractures, cut tendons and nerves, etc.

**Causation**

In many of these claims, the cause is either:
- **cognitive error** – the thought of the correct diagnosis just did not cross the doctor's mind.
- **a system error** – eg, the doctor never saw the biopsy or mammogram report because of a systems failure, or a positive report was not appropriately actioned.

Some of these claims fail because while in hindsight it may be obvious that the doctor missed a diagnosis or made an incorrect one, being wrong is not the same as being negligent. The diagnosis made at the time, based on the patient's history and signs that they presented, may have been entirely reasonable. "Hindsight bias" figures prominently when negligence is asserted.

**Types of missed diagnosis claims**

**Malignancy**

Breast and bowel are the commonest sites for a missed cancer diagnosis, collectively forming about half of all missed cancer claims. They are followed closely by melanoma – even in the UK. Less common missed cancers are cervix, prostate, brain, lung and testicle, and also lymphomas and sarcomas.

With cancer claims, there is a subtle undercurrent of guilt. An entire generation has grown up being pressurised to have cervical cancer, breast cancer and bowel cancer screening because we have told them that early detection improves their chances. That can be heard as early diagnosis guarantees a cure. The reasoning then could be: "I haven’t been cured. Therefore my cancer was not diagnosed early enough.”

**Cardiovascular**

Myocardial infarction heads this list. The assertion is either that coronary ischaemia was not diagnosed at the pre-infarction angina stage and hence the patient suffered a preventable infarct or, more tragically, it is a claim for compensation by relatives where a patient treated for “indigestion” today is found dead in bed from an infarct the next morning.

Other examples:
- There are patients who have suffered strokes when premonitory transient ischaemic attacks were not diagnosed as such. Also, the subtle premonitory symptoms and signs of a subarachnoid haemorrhage can be easily overlooked.
- The patient who becomes suddenly blind in one eye often wonders why the doctor did not pick up the early symptoms of temporal arteritis.
- The patient who develops a pulmonary embolus may be angry that the doctor did not more actively investigate his or her sore leg.
- Claudication is sometimes not considered in patients presenting with leg pain.

**Infection**

Every GP dreads the thought of missing the early signs of bacterial meningitis. How can you remain alert when an average GP who provides, say, 200,000 consultations in their professional lifetime, of which, say, 20,000 are about an unwell child with a temperature – of which perhaps one may be developing meningitis. A very weak signal against a background of noise.

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**The retrospectoscope**

“The view through scopes — colonoscopes, arthroscopes and laparoscopes, to name a few — routinely aid physicians in narrowing diagnoses and arriving at a plan of care. But none is as illuminating as the one doctors refer to as the “retrospectoscope”, the scope of hindsight. The retrospectoscope brings startling clarity to the most mysterious disease processes: difficult decisions become brilliant choices, minor missteps turn into devastating errors, and the best of intentions can transform into deep regret and persistent what-if’s.”

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**Being wrong is not the same as being negligent**, says Dr Paul Nisselle, a senior consultant at MPS Educational Services. Here he explores what can be learned from missed diagnosis.
A diagnosis of appendicitis can take a long time to be made, or be missed. In particular, infection in a retrocaecal appendix can be very difficult to diagnose as the symptoms and signs may not localise into the right iliac fossa. The author knows of a case of a woman with weight loss and cachexia who became more and more unwell over months. It wasn’t until her second colonoscopy (looking for a malignancy) that a bead of pus was seen at the opening of the appendix into the caecum. She had subacute infection in a retrocaecal appendix.

**Metabolic**

An infant can become just as neurologically damaged from dehydration associated with gastroenteritis as he or she can from bacterial meningitis or birth hypoxia. Careful assessment of hydration in a baby with “D & V” requires a physical examination, not just advice over the phone. In older children and adults, failure to diagnose diabetes is another cause of claims.

**Why do patients bring these claims?**

Patients, like doctors, exhibit hindsight bias. They do not know that perhaps 99.995% of the children you see who are fretful and have a mild fever don’t have bacterial meningitis – theirs did. The fact that it was so early in the course of the disease that there was nothing to suggest their child was not in the 99.995%, is hard to accept.

Patients may also not appreciate that even pathology and radiology do not provide 100% certainty. In Australia, when mass chest x-ray screening programmes for tuberculosis were introduced, the pathologist who had popularised the use of gastric lavage to obtain specimens to screen for acid-fast bacilli, cautioned that “x-rays are but shadows on a screen”.4

Even histology is not 100% certain. For example deciding whether an excised pigmented lesion is a (benign) Spitz naevus or a malignant melanoma may be very, very difficult.

Poor communication is often at the root of a claimant’s decision to sue – for example not underscoring the limitations in the diagnostic process. This is more relevant if the relationship with the doctor was less than satisfactory before the missed diagnosis.

**Why do doctors miss diagnoses?**

1. **COGNITIVE REASONS**

In many American studies, the most common cause (around 55%) of a missed or delayed diagnosis was found to be failure to arrange an appropriate diagnostic test or refer for specialist opinion.

Other causes were:

- failure to create a proper follow-up plan and agree it with the patient (45%)
- failure to take an adequate history or perform an adequate physical examination (37%)
- incorrect interpretation of diagnostic tests (37%).

Trauma

We are still seeing claims where, due to inadequate assessment of a laceration, a divided tendon or nerve was not diagnosed until too late for primary repair. And there is still a steady trickle of missed scaphoid fracture claims.

