The RCGP Curriculum: Professional & Clinical Modules

2.01–3.21 Curriculum Modules

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How the curriculum is structured

The curriculum is organised in sections. The first section is the core curriculum statement, Being a General Practitioner. This defines the Capabilities and Competences expected of doctors practising in the discipline of General Practice in the United Kingdom.

The remainder of the curriculum, in this document, consists of a series of modules that explore the Core Capabilities in more depth. The first group, the Professional Modules, cover important professional areas such as consulting, patient safety, leadership, quality improvement and self-directed learning. The second group, the Clinical Modules, illustrate some of the areas of clinical practice you will encounter as a GP. These modules are intended as examples and should not be viewed as a complete list of every topic you will need to learn as a GP.

1: The Core Statement
1.00 Being a General Practitioner

2: The Professional Modules
2.01 The GP Consultation in Practice
2.02 Patient Safety and Quality of Care
2.03 The GP in the Wider Professional Environment
2.04 Enhancing Professional Knowledge

3: The Clinical Modules
3.01 Healthy People: promoting health and preventing disease
3.02 Genetics in Primary Care
3.03 Care of Acutely Ill People
3.04 Care of Children and Young People
3.05 Care of Older Adults
3.06 Women’s Health
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3.18 Care of People with Neurological Problems
3.19 Respiratory Health
3.20 Care of People with Musculoskeletal Problems
3.21 Care of People with Skin Problems

Adapted with permission from an original figure by Dr Chantal Simon for InnovAiT (2012), based on an original concept by Professor Justin Allen and RCGP Curriculum Development Group.
The Curriculum Modules

The following modules will help you to understand important areas of general practice by illustrating the key learning points with case scenarios, reflective questions, and advice for learning and teaching. It also contains a guide on the specific skills required for each area of practice.

Each module is intended to illustrate aspects of good practice, rather than provide a comprehensive overview of a clinical topic. It should therefore be considered in conjunction with other curriculum modules and educational resources.

The modules follow a common template:

- Summary
- Educational priorities (in the professional modules only)
- Case discussion and reflective questions
- Knowledge and skills guide
- How to learn this area of practice
- Useful learning resources
Professional Modules

The Professional Modules (2.01 – 2.04) cover important professional areas of practice such as consulting, patient safety, leadership, quality improvement and self-directed learning.

2.01 The GP Consultation in Practice

Summary

- As a general practitioner you must show a commitment to patient-centred medicine, displaying a non-judgmental attitude, promoting equality and valuing diversity
- Clear, sensitive and effective communication with your patient and their advocates is essential for a successful consultation
- The epidemiology of new illness presenting in general practice requires a normality-orientated approach, reducing medicalisation and promoting self-care
- Negotiating management plans with the patient involves balancing the patient’s values and preferences with the best available evidence and relevant ethical and legal principles
- As a general practitioner you must manage complexity, uncertainty and continuity of care within the time-restricted setting of a consultation
- The increasing availability of digital technology brings opportunities for easier sharing of information and different formats of consulting, as well as raising concerns around information security.

Educational priorities

The consultation is at the heart of general practice. It is the central setting through which primary care is delivered and where many of the curriculum outcomes are demonstrated. As a general practitioner, if you lack a clear understanding of what the consultation is, and how the successful consultation is achieved, you will fail your patients.

Underpinning the learning outcomes in this statement is a commitment to patient-centred medicine. This term is often used so loosely that it can sometimes seem to mean little more than ‘good’ medicine. For the purposes of the curriculum, however, as a patient-centred doctor you should be able to demonstrate an awareness of the following three key areas:

1. Understanding the wider context of the consultation: this means perceiving that your patient is a person; a belief that the sick patient is not a broken machine; and that ‘health’ and ‘illness’ comprise more than the presence or absence of signs and symptoms. A constant willingness, therefore, to enter your patient’s ‘life-world’ and to see issues of health and illness from a patient’s perspective, considering social, educational and cultural differences.
2. Recognising that patient-centred medicine depends on an understanding of the structure of the consultation – in particular that good consultations are often associated with particular consultation styles and skills. However, the expectations and preferences of your patients will vary, so that as a patient-centred doctor you must be able to select from a range of styles and skills.

3. Being committed to an ethical, reflective attitude that enables you to understand and monitor your practice, and develop it to the benefit of your patients.

Consulting and communication skills are often used interchangeably, but effective communication skills, while essential, are only a subset of the knowledge, skills and attitudes required to consult effectively. Within the consultation your patients rely on your skills as a doctor not only to identify any significant illness, but also more frequently its probable absence. Understanding the epidemiology of illness presenting in general practice requires a normality-orientated approach, as opposed to the disease-orientated approach in secondary care. This approach requires the recognition of ‘red flag’ elements in the patient narrative which may represent a significant illness in its early and undifferentiated stage, where urgent intervention is needed in order to minimise risk. Physical examination and investigations should be appropriate, timely and should follow the best available evidence. As a GP, one of the most effective tools at your disposal is the use of time, watching and waiting when it is safe to do so, and also using the continuity of contact with individual patients and their families. The long-term relationship between you and your patient acts as a repository for mutual trust and understanding, which enables high-quality care.

There are ethnic and cultural differences in the way that illness presents. Health beliefs and preferences have a major impact on patient management and on a patient’s willingness to engage with health services. You must be able to handle the challenge of consultations with patients who have different languages, cultures, beliefs and expectations, and in localities where the management possibilities are significantly different (many are illustrated in the case below). Management plans should be negotiated taking account of and respecting your patient’s values and preferences. As a GP you should understand the make-up of your practice population in order to understand the context of your patients. This includes socio-economic factors, ethnic and religious groupings, housing, and unemployment rates. In the increasingly complex world of modern-day healthcare you may also have to act as an advocate for your patients in helping them make choices concerning their own healthcare.

General practitioners, in common with all health professionals, are expected to act in accordance with the ethical principles set out in professional codes of conduct. These codes set both minimum standards and limits of behaviour beyond which a practitioner must not go. Within this framework health professionals make decisions that require application and interpretation of these codes and guidelines to the circumstances of particular cases or situations. To do this they must be able to identify ethical issues arising in practice, evaluate the moral reasoning for different courses of action, and justify their decisions. As a doctor you must be aware of your own personal attitudes, values, and ethical viewpoints and strive to ensure that these do not have a detrimental impact on your care of a particular patient problem.

Consultations are time-constrained. Longer consultations tend to be associated with better health outcomes, increased patient satisfaction and enablement scores. However, your clinical effectiveness depends on effective consulting skills to ensure that whatever time you have with the patient is used
efficiently, rather than consultation length per se. As a doctor you need to navigate the patient through the usual phases of the consultation in the appropriate sequence and at an appropriate pace. For example, if you don’t spend sufficient time discovering the reason for the attendance and your patient’s expectations of the consultation, then your management plan is less likely to be appropriate, and patient safety and satisfaction may be compromised.

International studies have shown that effective and informed primary care by highly trained family doctors delivers care that is more cost-effective and more clinically effective than systems with a lower emphasis on primary care. General practitioners need to make efficient use of available resources for any user of the healthcare system and therefore need to know how to find and apply best scientific knowledge that is relevant to a patient at the time they present in primary care.

Many doctors understand and value the consultation, which is often the ‘implicit curriculum’ that they are able to articulate without ever having read the curriculum statements. Appreciating the relationship between the consultation and the rest of the curriculum may help you to explore, learn, use and value the whole curriculum. The ‘areas of capability’ used in the consultation are transferable to other areas of the curriculum, where they can be used and developed further. For example:

- Your communication skills and attitudinal approaches with patients are transferable to working with colleagues
- The mindset of the ‘holistic approach’ is transferable to ‘community orientation’, where we move beyond considering the impact of problems on the patient/family unit to consider the community/societal impact and our responses to these
- Shared decision-making (to some degree) is transferable to the context of distributed leadership in the primary healthcare team
- ‘Specific problem-solving skills’ are transferable to a ‘comprehensive approach’, where they are applied in often more challenging contexts, e.g. dealing with multiple problems simultaneously rather than a single issue.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Understand that your attitudes, feelings and values are important determinants of how you practice
- Recognise your roles and responsibilities towards your patients as a GP
- Recognise the limits of your own abilities and expertise
• Recognise how personal emotions, lifestyle and ill-health can affect your consultation performance and the doctor–patient relationship

• Use the skills typically associated with good doctor–patient communication

**Core Competence: Maintaining an ethical approach**

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

• Demonstrate a non-judgmental approach, treating your colleagues, patients, carers and others equitably and with respect

• Value people’s beliefs and preferences in clinical and everyday working

• Recognise and take action to address discrimination and oppression by yourself and others

• Challenge behaviour that infringes the rights of others

• Reflect on how particular clinical decisions have been informed by ethical concepts and values such as consent, confidentiality, truth telling and justice

• Be able to clarify and justify your personal ethics to patients and to external reviewers

• Recognise that patients are diverse: that their behaviour and attitudes vary as individuals and with age, gender, ethnicity and social background, and that you should not discriminate against people because of those differences

• Be aware of the range of values that may influence your patient’s behaviour or decision-making in relation to his or her illness

• Apply ethical guidance on consent and confidentiality to the particular context of an individual patient

• Apply the law relating to making decisions for people who lack capacity to the particular context of an individual patient

• Apply ethical and legal frameworks to analyse issues and resolve conflicts of values

• Understand how the social context of primary care frames the identification and resolution of ethical issues by general practitioners

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:
• Respond flexibly to the needs and expectations of different individuals
• Demonstrate how to use the computer in the consultation while maintaining rapport with your patient
• Demonstrate effective and safe telephone, email and online consultations, applying an awareness of their uses and limitations while mitigating risks
• Share information with patients in an honest and unbiased manner, in order to educate them about their health (doctor as teacher)
• Negotiate a shared understanding of the problem and its management with patients, so that they are empowered to look after their own health
• Adapt communication skills to meet the needs of the patient, including working with interpreters to deal with patients from diverse backgrounds
• Achieve meaningful consent to a plan of management by seeing the patient as a unique person in a unique context
• Understand the importance of continuity of care and long-term relationships with your patient and their family in identifying and understanding the values that influence a patient’s approach to healthcare
• Demonstrate techniques to limit consultation length when appropriate

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

• Demonstrate focused questioning and examination to obtain sufficient relevant information to diagnose, manage and refer appropriately

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Formulate appropriate diagnoses, rule out serious illness and manage clinical uncertainty
• Base treatment and referral decisions on the best available evidence
• Make timely and appropriate referrals, using relevant information
• Demonstrate the ability to communicate risks and benefits in a way that is meaningful to patients

• Demonstrate the skills to offer patients health choices based on evidence so that an informed discussion can occur, taking into account patients’ values and priorities

• Recognise that the efficacy of evidence-based interventions depends on concordance with agreed therapeutic aims

• Understand the value of continuity of care recognizing that a long-term relationship can improve concordance with evidence-based interventions

• Recognise the scarcity of evidence derived from a patient’s perspective

• Recognise the range of values that influence decisions by your patients, their families and health professionals, and where these values conflict

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

• Demonstrate sufficient knowledge of the breadth of scientific evidence in order to provide the best information for patients about their illness

• Use time and resources effectively during the consultation

• Understand local referral pathways and services to ensure appropriate and efficient provision of care

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

• Use the consultation to educate patients about self-management of acute and chronic disease and be able to direct them to appropriate sources for further education

• Demonstrate a commitment to health promotion within the consultation, while recognising the potential tension between this role and a patient’s own agenda

• Understand that co-morbidity or disease progression may affect a patient’s decision-making capacity

• Recognise and respond to a patient entering a terminal stage of illness, and the values that are important in managing this

**Core Competence: Working with colleagues and in teams**
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Recognise the roles of health and social care colleagues and draw on this expertise appropriately
- Use the ‘best possible evidence’ to inform patients of the ‘best possible’ way to navigate the healthcare system

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand the principles of evidence-based practice and how you can apply these principles, given the condition of the patient and the healthcare system
- Demonstrate an awareness that a combination of evidence-based treatments is not always evidence-based in itself. Interactions between single interventions may increase or decrease efficacy
- Explore patient values and place them in context with clinical evidence, so that you can develop an appropriate shared-management plan
- Demonstrate an awareness of your own attitudes, values, professional capabilities and ethics so that, through the process of reflective and critical appraisal, you are not overwhelmed by personal issues and gaps in your knowledge
- Undertake self-appraisal through such things as reflective logs and video recordings of consultations, and seek out opportunities for your educational development based on this
- Understand the common models of the consultation that have been proposed and how you can use these models to reflect on previous consultations in order to shape your future consulting behaviour

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:
- Keep accurate, legible and contemporaneous records
- Effectively use patient records (electronic or paper) during the consultation to facilitate high-quality patient care

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Be able to explain the concepts of ethnicity and culture
- Include the cultural values and circumstances of your patient in the consultation
- Understand the process by which patients decide to consult, and how this can affect consulting outcomes
- Understand that consultations have a clinical, a psychological and a social component, with the relevance of each component varying from consultation to consultation (the ‘triaxial’ model)
- Recognise that episodes of illness usually affect more than merely the patient
- Understand the relationship between the interests of patients and the interests of their carers
- Negotiate whether and how relatives, friends and carers might become involved, while balancing your patient’s right to confidentiality
- Understand that your patient’s views and perspectives may change during the course of a chronic disease
- Accept that patients may wish to approach health (and illness) in a non-scientific way. The reality for patients is that they make their own choices on the basis of their own values and not necessarily on the basis of clinical efficiency or resource implications
- Accept that patients may prefer to delegate their autonomy to you as their GP, rather than accept this responsibility themselves

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Be aware of the obligation to use available healthcare resources in a prudent manner, balancing individual patient needs with fairness to other patients
- Manage the potential conflicts between personal health needs, evidence-based practice and public health responsibilities
- Recognise that socio-economic deprivation is a major cause of ill health
- Understand how the values and beliefs prevalent in the local culture impact on patient care
- Understand how the demography and ethnic and cultural diversity of your practice population impact on the range and presentation of illness in the individual consultation
- Identify lessons from individual consultations, such as unmet health needs and gaps in service provision, and use these to develop appropriate services for the community as a whole.
- Recognise how consultations conducted via remote media (telephone and email) differ from face-to-face consultations, and demonstrate skills that can compensate for these differences
- Understand interprofessional boundaries with regard to clinical responsibility and confidentiality

**Case discussion**

Mrs Leela Patel, a 45-year-old Indian lady who has breast cancer, attends your surgery to discuss her treatment following a recent hospital appointment. Her oncologist has informed her that the cancer has not responded to the latest course of chemotherapy and has suggested that she should consider further treatment with a new drug. She informs you that she had a terrible time with the chemotherapy and she does not wish to have any more treatment. She says that she would like to see an Ayurvedic doctor who specialises in cancer treatment. She says that she does not mind paying for this treatment if you are unable to refer her on the NHS.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How do I feel about this request? How might this affect my judgments and actions in the consultation?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How would I balance the conflicting demands of the patient's right to choose her treatment (respecting her autonomy) with the doctor’s duty to protect the patient from harm?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td></td>
</tr>
</tbody>
</table>
**Communication and consultation**
This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.

| What open-ended and sympathetic questions would I use in order to establish the facts and reasons for Mrs Patel seeking a referral to an alternative practitioner? |
| Are there possible language/cultural difficulties and how could these be managed (e.g. using an interpreter)? |

**Data gathering and interpretation**
This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

| What are Mrs Patel’s health beliefs, cultural norms and concepts regarding her health issues? |

**Making decisions**
This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

| What are the various potential benefits and harms that might result from different courses of action? |

**Clinical management**
This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

| What do I know about the regulation of complementary medicine, its availability on the NHS and, if not available, where it could be accessed? |

**Managing medical complexity**
This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

| What are the implications of Mrs Patel’s request and need for support in terms of service provision and time management? |

**Working with colleagues and in teams**
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

| Which health and social care colleagues could help Mrs Patel and how can I draw on their expertise? |

**Maintaining performance, learning and teaching**
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.

| What do I know about complementary medicine and the evidence base for it compared to the chemotherapy regime being offered by the oncologist? Do I need to find out more? |
Organisational management and leadership
This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

How can I use Mrs Patel’s records during the consultation to facilitate high-quality patient care?

Practising holistically and promoting health
This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

Do I understand Mrs Patel’s personal views regarding complementary medicine?

Do I have sufficient understanding of Mrs Patel’s cultural perceptions relating to our healthcare system and her health?

Community orientation
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

How would I ensure support and reassurance regarding continuity of care, primary care team support and assessing support for the carers?

How to learn this area of practice

Work-based learning
As a specialty trainee, primary care is the ideal place for you to learn about the GP consultation in practice. There will also be excellent opportunities in secondary care settings. Examples of how to make the most of your clinical experience include:

- Video analysis of consultations. This can be done using the consultation observation tool (COT)
- GP trainers can sit in with specialty trainees to give formative feedback. This can be done using the COT
- Random case analysis of a selection of consultations. This can be done using case-based discussion (CBD)
- Reflection on secondary care consultations using the clinical evaluation exercise (mini-CEX)
- Patients’ feedback on consultations using validated satisfaction questionnaires or tools, for example the RCGP patient satisfaction questionnaire (PSQ)
- Sitting in with GPs and other healthcare professionals in practice to observe different consulting styles
- Observation of consulting behaviour during outpatient clinics
Using the telephone and other digital communication tools to consult in the practice as well as in ‘Out of Hours settings’, initially under close supervision and later independently.

As a GP trainee you should have opportunities to discuss ethical and other values-related aspects of your practice with colleagues as these arise in your day-to-day work: in addition to contact with patients, their families and the wider community, relevant contexts include such areas as audit and significant event review meetings, and developing practice policies (e.g. on patient consent or on the appropriate use of health service resources). It is particularly helpful if there is ‘protected time’ for reflection and shared learning in which training resources (articles, case studies, etc.) are combined with discussion of real issues arising in your own practice. Presenting cases to your peer groups as part of the more formal training programme will promote reflective practice and can be used to illustrate the diversity of values within a specific professional group.

It is also important for specialty trainees to understand that the practice of medicine has its own culture, values, morals and beliefs that may set doctors apart from patients. During your training you should be supported to gain a better understanding of the diverse nature of the society in which you will work. You should also learn to ask questions and look critically at your assumptions and attitudes about people who are different from yourself, as well as to reflect on these issues and, importantly, on your own feelings. The specialty trainee working in a hospital or in primary care should be training in an environment that embraces differences and similarities in culture, backgrounds and experience. This should be an environment free from racism, sexism and bullying where there are positive role models and processes in place that promote equality and value diversity in the workplace.

Self-directed learning
Courses or teaching using role-played consultations are tremendously valuable in exploring consultation behaviour in a safe environment, especially those using ‘standardised patients’.

Peer-group meetings are an excellent forum for you to discuss, in confidence, video-taped consultations recorded in your surgery or using commercially available teaching packages. For example, the RCGP’s training DVD ‘Consulting Communication Skills for GPs in Training’ is an excellent resource for specialty trainees and established GPs who wish to improve their consultation skills.

Competent GPs who wish to develop further expertise in consulting may find the consultation expertise model useful. This model presents a schematic representation of what expert family doctors actually do, which can be used to analyse an individual consultation to produce a ‘fingerprint’ of the level of expertise demonstrated in that consultation. The consultation expertise model was developed to explain the observed differences in behaviour between specialty trainees and experienced GPs during simulated consultations.

Balint groups
The Balint group is a highly developed and tested method of small-group consultation analysis that aims specifically to focus on the emotional content, not just of single consultations but of ongoing doctor–patient relationships. Many doctors who have had the experience of Balint training attest to the lifelong benefits that it can bring in terms of interest in patients’ lives, self-knowledge, job satisfaction and prevention of ‘burn out’. A growing body of research evidence supports the effectiveness of Balint training in many countries.
The aims of a Balint group, as recognised by the Balint Society (www.balint.co.uk) are:

- To provide a safe environment where group members are able to talk in confidence about the feelings aroused in them by their patients

- To encourage the doctors to see their patients as human beings with a life and relationships outside the surgery, and a history going back to childhood that has helped to determine what they have become

- To help doctors explore in detail the emotional content of their interaction with a particular patient: to understand how their behaviour and reactions have been unconsciously affected by the feelings projected by the patient, and resonating with those of the doctor

- To help learn how to contain a patient’s feelings even when these are uncomfortable and to tolerate feelings such as helplessness and anxiety

- To help understand how a distressed patient may need to be held and supported in an ongoing therapeutic relationship, in a series of consultations with the same doctor over a period of time

If you have concerns about your own clinical performance – for example perhaps you are returning to work after a period of absence, or you have health problems which may be impacting on your performance – you can self-refer to the National Clinical Assessment Service (NCAS) through their telephone advice numbers on their website. They provide expert advice about the steps you can take and where you can go for help. See the NCAS website www.ncas.nhs.uk/.

**Learning with other healthcare professionals**

The consultation can be used as a focus for your discussion with other health professionals, either by observing a live consultation, using role-play or by watching video-taped consultations. Consultations are a rich learning resource that can trigger multidisciplinary discussion about consulting skills, patient management, ethics, evidence-based practice, clinical guidelines, and many other things.

The emerging integrated care pathways and multi-professional team meetings offer valuable means to learn from the wider team, including social workers and secondary care consultants.

**Useful learning resources**

**Books and publications**

- Neighbour R. *The Inner Consultation: How to Develop an Effective and Intuitive Consulting Style (2nd edn)* Oxford: Radcliffe Publishing, 2004
Web resources

BMA ethics section

Has a range of guidance for doctors on ethical issues in practice including a section on the questions practitioners most commonly ask of the ethics team. [http://bma.org.uk/practical-support-at-work/ethics](http://bma.org.uk/practical-support-at-work/ethics)

GMC website

Contains all recent GMC guidance including guidance on consent and confidentiality. The site also has a series of interactive case studies covering ethical issues faced in day-to-day practice called *GMP in Action* (from *Good Medical Practice*).

[www.gmc-uk.org](http://www.gmc-uk.org)

Institute of Medical Ethics website

This site has a range of learning resources for practising clinicians and teachers of medical ethics linked to the IME’s core curriculum for medical ethics and law. These include links to relevant guidelines and legislation, video clips and case vignettes as well as an extensive range of further reading. Resources are organised under useful headings such as mental health and care of children.

[www.instituteofmedicalethics.org/website](http://www.instituteofmedicalethics.org/website)

RCGP website

The RCGP website contains the key information about workplace-based assessment (WPBA) of communication skills in general practice. Several methods are available to assess competence in the consultation, in both primary and secondary care. These include case-based discussion (CbD), the consultation observation tool (COT) and the patient satisfaction questionnaire (PSQ). It is an essential site for GP specialty trainees.


RCGP e-learning resources

e-GP

For *The GP Consultation in Practice*, e-GP includes courses on The Consultation in Context, Practical Consulting, Clinical Ethics and Values, and Promoting Equality and Valuing Diversity.