Orthopaedic

Cauda equina compression symptoms are “red flags” calling for urgent investigation. Failure to do so can have tragic consequences. “Red flags” include:

- Severe low back pain with bilateral or unilateral sciatica
- Bladder or bowel dysfunction
- Anaesthesia or paraesthesia in the peroneal region or buttocks
- Significant lower limb weakness
- Gait disturbances
- Sexual dysfunction.2

A missed tear in or an undiagnosed rupture of an Achilles tendon can precipitate litigation. It is worth remembering that patients taking a fluoroquinolone antibiotic are at risk of tearing their Achilles.3 This is rare, perhaps 3 cases per 1,000 patient years, but is more common in patients over 60. It is also more common in patients taking corticosteroids. If the patient is taking a fluoroquinolone antibiotic and is both over 60 and taking corticosteroids, the rate of Achilles tendon disorders has been said to be as high as 87%! The association of fluoroquinolone antibiotic use and tendon disorders has been known since at least the early 1990s, but perhaps not the very much greater risk in older patients taking corticosteroids.

Gynaecological

Ectopic pregnancies can produce a variety of symptoms and should always be thought of in women of child-bearing age who present with unusual abdominal pain; especially if their period is a few days late and they have had a slight loss of PV.
In the UK, especially in general practice, the failure to take an adequate history or perform an adequate physical examination is more common because of the use of telephone triage. Has a decision been taken on sound medical grounds to give advice over the phone and not physically see the patient, or was it because no-one was available with time to see the patient? This is a particular hazard for out-of-hours services.

Having said that, it is worth repeating that the commonest reason for missing a diagnosis is because the doctor just did not think of it. In a minority of cases, the doctor thought of the diagnosis, but dismissed it.

**Confirmation bias**

As students, we are taught to take a comprehensive history, perform a complete examination, collate all that data – and then think (inductive reasoning). However, experienced doctors use deductive reasoning. We “sift” as we go. We (unconsciously) start to exclude diagnoses as soon as the patient walks through the door. Male patient? Not ectopic pregnancy. Teenage girl with abdominal pain? Not torsion of a testis.

As we acquire more and more facts, we narrow the differential diagnosis and make a presumptive diagnosis. At that point, it is human nature to (unconsciously) give greater weight to new facts that confirm the presumptive diagnosis and find reasons to challenge new facts that do not fit into our train of thought. This is confirmation bias.

**Tackling cognitive error**

**Diagnostic time out**

In the same way that “time out” is now recommended at the start of an operation to check if the right patient is having the right operation on the correct side etc, perhaps we should also use “diagnostic time outs”. Just before you close down your diagnostic thinking and move to a treatment plan, take a few seconds to ask yourself: “What else could this be?” And apply Occam’s razor – “entities must not be multiplied beyond necessity” – diagnostic parsimony – in preference to Hickham’s Dictum – “patients can have as many [different] diseases as they damn well please”.

As a very raw, young GP, the author correctly diagnosed Goodpasture’s syndrome in a female presenting with haemoptysis and haematuria, rejecting the diagnosis of bronchitis and a UTI, made by a physician.

This approach could lead to over-investigation for very unlikely diagnoses. However, considering a diagnosis does not necessarily mean you must test for it. We ultimately base most diagnoses on probabilities, not certainties. For example we don’t take a throat swab and do bloods on every patient who presents with a sore throat. We’re happy to think: “It’s probably viral. I can revise that thinking if they don’t get better in a couple of days.” In that circumstance, it is safe to make the passage of time your diagnostic test. It’s not if you’re deciding between a migraine and a subarachnoid bleed. It is often said: “If you hear hoofbeats, they’re more likely to be horses than zebras.” But zebras exist.

**Examine thoroughly**

Be prepared to perform appropriate examinations. Yes, the patient with bleeding PR may have visible haemorrhoids, but they may also have bowel cancer above the haemorrhoids. As has been said for over a century: “If you don’t put your finger in it, you’ll put your foot in it.” That probably now means a scope as well as a finger. It is easy to be deterred by a patient’s reluctance to have an uncomfortable, distressing or embarrassing examination.

Beware the patient who cries wolf. Sometimes even hypochondriacs are really ill. Be alert to a subtle change in their symptomatology. Spike Milligan was notoriously hypochondriacal. The epitaph inscribed on the headstone on his grave states: “Duirt me leat go raibh me breoite”, which in Gaelic means “I told you I was ill”.

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Experienced doctors use deductive reasoning. We sift as we go, often excluding diagnose as soon as the patient walks through the door.
Diagnostic challenges in general practice

A literature review by a King’s Fund research team identified these as common challenges to accurate diagnosis in general practice.7

The challenge of assessing evolutionary and undifferentiated symptoms.
Where a GP encounters disorders at an early stage and is confronted with vague or poorly differentiated symptoms, a certain diagnosis is difficult. The possibility that somatic complaints could be caused by psychological or social problems adds further to this complexity (Lindsey et al, 2002).

The difficulty of probability-based reasoning and the weak predictive value of diagnostic tests in primary care.
Correct assessment of the probability of specific diagnosis is a complex reasoning task made more difficult by the relatively weak predictive value of the tests and information at GPs disposal (Summerton, 2004).

Very low prevalence of certain conditions and the high degree of overlap in symptoms for serious and common conditions.
For example, in lung cancer, which has a relatively high incidence, a GP with a list size of 2,000 patients and a case mix matching the UK average might see only one or two new lung cancer patients in a year (calculation based on Cancer Research UK 2006), whereas the core symptoms of lung cancer (cough and wheezing) are very common. Similarly, symptoms of acute otitis media overlap with those of the common cold.

The high prevalence of multiple co-morbidities.
Studies suggest the majority of patients presenting in general practice have multiple problems, including physical, psychological and social (Fortin et al, 2005).

Lack of reliable data on family history or past patient history.
Patients may forget things, be unaware of facts (eg, regarding family history), fabricate information, or merge different symptoms into a single event (Barksy, 2002).

The gatekeeping function of general practice.
A GP who is keen not to miss any serious condition could, for example, refer all patients presenting with unexplained fatigue to an endocrinologist, but the acute sector would become quickly overburdened and patients would be subjected to unnecessary investigations. GPs must therefore base their judgments partly on an awareness of the need to limit access to specialist services to those most likely in need of them (Knottnerus, 1991).

Follow guidelines
National referral guidelines and diagnostic algorithms are important safety nets. Ignore them at yours and your patient’s peril. “Rules are for the obedience of fools and the guidance of wise men” is a saying attributed to the World War II flying ace, Group Captain Sir Douglas Bader. It applies as much to medicine as it does to aviation.

Tackling systems error
If you held in your hand a report diagnosing a serious illness, say cancer, or a potentially serious problem (eg, a haemoglobin of 9.5, or a potassium of 2.8) you would probably do your best to contact the patient to get them to come in, so you could give them the result, and arrange prompt referral for definitive assessment and treatment. You would not wait for the patient to ring to obtain the report.

How can you be sure that there is not such a report floating around somewhere in the ether that you have not seen? Do you have a system that checks whether a report has been received and seen by you for every test you have ordered or referral initiated? If not for every test, what about reports on tests for dread diseases — cervical smears, mammograms, skin biopsies?

You might have said to the patient “ring me to get the result” or “come to see me in two weeks”, but if they don’t, and that was your only safety net, a court is unlikely to accept that the patient’s “contributory negligence” cancels out yours.

In one such case, the judge said it was “unreasonable for a [doctor] to base his whole follow-up system, which can mean the difference between death and cure, on the patient taking the next step”. The judge in that case underscored that the claimant “was entitled to assume that if the outcome of the testing of the biopsy gave cause for concern, she would be informed”.4

In general practice, there is an emerging responsibility to ensure test results are seen and acted upon. That applies both to the individual GP and the practice as an entity. Where the referring GP is a locum, or is on holiday or off sick, arrangements should be in place to ensure that ALL results of tests received into the practice are managed appropriately. That still leaves the more difficult problem of detecting test results that have NOT been received.

Atul Gawande, surgeon, author and patient safety advocate, has written that we now know of 13,600 diagnoses, or “ways in which the human body can fail”. Trying not to miss one of them requires diligence, awareness and constant attention to both system improvement and cognitive awareness.

This article draws on the chapter “Missed diagnosis in general practice”, which features in MPS’s GP handbook, The GP Compass: Navigating your Way to Safer Practice. For a copy please email charlotte.church@mps.org.uk.

Dr Nisselle has always advocated a major role for the MDOs in clinical, systems and communication risk management, believing it is as important for an MDO to help members avoid claims and complaints. He was a GP in suburban Melbourne for 18 years, before entering the medical indemnity industry in 1989, as MPS’ Australasian Secretary. Since then he has worked for MPS, the Medical Indemnity Protection Society (MPS’ subsidiary company of MPS in Australia), Avant, Australia’s largest MDO.

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Being a doctor is difficult. Being a GP is even more difficult. Being a sessional GP— that is really, really difficult! In addition to looking after people in various levels of distress, we have to keep our knowledge and skills up-to-date, discard the obsolete and develop the new, and then engage with the running of the health service.

There are many and various reasons why you have opted to do the job sessionally. Some of your own choosing, others that have been thrust upon you, eg, life, illness etc. You might have another string to your professional bow and are running parallel career lines. None of this makes life easier and none of your development is part-time.

The model of resilience has been developed to describe and explain the way oppressed children and adults develop despite difficult circumstances. It is used in safeguarding the vulnerable groups in society and is part of the schools agenda in areas of social deprivation. It has been little used as a theoretical framework in clinical education despite our using it clinically. The difficulties we face day-to-day hardly rank with living through genocide or being raised in a deprived neighbourhood. But we do have to live with and manage our own and our patients’ traumas on a day-to-day basis.

We start building our personal identity possibly before and certainly at the time of our birth. By the time we entered medical school we had a well formed identity, our autobiography. A sense of values that we tested against our cultural and parental values, developing beliefs as our world view increased. Then we developed our professional identity, heavy in knowledge, rich in skills and overwhelming in ways of practice. As a sessional GP you might have another identity such as a care giver, an artist or another sort of doctor. These identities will overlap: they should do and they need to. Each identity will have at its core a set of coping mechanisms or resilience.

We know that those who do survive and thrive are autonomous, self-aware and problem solvers, and have intellectual and emotional intelligence, peer relationships, curiosity and a sense of purpose and humour.

As a GP you will undoubtedly have intelligence, problem-solving skills and empathy. So, let’s take the resilience model and translate it into the day-to-day life of a GP.

The job of general practice is lonely. You sit with your patient in your room listening, explaining, negotiating and making decisions. If you have a part-time GP commitment, with a competing timetable, then you might miss the camaraderie of the practice staff and other clinicians.

**Why is reflective practice important?**

Reflective practice is how we can use the workplace as a rich learning environment and understand our place in it. You are a person with your own personal needs. You are doing it for your patients; who is doing it for you? Pause for a moment and ask yourself these questions:

- Are you a member of a professional or peer support group in your area?
- Do you belong to the RCGP as your professional base?
- How do you keep a vital sense of purpose and humour alive when competing with multiple agendas and pressures?
- Do you know how important they are for your survival and that you need to cherish these positive attitudes?
- What are your personal strengths?
- What do you do well and how are you developing it? It is from our strengths that we develop the confidence to manage our weaknesses.
- How easy do you find it to reflect? How well developed is your self-awareness?
Reflection is the way we make sense of and develop in our professional worlds. It is one of the positive drivers of our personal and professional identities. It is the lubricant of building experience and gaining insight.