[www.e-GP.org](http://www.e-GP.org)
2.02 Patient Safety and Quality of Care

Summary

- The RCGP aims to improve the quality of healthcare by defining and upholding high standards for general practice education and training, aiming to improve health outcomes for all by promoting high quality general practice at the heart of the health service.

- As a GP you are in a strong position to influence the care of your own patients, that of your practice population and that of the wider healthcare community.

- Understanding how and when to apply tools and metrics to improve the quality of care is a key skill that can and should be learnt during your training, as well as enhanced in lifelong learning.

- Working in partnership with your patients and understanding their needs is vital to improving clinical care and reducing health inequalities.

- Patients, their families and carers have an important role in the assessment of healthcare; their views are therefore essential for the development of high-quality health care. Patients should be encouraged to be actively involved in planning their care and in the development of services at practice level and beyond.

- How we learn from and share lessons regarding clinical care is an important marker of our personal and collective professional development.

Educational priorities

The GMC Duties of a Doctor clearly states ‘you must make the care of your patient your first concern’, with quality and safety of healthcare being a key concern for the public.

General practitioners and practices do not work in isolation but are an integral part of systems of care. As a GP, understanding teams, interfaces, organisational relationships and care pathways is essential to the delivery and development of high-quality, safe patient care. Because of this there are many opportunities for you to have a positive impact upon healthcare and to improve the quality and safety of care for your individual patients, your registered population and for those patients within your locality.

As such all GPs need to make sure that their practice has good systems in place to monitor the quality of care that they provide. This requires leadership, team working and good information systems. GPs increasingly need to be able to demonstrate that they keep up-to-date and are fit to practise, and can account for the standard of care they are providing.

Techniques to look at patient safety and to begin to compare quality of care is a relatively young field and, whatever your age and experience, you will require ongoing training to introduce and enhance your skills. Clinical audit, significant event audit and improvement methodology are key tools to improving the quality of care. There are a variety of definitions of ‘quality’, most encompassing...
clinical effectiveness, patient safety and awareness of the patient experience. All GPs should have a thorough understanding of clinical governance and contribute actively to creating a practice culture which is conducive to learning, team working and the promotion of clinical excellence, focused on meeting patients’ needs.

A variety of measures capture different information. Looking across a broad spectrum of data is important and helps healthcare organisations to triangulate impressions. No one source is perfect and because of the diversity of practices and the variation in patient demographics it is essential to take a broad, balanced view. Patient safety incidents, near misses and complaints are part of a jigsaw of information that can be used to ‘share and learn lessons’. How we share lessons is key to our personal and collective professional development. Clinical governance aims continuously to improve the quality of healthcare and to ensure equality of standards, as well as to demonstrate accountability to the public. In addition, it includes identifying and responding to poor practice. As a GP you need to understand the principles underpinning clinical governance by demonstrating the appropriate knowledge, skills and attitudes.

The role of information technology (IT) has changed substantially over the past few years, as well as during the clinical lifetime of most working doctors. General practice in the UK has especially embraced computerisation. Understanding what opportunities and risks this introduces is an important part of your experience in general practice. In particular, prescribing and monitoring of medication needs to be understood, developed and explored to ensure high-quality, safe care. Understanding what contribution reliable design and human factors play in helping this can be a useful transferable skill and understanding human factors and its impact on both practitioners and systems offers opportunities to identify risks in healthcare and possible ways to reduce them.

Dealing with feedback to patients and carers in an open and transparent way is another feature of a ‘safety culture’ within a practice that values a quality service. Also, working in partnership with your patients and understanding their needs is key to improving clinical care and governance and to tackling health inequalities.

Increasingly different parts of the NHS within England, Scotland, Wales and Northern Ireland are influenced by devolved organisations, so understanding their contribution and comparing their impact can be a useful learning experience. The National Institute for Health and Care Excellence (NICE) affects England as does the Care Quality Commission (CQC). In Scotland the role of the CQC is fulfilled by the Care Inspectorate (www.careinspectorate.com) and in Wales by the Care Standards Inspectorate for Wales (www.cssiw.org.uk). In Northern Ireland, the role is carried out by the Regulation and Quality Improvement Authority (RQIA) (www.rqia.org.uk), which includes registration of providers including GP practices. The RQIA seeks to formally explore quality and variation. How we deal with such variation is important.

The requirements for appraisal and revalidation have been developed by the RCGP and GMC. As a GP you need to understand the requirements and collect the relevant supporting information as part of your professional development, including links to the quality and safety domain within the GMC’s Good Medical Practice.
Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Demonstrate a commitment to clinical excellence and patient safety, to monitoring the quality of care provided and to accounting for it to peers, patients and the NHS
- Admit when an error has occurred, apologising for failings in the delivery of care and communicating this openly to patients and their families, reassuring them that the appropriate lessons have been learned
- Describe the interaction of work and private life for oneself and others, and strive for a good balance between them

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Have an awareness of your own capabilities, values and ethics
- Identify ethical tensions inherent in governance processes and resource allocation
- Help to shape an organisational culture that prioritises safety and quality through openness, honesty, shared learning and continual incremental improvement
- Describe your accountability as a GP
- Tell patients and their families as soon as possible when incidents occur and do so fully, honestly and compassionately

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

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This means that as a GP you should:

- Communicate openly, listen and take patients’ concerns seriously. Consider patient issues when reflecting on consultation experiences
- Describe the NHS complaints systems and optimal methods for learning from complaints and dealing with patients
- Describe the techniques for obtaining the views and feedback from patients, including both quantitative methods such as surveys and qualitative techniques such as focus groups
- Consider the benefits of involving lay people in the improvement of health services
- Understand what is involved in establishing a Patient Participation Group (PPG)
- Consider the advantages and disadvantages of patients accessing their own records
- Provide patients with information on the risks and benefits of treatments to allow them to make informed decisions

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Decide the criteria for when the organisation should undertake a root cause analysis or significant event audit
- Be able to conduct a clinical audit
- Build and enhance the safety culture in your general practice setting including attending meetings
- Know how organisations and individuals can learn to improve systems by analysing patient safety incidents and near misses

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Be aware of the limitations of your own skills in risk management and illustrate that you understand when the skills of colleagues trained more extensively in risk management should be called upon
- Describe when an improvement project would help patient care and consider undertaking an evaluation e.g. audit or PDSA cycle (plan–do–study–act)
• Describe how practice systems can be used to analyse practice performance
• Appraise critically data about practice indicators (e.g. prescribing, referrals, chronic disease management, access and availability)
• Describe the variation in GP and practice performance and the determinants of this
• Locate information about standards, clinical guidelines, critical appraisal and databases

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

• Understand the principles of medical device management and the use of the adverse incident centre for reporting device-related adverse incidents
• Know the elements that contribute to an appropriate infrastructure for risk management, such as: create a culture that is open and fair with systems and policies, helping staff understand what actions to take following an incident and the mechanism of investigation
• Demonstrate an understanding of the definition(s) of clinical governance and describe the standards used to assess the quality of health care, for example the seven domains of ‘Standards for Better Health’ used in England:
  o Safety
  o Clinical and Cost Effectiveness
  o Governance
  o Patient Focus
  o Accessible and Responsive Care
  o Care Environment and Amenities
  o Public Health
• Describe the uses and abuses of clinical indicators and metrics such as benchmarking
• Understand the concept of variation in clinical care, how it is determined and measured and what actions might need to be taken to address inappropriate variation, for example in referrals, prescribing, admissions
• Describe the local clinical governance arrangements
• Demonstrate an understanding of the principles of medicines management
• Describe how to report adverse drug reactions and clinically significant errors through the appropriate national reporting systems

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also
covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Describe how the lessons of patient safety can be applied prospectively to doctor–patient interactions, especially through the identification and discussion of risk
- Reflect on the risks to patient safety in a care pathway in which a variety of healthcare professionals are involved, looking at interface issues and be able to comment on the ways in which, as a GP, you can work to minimise these
- Compare the systems and processes in place in your practice to identify and manage risk in the primary care setting and compare these with other practices
- Be able to describe the basic principles of human error
- Compile a simple risk matrix
- Describe the structures and processes for managing clinical and non-clinical risk, and how these are integrated with patient and staff safety, complaints, clinical negligence and financial and environmental risk
- Explain the importance of good clinical governance and its key components in a practice
- Demonstrate the measures that the organisation takes to ensure that reports are dealt with fairly and that appropriate learning and implementation takes place
- Understand principles of improvement methodology to facilitate change
- Comment on the use of situational awareness theories

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Illustrate how changes in behaviour and/or systems can influence patient safety
- Describe when it is appropriate to raise concerns and policies for whistle blowing, and what action to take when a colleague gives you cause for concern, including what support is available
- Discuss with colleagues in different practices how high-quality multi-professional working can benefit patient safety, and consider the steps needed to facilitate such co-working

2 e.g. ‘The three bucket model’ proposed by James Reason ([www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60160&](www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60160&)) where each bucket is variably filled according to the context, the domestic feelings of the doctor and the complexity of the task
• Contribute to the regular significant event audit (SEA) meetings and describe the benefits of a multidisciplinary team, as well as give effective feedback to colleagues about incidents

• Comment on the participation of whole teams in significant event audits within the practice and give reasons for inclusion or exclusion of different team members

• Share lessons from the analysis of patient safety incidents within the team

• Describe the role of a practice clinical governance lead and their key relationships internally and externally

• Show that, as a specialty trainee (GP) within the team environment of general practice, your experiences gained in previous settings can be shared with colleagues. Recognise that the formal Patient Safety Agenda is relatively recent and may be unfamiliar to well-established colleagues

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

• Develop and maintain an approach to continuing learning and quality improvement

• Be able to describe the tools and principles that can be applied in risk management and patient safety issues

• Describe how the analysis of patient safety incidents can enhance rather than undermine professional integrity and performance

• Write up an SEA from a patient that you were involved with during the general practice period of training (significant event analysis in the learning log of the RCGP ePortfolio)

• Reflect on the learning and consider whether reporting locally and or nationally would be appropriate

• Demonstrate an awareness of the all-encompassing approach to patient safety, for example by keeping a log diary of consecutive consultations for at least one day per month and commenting on any actual or potential patient safety incidents within those consultations

• Be aware of clinical guidelines and pathways and demonstrate their appropriate use

• Prepare a folder for educational supervision and when appropriate revalidation containing relevant evidence

• Describe the relationship between clinical governance, appraisal and revalidation, including the requirements for revalidation and describe the process and roles of the GP, the responsible officer, the RCGP and the GMC

• Compare Good Medical Practice as published by the GMC and the RCGP’s Good Medical Practice for General Practitioners
• Be familiar with the RCGP guide to revalidation and the requirements for medical appraisal (www.rcgp.org.uk) and your revalidation portfolio

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

• Demonstrate an awareness in how changes in the IT structure of the NHS will both reduce and increase the chance of patient safety incidents
• Demonstrate the use of call/recall systems within the practice to the benefit of patient care
• Demonstrate an understanding of the connection between good data entry and improved patient health outcomes
• Demonstrate how to use information management and technology (IM&T) to share information and co-ordinate patient care with other health professionals
• Demonstrate an understanding of the need for information recorded in the practice clinical system to be fit for sharing with different health professionals in different organisations
• Demonstrate how to use NHS electronic booking systems to tailor healthcare provision to the needs of the individual patient
• Demonstrate the use of the practice’s computer system to improve the quality and usefulness of the medical record, e.g. through audit
• Demonstrate effective use of interagency systems such as pathology links and GP–GP record transfer
• Demonstrate an understanding of information governance, patient consent and privacy issues that relate to the sharing of electronic health records and the central storage of health information
• Demonstrate an understanding of the power of reporting from clinical systems for personal/practice audit and data analysis; and for comparisons with other practices that assist in setting the agenda for improving quality of care and recording of care

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.
This means that as a GP you should:

- Help facilitate the implementation of solutions to prevent harm, by embedding any lessons learnt in the practice processes and systems
- Identify which other elements of patient services may be affected in future and share learning more widely on the basis of this
- Involve patients and carers in their care, in decision-making and in quality improvement processes

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Be aware of the current pattern of patient comments through, for instance, the local patient representative body
- Describe the ways in which general practice and community pharmacy can work together to minimise the potential for patient safety incidents
- Know how patient groups may be put at increased risk of mishaps by virtue of their particular characteristics, such as language, literacy, culture and health beliefs
- Know the new roles that have emerged in the community setting and give examples of how these new roles have impacted upon patient safety
- Consider why patients from varied backgrounds that reflect the population of the area should be involved
- Describe the problems resulting from inequalities in healthcare provision
- Describe approaches to improving access to services for hard-to-reach groups
- Recognise the importance of practice- and community-based information in the quality assurance of each doctor’s practice
- Describe the impact of the working environment on the care the doctor provides and the likelihood of adverse incidents as a result of this

**Case discussion**

A patient, Juliet Brown, asked for a home visit for her frail elderly mother, Mrs Jones, who had come to stay with her. Dr G visited that afternoon and found that Mrs Jones had atrial fibrillation and was on warfarin. She had no patient-held record but her daughter Juliet reported that each day she was taking 3 mg of warfarin. Dr G advised her to continue with this dose and that he would arrange for an INR (international normalised ratio) blood test.
On returning to the medical centre, he entered her medication on the clinical system and issued a prescription for 3mg warfarin tablets. He asked a receptionist to email the community nurses, requesting blood tests, including an INR. The email was never sent and the INR test was not done.

A week later Mrs Jones was admitted to hospital and died six hours after admission. After a post-mortem the primary cause of death was recorded by the coroner as a haemorrhagic cerebrovascular event (CVA). A few days following the death of Mrs Jones, her daughter Juliet phoned the practice manager to say that a junior doctor at the hospital had said Mrs Jones had a bleed in the brain, which can occur when people are on warfarin. A blood test done soon after admission had shown her INR was ‘a bit high’.

Juliet asked the practice manager why the blood test had not been done as Dr G had said it would be; whether the warfarin might have been a cause of her mother’s death; and whether the blood test might have saved her mother’s life. She also wanted to know if her mother’s own general practice had been at fault because it appeared that her INR had not been done for about six months. The practice manager explained that she didn’t have the answers straight away, but would come back to Juliet soon.

The practice held monthly significant event audit meetings. Dr G presented the case of Mrs Jones at their next meeting. All present shared their distress at what had occurred, as well as their view that it could easily happen again. They then got down to a frank discussion of what might have gone wrong, agreeing that:

- Home visits presented particular risks for clinical care
- If the patient had carried a patient-held record then the previous INR would have been available
- There was a well-established system for communicating with the community nurses, which generally worked well; but on this occasion human error had occurred
- The originating clinician remains responsible for delegated actions/commissions
- There might be some other patients in their practice not having regular INR reviews and such patients might also have raised INRs

Actions from the meeting included the following points:

- Undertaking an audit of all patients on long-term warfarin
- The message-taking and message-passing systems in the practice would be a major subject for the practice’s next internal protected learning time event for the whole team
- The dosing regimen was likely to lead to confusion (a 3mg tablet on one day and a tablet and a half alternate days), but it is often safer to continue with such a regimen short term in a temporary residence while waiting for an INR
- Dr G was under high time-pressure that afternoon because he had had a minor surgery session after morning surgery, a teaching session with the registrar at lunchtime, and was
fitting in two visits before the mid-afternoon surgery session. This particular day in the four-week cycle was always known to Dr G as his ‘black day’

- The practice manager was to look at the timetabling issues, not just for Dr G but for other partners, to minimise the risks of such predictable time pressures occurring. This was to be a root cause analysis (RCA). A letter would be written to Juliet Brown telling her what the practice had discussed and what it was doing, and inviting her to a meeting with Dr G and the practice manager

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
</table>
| **Fitness to practise**                 | Consider how context (such as the setting of the consultation or time pressures on the doctor) can impact upon clinical care.  
                                           | How would my approach change if, on reviewing the situation, the practice manager finds that staff have to chase Dr G regularly for reports and referral letters and that staff also report that, when on call, it can be hard to contact Dr G and that sometimes his records are poor? |
| **Maintaining an ethical approach**     | What are the complexities of a single home visit in the current system of healthcare?  
                                           | Thinking more about this, how can I respect the values of patients and carers, and how might these values influence the outcome of care? |
| **Communication and consultation**      | How might I improve my communication skills, both with the patient and her daughter, so that they know when to question the planned process of care? |
| **Data gathering and interpretation**   | How could I have found out when the last INR was taken, and made sure that the INR was done?                                                                 |
| **Making decisions**                    | What are the particular issues I need to consider when visiting a patient, such as a temporary resident, for whom... |
consultation and in wider areas of practice.  

<table>
<thead>
<tr>
<th><strong>Clinical management</strong></th>
<th>I may have little, or no preceding information?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
<td>Are there any particular features of this case, which would have indicated that the patient was at increased risk of haemorrhagic stroke?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Managing medical complexity</strong></th>
<th>What steps could I put in place to prevent this happening to any other patient? What should be discussed in a practice Significant Untoward Incident (SUI) meeting?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
<td>Consider different approaches to the rota arrangements. How could these help to predict and reduce vulnerable times for doctors and patients?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Working with colleagues and in teams</strong></th>
<th>How would I use clinical audit and the team-based use of significant event audit to further understand the issues here?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
<td>What validated service improvement tools could I also use to monitor improvement in the practice once changes have occurred?</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Maintaining performance, learning and teaching</strong></th>
<th>How are the systems and processes that a practice puts in place to ensure simple blood tests and tasks are carried out and how would I ensure these processes continue to function?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Organisational management and leadership</strong></th>
<th>What are the clinical risk management issues when thinking about co-morbidity?</th>
</tr>
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<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
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</table>
patients and carers.

<table>
<thead>
<tr>
<th>Community orientation</th>
<th>How might I predict and meet the needs of a frail relative staying with a patient of the practice – thinking, in particular, of the interrelationship between health and social care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
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### How to learn this area of practice

#### Work-based learning

##### In primary care

It is important that GP trainees gain a good understanding of clinical governance in primary care before completing training. Primary care both inside and outside the practice is the ideal environment to learn about the principles and to engage in their application.

All GP trainees should complete a clinical audit cycle or quality improvement project relating to patients in their training practice and actively contribute to the practice’s significant event audit meetings. Recognising this as an opportunity for reflection as well as possible celebration of good care is a particular feature of primary care teams.

As a GP specialty trainee you should take the opportunity to visit the relevant local primary care organisation in order to understand the role of clinical governance leads, and observing a governance committee would help you in understanding their associated processes. This may change over time with the impact of practices working as federations and also within GP clinical commissioning groups.

Being part of a multidisciplinary team is a particular feature of primary care. It is important that you understand the influence of being a doctor in that team and the effect on the culture and systems within the practice. It is also useful for you to observe and be aware of the varying levels of influence arising from the different roles such as partner, sessional doctor and locum. This has clear links to leadership competencies.

Observing systems developed by each practice to manage its repeat prescribing system and decisions about how much risk to ‘tolerate’ in this process is unique to primary care. Considering the variation in impact and uptake of NICE guidance is also worthwhile. Likewise, the processes that occur during a consultation when a decision to refer is made, as well as the practical systems in place to achieve the referral, are ideally explored within the primary care setting. Reflecting on cases that illustrate a delay in diagnosis using tools such as SEA can help in understanding the complex process of diagnosis, within both the primary and the secondary care setting.

##### In secondary care

Learning about the differences between primary and secondary care will help the specialty trainee gain a broader understanding of the principles and practice of clinical governance and how to
maximise benefit for patients. There should be opportunities to undertake clinical audits and critical event analysis with hospital colleagues.

Root Cause Analysis (RCA) is the standard risk tool used in secondary care and familiarity with its application can be best observed in this setting. Specialty trainees should be able to describe the particular role of risk managers in acute trusts and this is best appreciated while in this environment.

The primary/secondary care interface is especially vulnerable to patient safety incidents. Observing and understanding how different systems and processes influence this can be appreciated during a secondary care-based experience.

**Self-directed learning**

There are many web-based sites that offer educational modules in patient safety and quality of care, in particular e-GP, which provides a free programme of e-learning courses covering the RCGP curriculum ([www.e-GP.org](http://www.e-GP.org)).

**Learning with other healthcare professionals**

Primary care teams are highly sophisticated multi-professional groups. The opportunities for you to participate in shared learning with colleagues have expanded, particularly following the extension of non-medical prescribing and extensive collaborative working on long-term conditions and integrated care.

In addition, you have many opportunities in primary care to discuss clinical governance with nurses, allied health professionals and managers, all of whom should be engaged in the practice’s education and clinical governance programmes.

Unscheduled care in the community, both in hours and out of hours, is provided by a variety of different contractors utilising the skills of practitioners such as paramedics, emergency care practitioners, urgent care centres, crisis mental health teams and walk-in centres. These are ideal places for you to see and understand skill-mixing in healthcare and to compare and contrast the benefits and disadvantages of each option, including the usage of telephone calls triage and calls using clinical pathways (such as the 111 service).

**Useful learning resources**

**Books and publications**

- Houghton G and Wall D. Twelve tips on teaching about clinical governance *Medical Teaching* 2000; 22(2): 145–53
- Payne RA and Avery AJ. Polypharmacy: one of the greatest prescribing challenges in general practice *British Journal of General Practice* 2011; 61: 83-84

**Web resources**

**General Medical Council**

The GMC guidance *Raising and acting on concerns about patient safety* (2012) sets out the expectation that all doctors will, whatever their role, take appropriate action to raise and act on concerns about patient care, dignity and safety. [www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp](www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp)

GMC information about revalidation. [www.gmc-uk.org/doctors/revalidation.asp](www.gmc-uk.org/doctors/revalidation.asp)

**National Institute for Health and Care Excellence (NICE)**

The learning from the extensive National Prescribing Centre work was incorporated into NICE into 2012. There is a considerable evidence base in medicines management and safe systems. [www.nice.org.uk/mpc/goodpracticeguidance/home.jsp](www.nice.org.uk/mpc/goodpracticeguidance/home.jsp)

**National Reporting and Learning Service**

The National Reporting and Learning Service (NRLS) is working with healthcare organisations and royal colleges to improve how patient safety incidents from general practice are reported so that national learning can be developed.