Everyone can reflect and most people tend to become better at it once they see the benefits it can bring. For doctors (and especially GPs), patterns of illness and patient behaviours are complex and, in order to become proficient, a great deal of understanding is needed. For this reason, becoming a reflective practitioner is vital.

Elements of reflective practice
One of the vital elements of developing and reflecting is recording, writing it down. Some GPs have kept journals or day books of their years in practice. Others keep a notebook of interesting patients and some keep a formal diary. Many of us have been encouraged to keep a reflective diary of our studies or work. It’s not a bad idea and it is the root of scholarship, which is itself the foundation of good medicine.

Figure 2 summarises the elements of reflection, and shows how you might demonstrate them in a visual form.

This work has come from postgraduate training and the use of the ePortfolio, but it doesn’t stop when you get your place on the register. The skills learnt as a trainee should flow into practice and your revalidation portfolio. Those who choose to keep such a record, must keep it in an anonymised form.

Why do we need reflective practice?
- To increase our knowledge and apply it.
- To widen our professional boundaries.
- To benchmark our performance against our peers.
- To develop as adaptive experts.
- To generate the questions that will inform the service and research agendas.
Making observations
From almost your first day in medical school you will have been taught about making observations and you will have practised them daily since then. Giants of diagnosis and detection are held up as examples for writers and ourselves. Observation is also the key skill of anthropologists and sociologists and indeed for every scientist and artist. The picture that is drawn is dependent on how we detect and record these observations, usually according to our tradition or professional culture.

Several people who observe a single event will record it differently; some of this is through thinking and some of it is through sensing. It is important that we understand how we as individuals can affect the final picture, colouring it through our personal values and attitudes, which determine our interpretation of events.

In order to build up a picture we need to use all our available senses and practise using them. Everyday life situations offer a rich opportunity to practise and to interpret, because to develop our understanding, we not only need to recognise the event (the freeze frame), but to think about the story behind the picture. It is often our senses that determine our reactions and therefore feelings. Smell is a very potent recall process that establishes context and fixes stereotypes and half finishes the picture.

Intrapersonal factors (self-awareness and self-regulation)
The concept of insight in relation to personal performance is strong. It has widespread currency in the management of poor performance. Those whose performance is giving concern are often described as lacking insight. So by contrast it could be argued that those who are performing effectively have insight.

In the realms of psychotherapeutic theories insight is dependent upon the ability of the individual to have an internal conversation, to have a language that can articulate feelings and to take ownership of their beliefs and actions.2,3 The internal conversation is not about the first sign of madness; in fact it is a marker of sanity. It can be objective, cool and journalistic. If it is to have an impact on the individual then it needs to have a vocabulary that articulates feelings. Feelings are the facts that shape our beliefs and attitudes and, in turn, determine our behaviours.4

Acknowledging the discomfort of a particular encounter can help you to manage it. When a particular patient makes your heart sink, don’t label the patient – analyse your feelings and belief set.

Previous experiences and traumas can hinder your ability to have the internal conversation and stunt your vocabulary. As with any language we need to practise to gain vocabulary and fluency.

Reacting to feedback
The ability to handle feedback about personal performance is a marker of insight. Now-one apart from a champion performer totally relishes feedback. Only when you are trying to shave microseconds off your personal best or to create the most exquisite performance are you thirsty for feedback. Because our clinical performance always carries an element of our personality, feedback or criticism creates a level of anxiety even if it is constructed to conform to all the rules.

Feedback exercise
Recall the last time you received feedback on your performance. How did you react? Which set of words most accurately describes your reaction?
1. Defensive
2. Head in the sand
3. Mildly anxious
4. Take it or leave it
5. With open arms

Let’s examine these responses, all of which we have probably exhibited from time to time. Indifference (answer 4) hides a mass of potential blockers and needs serious reflection; indifference is not a professional response to feedback.

Mild anxiety is associated with more effective learning, and should be welcomed as an indicator that we have our faculties primed for success – it is the normal arousal response to a challenge.

The head in the sand (answer 2) is a defence mechanism to avoid challenge, used in the hope that bad things will pass. Such a reaction can be due to poor experiences in the past or by observing and repeating behaviour patterns in respected role models. If this is your preferred response, ask yourself why and explore it with a trusted person such as a mentor.

At its extreme, the defensive (answer 1) response represents a lack of personal ownership for actions taken. “Still waiting for the lab”, when the lab is in reality still waiting for you. “The
nurse advised it”, but you signed the script. Untruths presented as explanations – “not my fault”. Learning from feedback requires the learner to be secure and for the person giving feedback to create a safe environment. Neither happens with teaching by humiliation. If you are still feeling the effect of such teaching, talk about it with a trusted colleague or mentor. Don’t underestimate its impact on your continued learning and practice. Your future learning depends upon your self-esteem.

For those heroes who welcome feedback, put aside your halos for one moment and ask yourself, “Is this a device to deflect the more challenging elements?”

**Reflective analysis, recording and learning**

The cornerstone of reflective practice is learning to do differently and hopefully better. An experience is observed, reviewed, analysed, incorporated into your experience bank and results in a new set of actions. It is the analysis and the reflective framework that fixes the learning experience and generates the questions that will lead to personal improvement and service development, and research is a tool a doctor should use daily. Now that is education.

You could probably survive with just some of the resilience characteristics but by tying in reflection to resilience you can survive and thrive.

Professor Hibble is Director of GP development and Primary Care Education at the Anglia Ruskin University. He can be contacted at: arthur.hibble@anglia.ac.uk

**Useful links**

- BMA – www.bma.org.uk
- NASGP – www.nasgp.org.uk/
- RCGP – www.rcgp.org.uk/

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**Patient summary sorrows**

Learn from others’ mistakes and think before you print, says MPS medicolegal adviser and GP, Dr Zaid Al-Najjar

Referring patients to fellow healthcare professionals for further treatment is something that GPs do on a daily basis. Usually what is complained about is that the letters, by which they communicate these referrals, contain less information than is needed. Sometimes, however, too much information can get you into hot water, as this case demonstrates.

Dr A had just finished a busy morning surgery and had a particularly difficult consultation with Mrs X, who had been suffering with very strange abdominal discomfort for the last six months; this was her follow-up. Having discussed the possible diagnoses of IBS and constipation, performed umpteen blood tests, received a clear ultrasound report and conducted a very thorough abdominal examination (including PR), Dr A decided to refer her onwards as he was unsure about the diagnosis.

Dr A typed what he thought was a very helpful referral letter, as he always wrote his own letters either with patients present at the time or just afterwards. As he had several home visits to attend, rather than sift through her medical history, he printed out her medical summary, which read the following:

- 1983 Termination of Pregnancy
- 1984 Tonsillectomy
- 1985 Genital Warts
- 1986 Suspected UTI
- 1988 Rosacea
- 1991 Attempted suicide
- 1996 Post-Coital Contraception
- 1998 Scabies
- 2000 Stress at home
- 2008 Back pain
- 2011 Abdominal pain
- 2011 Ultrasound normal

When Mrs X discovered what had been disclosed she was mortified, and complained to the Information Commissioner’s Office, the GMC, and the local commissioning body. Dr A learnt his lesson the hard way.

Although patient summary printouts and computer-generated summaries are often really helpful when doing home visits or constructing referral letters, you should always check the information that you are forwarding on to your fellow health professionals when making referrals. When patients agree to being referred, you act with implied consent to pass on the relevant clinical information to the relevant clinician. Because software programme summaries often contain sensitive and personal information, and because it can be difficult to continuously monitor and keep active any past problems on the database, it is always advisable to check the automated data that you intend on sending out of the practice.

These days, PCTs or LCBs often screen referrals to ensure they are ones that they will pay for and with choose and book, hubs/call centres sometimes contact your patient to set up an NHS appointment. Always keep in mind when you print off the referral letter that several people in the process of it getting to the relevant clinician may see it.

It is good practice to include as much information as is relevant for the clinician that you are referring to, but it is always helpful to take that extra minute or two to screen any automated printout from the software system, to see if there is any sensitive or irrelevant information that the patient may object to the practice sharing with anyone else. If you feel that the information is relevant, then by all means include it, but inform the patient of your intention to do so. The extra few minutes doing this may save you a lot more time in the long run.

If you have an idea for a Hot Topic contact sara.williams@mps.org.uk.
Revalidation is being introduced later this year by the General Medical Council (GMC) and will be the new way of regulating doctors, giving further assurance to patients that they are up-to-date and fit to practise.

Doctors will revalidate by having annual appraisals, and will have to collect extensive evidence to demonstrate how they are meeting the professional values set out by the GMC in their guidance.

Supporting information that can be used as evidence includes CPD, clinical audit, and feedback from colleagues and patients.

But, as a sessional or locum GP working at more than one practice, is this going to prove to be a more difficult task than for practice-based GPs?

Dr Weeks says: “From our perspective, what is most concerning is how sessional GPs will collect the evidence, but if you read the GMC guidance it actually is quite flexible. There are alternatives, for example, if you can’t actually do a 100% gold-plated audit, there are other things that non-standard GPs can present as evidence. The question is: how is that going to be implemented on the ground?

“The key to that is appraiser training, we are a broad group – salaried, locum, out-of-hours, secure environment, you name it, we cover it. We are everything that is not a partner practice-based GP. Key for us is having that appraiser understand and have knowledge of what it is to be a sessional GP, as evidence that is relevant and personal that we can reflect on.”

Providing evidence
Providing evidence is achievable, says Dr Weeks. But it may not be achievable in the same way that it is for a practice-based GP. There will be a different emphasis on the type of evidence that sessional GPs can bring and there needs to be flexibility in how sessional GPs record evidence and what they are allowed to use, she adds.

“For example, with a patient satisfaction questionnaire, it all depends on the model we can use – the one for a secure environment or out-of-hours isn’t going to be the same for someone that has been practice-based for the majority of their working career. It is about understanding the differences.”

In the hot seat: Dr Vicky Weeks

She was voted number 39 in Pulse’s list of the top 50 most influential GPs of 2011, and is chair of the BMA’s Sessional GP subcommittee.

Dr Vicky Weeks chats to Charlotte Hudson about how revalidation will affect sessional GPs
The GMC’s Supporting Information for Appraisal and Revalidation says: “All doctors, regardless of the nature of their practice, should be able to meet these requirements, although the underlying information may differ in certain categories depending on the practice and the context in which they work.”

When discussing supporting information with an appraiser, they will be interested in hearing about what you did with the information and your reflections on it, so you should start thinking about this now, whilst collecting the evidence.

Preparing
Dr Weeks says that GPs should start preparing for their appraisals now; it is a continuous learning cycle, so you should make sure you have the relevant and appropriate tools for their needs. There are different ways of recording evidence; some new doctors coming out of training will use ePortfolios, whereas a GP who has been practising for 30 years may have different ways of recording evidence. It is about understanding the differences in that.

The BMA’s sessional GP subcommittee has several workstreams to support sessional GPs with preparing for appraisal.

Networking
As well as being the chair of the BMA Sessional GPs subcommittee, Dr Weeks is a salaried GP in west London. She balances her work by being flexible and working as a team. She describes the members of the subcommittee as being a “real pleasure to work with” and as having an exciting portfolio, with a huge range of skills that are utilised when supporting their sessional GP colleagues.