General practice resources [www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice](www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice)

- Root Cause Analysis (RCA) investigation guidance [www.nrls.npsa.nhs.uk/resources/?EntryId45=75355](www.nrls.npsa.nhs.uk/resources/?EntryId45=75355)
- Seven steps to patient safety in general practice [www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice/?entryid45=61598](www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice/?entryid45=61598)
- Significant event audit guidance [www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice/?entryid45=61500&q=0%c2%acssignificant+event+audit%c2%ac](www.nrls.npsa.nhs.uk/resources/healthcare-setting/general-practice/?entryid45=61500&q=0%c2%acssignificant+event+audit%c2%ac)
- Delayed diagnosis of cancer: thematic review [www.nrls.npsa.nhs.uk/resources/type/data-reports/?entryid45=69894](www.nrls.npsa.nhs.uk/resources/type/data-reports/?entryid45=69894)
- Manchester Patient Safety Framework [www.nrls.npsa.nhs.uk/resources/?entryid45=59796](www.nrls.npsa.nhs.uk/resources/?entryid45=59796)
Royal College of General Practitioners

The Royal College of General Practitioners (RCGP), the professional membership body for family doctors in the UK and abroad, is committed to improving patient care, clinical standards and GP training. [www.rcgp.org.uk](http://www.rcgp.org.uk)

- e-GP: e-learning to support the curriculum statements: [www.e-GP.org](http://www.e-GP.org)
- Information on revalidation: [www.rcgp.org.uk/revalidation.aspx](http://www.rcgp.org.uk/revalidation.aspx)
- Information on GP commissioning: [www.rcgp.org.uk/policy/centre-for-commissioning.aspx](http://www.rcgp.org.uk/policy/centre-for-commissioning.aspx)
2.03 The GP in the Wider Professional Environment

Summary

- The purpose of clinical leadership is to improve health outcomes and quality of care for your patients
- Effective primary care requires the co-ordination and commitment of a multi-professional team working in partnership with patients
- Leading and managing improvement in healthcare systems is just as important as acting on behalf of the individual patient
- Leadership is everyone’s responsibility as a well led organisation is a safer place to work and receive care
- As a GP you have a wider social responsibility to use healthcare resources economically and sustainably

Educational priorities

As a clinician at the frontline of health services, you will need to understand not only how to work within systems of healthcare but also how to work with those systems for the benefit of your patients. This will require an understanding of the context, structures and processes in and by which care is delivered that goes beyond that of your specific clinical role.

As a GP you require a number of skills to enable you to manage your own practice or organisation effectively. However, doctors also have a leadership role within society, placing themselves in the service of patients by taking an active, informed and altruistic interest in issues that would benefit from their involvement. Patients and staff will look to GPs to influence and help determine the future direction of services; in leading and managing change there is a need for you as a GP to understand yourself, how you can work effectively with your teams and others, and how to take people with you. GPs must participate in the development and sustenance of all healthcare organisations that enable those involved in them to flourish. This means contributing to the well-being of your colleagues as well as your patients through good management of all involved in the provision of care and the design of robust systems that encourage good care and effective, sustainable and environmentally sensitive use of resources.

This statement explores the breadth of the core curriculum capabilities – but will focus on issues relating to clinical management and community orientation as it describes the need for you as a GP to marshal available resources across systems of healthcare for the benefit of your patients. Working in partnership with your patients, you need to be prepared to take a role in leading changes in service delivery with the purpose of improving population health outcomes and quality of care. On behalf of patients and the wider society, you also have a responsibility to use healthcare resources economically and sustainably. Just as in the clinical sphere of practice, where a person-centred approach to care focuses on the patient, in managing and leading services the GP should take into
account patient preferences and expectations, and use information to inform the development of healthcare provision. As a GP you will ensure that your patients remain at the heart of decisions about the nature and future shape of healthcare services.

As a GP you have a responsibility for your individual patients, their family and the wider community. You will be involved in the management of healthcare delivery in your practice and improving the health and well-being of the community. Because your work is determined by the make-up of the community in which you work, you must understand the characteristics of the community including socio-economic, ethnic and health features. Increasingly this will include an awareness of the environmental impact of contemporary health services and the need for a sustainable approach to the use of resources. Many of the competences needed to undertake these roles effectively are covered in the RCGP curriculum module 3.01 *Healthy People, Promoting Health and Preventing Disease*.

Contextual and attitudinal features of you as a doctor are also predominant as the statement describes the need for GPs to understand both themselves and others and also the wider professional context in which they work. The scientific mindset required of a doctor is covered extensively in the curriculum statement 2.04 *Enhancing Professional Knowledge*. One particular area of relevance to this statement is the ability to identify the need for, and implement, quality and safety improvements. This will require a number of skills around change management. Elsewhere, there is some inevitable overlap with the statement 2.02 *Patient Safety and Quality of Care*.

Two other professional and curricular frameworks are important to mention: the General Medical Council’s *Good Medical Practice Framework for Appraisal and Assessment* described in *Being a General Practitioner*, and the *Healthcare Leadership Framework*, developed by the NHS Leadership Academy. The *Healthcare Leadership Framework* describes the competences that doctors and other healthcare professionals, of all disciplines, will require if they are to be actively involved in the planning, delivery and transformation of health services. The key elements of the *Healthcare Leadership Framework* are outlined in Figure 1 below. The framework, which can be viewed at [www.leadershipacademy.nhs.uk](http://www.leadershipacademy.nhs.uk), is built around delivering a service to the patient and founded on the concept of ‘shared leadership’. This is where responsibility for leadership is not restricted to those with designated leadership roles but can come from anyone, at any level within the organisation, at any time. Leadership then becomes a shared responsibility and is focused on the achievements of the team, not just the individual. In common with many such frameworks, the Healthcare Leadership Framework is not there to be slavishly followed but to provide a language by which we can think, talk and be guided about ourselves, about our actions and about leadership.

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Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Identify your own strengths and limitations, the impact of your behaviour on others and the effect of stress on your own behaviour
- Take personal responsibility and hold yourself accountable

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Be aware of your own capabilities and values, and understand how these might differ from those of other individuals or groups
• Identify your own emotions and understand how these can affect your judgement and behaviour
• Identify ethical aspects relating to management and leadership in primary healthcare, e.g. approaches to use of resources, rationing, patient involvement in decision-making
• Engage positively with change

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

• Place your patients at the centre of decisions about services
• Maintain a patient-focus in the midst of structural and political change
• Be aware of the expectations that patients, carers and families have of their practice and local primary care services
• Involve patients in the management of the practice and local primary care services

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

• Actively seek and take account of the views of others
• Take into account the needs, feelings, values and expertise of others
• Gather feedback on the planning of healthcare provision from the wider healthcare team

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Use resources efficiently to improve care for individual patients and groups
• Understand the environmental impact of commissioning and planning decisions in relation to healthcare
Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches. This is about your ability to:

- Co-ordinate care with other professionals in primary care, and with other specialists

This means that as a GP you should:

- Demonstrate the ability to be an effective member and, where appropriate, be a willing leader of a team
- Create opportunities to bring together individuals and groups to achieve goals
- Communicate effectively with individuals and groups
- Promote the sharing of information and resources
- Gain and maintain the trust and support of your colleagues
- Understand and employ strategies to manage team dynamics
- Maintain team focus on delivering and improving services to patients

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

As a GP you have an important role working with managers and other members of the primary healthcare team to develop appropriate systems for delivering health promotion, prevention, cure, care, rehabilitation and palliation. These aspects of general practice are covered in the other areas of capability and so have not been repeated here.

This is about your ability to:

- Master effective and appropriate care provision and health service utilisation

This means that as a GP you should:

- Demonstrate the ability to co-ordinate a team-based approach to the care of patients, particularly those with complex care needs
- Understand primary care in the context of the wider NHS and actively seek the views of your patients on services provided and services needed
- Signpost patients appropriately to the relevant service
- Participate in decisions about local healthcare provision, planning and commissioning
• Take into account, in such decisions, the environmental impact of commissioned healthcare activity

➢ Act as an advocate for your patient

This means that as a GP you should:

• Negotiate effectively with colleagues on behalf of your patients
• Through shared dialogue, seek to enable your patients to be partners in decision-making on significant changes to services
• Proactively seek to improve services by questioning the status quo
• Develop and communicate aspirations for the improvement of services
• Actively seek to inform and influence decision-makers
• Provide appropriate choices for your patients in relation to their future healthcare
• Demonstrate an awareness of where conflicts of interest might arise in the commissioning and provision of services for patients
• Understand the wider social responsibilities of doctors in relation to the environmental contributors to social determinants of health

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

• Work effectively with the full range of primary care services, and across the primary–secondary care interface for the benefit of patients
• Take appropriate action when faced with staff or colleagues who act unprofessionally or irresponsibly

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

• Obtain, analyse and act on personal feedback from a variety of sources
• Understand the process of change and factors that influence it, and use resources for obtaining support in developing and leading change
• Apply quality improvement methodologies
• Know the strengths and limitations of quality measures in improving patient outcomes

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

• Describe the management structure of the practice, how decisions are made and how responsibilities are distributed
• Understand how the practice functions as a business and the implications various activities and expenses have for profitability
• Understand the various organisational forms of general practice and the means by which GPs may be contracted
• Delegate tasks effectively
• Understand and participate in the motivation of staff
• Contribute to staff development and training
• Conduct an appraisal interview with staff and/or colleagues
• Participate in the recruitment and selection of staff or colleagues, observing the law relating to diversity and equal opportunities
• Understand employer and co-worker responsibilities in relation to occupational safety
• Organise effective meetings
• Manage your own time effectively
• Demonstrate the ability to improve the quality of healthcare delivered to your patients by the practice
• Successfully manage a simple quality improvement project
• Demonstrate effective and sustainable utilisation of resources
• Identify the appropriate type and level of resources required to deliver safe and effective services
• Gather and analyse information about organisational performance
• Participate in taking action to improve organisational performance
• Prioritise and appropriately expedite service improvement as prompted by feedback (e.g. significant events) or analysis of need
• Seek out, adopt and disseminate models of good practice

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

• Lead and provide a service that treats your patient as a ‘whole’ person
• Foster an organisational culture that respects diversity
• Tailor services to the cultural needs of specific individuals and populations

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Understand the individual’s needs, the GPs' needs and the practice’s needs and reconcile these with the needs of the wider health economy
• Understand the structure of the local healthcare system and its economic limitations
• Understand the variety of ways in which healthcare and health promotion may be appropriately delivered in the community
• Understand the role of local government and social services in the maintenance and promotion of health
• Understand the contribution of the private and third sector in healthcare delivery
• Understand the importance of involving the public and communities in managing health services, e.g. encouraging patient participation in decisions about the local provision of healthcare
• Understand the need to reconcile the health needs of individual patients with the health needs of the community in which they live, balancing these with available resources
• Understand that influencing change across a system of healthcare can have a profound effect on the care of individual patients
• Be aware of key national guidelines that influence healthcare provision in the locality and country in which you work
• Understand your role as a GP in the commissioning of care
• Understand the need to work in partnership with other professionals and organisations to improve population health outcomes
• Understand the health impacts of climate change and its relationship with health inequalities
• Understand how medical professionals can contribute, personally and collectively, to positive societal change in relation to CO2 production and climate change
• Contribute to service management and service improvement in your local health community
• Take an active, informed and altruistic interest in societal issues that would benefit from your involvement
• Consider the impact of the local community, including socio-economic factors, geography and culture, on your workplace and patient care
• Be aware of local, regional and national health priorities, e.g. quality, innovation, productivity and prevention (QIPP) and how these impact on the local delivery of healthcare
• Familiarise yourself with the debates on the management of health services locally, regionally and nationally
• Understand the role of national policy in influencing the way GPs work with each other and with other professional groups
• Consider the impact of how the health service is organised locally and nationally, and how variation in resources and facilities may affect the delivery of healthcare
• Understand the principles of co-benefits (this is where an intervention is designed to provide multiple advantages to a population – such as improving health and reducing climate change simultaneously)
• Take action to improve the sustainability of local healthcare provision

Case discussion

Dr Evans is a general practitioner in a small inner city practice. He has always had an interest in lung disease. Recently, he has noticed that one of his patients, a 72-year-old smoker, Mr Johnson, with chronic obstructive pulmonary disease (COPD) has had several admissions over the past 12 months. On speaking to his colleagues in the practice, others recount similar stories with their patients. His interest piqued, Dr Evans decides to find out a little more about this. He does a survey to find out how many patients the practice has with a diagnosis of COPD. He discovers that the proportion of patients diagnosed with COPD is below the local and national average using data from Population Manager and the online health observatory for his city.

Dr Evans wonders if there are any steps that can be taken to improve the care of his COPD patients and reduce admissions to hospital. He gets in touch with the local primary care organisation who tells him there is a community-based respiratory nursing service that helps GPs to improve the care of patients with respiratory disease.

Dr Evans is keen to collaborate with the specialist respiratory nurses. With their help he develops an in-house service for spirometry to improve the identification and diagnosis of patients with COPD. With the help of the community respiratory team he is able to identify patients who are at high risk of repeated admissions to secondary care. He also brings to the attention of the practice
commissioning lead a Met Office early warning system of adverse weather conditions for patients with COPD.

The respiratory team also introduces him to a new programme whereby patients at high risk of repeated admissions are linked to a community matron. This service, based upon work done in the USA, is known to improve the quality of life of patients with COPD and reduce admission rates by up to 50%.

During the following winter, Mr Johnson rings Dr Evans requesting a home visit. He tells Dr Evans that his breathing has got worse and he needs help. After visiting him, Dr Evans refers Mr Johnson to the community respiratory matron.

She visits Mr Johnson at home, talks to him about his concerns, shows him how to use the inhalers properly and organises a physiotherapist to assist with his breathing. In addition, she organises carers for him at home while he is unwell. She monitors his progress over a course of weeks.

Mr Johnson steadily improves, he does not require an admission, he is better aware of the early signs of an exacerbation, and knows when to initiate steroid and antimicrobial therapy. In addition, he attends a group course run by the respiratory physiotherapists to improve his respiratory fitness. The nurse also refers him to the local smoking cessation service.

This case study shows how effective GPs can be working outside of their consulting room. In this illustration, Dr Evans, working in concert with other health professionals, has improved the system of care and health outcomes not only for an individual patient but for an entire practice population.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>What appears to motivate Dr Evans to take these actions?</td>
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<tr>
<td>This concerns the development of</td>
<td>What personal qualities may have helped Dr Evans to achieve these results?</td>
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<td>professional values, behaviours and</td>
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<td>personal resilience and preparation</td>
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<td>for career-long development and</td>
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<td>revalidation. It includes having</td>
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<td>insight into when your own</td>
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<td>performance, conduct or health might</td>
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<td>put patients at risk, as well as</td>
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<tr>
<td>taking action to protect patients.</td>
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<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>If Dr Evans was working in my practice, what issues are there in relation to culture</td>
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<tr>
<td>This addresses the importance of</td>
<td>and ethnicity?</td>
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<tr>
<td>practising ethically, with integrity</td>
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<tr>
<td>and a respect for diversity.</td>
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<tr>
<td><strong>Communication and consultation</strong></td>
<td>How can I engage the wider multi-professional team in service re-design?</td>
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<tr>
<td>This is about communication with</td>
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<tr>
<td>patients, the use of recognised</td>
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<td>consultation techniques, establishing</td>
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<td>patient partnerships, managing</td>
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<td>challenging consultations, third-</td>
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<td>party consulting and the use of</td>
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<tr>
<td>interpreters.</td>
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<tr>
<td>Data gathering and interpretation</td>
<td>What performance data can I use to prioritise service development?</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Making decisions</th>
<th>What skills would I need in order to drive change in service provision?</th>
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<tbody>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
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<table>
<thead>
<tr>
<th>Clinical management</th>
<th>Why is knowledge and understanding of service improvement important in managing long term conditions?</th>
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</thead>
<tbody>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
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<table>
<thead>
<tr>
<th>Managing medical complexity</th>
<th>How does service re-design take into account multiple morbidities in an ageing population?</th>
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<th>How has the multi-disciplinary team approach augmented the quality of care?</th>
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<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
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<th>Maintaining performance, learning and teaching</th>
<th>How has Dr Evans used data to drive improvement?</th>
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<tbody>
<tr>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
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<tr>
<th>Organisational management and leadership</th>
<th>What has Dr Evans achieved for his patients?</th>
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<tr>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and</td>
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| What knowledge of the healthcare ‘system’ did Dr Evans need to be able to bring about these changes? |
developing relevant business and financial management skills.

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<th>How might Dr Evans’ actions have an impact on healthcare resources?</th>
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<th>How are issues of climate change relevant to this case illustration?</th>
<th>How has Dr Evans addressed health promotion and disease prevention?</th>
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<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
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<td>How has Dr Evans addressed health promotion and disease prevention?</td>
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### How to learn this area of practice

#### Work-based learning

**In primary care**

There is a real opportunity here for you to learn beyond the consulting room in order to understand the context in which care is provided. As a first step, the specialty trainee should try to gain an overview of the various meetings that take place within the practice or that require attendance by a member of the practice team. Breaking these meetings down by purpose and content, e.g. finance, prescribing, referral management, service development, will help to gain an understanding of the complex issues facing GP practices. Structuring tutorials based on content identified through this approach will help to develop greater understanding.

Arranging visits to a wide range of healthcare organisations can be invaluable. This might even include your visiting a neighbouring practice to gain a different practice perspective. Understanding how other members of the primary care ‘family’, such as community pharmacists and community nurses, are contributing to improving the health of your practice’s patients will be important in order to understand the broader primary care contribution. It will also be a good idea to visit or arrange to meet with relevant colleagues locally, particularly those involved in commissioning services or those leading service developments.

Most practices in the UK will be involved in some way in developing services for patients. This might include improving access for particular groups of patients or developing an improved care pathway. A great way of learning will be to tackle a small re-design or quality improvement project to develop some aspect of your practice’s service to patients and if possible evaluate its impact. This differs from traditional clinical audit as the emphasis is shifted from the mundane collection of data to the more challenging arena of change management. Sharing findings and experiences with colleagues both inside and outside the practice will help consolidate your learning.
In secondary care

Many of the intended learning outcomes can be addressed in the secondary care setting where there are ample opportunities to participate in and lead teams, to bring about change and healthcare improvement and to participate in staff development. Understanding the journey of your patients from primary care through secondary care settings is invaluable in determining which aspects of the service are working well and which might need to be developed.

Learning with other healthcare professionals

GP specialty trainees will benefit from one-to-one sessions with the various members of their primary healthcare team in order to find out what others do, how they are managed and how they contribute to the development of the organisation. Understanding the perspectives of professionals drawn from the wider primary, community and social care settings is also important to understand how they contribute to delivering care to patients. Many opportunities exist in primary care to research, discuss, evaluate and implement change across a wide range of professions from health and social care settings.

Formal learning

Formal tutorials or teaching sessions on NHS structures, policies and strategic direction may be necessary. These should be based on your learning needs identified through active participation as identified above. Regular review through discussion with your colleagues will be needed, given the pace at which some NHS policy is changing.

You might also need specific learning sessions on some of the constructs underpinning theories of leadership, developing teams and management strategies. Many of these subjects are readily available as e-learning modules accessible from your desktop (see ‘Learning resources’ below).
Useful learning resources

Books and publications

Books

The available literature on management and leadership is vast and it has only been possible to list a few of the relevant texts here.

- Peckham S and Exworthy M. Primary Care in the UK: policy, organisation and management London: Palgrave Macmillan, 2002

Journals

As a GP, keeping abreast of political, policy and strategic developments in the NHS is important to ensure that you act in the best interests of your patients and the local health economy. The British Medical Journal (BMJ), BMJ News and the trade ‘glossies’ are all useful in this regard. The British Journal of General Practice also carries some news and editorials. For a more in-depth view of health service management, trainees are directed to the Health Service Journal (HSJ), and those with a developing special interest in leadership and management may wish to look further afield at general management journals such as the Harvard Business Review.
**Web resources**

It would be impossible to provide a comprehensive list all of useful and relevant websites. Listed here is a selection, both organisational and instructional.

**The Centre for Sustainable Healthcare**

The Centre for Sustainable Healthcare (formerly known as the Campaign for Greener Healthcare) works through a wide network of partners, in the fields of health and the environment on a range of projects to ‘green’ the NHS. The Centre’s mission is to help people realise the vital importance of the overlap between their wellbeing and environmental sustainability, particularly in the field of healthcare. [http://sustainablehealthcare.org.uk](http://sustainablehealthcare.org.uk)

**Climate and Health Council**

The Climate and Health Council has a board of senior health professionals, committed to health professional advocacy against climate change. The Council’s members take action through informing and influencing professionals, organisations and government about issues related to climate change and global health. [www.climateandhealth.org](http://www.climateandhealth.org)

**e-GP**

e-GP includes access to the medical leadership course (see LeAD below) and sessions on identifying and enabling change. [www.e-gp.org](http://www.e-gp.org)

**Faculty of Medical Leadership and Management**

The Faculty of Medical Leadership and Management was established in 2011 through the Academy of Medical Royal Colleges to promote the advancement of medical leadership, management and quality improvement at all stages of the medical career for the benefit of patients. The Faculty aims to work on behalf of doctors and medical students in the UK to provide leadership and act as a focus for all doctors including those who move into formal leadership roles. [www.fmlm.ac.uk](http://www.fmlm.ac.uk)

**Healthcare Quality Improvement Partnership**

The Healthcare Quality Improvement Partnership (HQIP) was established to promote quality in health services, and in particular to increase the impact that clinical audit has in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. [www.hqip.org.uk](http://www.hqip.org.uk)

**Institution of Occupational Safety and Health**

The Institution of Occupational Safety and Health (IOSH) is Europe’s leading body for health and safety professionals. The Institution was founded in 1945 and is an independent, not-for-profit organisation that sets professional standards, supports and develops members, and provides authoritative advice and guidance on health and safety issues. [www.iosh.co.uk](http://www.iosh.co.uk)
The Kings Fund

The Kings Fund is a charity that seeks to understand how the NHS in England can be improved. Through research and analysis the organisation aims to help shape policy, transform services and bring about behaviour change. www.kingsfund.org.uk

LeAD

LeAD is a free e-learning resource to help clinicians develop their understanding of how their role contributes to managing and leading health services. The e-learning resource has been created by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement, in partnership with e-Learning for Healthcare. LeAD provides over 50 interactive e-learning sessions, reflecting the five leadership domains outlined in the Medical Leadership Competency Framework. www.e-lfh.org.uk/projects/leadership-for-clinicians/

National Association of Primary Care (NAPC)

The NAPC is a leading national membership organisation which represents and supports the interests of all healthcare professionals, both clinicians and managers, working in primary care. Its aim is to be recognised as the organisation which shapes the future of healthcare delivery, enabling its membership to effectively commission and provide world-class patient care. www.napc.co.uk

NHS Alliance

The NHS Alliance is an independent organisation that brings together primary care organisations with practices, clinicians, managers and board members; and NHS primary care with its patients. The Alliance champions, supports and represents the breadth of professionals working in NHS primary care. www.nhsalliance.org

NHS Confederation

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. It aims to provide a coherent and strong voice for NHS leaders, influence policy and shape public debate about health services. www.nhsconfed.org

NHS England

The NHS England website is the portal for local NHS services in England and provides national information about the NHS. www.england.nhs.uk/

NHS Improving Quality

NHS Improving Quality supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership. The NHS Improving Quality website contains advice and information about leading change and quality improvement, introduces the NHS leadership qualities framework, and a host of change management and quality improvement tools, and provides a useful list of lectures, presentations and publications available. www.england.nhs.uk/ourwork/qual-clin-lead/nhsiq/
NHS Leadership Academy