Dr Weeks explains that networking is another important factor in preparing: “The key to addressing many of the challenges that sessional GPs can be at risk of facing, particularly isolation, is to be a member of a group. This is intrinsic, through peer support and review; educational events and then reflecting on them as a group. You can’t be a GP in isolation anymore – and being part of a network is going to be vital in order to be able to develop as a GP.”

Useful links
Further information on revalidation can be found on the GMC website – www.gmc-uk.org/doctors/revalidation.aspx

In the spotlight: RCGP’S First5 Initiative

Dr Clare J Taylor, First5 clinical lead at the RCGP, discusses the new learning and support initiative

What is First5® and where did it originate?
First5 is an initiative that has been developed by the Royal College of General Practitioners (RCGP) since 2009 to support new GPs when they complete their training and start general practice. It aims to support them through those challenging first five years in independent practice. The majority of First5 GPs work on a sessional basis.

What does it aim to do?
First5 is about empowering the next generation of new GPs, developing their energy and enthusiasm and equipping them with the skills needed to lead the profession in the years ahead. The concept seems to have captured the essence of what being a new GP is all about and given an identity to this somewhat lost tribe.

Where does the name originate and what are the five pillars?
First5 has recently been trademarked so the name and concept remain true to the original aims set out by RCGP in 2009. The five pillars of First5 are:

1. Connecting with College
2. Facilitating networks
3. Supporting revalidation
4. Career mentorship
5. Continuing professional development (CPD)

Who leads the groups?
We have created a network of First5 faculty leads across the UK. Faculty boards are responsible for appointing the First5 faculty lead using their usual processes. Each faculty lead is also a member of the First5 discussion forum; a closed online group. Senior college officers, including RCGP chair Dr Clare Gerada, are on the discussion forum, meaning the voice of First5 is heard at the highest level.

How do the groups communicate?
The First5 group was one of the first to embrace social media in RCGP. We have an active Facebook group (RCGPFirst5) and Twitter (@rcgpfirst5). First5’s email is: first5@rcgp.org.uk.

We held the inaugural First5 faculty leads meeting last year. We continue to communicate electronically on a daily basis, via the online discussion forum. To find out who is your First5 faculty lead and get involved locally please visit – http://www.rcgp.org.uk/new_professionals/first5/first5_faculty Leads.aspx

How is First5 linked to CPD?
The First5 CPD project has been running since 2009 and aims to meet the educational needs of new GPs. We undertook a large survey of First5 GPs and we have subsequently developed First5 CPD courses, which have been specifically designed for First5 GPs. To find out more go to www.rcgp.org.uk/first5courses or e-mail first5@rcgp.org.uk.

In the First5 survey we also found that many new GPs are keen to learn in a small peer group. We have produced a guide to forming and running a First5 CPD group, which can be downloaded from the website at: http://www.rcgp.org.uk/new_professionals/first5/cpd_groups.aspx

What is your final message to potential members?
The First5 initiative is a vehicle for the RCGP to support new GPs through the early formative years of a career in general practice. If you are a First5 GP, or have colleagues who are, please do get in touch.

Full details of the initiative can be found on the First5 website at www.rcgp.org.uk/first5

REFERENCES
2. Taylor CJ, Turnbull C and Sparrow N. Establishing the Continuing Professional Development Needs of General Practitioners in their First Five Years after Training. Education for Primary Care 2010; 21(5): 316-9
Only last week a fellow GP said: "I have been at work all week and yet the only people I have spoken to are patients and receptionists. The other doctors work different times to me and I rarely get to meet with medical colleagues." This experience is far from uncommon among sessional doctors. Many can find themselves isolated and uncertain about how to access educational activities and feel they miss out on the informal, as well as formal practice discussions that take place between partners where important information is often exchanged.

Professional isolation was a major theme in a large study of sessional GPs published last year by the Royal Medical Benevolent Fund (RMBF). Setting up peer support groups was identified as a way of tackling this problem.1

My journey
The start of my journey into networking with sessional GPs is one of serendipity. Eight years ago I had just finished my GP training, had my first child, and moved to a totally new area. On a tentative visit to a local mother and baby group, I met a friendly mum who not only happened to be a GP, but also belonged to an established non-principal group that I subsequently joined. The group comprised mainly working mothers who had originally met informally for peer support.

As the group grew it became an established “learning set” with monthly meetings at the local postgraduate centre that covered a huge variety of topics. A popular member left to take a position in Belgium and one weekend we all went to Brussels to see her new practice and hear about the Belgian healthcare service. I met the most wonderful and supportive group of GPs at the start of my career in general practice and even today I often reflect on their wise words.

Moving on
When I relocated again four years later to South Essex, I felt like I had left my safety net behind and was disappointed not to find a similar network of sessional GPs.

Starting out
I then decided to invite a couple of people whom I’d met at a local GP refresher course to set up a sessional group. For two years a colleague and I took it in turns to host monthly meetings from our homes. The ideas and enthusiasm of the founding members of this group culminated in the first Essex Sessional GP Conference held at the Postgraduate Medical Institute at Anglia Ruskin University in October last year. It was attended and well received by 50 sessional GPs across the region.

Success
Since the conference our group has expanded and we now meet in the boardroom of a local private hospital. The group is run without any costs as communication is done by email. We have put postings on the sessional GP page of the North and South Essex LMC website, set up a Facebook site, got in contact with the NASGP and there are now more than 20 sessional GPs on the emailing list.

Back to basics
Peer support groups offer considerable peer support, networking opportunities and sharing of useful knowledge about educational events and local job vacancies (see Figure 1 on page 17).

The concept of a GP support group is not new. GPs who have just qualified may form a “young GP group” to maintain contact with one another and continue the group learning they enjoyed as trainees, but these sometimes trail off as trainees join practices. Many sessional groups have been running for years, eg, Balint groups, but with rising numbers of sessional GPs and a marked change in the general practice workforce, together with appraisal and forthcoming revalidation, the needs of sessional GPs have evolved as their individual needs have increased.