The NHS Leadership Academy (NLA) was established in 2011 to develop outstanding leadership in health, with a continual focus on improving patients' experiences and their health outcomes. It brings together all the national activity supporting leadership development in health and NHS funded services and has four key areas of work; developing and embedding a common vision for health leadership, leading the way in leadership development for a new health system, supporting local leadership development and developing and delivering national leadership programmes. The NHS Leadership Academy website has full details including the NHS Leadership Framework
  www.leadershipacademy.nhs.uk

NHS Scotland

The SHOW (Scotland’s Health on the Web) service is an excellent website for those working in Scotland. It provides a wealth of information and access to NHS sites across Scotland. It is provided by a team of people based within the Information and Statistics Division of NHS Scotland. SHOW is supported and funded by the Scottish Executive Health Departments.  www.show.scot.nhs.uk

NHS Wales: Health in Wales Information Service

The official website of NHS Wales is a seamless service bringing together information sources about the health and lifestyle of the population of Wales into a simple, electronic-based service.
  www.wales.nhs.uk

Northern Ireland: the Department of Health, Social Services and Public Safety

This website provides access to information about health and social care in Northern Ireland. It has links to important policy papers and to the different departments, health organisations and professional groups that together contribute to leading and managing health and social care in the country.  www.dhsspsni.gov.uk

Nuffield Trust

The Nuffield Trust is one of the leading independent health policy charitable trusts in the UK. The Trust’s mission is to promote independent analysis and informed debate on UK healthcare policy. The Trust’s purpose is to communicate evidence and encourage an exchange around developed or developing knowledge in order to illuminate recognised and emerging issues.
  www.nuffieldtrust.org.uk

Royal College of General Practitioners

The Royal College of General Practitioners (RCGP) website provides essential sources of information about the curriculum, including management and leadership issues. The Information Services pages include many helpful fact sheets and summaries of key papers and policy documents.
  www.rcgp.org.uk
**Sustainable Development Unit**

The Sustainable Development Unit (SDU) for England was established in 2008 to provide leadership, support and policy input to ensure the NHS in England is the leading public sector organisation in promoting sustainable development and mitigating climate change.  [www.sdu.nhs.uk](http://www.sdu.nhs.uk)
2.04 Enhancing Professional Knowledge

Summary

- As a GP you should have the skills to learn, critically appraise and teach
- You should be able to appraise research and guidelines critically, understanding their generalizability and validity
- You should be able to apply evidence in the context of the patient, the community and the healthcare setting
- You should be able to audit your own practice and that of your organisation, and develop changes in the light of the findings
- You should be able to work within a multidisciplinary team so that the views and knowledge of the whole team are applied when discussing the care of a patient
- You should be able to demonstrate the competences of shared leadership so as to maximise the effectiveness of healthcare delivery
- You should ensure you are up-to-date in managing the acute care of patients
- You should, as part of supervising others in your team, be able to teach the need for safer practice and better patient care
- You should be willing to receive feedback as a teacher from individuals or groups in order to improve and learn from your teaching and educational sessions
- You should be aware that your own health and that of your colleagues should be optimal to ensure safe practice

Educational priorities

The ability to maintain and build on existing knowledge and skills is vital to sustain an individual doctor over a lifelong career. Central to this is the safety of patients and the quality of care delivered. As a GP you will need to be a lifelong learner and, in doing so, you must be able to keep up-to-date, reflect on your own practice and take action to address identified learning needs. The primary role of the GP is enacted in the consultation with the patient(s), and being able to run the GP consultation is the defining role. However, the need to consider the wider environment and global issues is vital:

- **Within the practice** your role is to work in and lead teams, and take part in managing the practice
- **Leadership competencies** need to be applied within your practice and beyond, in the development of services. This includes your ability to apply ethical analysis and critical review
- **Working with other agencies** and learning what they do is vital particularly when addressing health inequalities and to deliver many elements of healthcare to vulnerable groups (such as victims of domestic abuse or those with a learning disability), the socially excluded and those with complex healthcare needs
New themes emerge and policies develop and, as a GP, engaging with current debates enables you to influence health outcomes. The range is from local healthcare commissioning and public health policy to global climate change and sustainability.

The above depend on your maintaining and developing your personal knowledge to retain your effectiveness and enthusiasm. To be a good professional you need to reflect upon your practice and develop yourself by keeping up-to-date with progress in your fields of practice and by abandoning ineffective practices. This might mean you need to challenge established practice and examine current evidence. In order to enhance professional practice GPs often take on new areas of work such as teaching, out-of-practice management and research, or specialist roles to become GPs with Special Interests within their localities. These require deeper knowledge and/or additional skills, and often new qualifications.

Teaching other staff, students and trainees, sharing professional knowledge with colleagues and patients, and engaging in lifelong learning are core activities of any medical practitioner. As a GP you should expect to be involved in teaching, training and the development of yourself and others. In doing so, you will need to create and maintain an environment for learning, working with a range of appropriate teaching tools and techniques, using feedback and assessment to support learning, and balancing the needs of patients with those of learners. You will also need to play a role in the personal and professional development of others through activities such as coaching, mentoring and supervision. All this will require an understanding of the processes of learning. Practising these enhanced roles will give you more personal knowledge and may add to the overall body of professional knowledge and practice.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Understand how your own health and that of your colleagues will affect your ability to function safely as a doctor
- Recognise your own health needs when looking after patients and take appropriate action to prevent harm to patients

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:
• Include a non-judgmental evidence-based approach to problem-solving, taking into account your patients’ values

• Have an awareness of your own attitudes, values, professional capabilities and ethics so that, through the process of reflective and critical appraisal, you are not overwhelmed by personal issues and gaps in knowledge

• Understand that as a teacher you need to be able to engage those you are teaching in a dialogue about their values

• Reassure patients that all participation in research activity should be voluntary and that GPs will ensure confidentiality, research governance and, in particular, comply with relevant information governance legislation

• Be aware of the role of ethics committees

• Understand the value of incentives (e.g. prescribing) and interventions, and be able to recognise where conflicts of interest may occur

• When you are asked for your expert opinion, take care to ensure this is evidence based, and be clear when you are stating an opinion based on experience rather than evidence

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

• Be prepared to provide full information and informed consent and adhere to the rights of patient choice in both clinical research studies and clinical practice

• Be able to communicate to the patient the rationale for evidence-based interventions to encourage patient participation within a therapeutic aim, taking into account the patient’s objective, values and priorities

• Indicate the lack of evidence-based interventions at the appropriate time and have a clear understanding of how this lack of evidence might have arisen (rare conditions, conditions that have low morbidity or low pharmacological input)

• Be aware of how you impart information about evidence so that patients can best understand relevant evidence and be helped in making a decision

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.
This means that as a GP you should:

- Formulate a clinical hypothesis and then use the skills of effective consultation and examination skills to prove or disprove a diagnosis or hypotheses.

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Acquire the research and academic skills required of a general practitioner that aid decision-making which include a non-judgmental evidence-based approach to problem solving and recognising how individual bias may affect your interpretation
- Set your own learning objectives based on clinical experience
- Use your knowledge of the literature and evidence to solve and manage clinical problems
- Have a key understanding of the prevalence of chronic disease, which is dependent on the demographics of the local practice population
- Have a basic knowledge of how to define a research question and then how the appropriate research methodology is chosen to answer that question

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Be able to demonstrate and provide high quality evidence-based healthcare and healthcare practice
- Understand the differences between research activity and clinical audit
- Understand the strengths and limitations of surveys and local healthcare reviews
- Have an understanding of basic research methodology (e.g. you must understand the difference between qualitative and quantitative data and studies using social science methods, as well as bioscience) and how different types of research activity may contribute to patient care
- Have the skills to appraise research findings critically with a working knowledge of statistics
- Apply the findings from research, national guidance and audit in the context of day-to-day clinical and organisational management of patients
- Provide effective and evidence-based prescribing, adhering to the GMC’s principles of good medical prescribing
Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Deal with uncertainty and manage uncertainty through retrieval of best evidence available and communicate that uncertainty with appropriate safety netting
- Oversee and overview clinical and social and psychological aspects of patient care
- Apply findings from multi-morbidity research, taking into account limitations in the evidence and the fact that certain groups, e.g. the elderly, are excluded from research trials
- Develop medical leadership skills alongside clinical and research skills to enable safer working systems
- Have an understanding of the evidence base behind health promotion and preventative medicine which may help the individual and the practice develop an integrated approach to developing the quality agenda

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Realise that you will always work better in a multidisciplinary team and that your patients will benefit if the whole team works well; developing skills so that you and your organisation learn together will benefit patient care
- Implement a community-based approach to disease prevention through effective multidisciplinary and interdisciplinary teamwork
- Develop the skills of shared leadership (as described in the medical leadership curriculum and medical leadership competency framework\(^5\)) so that the primary healthcare team can function at its most efficient to provide safe and effective healthcare, and the care needs of patients can be co-ordinated safely

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• Understand the consequences to patients and staff when taking part in GP research, and contributing to research networks

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

• Use the type of best evidence relevant to the needs of your patients with an awareness of the principles and limitations of evidence-based practice

• Understand the value of clinical audit and make a clear distinction between audit, surveys, and research

• Understand patient factors, in particular concordance with treatment, which requires both qualitative (involves focus groups, in-depth interviews etc.) and quantitative studies (involves clinical trials, epidemiology etc.) and analysis

• Understand how to critically appraise data. Extrapolate evidence using meta-analysis to individual patient care.

• Be able to search for valid information using the process of evidence-based practice (as in the Sicily statement, 2003) which involves:
  o translation of uncertainty into answerable questions
  o systematic retrieval of the best evidence available
  o critical appraisal for validity, clinical relevance and applicability
  o application of results in practice
  o evaluation of performance (either at an individual or organisational level)

• Be able to teach and mentor others within the team effectively, including giving effective feedback as described in the General Medical Council’s guidance document Good Medical Practice

• Be aware that not every healthcare team member will learn in the same way, so be able to adjust your teaching style to suit the individual as well the subject

• Understand that teaching others is more than imparting information

• Be aware that you have a certain teaching style, so that you are able to facilitate learning appropriately

• Understand the difference in educational governance terms between clinical and educational supervision and the different competences required in the two roles

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6 Dawes M, Summerskill W, Glaziou P et al. Sicily Statement on evidence-based practice *BMC Medical Education* 2005: 5; 1
Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Learn how best to utilise information management and technology when communicating with both individuals and groups of people
- Record patient information on computer systems with an understanding of how data are recorded and used in general practice
- Be aware of how to contribute patient data to large GP databases to facilitate epidemiological research with a clear understanding of information governance and how to protect confidentiality.
- Understand the value of large-scale clinical population studies, and be aware of the use of large GP databases (e.g. Qresearch, the clinical practice research database etc.)

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Take into account psycho-social factors, learning disabilities, the vulnerability of patients, and cultural backgrounds when taking an evidence-based approach and apply the findings on both an individual and a population level
- Understand that patients may wish to self-manage, independent of or according to their own interpretation of scientific knowledge, making their own choices based on their own understanding and values
- Base decision-making on good evidence-based practice, taking into account patient values in order to provide the most appropriate care for the patient
- Use clinical examples that reflect your experience of working in the community and the impact of disease on the individual and the family in the widest sense (physiological, psychological, social and cultural)
- Recognise the importance of how occupation can affect the health of patients and their ability to self-manage illnesses and follow through with evidence-based interventions, recognising how your understanding of an occupation can enable patients to return to work in a safe and timely manner
• Demonstrate an awareness of the possibilities of predictive personalised care, for example with drug treatment. This takes into account how environmental and/or social factors may interact with genetic variation (genotype) and influence the phenotype

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Recognise the inequalities of healthcare delivery and how some evidence may not reflect the diverse nature of the population where you work
• Demonstrate an awareness that poverty is a common cause of poor health and follow the guidelines of the GMC’s Good Medical Practice in respecting culture, disability, religion, gender, social and economic status
• Accept that health economics studies and healthcare resource allocation will help to support the recommendations on which treatments are offered
• Recognise the public health skills needed in meeting the needs of population health as well as individual health
• Be seen as a leader of healthcare provision based on your clinical experience of chronic disease management and acute care of those presenting to general practice as a first port of call
• Be prepared to act as an educator within your local community
• Know it is important to keep up-to-date with how changes in the structures of healthcare systems may influence the service you provide, and have a broad understanding of the political environment and how primary care changes affect the whole of healthcare
• Have an evidence-based perspective and recognise that primary care research may lead to greater understanding around the prevention and treatment of disease, disease causation and the implementation of effective health policies and practice

**Case discussion**

Dr Chan, a GP in an inner city practice, had noticed that the Quality Outcome Framework (QoF) findings for diabetes in his practice were below the average for his area. He and the practice team set themselves a task to look at the reasons for this with a view to improving all aspects of diabetes care. Dr Chan and the practice nurses looked at all of the guidance from NICE, and Diabetes UK, on diabetes care and hypertension. They then involved a PCT pharmacist to look at how their prescribing patterns fitted with best practice and to develop prescribing guidelines. They met with the local secondary care diabetes team. The practice manager also went to visit a couple of high-achieving practices to see how care was co-ordinated.
After six months they all pooled their findings and worked together to form an enhanced template for diabetes care, which not only collected the data in codes appropriate for QoF but also included evidence-based parameters for BP, weight and glycaemic control, with hyperlinks to guidance documents. The practice manager streamlined the pathway of care for patients, aiming to reduce the number of times they came for diabetes appointments but giving them longer each time. In addition, the practice employed a dietician who was able to speak the language of many of their non-English speaking patients, for a session a week. The team found that by using principles of evidence-based practice and clinical leadership competences they were able to significantly improve both the care and the experience of those with diabetes registered at their practice.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How do I know if I communicate well enough with my staff and patients to foster improvements in the practice? Where are my strengths and weakness in understanding the evidence base around diabetes?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>What are the health inequalities that exist in my practice area and how has this impacted on the practice healthcare provision for diabetics?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
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<tr>
<td><strong>Communication and consultation</strong></td>
<td>How will I know if my patients are not engaging with the practice? If so, is it because they don’t understand the importance of good diabetic control? In what ways could I improve both the way I consult and my skills in shared decision-making?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>If I wanted to implement a change, how would I identify the appropriate patient population?</td>
</tr>
<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
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<tr>
<td><strong>Making decisions</strong></td>
<td>What is the process for managing diabetic patients in my practice, and how should it be improved? What do I think of the templates, if any, that we are using?</td>
</tr>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>Am I applying the latest available evidence to help diagnose and manage diabetic patients?</td>
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<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
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<tr>
<th><strong>Managing medical complexity</strong></th>
<th>How does service improvement take into account multiple morbidities in an ageing population?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
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<thead>
<tr>
<th><strong>Working with colleagues and in teams</strong></th>
<th>What does the research evidence tell us about diabetes management by the multi-disciplinary team?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
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<table>
<thead>
<tr>
<th><strong>Maintaining performance, learning and teaching</strong></th>
<th>What evidence base should I be using to improve the care of my patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Organisational management and leadership</strong></th>
<th>What organisational issues (e.g. appointments) may be relevant here?</th>
</tr>
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<tbody>
<tr>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
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<table>
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<tr>
<th><strong>Practising holistically and promoting health</strong></th>
<th>How might understanding the cultural values of our patients influence the management of their diabetes?</th>
</tr>
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<tbody>
<tr>
<td>This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-</td>
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</table>

What organisational issues (e.g. appointments) may be relevant here?
How accurate is our data recording, and how might it be improved?
In what way does GP commissioning help me to provide a responsive service to our patients?
How could I use practice and demographic data to assist local commissioners with the provision of services such as podiatry, dietetics and community-based diabetologists?

How might understanding the cultural values of our patients influence the management of their diabetes?
How can I find out about relevant psycho-social factors?
management and care planning with patients and carers.

<table>
<thead>
<tr>
<th><strong>Community orientation</strong></th>
<th>Why is there a national variation in care for diabetes and what evidence-based factors may influence the care of my patients in my locality?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
<td>What is the need for patient education?</td>
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<tr>
<td></td>
<td>What is the role of our practice patient group in assisting us to promote the value of good diabetes care?</td>
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<td></td>
<td>How could we target difficult to reach groups, such as the unemployed, deprived, or depressed?</td>
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</tbody>
</table>

**How to learn this area of practice**

Practise clinical appraisal in teams where the validity and generalizability of your findings can be discussed.

Use portfolio-based learning (e.g. the RCGP e-Portfolio) as a continually updated document to enable knowledge, reflections and learning from:

- The patient’s unmet needs
- Critical and significant event analyses
- Audits
- Practice feedback
- Complaints
- Attendance at lectures and workshops
- Journal and electronic materials
- Guidelines (e.g. NICE, SIGN)
- Practice-based learning or learning with a group of peers
- Personal learning and e-learning
- Feedback from teaching sessions
- Discussion with peers, mentors and practice-based teams

Embed continuing professional development (CPD) as a daily activity and have an understanding of how to do this by understanding your own learning style and the context of where you work.

A discussion with an appraiser or mentor will enable you to recognise not only your preferred learning style but also the best learning opportunities by subject. For instance, new NHS guidelines can be learnt through reading documents or attendance at a lecture, but the development of a new
system of care within a practice may best be done by learning and working with the practice team (see RCGP professional development guidance).

A good understanding of how you and others learn will help you not only in your own CPD but also enable you to help develop the whole team through practice-based or group learning.

**Academic work in general practice**

Many GPs wish to develop academic practice. This can be done through specific academic training posts, developed jointly by postgraduate/workforce deaneries and universities, or through becoming tutors in undergraduate medicine and developing academic research skills related to that. There are pathways for entering academic practice after getting your Certificate of Completion of Training (CCT), and you can get help through the RCGP (see links below).

**Work-based learning**

**In primary care**

Direct clinical contact will bring you many challenges in applying evidenced-based practice when faced with patients who prefer a more holistic approach to medicine and how it is delivered. Patients will feel confident in you as their GP if you have a sound knowledge base gained from understanding the findings from research papers, reviews and clinical guidelines. Learning from contact with patients is a prerequisite for good practice. Similarly many of your learning opportunities may come from significant event audits, audits performed in the practice or from audit data collected around the locality and used as a benchmarking tool to compare practice performance.

Also, working with research networks allows you as a doctor in general practice to get a sense of research governance and the principles of good research practice.

The principles of direct observation of clinical contact allow the learner to be fed back important messages around clinical management.

**In secondary care**

As a GP with a specialist interest there will be opportunities to learn skills and methods in a secondary care setting that could be applied back into primary care. With an evidence-based approach these skills could also be used to encourage those in secondary care to see the GP perspective. This may be relevant to a number of areas including prescribing, integrated models of care requiring primary to secondary care interfaces, and community-sited clinics with secondary care support.

**Self-directed learning**

Self-directed learning, reading journals, abstracts, reviews, editorials and teaching journals will provide you with many opportunities to learn and apply your knowledge as a GP. The use of e-learning modules such as the Essential Knowledge Updates provides opportunities to learn about new guidelines that have been produced, based on research evidence. Local audit group meetings may exist and provide opportunities to learn about audit. Similarly, findings from National Audit projects may also give you opportunities to learn.
Learning with other healthcare professionals

Primary care offers you the opportunity to learn from the many different professionals who work with general practitioners. The learning could of course be direct clinical contact such as with midwives in antenatal clinics or with health visitors in immunisation clinics. Opportunities also exist from reading correspondence carefully from other healthcare professionals. Other sources include in-house or locality-based educational programmes. The Gold Standard Framework offers the opportunity for many different staff to work together and understand each others’ perspectives.

Formal learning

There are many opportunities for formal learning open to you. These include attending research and update study days, which could be offered through RCGP faculties or local university Departments of General Practice. The Deaneries will offer updates and workshops for trainees and the local programme directors will assist in highlighting these.

Useful learning resources

Books and publications

- Department of Health and the Welsh Assembly Government. New academic training pathways for medical and dental graduates. A guide to programmes, starting on or after 1st August 2007)

Other reading

- Gray M. Evidence-based Healthcare and Public Health: how to make decisions about health services and public health London: Churchill Livingstone, 2009

Educational resources to develop teaching skills

• Ramani S. Twelve tips to promote excellence in medical teaching *Medical Teacher* 2006; 28(1):19–23
• Ramani S. Twelve tips for physical examination teaching *Medical Teacher* 2008; 30(9–10): 851–6
• Ten Cate O and Durning S. Peer teaching in medical education: twelve reasons to move from theory to practice *Medical Teacher* 2007; 29(6): 591–9
• Trowbridge RL. Twelve tips for teaching avoidance of diagnostic errors *Medical Teacher* 2008; 30(5): 496–500

**Web resources**

**BMJ learning**

Online learning, free for BMA members, some free access to all.  
[http://learning.bmj.com/learning/main.html](http://learning.bmj.com/learning/main.html)

**The Cochrane database of systematic reviews**

Database of systematic reviews that have reached the quality level set by Cochrane.  

**e-GP evidence-based practice modules**

e learning based on the GP curriculum and hosted by e learning for health.  
[www.e-GP.org](http://www.e-GP.org)

**Health talk online**

A collection of videos looking at patient and clinical experiences of health.  
[www.healthtalk.org](http://www.healthtalk.org)

**LeAD/e-GP modules on leadership and management**  

**NHS Evidence**

A comprehensive web-based portal managed by the National Institute for Health and Care Excellence, including links to many evidence-based healthcare resources and guidelines.  
[www.evidence.nhs.uk](http://www.evidence.nhs.uk)

**NHS Leadership Academy**

Source of online learning and resources that underpin the Healthcare Leadership Framework  
[www.leadershipacademy.nhs.uk/](http://www.leadershipacademy.nhs.uk/)

**PubMed**

A freely available version of Medline from the National Library of Medicine.  

**RCGP guidance on professional development**  
RCGP online learning environment (includes e-GP and LeAD)

e-GP and LEAD back up the curriculum, and provide online learning across most of the curriculum. LeAD is a specific elearning programme for clinicians in training on leadership, and can be accessed through the link on the eGP page and on the eLFH web site http://elearning.rcgp.org.uk

Quality and the Educational Supervisor’s Report elearning course - this course explains how to produce a good quality educational supervisor’s report (ESR) and gives practical tips on how to make the process easier. It also describes the benchmarking process for clinical encounters and how to decide whether a learning log is reflective.
Clinical Modules

The Clinical Modules (3.01 – 3.21) illustrate some of the areas of clinical practice you will encounter as a GP. These modules are intended as examples and should not be viewed as a complete list of every topic you will need to learn as a GP.

3.01 Healthy People: promoting health and preventing disease

Summary

- The optimal approach to the public’s health requires co-ordination of the three domains of public health: health improvement, health protection and healthcare services
- As a general practitioner (GP), you have a crucial role to play in promoting health, preventing disease, and delivering brief advice and interventions where appropriate
- Factors predisposing to poor health operate across the whole life course from pre-birth to old age
- Health inequalities are important determinants of health
- Screening and immunisation have risks as well as benefits
- Work offers an opportunity to promote health and well-being

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Understand your own capabilities and values, and be aware that your attitudes and feelings are important determinants of how you approach health rather than disease
- Recognise the importance of setting a personal example of healthy living by striving for a good balance between your work and your private life.

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.
This means that as a GP you should:

- Be able to explain to patients the need to prioritise healthcare provision, and at the same time minimize barriers to accessing care, within the context of the rising costs of delivering a National Health Service
- Understand the ethical aspects of prevention, presymptomatic diagnostics, asymptomatic therapy and factors that influence lifestyles
- Understand the importance of ethical tensions between the needs of the individual and the community, and act appropriately

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Know the ‘Stages of Change’ models for behaviour change
- Understand the concept of risk and be able to communicate risk effectively to patients and their families
- Be able to explain the benefits and risks of child immunisation and vaccination in order to reassure parents effectively
- Understand the effects of smoking, alcohol and drugs on patients and their families
- Negotiate a shared understanding of problems and their management (including self-management), so that patients are empowered to look after their own health and have a commitment to health promotion and self-care
- Encourage patients, their carers (and family when appropriate) to access further information and use patient support groups
- Explain to the patient and/or their relatives the evidence about a screening programme and debate whether it is worthwhile – for individuals or groups
- Explain the concept of the hierarchy of evidence to patients requesting Interventions Not Normally Funded (INNF)
- Be able to explain to patients the long-term impact on health of risk factors such as alcohol and substance misuse, poor diet, inadequate exercise and risky sexual behaviour

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Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Assess a healthy individual patient’s risk factors
- Understand the multiplicity of the determinants of good health
- Use routinely available data to understand the health of the local population, compare it with that of other populations, and identify localities or groups with poor health within it
- Understand the surveillance systems that GPs are involved in, such as the RCGP Weekly Returns Service

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Recognise and contend with the potential tension between your health promotion role as a GP and the patient’s own agenda
- Know the main risk and safeguarding factors for specific patient groups – for instance, frail elderly, children at risk of accidents, domestic and child children and young people at risk of abuse
- Critically appraise the health needs assessment of a target group or service

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Promote health through a health promotion or disease prevention programme
- Promote people with a disability in the workplace by encouraging and advocating disabled patients
- Promote the positive benefits of work and health to patients

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8 Dahlgren and Whitehead’s model of the social determinants of health, e.g. http://jech.bmj.com/content/64/4/284.full
• Promote return to work and rehabilitation after illness or accident
• Understand the concepts of promoting health and wellbeing, acknowledging that patients’ view of quality of life may differ

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:
• Promote self-care and empower patients and their families whenever appropriate
• Consider how to minimise the impact of the patient’s symptoms on his or her well-being by taking into account the patient’s personality, family, daily life and physical and social surroundings
• Understand approaches to behavioural change and their relevance to health promotion and self-care
• Be able to judge the point at which a patient will be receptive to the concept and the responsibilities of self-care

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:
• Work with other members of the primary healthcare team to promote health and well-being through appropriate health promotion and disease prevention strategies

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

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This means that as a GP you should:

- Seek to apply the same scientific discipline to elements of practice concerning healthy people as those who are sick
- Understand the evidence base that informs the effectiveness of interventions in healthy people and how these differ from the evidence base for treatments in those who are sick
- Link essential scientific aspects relating to healthy people to other examples in the RCGP Curriculum

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Engage in the implementation of locally agreed health programmes

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Demonstrate an understanding of the patient’s (and, where appropriate, the family’s) expectations and the community, social and cultural dimensions of their lives that affect their lifestyle choices
- Demonstrate tolerance and understanding of the patient’s experiences, beliefs, values and expectations regarding preventative medicine such as screening and lifestyle modification
- Understand the interaction between work and illness in patients
- Gain confidence in supporting patients with common illnesses to remain in work, or to return to a working role after illness where appropriate
- Understand the links between health and work, including the positive benefits of work on well-being
Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Understand the characteristics of the community in which you are working including socio-economic, ethnicity and health inequalities
- Assess the health needs of local populations and sub-groups, e.g. working families, ‘sedentary’ children, the elderly, the unemployed
- Appreciate the different perspective required in managing work and health issues (e.g. back pain, repetitive strain injury, anxiety) and the range of professionals who can help you support patients at work such as occupational health staff, physiotherapists and counsellors
- Realise the impact of overall GP workload on your ability to deliver health promotional care to well patients
- Consider whether the ethos of your workplace embraces preventive care and health promotion

Case discussion

Tracy Bennett, 47 years old, attends your surgery for a repeat blood pressure check following a pre-operative assessment for her forthcoming laparoscopic cholecystectomy. She was told that her smoking and ‘borderline’ blood pressure meant that the health risks were too high and her surgery would be deferred until it was under control.

Tracy is angry at the delay. She has been intermittently off work for four months, with some episodes certified as biliary colic and others self-certified, and this has affected relationships with the residential care home manager and her fellow care assistants. She is dismissive of her blood pressure as it has ‘never been high before’. She tells you that it was probably high because she is very worried about her family: her 25-year-old daughter Gemma has recently had her first cervical cancer screening test and been advised that she needs further investigation. Her daughter is reluctant to do this and is suffering from panic attacks when thinking about hospitals; Tracy’s mother has recently moved in because she is not coping with hip arthritis (her previous doctor had said that hip replacement surgery was risky owing to her frailty); and Tracy’s husband has been made redundant and has started drinking heavily – this was also a feature of their early relationship but had improved for some years until the redundancy.

As her GP you feel the priority at the initial consultation is to establish rapport and acknowledge Tracy’s anger, knowing that her engagement in self-help approaches will depend on her attitude. You observe that Tracy has a raised BMI and note from her computer records that she smokes 15
per day. Today’s blood pressure is 158/94. There is no previous record of giving lifestyle advice (e.g. through ‘brief interventions’).

You ask Tracy to prioritise her concerns. These are: to be deemed fit enough for surgery and to help her mother, whose health is deteriorating. She is also concerned about her daughter’s low mood since the cervical smear results. As a result, Tracy is now smoking heavily and her weight is ballooning.

After you explain how health risks accumulate from a poor lifestyle and how they influence many diseases, you explore Tracy’s perceived barriers to improving her lifestyle. She has always struggled with her weight, which makes her feel defensive, and is too busy to exercise. She smokes to cope with stress and feels she could not cope without smoking. Her poor relationships at work are making things worse.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong>&lt;br&gt;This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td>As Tracy’s GP, how important is it for me to role model a healthy lifestyle?</td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong>&lt;br&gt;This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td>What action should I take when a patient refuses to attend follow-up after a screening test?&lt;br&gt;How involved should I be in helping to resolve Tracy’s family problems; to what extent are they for her to resolve independently?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong>&lt;br&gt;This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>How do I secure her commitment to long-term changes to her lifestyle?&lt;br&gt;What social and lifestyle factors might I ask about?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>How do we reliably diagnose true hypertension, as</td>
</tr>
</tbody>
</table>

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10 Brief interventions and ‘Every Contact Counts’ give patients advice and encouragement to consider the positives and negatives of their lifestyle and habits, plus support and information for positive change. For further information, see [www.ncl.ac.uk/ihs/engagement/documents/trainingsession1.ppt](http://www.ncl.ac.uk/ihs/engagement/documents/trainingsession1.ppt) and [www.everycontactcounts.co.uk](http://www.everycontactcounts.co.uk)
<table>
<thead>
<tr>
<th><strong>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</strong></th>
<th>opposed to ‘white coat’ syndrome?</th>
</tr>
</thead>
</table>
| **Making decisions**  
This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice. | How do I assess whether or not a trial of lifestyle modification is worthwhile for mild hypertension?  
How could I support Tracy in deciding how to manage her stress? |
| **Clinical management**  
This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches. | What non-drug management options could Tracy consider?  
What techniques can I use to help patients manage anxiety about hospital investigations/procedures?  
What strategies do I know of for helping with weight reduction? |
| **Managing medical complexity**  
This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation. | How can structured care planning help to reduce risk and need for health services?  
What scope is there for a whole-family intervention to improve their overall health?  
What sources of support and advice could I offer to Tracy in her role as carer for other family members? |
| **Working with colleagues and in teams**  
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development. | How do GPs work with Public Health colleagues in managing the health of the population?  
What is the role of the practice nurse in encouraging healthy living? |
| **Maintaining performance, learning and teaching**  
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity. | What are the characteristics of a good screening programme?  
How quickly might lifestyle changes lower Tracey’s blood pressure levels? |
| **Organisational management and leadership**  
This is about the understanding of | How can I make changes to our practice's services to encourage self-care and healthy living? |
organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

What is the role of the GP as a commissioner or advisor to commissioners in facilitating independence?

Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

How might Tracy’s family circumstances influence her uptake of services and her engagement with lifestyle change?

Consider the disclosure that Tracy’s husband is drinking heavily again. What effect might this have on my management plan?

Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

What is my role as a GP in encouraging patients to participate in population screening programmes?

What is the role of the voluntary sector in my own practice community?

In my own practice community, what are the factors that encourage or inhibit older people from moving in with their children? What are the costs and benefits?

How to learn this area of practice

Work-based learning

In primary care

Primary care both inside and outside the practice is the ideal environment for you to learn about the principles of public health, to acquire the appropriate skills and to engage in their application. All three elements of public health (HI, HP and HCPH)¹¹ can be learnt in the practice setting.

Doctors are trained in diagnosing and managing disease, and the concept of health does not fit the traditional disease model, especially when dealing with individual patients. Primary care is the ideal environment to explore and become conversant with health and health promotion. As a GP trainee, you should be involved in your teaching practice’s public health, health promotion, prevention and screening activities, as part of the multiprofessional primary healthcare team.

You should arrange to visit your local public health team and your local health protection unit or local public health office (e.g. Public Health England or the equivalent organisation in the devolved nations) to meet the public health specialists and their teams to discuss the wider public health

¹¹ Health Improvement (HI), Health Protection (HP) and Health Care Public Health (HCPH) – see also Web Resources below, Faculty of Public Health
agenda. You may also be able to help with particular projects or undertake mini-sabbaticals or formal attachments.

**In secondary care**

All NHS Trusts and Healthcare Providers have to meet basic standards for promoting health as part of their registration with the Care Quality Commission (CQC). Most acute hospital boards have a public health strategy and action plan. While working in hospital placements you will find there are many opportunities for you to explore the public health agenda, particularly in the area of screening, e.g. breast screening services.

**Self-directed learning**

As a GP trainee you should have access to courses on public health issues provided locally as part of training programme activities or by postgraduate deaneries working with public health specialists and primary care organisations. Remember that voluntary organisations, schools and workplaces also contribute to maintaining health, both explicitly through projects and implicitly through their core business. You may also learn from your own personal involvement in such organisations in your role as a parent, volunteer or service user, or by visits and courses.

**Learning with other healthcare professionals**

Many opportunities exist in primary care for you to be involved with nurses, health visitors and public health specialists, all of whom should be engaged in the practice’s education and public health programmes.

**Formal learning**

The RCGP itself has developed some resources about public health as part of the Centre for Commissioning. The Faculty of Public Health is developing certificate courses for healthcare professionals from any discipline who wish to acquire recognised knowledge in this area. You will also find that several universities award post-graduate diplomas and Masters’ degrees in public health. These enhance specific areas of capability and develop essential features such as community orientation, taking a holistic approach and scientific features.

Clinical commissioning groups require an understanding of health and disease prevention in order to commission effectively. A range of providers offer educational resources. As a trainee you should take advantage of these to enhance your understanding of the curriculum.

**Useful learning resources**

**Books and publications**

- Black D (Chair of working group). *Inequalities in Health* London: DHSS, 1980
The Department of Health

The Department of Health or the relevant body in all parts of the UK has extensive information for patients and professionals on lifestyle advice, to inform and enable people to make positive changes through the systematic delivery of consistent and simple healthy lifestyle advice combined with appropriate signposting to lifestyle services; for example, the Every Contact Counts initiative and e-learning tool for the delivery of brief advice. www.everycontactcounts.co.uk

The Faculty of Public Health

The Faculty of Public Health is the standard-setting body for specialists in public health. It is a joint faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and
Glasgow). It was established as a registered charity in 1972. Its aims and charitable objectives are to promote, for the public benefit, the advancement of knowledge in the field of public health and to develop public health with a view to maintaining the highest possible standards of professional competence and practice, and to act as an authoritative body for consultation in matters of education or public interest concerning public health.  [www.fph.org.uk](http://www.fph.org.uk)

**The Health and Safety Executive**

The UK Health and Safety Executive website is an excellent central resource for doctors, patients and employers on all aspects of health and safety in the workplace. It is searchable by industry and occupational health problems.  [www.hse.gov.uk](http://www.hse.gov.uk)

**National Office for NHS Cancer Screening Programmes**

This site gives information about national screening programmes for breast and cervical cancer. It also provides information about screening for bowel and prostate cancer.  [www.cancerscreening.nhs.uk](http://www.cancerscreening.nhs.uk)

**NHS Immunisation Information**

The most comprehensive, up-to-date and accurate source of information on vaccines, disease and immunisation in the UK – an excellent site for both patients and health professionals.  [www.gov.uk/government/organisations/public-health-england/series/immunisation](http://www.gov.uk/government/organisations/public-health-england/series/immunisation)

**Picker Institute Europe**

Works with patients, professionals and policy-makers to promote understanding of the patient’s perspective at all levels of healthcare policy and practice. The aim of the organisation is to make patients’ views count through a combination of research, development and policy activities.  [www.pickereurope.org](http://www.pickereurope.org)

**Public Health England**

Public Health England is an Executive Agency of the Department of Health set up as part of the reorganisation of health services resulting from the Health and Social Care Act 20121. It took on the role of the Health Protection Agency, the National Treatment Agency for Substance Misuse and a number of other health bodies including Cancer Registries and Public Health Observatories.  [www.gov.uk/government/organisations/public-health-england](http://www.gov.uk/government/organisations/public-health-england)

**RCGP e-learning**

**e-GP**

e-GP includes sessions on screening, obesity, travel medicine, supporting self care, health e-working, and supporting carers  [www.e-GP.org](http://www.e-GP.org)

**Obesity and Malnutrition** is a 3 hour course, funded by Public Health England and delivered as part of the clinical priority of Nutrition for Health. It gives an outline of essential knowledge and basic skills in obesity management. Sessions include *Community Approaches to Obesity Prevention, Understanding Nutrition, Malnutrition and Hydration* and *Encouraging Weight loss Using Motivational Interviewing*.  

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You can access this course here - [http://elearning.rcgp.org.uk/obesity](http://elearning.rcgp.org.uk/obesity). It is free to all primary care professionals in the UK.

**Lipoedema – An Adipose Tissue Disorder** is a 30-minute course describing the presentation, pathophysiology, diagnosis and management of lipoedema in primary care. It was developed in partnership with Lipoedema UK and has been endorsed by RCN.

You can access this here - [http://elearning.rcgp.org.uk/lipoedema](http://elearning.rcgp.org.uk/lipoedema). It is free to all primary care professionals in the UK.

**Society of Occupational Medicine (SOM)**

SOM is the UK organisation for all doctors working in or with an interest in occupational health in the workplace, the armed forces and academic institutions. [www.som.org.uk](http://www.som.org.uk)

**UK National Screening Committee**

The UK National Screening Committee (NSC) is chaired by the Chief Medical Officer for Northern Ireland and advises ministers, the devolved national assemblies and the Scottish Parliament on all aspects of screening policy. It has a Fetal, Maternal and Child Health Co-ordinating Group (FMCH) that deals with antenatal and child health screening issues. In forming its proposals, the NSC draws on the latest research evidence and the skills of specially convened multidisciplinary expert groups, which always include patient and service user representatives.

The NSC assesses proposed new screening programmes against a set of internationally recognised criteria covering the condition, the test, the treatment options, and the effectiveness and acceptability of the screening programme. Assessing programmes in this way is intended to ensure that they do more good than harm at a reasonable cost. In 1996, the NHS was instructed not to introduce any new screening programmes until the NSC had reviewed their effectiveness. [www.screening.nhs.uk](http://www.screening.nhs.uk)
3.02 Genetics in Primary Care

Summary

- It has been estimated that at least one in ten of the patients seen in primary care has a disorder with a genetic component.

- There are three main themes of genetics in primary care: identifying patients with, or at risk of, a genetic condition; clinical management of genetic conditions; communicating genetic information.

- Taking and considering a genetic family history is a key skill in identifying families with Mendelian disorders and clusters of common conditions such as cancer, cardiovascular disease and diabetes.

- General practitioners (GPs) have a key role in identifying patients and families who would benefit from being referred to appropriate specialist genetic services.

- General practice plays a key part in discussing results from the antenatal and newborn screening programmes which are identifying carriers and people affected with genetic conditions.

- Information about genetic susceptibility in common conditions (currently being gathered through research studies) is likely to offer additional information about risk factors to aid management.

- Genomic information is currently being utilised in the stratified use of certain medicines.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Demonstrate an awareness of your professional limits in regard to managing genetic conditions and know when and where to seek advice.

- Demonstrate an ability to discuss information about genetic conditions in a non-directive, non-judgemental manner, ensuring that your own beliefs do not influence the content of the consultation and the management options offered to a patient.

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.
This means that as a GP you should:

- Demonstrate an awareness of the ethical issues that may arise, including confidentiality and non-disclosure of genetic information within families; genetic testing in children; the 'right not to know' and exercising care in the use of information (for instance in access to insurance or employment issues)
- Demonstrate an awareness of the different implications for other family members depending on the genetic cause of a condition (autosomal dominant and recessive and X-linked single-gene inheritance; de novo and inherited chromosomal anomalies; mitochondrial inheritance and somatic mutation)

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Demonstrate appropriate skills to communicate information and risk to patients about genetics in a comprehensible way with particular awareness of the need:
  - for confidentiality when information received from or about one individual can be used in a predictive manner for another family member in the same practice
  - to remain non-directive and non-judgemental
- Demonstrate an awareness of the potential emotional, psychological and social impacts of a genetic diagnosis on a patient and his or her family, particularly associated with guilt about ‘passing on’ a condition
- Demonstrate an awareness that a genetic diagnosis in an individual may have implications for the management of other family members who may ask for a consultation
- Demonstrate an awareness that consultations involving the giving of genetic information and discussion may require more time

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Be able to take and interpret a family history. This involves:
  - knowledge of relevant questions
  - knowledge of basic inheritance patterns (autosomal dominant and recessive, X-linked, mitochondrial, multifactorial)
understanding that while some genetic conditions always present with the same signs and symptoms, others can show variability between family members, particularly some autosomal dominant conditions (such as neurofibromatosis type 1)

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Be aware that variations in the human genome may have no effect, may lead to a predisposition to common diseases (such as coronary artery disease or cancer), or may result in serious conditions in a significant minority of your practice
- Demonstrate an awareness of the heterogeneity in genetic diseases and understand the principles of assessing genetic risk, e.g.
  - principles of risk estimates for family members of patients with Mendelian diseases
  - principles of recurrence risks for simple chromosome anomalies, e.g. trisomies
  - the use of information from susceptibility loci in common complex conditions
  - the ability to use online risk assessment tools as they become available
- Demonstrate an awareness of the different uses of genetic tests (diagnostic, predictive, carrier testing), their limitations and ethical considerations (for instance associated with testing in children and with presymptomatic testing)
- Demonstrate an awareness that it is not always possible to determine the:
  - cause of a condition (e.g. a learning disability) that may be genetic in origin
  - mutation responsible for a genetic condition
- Demonstrate an awareness of the genetic aspects of antenatal and newborn screening programmes (e.g. Down’s syndrome, cystic fibrosis, sickle cell and thalassaemia) and know their indications, uses and limitations, and from where to obtain information

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Describe how to identify patients with, or at risk of, a genetic condition through considering the family history and applying knowledge of inheritance patterns, or patients with diagnoses known to have a genetic cause
- Demonstrate an appreciation of the importance of identifying families with autosomal dominant conditions such as familial hypercholesterolaemia and polycystic kidney disease to ensure that affected family members receive appropriate treatment, and the importance of offering carrier
testing for families with autosomal recessive conditions such as sickle cell, thalassaemia or cystic fibrosis

- Describe the reproductive options available to those with a known genetic condition (including: having no children; adoption; gamete donation; prenatal diagnosis)
- Describe local and national referral guidelines (for instance, for a family history of breast or colon cancer)
- Describe how to access guidelines for managing patients with genetic conditions (such as familial hypercholesterolaemia or sickle cell disease)

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Demonstrate comprehensive management for those patients with, or at risk of, genetic conditions through co-ordination of care with other primary care professionals, geneticists and other appropriate specialists. This is particularly important because genetic conditions are often multisystem disorders
- Demonstrate an awareness that preventative measures or targeted treatments exist for some genetic conditions (for example: lifestyle interventions; mastectomy and/or oophorectomy for BRCA1/2 mutation carriers; colectomy for adenomatous polyposis coli (APC) mutation carriers; statin use for familial hypercholesterolaemia; venesection for haemochromatosis; losartan for patients with Marfan syndrome)

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Describe the organisation of genetics services and how to make appropriate referrals
- Describe the support services available for those with a genetic condition (e.g. Contact a Family)
Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Demonstrate an awareness that genetics is a rapidly evolving area. It is therefore important that you keep up to date with clinical advances and their implications on ethical debate and service planning, particularly how genomic information can contribute to risk factors in common conditions and the personalisation of management through stratified use of medicines.

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Demonstrate an awareness of the need to ensure that systems are in place to follow up patients who have, or are at risk of, a genetic condition and have chosen to undergo regular surveillance (for example: imaging for breast cancer and for adult polycystic kidney disease; or endoscopy for colon cancer).

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Demonstrate an awareness that a patient’s cultural and religious background and beliefs concerning inheritance and genetics are important to consider in providing care for people and families with, or at risk of, genetic conditions. An example of a belief concerning inheritance is that a particular genetic disease in a family is linked with a particular physical appearance.

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.
This means that as a GP you should:

- Demonstrate an awareness that the makeup of the local population may affect the prevalence of genetic conditions and attitudes towards genetic disease

**Case discussion**

Adrian, a healthy 44-year-old man, is concerned about developing cancer because his father was diagnosed with bowel cancer at the age of 45, and died at the age of 48. As this seemed a very early age for Adrian’s father to have cancer, the general practitioner asked if anyone else in the family had cancer.

Adrian said that his paternal grandmother also died from bowel cancer in her 60s, as did one of his father’s sisters in her 50s. Another sister (Diana) had a cancer in her early 50s, which was treated by hysterectomy. She is now well and in her mid-60s.

The general practitioner checked the guidelines on the local Regional Genetics Centre website and saw that such a cluster may suggest an underlying inherited predisposition. The GP referred Adrian to the clinical genetics service. A genetic counsellor telephoned him and took a more detailed family history. The genetics service then checked the histological diagnoses in the cancer registry and found that his aunt had had endometrial cancer.