Benefits of peer support
A forum to raise concerns
Belonging to a sessional group can help otherwise isolated individuals feel part of a safe supportive community of local colleagues, with whom they can share work-related problems,

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Every sessional GP should join a peer support group, and if there isn’t one in your area form your own, says sessional GP facilitator and LMC vice chair Dr Kamilla Porter
interesting events and clinical cases. It can be difficult for sessional GPs to find opportunities to talk through significant events, and such discussions are an essential component of appraisal.

Sessional GPs are a diverse group, a significant proportion are newly-qualified doctors who may feel uncertain about how to raise concerns about situations where patient safety may have been compromised; some may feel that this is the remit of a GP partner rather than a locum.

The recent GMC guidance, *Raising and Acting on Concerns About Patient Safety*, stipulates that all doctors whatever their role should take action to raise and act on concerns about patient care, dignity and safety.2 A sessional group provides an ideal opportunity to discuss such concerns and may include more experienced members who can offer points of contact to take matters further, eg, to the local medical committee (LMC).

Care must be taken when encountering a member who may have problems or health needs that could impact on patient safety. In such situations GMC guidance must be heeded.3 The LMC can be a good first port of call if there are doubts or concerns about how best to proceed if a problem arises. The BMA stipulates that sessional groups do not provide official quality control on its members and it is for individual groups to decide on accommodating a doctor who may be in difficulty. The GMC encourages doctors, as far as possible, to support colleagues who are experiencing performance problems but in all cases to remember the overriding duty to raise concerns if there is a possible risk of harm to patients.

Enhanced CPD

A sessional group can provide informal support and guidance for GPs who are new to an area, in-between jobs or who are off work for other reasons. One example is a GP who was off sick for several months, but remained in contact with her sessional group during her cancer treatment. Her good friends in the group rallied round her and she felt greatly supported at a distressing time, and also appreciated being able to maintain some professional contact during her illness.

Another GP wanted to keep in touch with colleagues while she was on maternity leave, so she continued to attend meetings with her small baby. As a result, she felt more informed and confident about local general practice issues when she returned to work.

Employment opportunities

Sessional group meetings can be an opportunity to discuss swapping out-of-hours shifts or sharing locum positions and developing this further into setting up formal locum chambers. Those with children may discuss experiences about local childcare facilities and even share babysitters’ details. Meeting up regularly with colleagues may inspire some to put themselves forward as a sessional

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**Feedback from GPs at sessional groups**

“GP partners have to understand that we exist and we have a say”

“The group has been a great source of support after I left a partnership and was starting out as a salaried GP”

“I feel like I am part of a community”

“It’s really useful being able to discuss work-related issues amongst peers”

“The group includes those who are just starting out in general practice and others who are approaching retirement. It is always fascinating to hear the different perspectives from such a group”

“The group is a hive of information”

“It’s just nice to know that there are people out there who care”
representative for their LMC or the BMA. Sessional groups are a vital source of grassroots opinion that can be fed back to local and national bodies.

Motivational tool
As a group gets going it can offer much more than initially envisaged. Members may be more motivated to attend conference or educational events, if they know their colleagues are going too. Furthermore, group bookings often qualify for discounted course fees and lifts can be shared.

Social opportunities
Each sessional group is unique and will be moulded according to members’ wishes, experiences and aspirations. Some groups may take on a more social function, others a structured self-directed learning approach or some may wish to develop a more political influence and of course many choose to combine all these roles.

Enhanced professional development
Getting involved in a sessional group can also be seen as a means of demonstrating shared leadership among sessional doctors. The recent GMC guidance on Leadership and Management for All Doctors says that good leadership can be achieved by a team of professionals identifying problems, solving them and implementing appropriate action.4

This model is aimed at workplaces and healthcare teams, but is applicable to sessional GPs. The GMC states that being a good doctor means more than simply being a good clinician. By encouraging communication and reducing isolation amongst sessional doctors can help to boost morale, raise professional standards and thus improve patient care.

Getting involved
The first step to getting involved in a sessional group is to seek out any established local groups (see Figure 1, b). If there are none, or the group does not meet your expectations, take the plunge and form a new group. There is no prescriptive formula; the most important prerequisites are simply enthusiasm and commitment. The BMA’s recent guidance is extremely helpful, as is the NASGP guide to setting up and running a sessional GP group.5 A group can start off simply with a small number of doctors gathering for an informal chat to share ideas (See suggestions in Figure 1, c).

Meetings can be held in a variety of venues (see Figure 1, d). A cafe or restaurant may be appropriate for initial or more social meetings, however, as the group progresses, it is likely to include the discussion of clinical cases or significant events, which should not be held in a public setting. It is important to consider your personal safety if you are setting up a group on your own and opening it to people you have never met before (see Figure 1).

As the group gets bigger, organisation can become challenging, the BMA and NASGP provide lots of pointers and suggestions on how to manage this effectively. Consider getting in contact and seeking advice from other established groups, whether local or not. The NASGP newsletter includes a regular round-up of sessional group activities across the UK and the BMA is currently developing its website to include information about local sessional groups. Joining and being involved in setting up a peer support group has changed my life, will it change yours?