Adrian saw a consultant clinical geneticist who explained that the family pattern could be consistent with one of the family cancer syndromes inherited in an autosomal dominant manner. The geneticist felt that it might be helpful to ask if Adrian’s aunt Diana would be seen in the genetic clinic to discuss the possibility of giving a blood sample to see if a mutation could be found in a particular gene. The consultant also recommended that Adrian be referred for colonoscopy.

Adrian’s aunt Diana was also one of the GP’s patients. She agreed to see the genetics service and that her results could be shared with her family. A test revealed a pathogenic mutation in the MSH2 gene, which predisposes to bowel and endometrial cancer. Diana went to see her GP to discuss the fact that the genetics service had recommended screening by colonoscopy. She was concerned because she thought the treatment for her ‘cancer of the womb’ had been the end of the matter.

Adrian decided to be tested to see whether he had inherited the mutation. However, while waiting for the result he became concerned about how best to explain the findings to the rest of his family, and particularly any implications for his two children. He discussed these concerns with his GP, whom he asked to review autosomal dominant inheritance with him, and the contents of the letter from the regional genetics service.

Adrian was delighted to find that he had not inherited the MSH2 mutation and therefore had the same probability as anyone else in the population of developing bowel cancer. During a subsequent consultation for another matter, Adrian mentioned that although he was pleased that his children would not be at risk, he did feel guilty that he had been ‘the lucky one’ in the family. He had also originally interpreted the fact that he had not inherited the mutation to mean he had no risk of bowel cancer, so his GP stressed that it would be wise to take part in the population screening for colorectal cancer at the appropriate age.
### Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How do my own views and experience influence the way I share information about genetic tests and results, in particular those that may impact on the wider family?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>What potential ethical dilemmas could such a case present, and how would I address them?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td></td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>How can I, as a GP, communicate the risk of various common patterns of genetic inheritance in simple language to the patients and their families?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>What do I need to be mindful of when giving any information relating to a genetic disorder?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What tools are available to GPs to recognise and stratify patients with potential genetic cancers?</td>
</tr>
<tr>
<td>This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
<td>How can I recognise individuals or families at the highest risk of genetic conditions?</td>
</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>What are the best ways of taking, recording and interpreting a genetic family history?</td>
</tr>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
<td>When am I likely to refer patients to secondary care?</td>
</tr>
<tr>
<td><strong>Clinical management</strong></td>
<td>What guidelines exist to guide my management of people with genetic conditions?</td>
</tr>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
<td></td>
</tr>
</tbody>
</table>
### Managing medical complexity
This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

- **What roles should the GP play in referral, and in the co-**
  **ordination of screening and management in this family?**
- **What other sources of advice and support are available to GPs?**

### Working with colleagues and in teams
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

- **How can GPs work with the local genetics department to facilitate a seamless transfer of information in both directions?**
- **How can the practice work as a team to ensure that patients with identified cancer predisposition are not lost to follow ups?**

### Maintaining performance, learning and teaching
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.

- **How can I ensure that information for my patients about the availability of genetic tests and targeted management is up to date?**
- **How do I keep myself updated about new developments in genetics?**
- **Where can I access quick and reliable information about any query regarding a genetic disorder?**

### Organisational management and leadership
This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

- **What are the Read codes for recording a family history of cancers or any other genetic disorder?**
- **What systems are in place to follow up patients who have, or are at risk of, a genetic condition and have chosen to undergo regular surveillance?**

### Practising holistically and promoting health
This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

- **Why might the person who was found not to have inherited a predisposition feel so guilty?**
Community orientation
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

How would the views of the local community towards genetics and screening impact on the ways in which the family are likely to take up services?

Where are the local genetic departments and are there any agreed local protocols for referrals?

How to learn this area of practice

Work-based learning

In primary care

As a GP trainee, primary care is the ideal setting for you to learn about genetics because of the family-based focus and opportunities for staged counselling.

Learning opportunities which present during consultations include: how to recognise conditions with a genetic component; the appropriate management of the genetic implications for the individual and the family, particularly where there are ethical, social and legal issues; and referring patients appropriately to specialist services. As many common conditions seen in primary care are multifactorial, with a genetic component – including cancer, diabetes and heart disease – these can contribute to a developing awareness of how genetic components can affect disease.

Many of the skills required for management of families with conditions with a genetic component are part of the core skills of a general practitioner, and will be consolidated through reflective practice and discussion with your GP trainer. You should also supplement your counselling and management skills with the theoretical knowledge outlined in the ‘knowledge base’ in this statement.

In secondary care

GP trainees with a particular interest in genetics may also wish to take up the opportunity to learn from consultant geneticists and genetic counsellors working in regional specialist genetics services. This should include developing your understanding of the genetic counselling process, diagnosis and management of genetic conditions, and reproductive options including prenatal diagnosis for at-risk couples.

Useful learning resources

Books and publications

- Harper PS. Practical Genetic Counselling London: Hodder Arnold, 2010
Web resources

*Genetics in Practice:*

**Taking a genetic family history**

The NHS National Genetics and Genomics Education Centre website has a number of resources designed around taking and drawing a family history, including a series of factsheets, pedigree drawing exercises and videos. In addition, the website contains information about core concepts in genetics, information about genetic conditions and an extensive knowledge base of genetic terms.

[www.geneticseducation.nhs.uk](http://www.geneticseducation.nhs.uk)

**Information for families:**

*Contact a Family*

Contact a Family is a UK-wide charity that provides advice, information and support to parents who have a child with a disability. [www.cafamily.org.uk](http://www.cafamily.org.uk)

*Unique*

Unique is a UK-based charity which provides information and support to both families and individuals affected by rare chromosomal conditions, as well as the health professionals involved in providing ongoing medical management and care. [www.rarechromo.org](http://www.rarechromo.org)

*Genetics education for primary care physicians:*

*e-GP*

The e-GP course on Genetics in Primary Care includes topics such as taking, drawing and interpreting genetic family histories, communicating genetic information and managing and referring patients. [www.e-GP.org](http://www.e-GP.org)

**Screening:**

*UK National Screening Committee*

This webpage give access to all the UK screening programmes, including the antenatal and newborn and cancer programmes. [www.screening.nhs.uk](http://www.screening.nhs.uk)
3.03 Care of Acutely Ill People

Summary

As a general practitioner (GP) you must:

- Recognise the signs of illnesses and conditions that require urgent intervention
- Work effectively in teams and co-ordinate care
- Prioritise problems and establish a differential diagnosis
- Make the patient’s safety a priority
- Consider the appropriateness of interventions according to the patient’s wishes, the severity of the illness and any chronic or co-morbid diseases
- Be able to make mental state assessments and ensure the safety of others
- Accept responsibility for your actions, at the same time recognising any need for involving more experienced personnel
- Keep your resuscitation skills up to date – this would normally involve a yearly certified resuscitation course
- Act calmly in emergency situations and follow agreed protocols
- Know the processes and arrangements for commissioning and delivering urgent and unscheduled care in your community
- Be aware of how the management of patients with continuing conditions affects the need to give urgent and unscheduled care

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Know the GMC requirements as set out in Good Medical Practice and Good Medical Practice for GPs
- Ensure that if you feel you are not able to provide effective care because of personal circumstances (such as illness), particularly in more stressful environments such as out of hours, that you inform the organisation so that alternative arrangements can be made to ensure patient safety
• Know your ability and capacity to work under pressure, and how to manage yourself effectively and appropriately with regard to:
  o Time management
  o Heightened emotion
  o Prioritisation and decision-making
  o Relaxation and rest

**Core Competence: Maintaining an ethical approach**

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

• Have an awareness of your own beliefs, ethical system and attitudes towards the care of patient
• Be aware of other models of belief, ethical systems and attitudes that patients and their relatives and carers may hold
• Ensure that your beliefs and attitudes do not compromise the delivery of effective and safe care to all patients or appropriate professional decisions in relation to patients, their families and carers
• Manage the difference between what you think is an appropriate medical course of action and the course of action desired by patients, their relatives and their carers
  o This is particularly important for patients receiving palliative or end-of-life care (see also statement 3.09 End-of-Life Care)
  o Some patients may make frequent contact for unscheduled care that is often unnecessary (e.g. because of a disorganised lifestyle)
• Be aware of equality and diversity legislation and have a positive and respectful attitude to the other healthcare professionals and colleagues with whom you will be working
  o This is particularly important in the out-of-hours context where you may be working with individuals you have not met before on each session
• Demonstrate knowledge of the legal frameworks affecting acute healthcare provision, especially regarding compulsory admission and treatment – in particular, knowledge of the Mental Health Act and how to access the information and guidance for this
• Understand the ethical and professional guidance relating to managing conflicts of interest between patients who are acutely ill and relatives, carers and other healthcare professionals

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.
This means that as a GP you should:

- Communicate effectively with patients, relatives and carers over the telephone in order to accurately assess a patient who is acutely ill
- Understand the ways in which the acute illness itself and the emotions caused by it can affect the communication between the doctor and the patient
- Understand how to acknowledge and maintain patients’ autonomy when they are acutely ill and in situations where the doctor and others may need to make significant decisions on behalf of the patient
- Understand how continuity of care for an individual patient undergoing an episode of acute illness can be maintained in all contexts
- Understand the ways in which patients from different cultures and social backgrounds may interpret and report symptoms of acute illness
- Communicate sensitively and professionally with seriously, acutely ill patients who may not wish to follow appropriate medical advice

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Know the symptoms, signs and presentation of common severe illnesses
- Understand the ways in which different individuals place emphasis on different symptoms and the significance of their acute illness
- Know the symptoms and signs of severe illnesses that may be also be produced by other less severe illnesses and ensure that effective processes are in place to avoid missing those severe illnesses when not obvious at initial presentation, e.g. viral symptoms in a child should not exclude your recognising possible meningococcal infection
- Use different modes of communication – such as closed and specific questions eliciting a yes/no response – as appropriate to the out-of-hours context and where the patient’s situation requires urgent action
- Know the main and common differential diagnoses for each presenting symptom of a patient who is acutely ill

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.
This means that as a GP you should:

- Determine whether urgent action is necessary for patients who are acutely ill to ensure correct and timely treatment and to ensure that patients with similar symptoms for whom urgent treatment is not needed are protected from the potential harm of unnecessary investigations and/or therapeutic interventions
- Take responsibility for a decision to admit an acutely ill person and not be unduly influenced by others, such as secondary care doctors who have not assessed the patient
- Understand:
  - when just giving advice to a patient or their relative/carer is sufficient and appropriate in order to manage the patient and the situation
  - when further assessment is necessary and when and where that should be carried out
  - when other healthcare professionals should be involved (e.g. ambulance service, paramedics, community nurses)
- Use timely review of acutely ill patients in order to monitor their condition and determine changes to your initial management plans
- Inform patients and offer appropriate explanations for any new symptoms, signs or changes in an existing condition that patients/carers should report back to you so that no serious conditions are missed (‘safety-netting’)
- Determine whether the older adult patient with an acute presentation needs predominantly social care or medical care, or a combination of both

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Recognise the importance of knowing the protocols for managing specific acute illnesses. These include the management of acute asthma, chest pain that could be cardiac in origin, stroke pathways, the management of possible deep vein thrombosis
- Know how age, gender, ethnicity and the presence of other conditions may alter the presentation of symptoms and signs of severe illness (this is particularly important for presentations in very young and very old patients)
- Manage patients in the out-of-hours context without access to their normal medical records or previous knowledge of them
- Recognise those illnesses where immediate action is needed to reduce death and/or significant morbidity
- Know when it is safe and appropriate to manage a patient in the community and when the patient needs to be referred to hospital for assessment or admission
- Recognise the signs of death and how to assess for these
- Know what you are required to do legally and appropriately following your diagnosis of sudden death of a patient, both expected and unexpected
- Be able to make complex ethical decisions and show sensitivity to a patient’s wishes in the planning of care
- Be aware of the need to maintain safety for individuals at all times (see also statement 2.02 Patient Safety and Quality of Care)
- Know how to diagnose and manage cardiovascular emergencies including interpreting an ECG and performing CPR
- Know how to manage acute respiratory problems, such as asthma
- Know how to manage acute arterial bleeding

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:
- Understand where the presentation of an acute illness is related to an underlying chronic illness and recognise that an acute illness may be an acute exacerbation of a chronic disease
- Know how the presence of underlying disease or long-term conditions and risk factors (e.g. hypertension, smoking) influences the incidence and presentation of acute illnesses
- Know how social and lifestyle factors influence the incidence and presentation of acute illnesses, e.g. delayed presentation – and mental stress – in cultures where it is considered ‘inappropriate’ to have certain illnesses; or acute illness from omitting medication during religious fasting
- Identify co-morbid diseases
- Describe the modifying effect of chronic or co-morbid disease and its treatment on the presentation of acute illness
- Recognise those patients who are likely to need acute care and offer them advice on prevention, effective self-management and when and who to call for help, e.g. the patient who lives alone or has a mental health problem
- Understand how the needs of others close to the patient (e.g. family members, carers) can be addressed appropriately

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying
leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Understand the roles of different members of the primary care team in managing patients who present, or request help, urgently during the day
- Understand the roles of different organisations and professionals who provide unscheduled care for patients both in and out of hours
- Co-ordinate care with other professionals in primary care and with other specialists
- Understand the ways in which patients can access urgent care in general practice during the day (in hours)
- Understand how the management of patients with chronic conditions in general practice influences the presentation of these patients to urgent and unscheduled care and their admission to secondary care services

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand how to access and use clinical decision support systems (e.g. algorithms for the management of suspected deep vein thrombosis, management of variations from the normal range of INR readings in patients who are anticoagulated, and changes in therapy for patients who have worsening asthma). You should also know how to make your interventions evidence-based, e.g. through resources such as the Cochrane Library database, or National Institute for Health and Care Excellence (NICE) guidance
- Be aware of how to access practice protocols and how these may be used appropriately in differing circumstances. You also need to demonstrate an understanding of the protocols that are available from national bodies (e.g. the British Thoracic Society asthma guidelines) and how these may be used appropriately in differing circumstances and for different individuals
- Evaluate how well you care for the acutely ill person, including significant event analyses, and take appropriate action
- Ensure that you record your learning activities whilst undertaking out-of-hours work, in order to demonstrate the achievement of learning goals and to provide further goals for your appropriate personal development plan
• Be aware of how to access and use the COGPED guidance for out-of-hours experience in GP training\(^\text{12}\)

• Understand the importance of analysing significant and untoward events relating to acutely ill patients that you, the OOH provider or the training practice may be involved in, both in and out-of-hours, and ensure that you are actively involved for the benefit of both the team and the organisation, and for your own, personal development

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Be aware of the organisational need to ensure processes and procedures are in place to ensure patient safety (i.e. clinical governance, quality control and management processes)
- Provide clear leadership, demonstrating an understanding of the team approach to care of the acutely ill and the roles of the practice staff in managing patients and relatives
- Know the requirements for effective continuity of care in the out-of-hours (OOH) setting and understand your responsibility to provide appropriate documentation and records of any patient contact, which must be handed over to the next professional who will be involved with that patient
- Know the arrangements for providing unscheduled and emergency care, both in and out of hours in the locality in which you are working
- Know the administrative and operating processes for any out-of-hours organisation in which you will be working, and ensure you have this knowledge (e.g. by appropriate induction) before working there. This includes understanding:
  - The appropriate information technology (IT)
  - The process for recording and transmitting information about patients and the outcomes of any contact with them
  - The communication systems within and without any out-of-hours organisation
  - The process for organising and booking any working sessions or shifts you will be having with the out-of-hours organisation
- Understand the information that OOH providers use to audit and map the service that they provide (e.g. the RCGP Urgent and Emergency Care Toolkit)
- Know the process by which you can give effective feedback to the out-of-hours organisation in which you have worked and trained, and ensure that you give this

\(^{12}\) COGPED (Committee of General Practice Education Directors), [www.cogped.org.uk](http://www.cogped.org.uk)
Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Know how presentations of acute illness are described and recorded by different patients and what this may mean for their understanding of what this means to them, and how it will affect their life in the future
- Know how the emotional impact of an acute illness on a patient may not equal the severity of the medical problem (i.e. some individuals may be very upset over minor illnesses and some may have little apparent emotional response to a significant and severe illness)
- Be aware of the different beliefs that different patients may have with regard to the cause and meaning of acute illnesses and how this may affect their ability to manage the immediate and longer term consequences of that illness
- Demonstrate an awareness of the important technical and pastoral support that a GP needs to provide to patients and carers at times of crisis or bereavement including certification of illness or death
- Demonstrate an awareness of cultural and other factors that might affect patient management
- Be aware of how different communities respond to and manage episodes of acute illness
- Be aware of the varying beliefs that patients have about the need to ask for medical help with regard to similar symptoms

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Know the factors that may determine patient responses to the acute presentation of illness within the community/communities that you will be responsible for, both in and out of hours (e.g. rural/urban, ethnic variation, presence of immigrant communities, mobile population, social demographics)
- Understand the factors that affect the demand for OOH and unscheduled primary care in different communities, and at different times of the day and the year
- Know the type of healthcare resources available, both in the community and in secondary care, in order to organise effective care in the most appropriate location for patients who present with urgent healthcare needs
- Know which other resources for help and care within the community are accessible to patients, and their relatives or carers, in order to manage the presentation of an urgent situation
- Know how to communicate effectively with patients, relatives and carers, who may make inappropriate and frequent demands on the health service, and what strategies to use to allow them to manage their problems more effectively
- Be aware of the differences between resources to manage patients in hours and out of hours and how you can appropriately alter your style of working to manage patients safely and effectively in both contexts (see also module 2.02 Patient Safety and Quality of Care)

**Case discussion**

You are undertaking a shift at the out-of-hours centre and take a phone call from a parent who is very worried about their 4-year-old daughter. Lisa is listless, not eating or drinking and feels very hot.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>Would my approach to the management of this child differ at different times of the day (e.g. the call was at lunchtime/midnight, or at the start of my shift/at the end of my shift)? If so, why?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>Do I think that a doctor who is a parent would manage this situation differently from a doctor who has, or has had, no children? What are my attitudes towards parents and families of a different social class or general educational achievement to my own?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td></td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>What skills do I need to consult effectively on the telephone?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>If I need to examine the child but the parents are reluctant to bring Lisa to see me, how would I deal with this?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What other factors do I need to know about the child? What other information about the family would be useful?</td>
</tr>
<tr>
<td>This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
</tr>
<tr>
<td><strong>Clinical management</strong></td>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
</tr>
<tr>
<td><strong>Working with colleagues and in teams</strong></td>
<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
</tr>
<tr>
<td><strong>Maintaining performance, learning and teaching</strong></td>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
</tr>
<tr>
<td><strong>Organisational management and leadership</strong></td>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
</tr>
<tr>
<td><strong>Practising holistically and promoting health</strong></td>
<td>This is about the physical, psychological,</td>
</tr>
</tbody>
</table>
socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

<table>
<thead>
<tr>
<th>Community orientation</th>
<th>How do I include the parents in the management of this situation? What questions would I ask?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
<td></td>
</tr>
</tbody>
</table>

How to learn this area of practice

Work-based learning

In primary care

As a GP specialty trainee you must gain experience in emergency care, which is a feature of both in-hours and out-of-hours work. Because there are particular features of the out-of-hours period that require a specific educational focus, such as isolation, the relative lack of supporting services and the need for proper self-care, it is important that you spend time in the out-of-hours primary care work environment.

During your training you should work in the local out-of-hours service, under supervision, in order to gain competence and confidence in delivery of these services. You should be supported by your GP trainer, who should make arrangements as part of your initial educational planning for your sessions with the out-of-hours service provider. This should follow an evaluation of your level of knowledge, skills and learning needs.

There are a number of organisations involved in the delivery of primary care out-of-hours services, including GP co-ops, commercial deputising services, NHS Direct, NHS 24, nurse triage, minor injury centres, primary care walk-in centres, accident and emergency departments and some remaining individual practices and practitioners. The model of service provided varies, but there will be a need for partnership and collaboration between all agencies at the local level. As part of your training programme, you need exposure to a variety of community-based emergency and out-of-hours models.

Example: Consultations with patients presenting urgently in general practice, observed consultations, recorded consultations and material for use for COT and CBD.

In secondary care

The hospital environment is the ideal setting for you to see concentrated groups of acutely ill children and adults. All doctors entering general practice training programmes will have acquired the competences in acute care laid down in the Foundation Programme Curriculum. Many doctors will have acquired additional competences during their hospital training, before entering GP training.
Some GP training programmes will contain placements of varying length in acute medicine and in accident and emergency departments that are ideal environments for learning about acutely ill people and their management. While you will have learnt cardiopulmonary resuscitation skills in the Foundation Programme or equivalent, it is important to maintain these skills once in practice. Hospital resuscitation departments are excellent learning resources for you to keep up to date with these skills.

**Self-directed learning**

All GP trainees and GPs should have access to cardiopulmonary resuscitation courses and learning resources to help them address their learning needs.

**Learning with other healthcare professionals**

Teamwork is essential for the effective management of acutely ill patients in primary and secondary care. In primary care, it is vital that all members of the primary healthcare team understand their roles in managing acutely ill patients and contribute to the development of practice guidelines.

Acute events are an important source of material for significant event analyses and team members should be encouraged to participate in these and learn from them at both the individual and team level. Working in the out-of-hours environment will help the specialty registrar gain valuable experience of working and learning in multiprofessional settings, which will include GPs, nurses, paramedics, accident and emergency staff, etc.

Example: Observing nurse practitioners triaging patients; undertaking home visits with paramedics.

**Formal learning**

Examples of formal learning are OOH induction processes, telephone consulting skills courses and e-learning opportunities.

**Useful learning resources**

**Books and publications**

- Committee of General Practice Education Directors. *Out of Hours (OOH) Training for GP Specialty Registrars* London: COGPED, revised 2010


**Web resources**


Guidance for Commissioning Integrated Urgent and Emergency Care – a whole system approach

This is a very useful comprehensive review of the models of delivery of urgent and unscheduled care in the UK and the data associated with these. It provides an understanding of the factors that GPs need to account for when involved in commissioning these services. [www.rcgp.org.uk/revalidation-and-cpd/centre-for-commissioning/~/media/Files/CfC/CfC-Urgent-Emergency-Care.ashx](http://www.rcgp.org.uk/revalidation-and-cpd/centre-for-commissioning/~/media/Files/CfC/CfC-Urgent-Emergency-Care.ashx)

Royal College of General Practitioners

e-GP includes a course on trauma, covering topics such as basic life support, managing major incidents, burns and scalds, limb and head injuries and sports injuries. [www.e-gp.org](http://www.e-gp.org)

Resources on urgent and emergency care are also available at: [www.rcgp.org.uk/clinical-and-research/clinical-resources/urgent-and-emergency-care.aspx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/urgent-and-emergency-care.aspx)
3.04 Care of Children and Young People

Summary

- As a general practitioner (GP) you have an important role in the care of children and young people.
- Most healthcare for children and young people is delivered outside the hospital setting.
- Patients under 15 years of age comprise around 20% of the average GP list and account for one in four GP consultations.
- School children visit the GP between two and three times a year, but this figure is doubled in the under-fives (who visit the GP an average of six times per year).\(^\text{13}\)
- A child’s and young person’s experiences in early life – and even before birth – have a crucial impact on their adult health and life chances.
- There is an opportunity to promote health in all contacts with children, young people and families, and this should be targeted particularly at the vulnerable and socially excluded.\(^\text{14}\)
- All general practitioners need to be competent in dealing with safeguarding matters concerning children.
- GPs should be able to recognise the support needs of those children and young people who care for others.
- General practitioners should recognise and respond to the needs of children and young people in special circumstances, through referral and joint working.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Show respect for the sensitivities of young people regarding their health attitudes, behaviours and needs.

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\(^\text{13}\) Van Dorp F. Consultations with children InnovAiT 2011; 4(7): 54–61

• Describe the principles of child-focussed clinical governance and risk management such as safety of treatment and care, safeguarding, the use of evidence-based practice, clinical audit, effective prescribing and referrals

• Safeguard children and young people, understanding that:
  o The welfare of the child and young person must be the paramount consideration  
  o In dealing with vulnerable children and young people, a focus on the family risks losing sight of the child
  o Often children and young people in special circumstances are ‘invisible’ to the system because they live in the shadow of their parents’ problems
  o Dealing effectively with maltreatment of children and young people involves recognising the clinical features, knowing about local arrangements for child protection, referring effectively and playing a part in assessment and continuing management, including prevention of further abuse
  o Child abuse can take many forms such as physical abuse, emotional abuse, sexual abuse and exploitation, and neglect

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

• Be aware of the impact of your attitudes to treating children and young people equitably, with respect for their beliefs, preferences, dignity and rights
• Understand how to manage the issues of confidentiality and consent
• Be aware of how and when you share information with other agencies

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

• Develop and apply the primary care consultation to bring about an effective doctor–patient–family relationship to enable parents or carers, children and young people to:
  o Participate in their own care-planning and delivery

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15 Children in Scotland. The paramountcy principle, embodied in (i) 1989 Children Act: ‘When a court determines any question with respect to … the upbringing of a child … the child’s welfare shall be the court’s paramount consideration’ and also (ii) the Children (Scotland) Act 1995
Be routinely involved and supported in making informed decisions and choices about care, taking into account age and development, increasing autonomy with age, and the need for confidentiality balanced with the parents’ need for information.

Achieve concordance, including active listening and shared decision-making with you as their GP.

Receive information on medicines in a clear way that is appropriate to their understanding as children, young people and parents.

- Provide longitudinal continuity of care as determined by the needs of the patient and family:
  - Understanding the problems with transitions from child to adolescent, and from adolescent to adult. This applies to all children but especially the vulnerable.

- Manage primary contact with children and their families – and, with older children, on their own.

- Support young people with a chronic disease and their parents to negotiate the process of transition.

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Manage conditions and problems which may present early and in an undifferentiated way, and recognise a seriously ill child (and intervene urgently when necessary) by:
  - Having a thorough understanding of normal development, and being able to recognise delayed development through childhood and adolescence.
  - Recognising normal growth, and dealing with faltering growth and failure to thrive.
  - Recognising children and young people who are at risk in some way, whether physically, mentally or emotionally.
  - Being aware that consultations about children may be a presentation of a mother’s postnatal depression; and being aware of the effect that postnatal depression may have on her children.
  - Recognising the significance of non-attending.
  - Showing concern and following up when children and young people fail to attend appointments (in primary or secondary care), given that they are reliant on their parent or carer to take them to the appointment.
  - Being conscious that failure to attend can be an indicator of a family’s vulnerability, potentially placing the child’s welfare in jeopardy.
  - Acknowledging that failure to attend can be an indicator that services are difficult for families and young people to access or considered inappropriate, and need reviewing.
Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Use a decision-making process determined by the prevalence and incidence of illness in the community and the specific circumstances of the patient and family:
  - Being aware of normal growth and development in children and young people
  - Being aware of neonatal problems including jaundice and feeding problems, breastfeeding and nutrition
- Ensure that parents or carers, children and young people receive information, advice and support to enable them to:
  - Manage minor illnesses themselves, using community pharmacists and triage services where appropriate
  - Access appropriate services when necessary
  - Have shared responsibility for self-care of chronic conditions and exacerbations
  - Use repeat prescribing and reviews appropriately
  - Access support groups

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Manage and appropriately treat common and rare but important paediatric conditions encountered in primary care, such as:
  - Neonatal problems: e.g. birthmarks, feeding problems, heart murmurs, sticky eye, jaundice
  - Constipation, abdominal pain (acute and recurrent)
  - Pyrexia, febrile convulsions
  - Cough/dyspnoea, wheezing including respiratory infections, bronchiolitis
  - Otitis media
  - Sensory deficit, especially deafness
  - Gastroenteritis
  - Viral exanthems
  - Urinary tract infection
  - Meningitis
  - Epilepsy
Chronic disease: e.g. asthma, diabetes, arthritis, palliative conditions such as neurological disorders, and intellectual disability (see also statement 3.11 Care of People with Intellectual Disability)

Non-accidental injury, maltreatment and neglect

Mental health problems such as attention deficit hyperactivity disorder (ADHD), depression, eating disorders, substance misuse and self-harm, autistic spectrum disorder and related conditions (see also statements 3.10 Care of People with Mental Health Problems and 3.14 Care of People who Misuse Drugs and Alcohol)

Psychological problems: e.g. enuresis, encopresis, bullying, school refusal, behaviour problems including tantrums

Assessment of child and young person development (physical and psychological)

- Be aware of the early presenting symptoms of childhood cancers and possible differentials, e.g. retinoblastoma, leukaemia, medulloblastoma, Wilms tumour

- Appropriately manage common symptoms like vomiting, drowsiness, developmental delay, infantile colic, ‘failure to thrive’ and growth disorders, behavioural problems, obesity

- Prescribe and advise appropriately about the use of medicines in children and young people, being competent at:
  - Calculating drug doses
  - Understanding the risks and benefits of medicines in relation to children
  - Understanding the needs of ethnic minorities, and cultural differences in beliefs about illness and the use of medicines

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Manage simultaneously both acute and chronic problems in the child, young person and family by:
  - Assessing children and young people’s developmental needs in the context of their family and environmental factors including school and community, and parenting capacity
  - Understanding the key vulnerability factors for children and young people in special circumstances, such as illness in the family, and responding to their needs, including through referral and joint working
  - Recognising inequalities and ethnic diversity, and addressing them proactively

- Recognise inappropriate eating habits such as the development of anorexia nervosa, bulimia or morbid obesity and make appropriate referrals if specialist help is required

- Recognise the importance of supporting parents who have special needs
• Recognise the needs of children of parents with substance or alcohol misuse, mental health or domestic violence and abuse problems; parents who are teenagers; and parents with severe chronic or short-term conditions that affect their capacity to look after their children. Some families may need referral for multiagency assessment and support services: this may include referral to the health visitor for a comprehensive family needs assessment to understand and address the impact of the parents’ needs on the children’s health and development.

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

• Demonstrate an understanding of the importance of multiagency working (working across professional and agency boundaries) and the principles of information sharing
• Co-ordinate care with other primary care professionals, paediatricians and other appropriate specialists, leading to effective and appropriate care provision, taking an advocacy position for the patient or family when needed, including for palliative and end-of-life care

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

• Maintain your knowledge and skills in the examination of the newborn child and the six-week check
• Be familiar with and access the best evidence about clinical management and prescribing of medicines for children
• Use significant event meetings and audit as tools with which to reflect on your clinical practice in children
• Use appraisal and your personal development plan in developing a clinical area of interest or refining existing skills
• Reflect on case-based discussions around child health and the identification of learning needs
• Reflect on this curriculum at regular intervals during your GP training and after qualification
• Reflect on aspects of protecting children and attend training
Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Describe the issues involved in delivering services for young people relating to access, communication, confidentiality and consent
- Provide access for young people to confidential contraceptive and sexual health advice services that are tailored to meet their needs

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Demonstrate an understanding of the welfare of the unborn baby by:
  - Being aware of the impact of parental problems including domestic violence and abuse, substance and alcohol misuse and mental health problems
  - Being able to recognise the symptoms and presentations of such problems and to make a sensitive enquiry if concerned
  - Providing information about, or referral to, local services for women who have substance and alcohol misuse problems as they are at greater risk of problem pregnancies and their care should be provided by an integrated multidisciplinary and multiagency team
- Have an awareness of disease prevention, well-being and safety in children and adolescents, including in the following areas:
  - Prenatal diagnosis
  - Breastfeeding
  - Healthy diet and exercise for children and young people
  - Social and emotional well-being
  - Keeping children and young people safe, safeguarding, accident prevention
  - Immunisation
  - Avoiding smoking, avoiding the use of volatile substances and other drugs, and minimising alcohol intake
  - Reducing the risk of teenagers getting pregnant or acquiring sexually transmitted infections
• Promote health and well-being by applying health promotion and disease prevention strategies appropriately, and using them to detect problems that may already be present but have not yet been detected, by:
  o Being aware of your role as a GP in promoting and organising immunisation
  o Being aware of your role as a GP in the prevention of accidents
• Support transitions (maximising children’s achievements and opportunities, and understanding their rights and responsibilities)
• Describe the impact of disability on the child, young person and their family
• Promote physical health, mental health and emotional well-being by encouraging children, young people and their families to develop healthy lifestyles
• Describe your role as a GP in dealing with enuresis, sleep disturbance, bullying and school refusal

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Adopt a family-centred approach in dealing with patients, their families and their problems. This requires:
  o Effective communication and engagement (listening to and involving children and young people, and working with parents, carers and families)
  o An understanding of the importance of supporting parents and having the skills to do this, noting that the role of fathers in parenting their children and teenagers is frequently overlooked. Their contribution to their child’s development and well-being is important. All GPs should be able to support fathers and have the skills for engaging with fathers as well as mothers
  o Being aware of the child that is ‘hidden’ behind the parents’ symptoms and illnesses
• Reconcile the health needs of patients and their families, and of the community in which they live, in balance with available resources. This requires:
  o an understanding of the legal and political context of child and adolescent care
  o an understanding of the organisation of care – care pathways and local systems of care
  o an assessment of needs, including an understanding of the assessment framework
• Describe the importance of the health care needs of the paediatric population of your community and the socio-economic and cultural features that might affect health
• Describe the importance of the workload issues raised by paediatric problems, especially the demand for urgent appointments and the mechanisms for dealing with this
**Case discussion**

James, a 14-year-old boy who is accompanied by his parents, presents to you in morning surgery following the discovery that he has been diagnosed with Juvenile Rheumatoid Arthritis (RA).

The parents are seeking further information from you regarding the condition, management and prognosis, as the shock of the diagnosis during their initial hospital consultation meant that they could not ‘take a lot in’ at the time of diagnosis.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>What are my own personal values and assumptions regarding this child’s diagnosis and how might these</td>
</tr>
<tr>
<td></td>
<td>affect my judgements and behaviours?</td>
</tr>
<tr>
<td></td>
<td>How would I manage a family complaint if they were unhappy with my support?</td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>What happens if there is a conflict between the child’s and parents’ wishes? What are the ethical</td>
</tr>
<tr>
<td></td>
<td>dilemmas?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>How might I adapt my consultation to take account of the differing needs of James and his parents?</td>
</tr>
<tr>
<td></td>
<td>How confident am I in explaining prognosis?</td>
</tr>
<tr>
<td></td>
<td>Which consultation models would help to improve my skills in managing this case?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>How should I investigate early childhood arthropathy?</td>
</tr>
<tr>
<td></td>
<td>Could there be a genetic element to this?</td>
</tr>
<tr>
<td></td>
<td>What is the prevalence of early childhood arthropathy in primary care?</td>
</tr>
<tr>
<td></td>
<td>Could I detect an arthropathy at an earlier stage?</td>
</tr>
<tr>
<td></td>
<td>What do the terms ‘sensitivity’ and ‘specificity’ mean in the interpretation of laboratory investigation?</td>
</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>How would I diagnose and manage juvenile RA (perhaps bringing in the principle of recognising acutely ill</td>
</tr>
</tbody>
</table>
**Clinical management**  
This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.  
- How confident am I to prescribe in this age group?  
- How does juvenile RA present?  
- How do I manage patients in the long term?

**Managing medical complexity**  
This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.  
- What are the risks of prescribing and monitoring disease modifying drugs in primary care?

**Working with colleagues and in teams**  
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.  
- Which other members of the multidisciplinary team would I involve (e.g. school nurses, faith organisations, psychologist and family counsellors)?  
- How can I work with my local paediatric services to manage a child with newly diagnosed RA?

**Maintaining performance, learning and teaching**  
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.  
- What mechanisms exist in my practice to ensure that I am kept up to date with a diagnosis of juvenile RA?  
- Should I be doing more to promote an awareness of childhood RA in my clinical practice and how do I do this?  
- How might resource constraints prevent me from providing the best-quality care to patients with this diagnosis?  
- What might be important to consider when thinking about managing long term illness in a child?

**Organisational management and leadership**  
This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.  
- What mechanisms are in place in my practice to ensure that RA patients and their relatives are reviewed on a regular basis?

**Practising holistically and promoting health**  
This is about the physical, psychological,  
- How do I plan to follow up James and his family?  
- How might I manage the psychological impact of his
socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

<table>
<thead>
<tr>
<th>Health professional focus</th>
<th>Disease on the family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How can I manage issues around potential school absence?</td>
<td></td>
</tr>
<tr>
<td>How do I manage the child and the parents’ ideas, concerns and expectations?</td>
<td></td>
</tr>
</tbody>
</table>

**Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

<table>
<thead>
<tr>
<th>Community orientation focus</th>
<th>Which voluntary sector organisations might be helpful to James and his family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the care services available in my area for children?</td>
<td></td>
</tr>
<tr>
<td>What psychological support services are available locally to children and adolescents?</td>
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</tr>
<tr>
<td>Who can advise on benefits if one parent gives up working to become a ‘carer’?</td>
<td></td>
</tr>
</tbody>
</table>

### How to learn this area of practice

**Work-based learning**

**In primary care**

Primary care is the ideal place to learn about the health of children and young people in the context of where they live and go to school. It is important that as a GP specialty trainee you are involved in antenatal and postnatal care, and that you follow a few babies through their first year of life. Attending an outpatient or community outreach clinic with a child and their parent is an ideal way for you to gain a better understanding of the patient’s journey. Exposure to baby clinics and immunisation clinics is essential. Exposure to consultations with young people will provide you with opportunities for learning about communication skills, as well as teamworking and specialist needs in prescribing. Look for opportunities for a visit or a placement at a dedicated youth clinic, a Child and Adolescent Mental Health clinic or attend a health session aimed at young people in a community setting.

As a GP trainee you should also take the opportunity to visit patients in their homes, attend case conferences and participate in the work of the multiprofessional team, which will include practice nurses, midwives, health visitors, school nurses and social care workers.

**In secondary care**

Some GP training programmes contain placements of varying lengths in a paediatric department. These will give you exposure to acutely ill children, young people and those who have been admitted to hospital for specialist treatment. Specialist care is, however, mainly provided in outpatient clinics and increasingly in primary care settings – particularly for children and young people who have rare conditions or require specialist treatment, or who have proven difficult to be managed by their GP. These are ideal places for you as a trainee to see concentrated groups of children and young people.
with health problems. Educational programmes provided in the hospitals are often of value for doctors who are training to be GPs; however, it is important that this education reflects the needs of GP trainees and is not just targeted at specialist registrars or for a particular specialist examination.

**Self-directed learning**

You will find that deaneries, often working with their local universities, trusts and social services, provide a variety of courses about child health issues including child protection, immunisation and child development. The RCGP also provides a selection of courses across the UK in both child and adolescent health. The best of these stimulate reflection on real cases seen in your work and help you as a professional to develop the knowledge, skills and attitudes required for high-quality, collaborative care. The changes taking place within child healthcare provide a significant opportunity to develop new ways of learning and teaching, especially in the interprofessional setting. To this end, the Department of Health has collaborated with the all the paediatric medical colleges and e-Learning for Healthcare to produce the Healthy Child Programme learning set which is be available through e-GP (www.e-GP.org). E-learning should be combined with case review and multidisciplinary reflection.

**Learning with other healthcare professionals**

The effective care of children and young people is a multiprofessional activity with different health professionals working in teams, often across the historical primary and secondary care divide. It is therefore essential that your learning takes place as often as possible with other health professionals. During your training for general practice you should gain experience of working in a collaborative way with other professionals in the team. You should also participate in the practice’s educational programme, audit and critical event meetings.

Interprofessional case-based learning is an effective way for you as a GP to learn about child protection (safeguarding children), and to remove some of the barriers to collaboration. You should participate in interprofessional education programmes provided by child protection teams in each locality. Child protection training often concentrates on physical signs and symptoms of abuse and provides limited understanding of the emotional and psychological implications for adults of early childhood abuse, trauma and neglect, and how these effects might be manifested in the consultation. The report of the Victoria Climbié inquiry\(^{16}\) argued that child protection is ‘everyone’s business’ and made a strong case for better communication between professionals. The report also made two specific recommendations that are of immediate relevance to a curriculum for the care of children and young people. The report included a recommendation (No. 87 Report, p. 381):

> ‘The Department of Health should seek to ensure that all GPs receive training in the recognition of deliberate harm to children and in the multidisciplinary aspects of a child protection investigation, as part of their initial vocational training in general practice and at regular intervals of no less than three years thereafter.’

Multiprofessional education and interprofessional education need to be distinguished. In multiprofessional education, different professionals happen to coincide in an educational event of

mutual interest. By contrast, interprofessional education involves an explicit examination of different roles. Interprofessional barriers can be a real problem in practice, particularly at times of change or stress within the health service, and this applies as much to education as it does to service delivery. Amongst other health professionals, negative attitudes about medical practitioners wanting to be involved in interprofessional education programmes can be a problem. These conclusions are supported by a survey of Primary Care Trusts, conducted by the London Deanery. This survey revealed that although all localities have Area Child Protection Committees, which are responsible for providing multiprofessional education in child protection, neither GP trainees nor established general practitioners were involved. Others have also reported similar findings. However, successful schemes bringing together GPs, health visitors and community paediatricians are possible. A key component of successful initiatives is that the teaching team should include a mix of professionals who are prepared to look at their own different roles and to challenge the stereotypes that many professionals have about each other.

A further challenge is the national shortage of health visitors. Health visitors, working in close partnership with GPs, have traditionally been central to the provision of child health promotion. Partly in response to the recruitment crisis and, in England and Wales, to the introduction of the Healthy Child Programme (2009), health visitors have recently been redefining their jobs, taking on a greater public health role and, in many areas, withdrawing from GP surgeries. This has caused tension both within and outside the health visiting profession.

Some aspects of a curriculum for the care of children and young people will be appropriately delivered in a uniprofessional format (i.e. tailored to the needs of one particular profession), but there should be an increasing emphasis on interprofessional approaches in order to encourage collaboration with other professionals. The challenge involved in this should not be underestimated.

Useful learning resources

Books and publications

- British Medical Association, Royal Pharmaceutical Society of Great Britain, Royal College of Paediatrics and Child Health. BNF for Children London: BMJ Publishing Group
- Craft A and Killen S. Palliative Care Services for Children and Young People in England: an independent review for the Secretary of State for Health London: Department of Health, 2007,
• Valman B. *ABC of One to Seven (5th edn)* London: BMJ Books, 2010

**Web resources**

**Contact a Family**

Contact a Family is a charity that exists to support the families of disabled children whatever their condition or disability. They provide resources for healthcare professionals including information for GP practices to assist them in coordinating care, Information to give to families and reliable medical information on a wide range of conditions. www.cafamily.org.uk/professionals/supporting-your-work-with-families/our-work-with-health-professionals/

**General Medical Council (GMC)**

Resources include:

• Guidance for doctors involved in the care of children aged 0 to 18 years www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp
• Guidance on the child protection responsibilities of doctors www.gmc-uk.org/guidance/ethical_guidance/13257.asp

**Great Ormond Street Hospital for Children NHS Trust (GOSH)**

The GOSH website provides a useful resource for health professionals and parents on a variety of children's conditions. www.gosh.nhs.uk
International Children's Palliative Care Network (ICPCN)

The ICPCN is the only international network of organisations and individuals working within all children's palliative care services across the world. [www.icpcn.org.uk](http://www.icpcn.org.uk)

Medikidz

Online and printed resources in comic book superhero format, providing good medical information for children. [www.medikidz.com](http://www.medikidz.com)

National Institute for Health and Care Excellence (NICE)


CG89: When to suspect child maltreatment, [http://guidance.nice.org.uk/CG89](http://guidance.nice.org.uk/CG89)

(Also other resources on constipation, fever, urinary tract infections.)