REFERENCES
1. RMBF, Support for Sessional GPs (July 2011) – www.rmbf.org
3. Ibid 2
5. Ibid 4; NASGP, Guide to Setting up and Running a Sessional GP Group – www.nasgp.org.uk

Find out more
- The next Essex Sessional GP Conference is on Saturday 13 October 2012 at Anglia Ruskin University, Chelmsford. All sessional GPs (including those outside of Essex) are welcome.
- For more details contact ARU or the North and South Essex LMC for more details. Visit: www.anglia.ac.uk/pmiedvents and www.essexlmc.org.uk/whatson.
- Join the NASGP – the only independent lobbying and information service for sessional GPs (locum and salaried) and retainer GPs. For further information please see the advert on page 19.
Peer support group checklist

(a) What can a sessional group offer?
- Peer support
- Professional and social networking
- Information about local educational events and updates
- Help with appraisal and revalidation
- Journal club
- Job opportunities
- Potential to set up locum chambers
- Raising the profile of sessional GPs to PCOs and clinical commissioning groups
- Springboard to set up local conferences.

(b) Finding out about established groups
- Contact your LMC and get in touch with your sessional representative
- Contact your regional BMA representative on the sessional GP subcommittee of the GPC
- Consult the BMA website (work in progress to include details of local sessional groups)
- Consider joining the NASGP
  Try searching Google, Facebook or LinkedIn.

(c) A few tips for starting a new group
- A few dedicated people are sufficient to set up a group
- Do not be disheartened if attendance is low to start with
- Establish ground rules or even a mission statement for the group
- Choose where (see d) and when to meet (evenings tend to be the most popular)

(d) Where to hold the meetings
- A member’s home (can be rotated)
- Local hospital postgraduate centre
- Local private hospital
- A GP practice.

(e) Safety measures when setting up a new group
- Ensure that the first few meetings will be attended by at least one other person you know well, whether holding the meeting at home, a postgraduate centre or hospital meeting room, which can be deserted in the evenings
- If setting up a group from your own home start with a few colleagues before you open the group to total strangers
- Before accepting a new member, ensure he or she is registered with the GMC.

 Decide how often you wish to meet (most groups have monthly meetings, but some meet more frequently)
- Collate contact details (emails and mobile phone numbers)
- Consider keeping minutes as this will be very helpful for members’ appraisals
- Decide who will minute the meetings and take responsibility for communicating with other members (usually done by developing a group email list)
- Inform local bodies, such as the LMC, PCO, CCG, RCGP faculty and local deanery.
Final thought: What you don’t know

Dr Euan Lawson explores the peculiarities of CPD and the unknown unknowns

It’s nearly ten years since I was handed my ticket to GP land, but I look back with fondness at the halcyon days of junior doctoring when everything one needed to know was contained within the yellow covers of the ‘Cheese and Onion’. If it wasn’t in the Oxford Handbook it was a clear signal that you needed to refer the problem to someone senior. As one talking meerkat would say: “simples”. Like most GPs, I now frequently feel a little panicky about my Johari window. I’m not referring to the state of my home glazing, but the idea that it’s the stuff you don’t know you don’t know that should be waking you in a cold sweat. Keeping updated takes on a surreal aspect when your first task is to find your blindspot. The problem is made worse by Big Pharma. The new drugs are a problem, but not because it’s difficult to learn how they work or when to use them; the issue is simply pronouncing them. I’m baffled by clopidogrel (I plump for cloppy-DOG-rel); it’s not helped by Big Pharma’s cynical habit of ensuring that generic names are illogical tongue-twisters compared with their snappy and distinctive brandnames. More worryingly, I’ve noticed that I’m moving into a more dangerous phase: never mind the drugs, I’m now battling to keep up with the new diseases that keep cropping up. We’ve embraced erectile dysfunction, swine flu and road-rage syndrome. I’m told that another, restless legs syndrome, isn’t new at all having first been described in 1861, but it’s been reinvigorated by Big Pharma now that they have a specific drug to sell for it. This kind of disease-mongering is playing merry hell with my PDP.

Curiously, I’m both overwhelmed by the prospect of keeping up with all the new research, national guidance and local guidelines while being completely underwhelmed at the thought of obsessively documenting all my activity. In short, when it comes to CPD, I’m simply whelmed. Predictably some GPs respond to this pressure with furious activity. They consider attack as the best form of defence and will bombard appraisers with reams of material; some are clearly education junkies who suffer from diplomatosis (there you go, now I’m inventing new diseases) – compelled to seek more and more qualifications. Sessional GPs may have to think harder about how they’ll get over the 50 credit CPD hurdle for revalidation. You won’t be able to utilise a generic appraisal folder with all the complaints, significant events and audits in the practice to bamboozle your appraiser. The senior partner may have spent the practice meeting absent-mindedly picking at his ear wax, but the savvy practice manager will still knock out a list of educational events at which he was present in body, if not wholly in mind. You could consider joining a set of locum chambers who may well offer a similar service. Like most GPs I’ve been forced to turn to update days for a quick CPD fix that will relieve my growing paranoia. These courses will take GPs, pat their head and tell them that they are, in fact, knowledgeable doctors who should be allowed within touching distance of a patient. They send them off with a manual, reassuringly thick enough that it could choke a shire horse. If you don’t have a shire horse to hand then you can use it to prop up a rickety examination couch. Everyone is happy.

It only takes a couple of bad education days and, like me, you may start to get an inkling into the mindset of that climber who got trapped under an enormous oppressive boulder and who was forced to cut off his own arm with a penknife to escape. The full spectrum of GP-kind in all its corduroy glory can be found mingling together. Old school traditionalists meander around looking a little guilty about having a day out of the practice. You may spot them if they ask a question. There is a decent chance it will be prefaced with the comment that they are just a ‘jobbing doctor’. It is not entirely clear what that represents, but is often a rather bitter reflection on the number of sessions they continue to work while the other GPs in the partnership have reduced to part-time. Locums, more likely to be self-financing, may be found scavenging at the Big Pharma stalls or minesweeping the buffet for any stray veggie spring rolls. Or is that just me?

Dr Lawson is a portfolio locum from Kendal. Visit his blog at: http://euanlawson.com/blog.
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