Patient.co.uk

Advice and health information for patients. [www.patient.co.uk](http://www.patient.co.uk)

Royal College of General Practitioners (RCGP) [www.rcgp.org.uk](http://www.rcgp.org.uk)

The e-GP course on the Care of Children and Young People includes topics such as care of neonates and infants, care of children, adolescent health and safeguarding children, as well as the Healthy Child Programme learning set. [www.e-GP.org](http://www.e-GP.org)

Other RCGP resources include:


Royal College of Paediatrics and Child Health

The college’s mission statement is to transform child health through knowledge, innovation and expertise. The website provides useful training updates and educational materials. [www.rcpch.ac.uk](http://www.rcpch.ac.uk)

Royal College of Psychiatrists

A number of useful leaflets on young people’s mental health conditions. [www.rcpsych.ac.uk/expertadvice/youthinfo/youngpeople.aspx](http://www.rcpsych.ac.uk/expertadvice/youthinfo/youngpeople.aspx)

Together for Short Lives

One of the resources available on this comprehensive site is the Children’s palliative care handbook for GPs [www.togetherforshortlives.org.uk](http://www.togetherforshortlives.org.uk)
UNICEF Baby Friendly Initiative

This site includes an e-learning package on breastfeeding. [www.babyfriendly.org.uk](http://www.babyfriendly.org.uk)

United Nations Convention on the Rights of the Child (UNCRC)

The Convention on the Rights of the Child is a universally agreed set of standards and obligations. Children have the same general human rights as adults but they are particularly vulnerable and so also have particular rights that recognize their special need for protection. [www.unicef.org/crc](http://www.unicef.org/crc)

Youthhealthtalk

A website with interviews and video clips of young people’s real-life experiences of health and lifestyle. [www.healthtalk.org/young-peoples-experiences](http://www.healthtalk.org/young-peoples-experiences)
3.05 Care of Older Adults

Summary

- The United Kingdom has an increasingly ageing population
- The care of older people will make up a higher proportion of your workload as a general practitioner (GP)
- Co-morbidity, difficulties in communicating, the problems of poly-pharmacy and the need for additional support for the increasingly dependent patients in general practice are important issues in the care of older people
- The epidemiology of problems presenting in primary care is different in older people. Many cancers are more prevalent in the elderly population and may be of insidious onset
- General practitioners working together with other members of the primary healthcare team have an important role to play in the delivery of improvements in the care of older people

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Recognise personal attitudes to the elderly, to the processes of growing old, becoming frail and to dying (see also statement 3.09 End-of-Life Care)
- Recognise your attitudes to the use of intensive or invasive tests and treatments and the use of limited healthcare resources in the care of the elderly
- Be aware of these broader factors in order to counter personal biases that are unhelpful to the care of the elderly
- Ensure that personal biases regarding the management of risk factors in the elderly do not influence management decisions, e.g. the cardiovascular risk factors of smoking, obesity, exercise, alcohol, age and race

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.
This means that as a GP you should:

- Understand moral, ethical and emotional issues relating to the end of life (see also statement 3.09 End-of-Life Care), as well as after death (e.g. living wills, palliative care)
- Understand the legal and ethical issues that may arise, e.g. regarding confidentiality, the Mental Health Act, the Mental Capacity Act, power of attorney, court of protection applications, guardianship, living wills, death certification and cremation

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Have appropriate communication skills for counselling, teaching and treating patients, their families and carers, recognising the difficulties of communicating with older patients including the slower tempo, possible unreliability or having to rely on the evidence of third parties

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Know the prevalence and incidence of disease in the elderly population
- Understand the changes in the normal range of laboratory values that are found in older people
- Know the signs and symptoms of the early presentation of cancer
- Know the special features of prognosis of diseases in old age and be able to apply the knowledge to produce an appropriate plan for further investigation and management, including end-of-life care (see also statement 3.09 End-of-Life Care)
- Know the epidemiology of older people’s problems presenting in primary care, such as dementia and cancers as well as their risk factors
- Recognise the common, early, ‘red flag’ symptoms and signs of malignancy (e.g. weight loss, dysphagia, melaena, diaphoresis etc.), many of which may be non specific if taken in isolation
- Understand the physical, psychological and social changes that may occur with age and relate them to the adaptations that an older person makes, and to the breakdown of these adaptations, e.g. when hearing, vision or cognitive function continue to worsen
- Know that many cancers are more prevalent in the elderly population and may be insidious
Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Know the way in which the management of disease processes in old age is influenced by the psychological state and the social situation of the old person
- Recognise and act upon suspicion of a cancer diagnosis early in the disease process
- Recognise the importance of a problem-based approach, taking in the ‘big picture’, rather than a disease-based approach to the care of older people, who often have complex physical, psychological and social problems

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Know the local rapid access referral pathways and common treatment options, along with their complications and side effects
- Understand the special factors associated with drug treatment, e.g. the physiology of absorption, metabolism and excretion of drugs, the hazards posed by multiple prescribing, non-compliance and iatrogenic disease
- Understand the physical factors – particularly diet, exercise, ambient temperature and sleep – that disproportionately affect the health of older people
- Understand the management of the conditions and problems commonly associated with old age, such as Parkinson’s disease, falls, gait disorders, stroke, confusion, dementia and cancer
- Know how to access support services for older patients, e.g. podiatry, visual and hearing aids, immobility and walking aids, meals on wheels, home care services
- Know the different forms of day-care and residential accommodation available and be able to advise patients about them
- Ensure that the provision of care promotes the patient’s sense of identity and personal dignity, and that the patient is not discriminated against as a result of their age
- Recognise abuse (emotional, mental and physical) in the elderly and deal with it appropriately

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also
covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Understand the complex nature of health problems in older patients
- Understand the special features of psychiatric diseases in old age, including dementia. This incorporates an appreciation of the effects of these conditions on the person, the family and community, and the effects of physical function on the patient’s mental state. This understanding should be framed within an understanding of the law relating to mental capacity.
- Understand how co-morbidity will influence the management of existing disease and delay the early recognition of adverse clinical patterns
- Understand the concept of health and be able to promote health on an individual basis as part of the consultation in the older patient
- Understand the theories of ageing
- Understand the ability of an elderly person to carry out all the activities commensurate with their mental competence (e.g. exercise, travel, sexual activity and independence, etc.)

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Be able to co-ordinate teamwork in primary care including involvement of family members nearby, or at a distance

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand and implement the key national guidelines that influence healthcare provision for older people
- Describe the key research findings that influence management of older people
- Appreciate the difficulties in extrapolating evidence from research to older populations
• Understand the difficulties in designing ethical approvable research studies with frail and elderly patients

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

• Have an organisational approach that allows easy access to the primary healthcare team for older people, appropriate timing of appointments, sign-posting to appropriate team members, and the systematic management of chronic conditions and co-morbidities

• Develop policies for the primary care team to ensure effective management of repeat prescriptions, the appropriate use of screening and case-finding programmes, and auditing the quality of care of elderly people in all forms of residential accommodation

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

• Be able to describe the personal structure as well as the wider and often distant family structure of older patients

• Be aware of issues related to carers, in particular the positive and negative impact of being a carer on their health and your holistic duty not to overlook these issues

• Be sensitive to apparently dated social and health beliefs and cultural traditions

• Know the preventative strategies required in the care of older people

• Describe how it is possible to manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation

• Be wary of possible neglect or abuse of the elderly

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.
This means that as a GP you should:

- Know the demography of the practice (number of elderly patients, prevalence of chronic diseases)
- Understand the impact of poverty, ethnicity and local epidemiology in the elderly
- Be aware of inequalities in healthcare provision in older persons (learning, physical disabilities, access to care, etc.)
- Consider the positive and negative ways in which socio-economic and health features interrelate, and the importance of this within the community
- Understand the key government policy documents that influence healthcare provision for older people
- Recognise how geographical distance influences your support and treatment of older people
- Know how to use the various statutory and voluntary organisations for support of older people in the community

**Case discussion**

An 80-year-old man presents in winter after having been discharged from hospital following treatment of a femoral fracture. He has severe back pain and raised prostate-specific antigen (PSA). He has vascular dementia and was being cared for at home by his wife although she is finding it hard to cope as he is incontinent and immobile. They have no extended family support network.

The man has multiple other medical problems including type 2 diabetes and hypertension. His prostate cancer was thought to be in remission. They live in a two-storey property with an upstairs toilet; he is the registered owner of the house. He is now unable to climb the stairs.

His wife, another patient of yours, has a right cataract impairing her vision and has previously made some minor errors when administering his medications. She also has poor mobility and is due to have a left hip replacement for osteoarthritis. She has been receiving a ‘carer’s allowance’ and wants to continue to care for him at home.

You make a home visit after the man’s hospital discharge to find him unkempt, in soiled bedding in a cold house. There has been inadequate discharge planning and no occupational therapist assessment of changes at home to help the man or his wife cope with his new immobility.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:
<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>What are the personal challenges I face in my working life when caring for my elderly patients? How would I manage this complex scenario during the working day while also maintaining my performance elsewhere?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How might I address concerns about the inadequate discharge planning? How can my patients retain autonomy in this situation? What is my role in safeguarding the needs of the demented man while also respecting his wife’s wishes?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
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<tr>
<td><strong>Communication and consultation</strong></td>
<td>What problems might I face in communicating with this couple? In the scenario described, who is my patient?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
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</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>Where can I access information on the management of vascular dementia?</td>
</tr>
<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
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</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>What are the most appropriate options for managing a situation where there is no clear clinical need for hospital admission?</td>
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<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>What are the immediate medical and social problems that I need to manage? What is the treatment of choice for this patient’s hypertension?</td>
</tr>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
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</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>How might I describe the complexity of this episode of healthcare provision? How would I make a risk assessment of this couple’s situation?</td>
</tr>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
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<tr>
<td>Topic</td>
<td>Question</td>
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</tr>
<tr>
<td>Working with colleagues and in teams</td>
<td>What arrangements would I make to improve continuity of care?</td>
</tr>
<tr>
<td>Maintaining performance, learning and teaching</td>
<td>What do I know about residential and care homes in my practice area?</td>
</tr>
<tr>
<td>Organisational management and leadership</td>
<td>How can I retain patient confidentiality when recording information about this couple in the notes?</td>
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<td></td>
<td>What information would I normally expect to receive following a hospital admission?</td>
</tr>
<tr>
<td>Practising holistically and promoting health</td>
<td>Considering the wife’s situation, what might be the consequences of her husband going into ‘care’?</td>
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<td></td>
<td>What sort of discussion should I be having with this couple regarding long-term care and placement?</td>
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<td>How can I manage this couple’s ideas, concerns and expectations?</td>
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<td></td>
<td>How might the practice team have anticipated the problems identified in this scenario? Which problems, if any, do I think might have been prevented?</td>
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<tr>
<td></td>
<td>What other services may be available to carers in my practice?</td>
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<tr>
<td>Community orientation</td>
<td>How common is this type of problem in my practice?</td>
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<td></td>
<td>How would I try to find out?</td>
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<tr>
<td></td>
<td>What voluntary support services are available to my patients?</td>
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<tr>
<td></td>
<td>What support can be offered by the primary care team</td>
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</tbody>
</table>
How to learn this area of practice

Work-based learning

In primary care

Time spent in general practice is the ideal setting for you to gain a better understanding of the care of older people. As a GP specialty trainee you will have the opportunity to care for many elderly patients with physical and mental illnesses who live at home or in residential accommodation. Many older patients experience multiple contacts with secondary care services and are cared for by different members of the primary healthcare team.

As a GP trainee you should be encouraged to look after some of the practice’s older patients throughout your placement. As you follow them along their journey you will gain a better understanding of their problems and of the social and medical care they receive. Case conferences and multiprofessional assessments of your older patients will give you a better understanding of disease processes and their functional consequences. You should also be aware of the current vogue for reclassification of many physiological and natural ageing processes as pathological, with the attendant recommendation for expensive poly-pharmacy (with the increased risks of significant cross-reactions and side effects).

In secondary care

A placement in a care of the elderly medicine (geriatric) department offers you the opportunity to learn how to manage complex co-morbidity, interacting with interprofessional teams, experiencing interagency work and working closely with the voluntary sector. You should also take the chance to deepen your knowledge and skills in end-of-life care and advance directives. Take the opportunity also to attend day hospital and clinics, as well as to accompany your consultant on any domiciliary visits.

Self-directed learning

Older patients often have many complex psychological, social and physical problems that provide rich subjects for tutorials and case-based learning.

Learning with other healthcare professionals

The discipline of care for older adults involves huge numbers of professionals, each with their particular areas of expertise. These include community nurses, physiotherapists, occupational therapists, speech therapists, opticians, audiologists, palliative care nurses, physicians and social workers, to name but a few. As a GP trainee you should endeavour to spend some time with these colleagues to ensure you understand the breadth of input that can be provided to the older adult, the effectiveness of such input and the appropriateness of referral to these agencies. You should also take the opportunity to visit patients at their homes with other members of the primary healthcare team and to accompany the occasional patient to hospital clinics to gain a better understanding of the ‘patient’s journey’.
Formal learning

Postgraduate courses in Gerontology can be taken as distance learning or residential modules, from certificate level to diploma and degree levels. These are administered by a number of universities. (Further details are available from the British Geriatrics Society website at www.bgs.org.uk.)

Useful learning resources

Books and publications

- Bogosh CW. *The Golden Years: Healthy Aging and the Older Adult* CreateSpace Independent Publishing Platform (19 May 2013) [Paperback]
- Burke M, Laramie M, Joy A. *Primary Care of the Older Adult* London: Mosby, 2000


• The Royal College of General Practitioners and the British Geriatric Society. *General Practitioner Vocational Training in Geriatric Medicine* London: Royal College of General Practitioners, 1978


www.wales.nhs.uk/Publications/NHSStrategydoc.pdf


www.wales.nhs.uk/sites3/documents/439/NSFForOlderPeopleInWalesEnglish.pdf


• Williams I. *Caring for Older People in the Community* Oxford: Radcliffe Medical Press, 1995

• Woodford H. *Essential Geriatrics (2nd revised edn)* Radcliffe Publishing Ltd, 2010

Web resources

Age UK

Age UK is the UK’s largest organisation working with and for older people. The website is an excellent resource for patients and carers. Their mission is to promote the well-being of all older people and to help make later life a fulfilling and enjoyable experience. GPs will find it full of useful facts and information. [www.ageuk.org.uk](http://www.ageuk.org.uk)

Alzheimer’s Disease Society

The Society has expert information and education for carers and professionals. It provides helplines and support for carers, runs quality day and home care, funds medical and scientific research, and gives financial help to families in need. It campaigns for improved health and social services, and greater public understanding of all aspects of dementia. [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

British Geriatrics Society

The Society is the only professional association in the United Kingdom of doctors practising geriatric medicine. The majority of the 2,300 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, GPs and scientists engaged in the research of age-related disease. The Society also has members in the nursing, therapy and pharmacology professions. It was founded in 1947 for ‘the relief of suffering and distress amongst the aged and infirm by the improvement of standards of medical care for such persons, the holding of meetings and the publication and distribution of the results of such research’. The website contains useful information, clinical guidelines and links. [www.bgs.org.uk](http://www.bgs.org.uk)
Department of Health Older People’s Services

The website includes access to the National Service Framework for Older People and lots of supporting documentation. www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people

NHS Scotland: Adding Life to Years


The Really Important Questions Group (RIQ)

The RIQ group is made up of over-50-year-olds who want to be involved in the shaping of health and social care. Their interesting website is at www.tamesidelife.co.uk/sites/the-really-important-questions-group-riqtameside-adult-services/intro

Royal College of General Practitioners

The e-GP course on Care of Older Adults includes sessions on the ageing population, normal changes of ageing, the role of the GP, prescribing, falls assessment, confusion and off legs, memory problems, dementia, assessing mental capacity, elder abuse, and support for older people and their carers. www.e-GP.org

Dementia resources can be found at www.rcgp.org.uk/clinical-and-research/clinical-resources/dementia.aspx
3.06 Women’s Health

Summary

- Women-specific health matters including contraception, pregnancy, menopause and disorders of reproductive organs will account for over 25% of your time as a general practitioner (GP).
- Women present with non-gender related issues in specific ways that you will also need to become sensitive to; domestic violence, depression and alcoholism can all present differently in women and may be interlinked. One woman dies every three days as a result of domestic violence. One in nine women using health services has been hurt by someone they know or live with.
- Women tend to take the larger role in caring for dependants – children, parents, ill or disabled spouses. Supporting them can help share that care and also reduce the burden on health and social care services.
- As a GP you will have a key leadership role in co-ordinating provision of community services for women: for example, offering the choice of access to services from female healthcare professionals, access in school hours and considering crèche facilities in surgeries.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Recognise your own values, attitudes and approach to issues such as abortion, contraception for minors, consent, confidentiality, cosmetic surgery, and be aware of how these might affect your management of patients who might take a different view.

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Know about the impact of culture and ethnicity on women’s perceived role in society and their attendant health beliefs, and be able to tailor healthcare accordingly: for example, mental illness is kept ‘hidden’ in some cultures because of the stigma attached to it.
- Describe the legislation relevant to women’s health (e.g. abortion, contraception for minors).
Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

• Communicate sensitively with women about sexuality and intimate issues (particularly in recognising the impact of past sexual abuse and the illegal procedure of female genital mutilation (‘female circumcision’); see also Learning Resources below and 3.08 Sexual Health statement)
• Integrate the fact that many women consult for lifestyle advice and that you as a GP should not over-medicalise these issues
• Recognise the issues of gender and power, and the patient–doctor relationship, and know how to prevent these issues adversely affecting women’s health care
• Understand that as the sexual partners of some women are women you must not make assumptions such as the need for contraception
• Describe the impact of gender on individual ways of thinking and lifestyle, and formulate strategies for responding to this. For example, some women, such as those from low socio-economic groups or those living with an addiction, may have limited control over lifestyle choices

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

• Demonstrate an understanding of the importance of risk factors in the diagnosis and management of women’s problems, e.g. is a patient who presents with a breast lump on hormone replacement therapy?
• Recognise the prevalence of domestic violence and question sensitively where this may be an issue
• Know how the social and biological features of the perimenopause and menopause period interact and affect health, social well-being and relationships (e.g. mood swings, anxiety and depression, reduced libido)
• Describe the issues relating to the use of chaperones (e.g. the added embarrassment that can come from the presence of a third person; your protection from malicious complaints and safeguarding issues for the patient)
Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Recognise common signs and symptoms of, and know how to manage, gynaecological disease; be the first port of call for pregnancy, eating disorders and other conditions confined to or more common in women, involving other members of the healthcare team as appropriate
- Intervene urgently with suspected malignancy and have a low threshold for the referral of breast lumps
- Recognise and intervene immediately when patients present with a gynaecological or obstetric emergency

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Demonstrate knowledge of women’s health problems, conditions and diseases, and recognise that some non-gender specific issues present differently in women, such as depression, alcoholism, eating disorders and domestic violence
- Describe how practice management issues impact on the provision of care to women, including choice and availability of female doctors
- Maintain patient records that are accurate, facilitate continuity of care and respect the patient’s confidentiality (particularly in relation to family issues, domestic violence, termination of pregnancy, sexually transmitted infections and ‘partner notification’)
- Provide information to patients on possible local support services, referral services, networks and groups for women (e.g. family planning, breast cancer nurses, domestic violence resources)
- Inform patients of the results of screening and ensure follow-up

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Use screening strategies relevant to women (e.g. cervical, breast, other cancers, postnatal depression) and advise patients on their advantages/disadvantages
• Be able to advise on prevention strategies relevant to women (e.g. safer sex, pre-pregnancy counselling, antenatal care, immunisation, osteoporosis)
• Understand the impact of other illness, in both the patient and her family, on the presentation and management of women’s health problems

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

• Be familiar with and implement the key national guidelines that influence healthcare provision for women’s problems
• Critically review the role of well-woman clinics in primary care

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

• Evaluate the effectiveness of the primary care service you provide from the female patient’s point of view

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.
This means that as a GP you should:

- Discuss the psychosocial component of women’s health and the need, in some cases, to provide women patients with additional emotional and organisational support (e.g. in relation to pregnancy options, hormone replacement therapy, breast cancer and unemployment)
- Describe the health needs of gay, transgender and bisexual women (beyond sexual health) and their partners (e.g. you should understand their lifestyle and risk factors)
- Understand the importance of promoting health and a healthy lifestyle in women and, in particular, the impact of this on the unborn child, growing children and the family

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Understand the issues of equity and access to health information and services for women
- Understand that the health needs of women are not homogenous and may vary depending on their environment: for example, if you are working as a prison doctor or in a family planning clinic

**Case discussion**

Jackie Wilcox, who is aged 48 and a smoker, comes to see you. She brings her four-year-old granddaughter Kylie who has come to stay while Jackie’s daughter Sharon is in prison for drug-related offences. Jackie is exhausted, which she puts down to lack of sleep through worry, travel to the prison to visit her daughter and from looking after Kylie.

Owing to a chaotic family situation, she has not paid much attention to her own health and has been ignoring some pinkish vaginal discharge. Now however she has irregular vaginal bleeding, which is becoming more frequent. She has not had a smear (cervical screening) for over 15 years and on examination you find an irregular, ulcerated area on the cervix. You refer Jackie under the two-week rule to a gynaecologist. Jackie is not keen on any further help at home as she fears social services will ‘take Kylie away’ but she agrees that you could ask the health visitors to see what support they can offer in terms of a nursery or play scheme for Kylie.

Jackie is diagnosed at colposcopy with a stage 1b cervical squamous carcinoma but, after a hysterectomy, histology shows the presence of more extensive disease than expected and Jackie needs post-operative radiotherapy. Because she is in reasonably good health otherwise, she is also offered adjuvant chemotherapy and for the next six weeks needs to travel daily to the local hospital for treatment. Her sister, who lives locally, is able to help at home and look after Kylie, taking her to her new nursery. Your surgery Community Driver Scheme agrees to provide transport for a subsidised fee.
Four months later Jackie comes to see you, fearful that her bilateral leg swelling represents a recurrence. However it turns out to be a short-lived complication of the radiotherapy. There is a local lymphoedema service and you refer her for decongestive lymphatic therapy.

Five years later, Jackie is attending for annual follow up and is still disease free.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>As a GP how might I manage my feelings if there are any aspects of a case where my personal beliefs and values are in conflict with those of my patient?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>What ethical dilemmas could such cases present?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
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</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>What tensions do I see between the scientific, political and patient-centered aspects of cervical screening?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
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</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>How confident am I in carrying out a speculum examination and a smear test, and being able to differentiate different common pathologies affecting the cervix?</td>
</tr>
<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
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</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>Do I know the ‘red flag’ symptoms that require urgent referral under the ‘two-week rule’?</td>
</tr>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>What is my understanding of the impact of human papilloma virus (HPV) infection in different social groups?</td>
</tr>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
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</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>How can I balance on-going health promotion and advice-giving at a time of serious illness?</td>
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</tr>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
<td>What steps would I take to understand the impact of this illness on the patient’s family?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Working with colleagues and in teams</strong></th>
<th>What is the protocol in my practice for calling, recalling and following up patients who attend and DNA for smears?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maintaining performance, learning and teaching</strong></th>
<th>When did I last attend or do any course relating to women’s health?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
<td>How might the practice improve the quality of smears done at the practice?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Organisational management and leadership</strong></th>
<th>What are the audit results of smear uptake and outcomes in my practice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
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<table>
<thead>
<tr>
<th><strong>Practising holistically and promoting health</strong></th>
<th>As the GP for more than one generation of a family, how do I balance their health and social care needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</td>
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<tr>
<th><strong>Community orientation</strong></th>
<th>What relevant social care assistance and support groups are available to patients in my area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural</td>
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</tr>
</tbody>
</table>
aspects of delivering evidence-based, sustainable healthcare.

How to learn this area of practice

Work-based learning

In primary care

The period of time spent training in general practice will help you gain a better understanding about women’s health. It is ideal for delivering training in screening, counselling and ‘longitudinal care’ (continuous care) for women, and to reinforce that the nature of healthcare requires a balanced overview of all factors affecting the patient at any time. There is no substitute for clinical experience supported by a GP trainer and experienced members of the primary healthcare team.

In secondary care

You are likely to experience obstetrics and gynaecology in a hospital placement during your GP training programme. You may also spend dedicated time in a hospital placement during your GP-based phase. GP specialty trainees should take the opportunity to attend outpatient clinics in specialties directly relevant to women’s health, e.g. gynaecology clinics, antenatal and postnatal clinics. Sexual health and family planning clinics are also excellent environments to gain a better understanding of women’s health concerns and problems. During these placements you should refer to this curriculum statement, and the relevant cross-references, to guide you and help consolidate your specific knowledge and skills in the area of women’s health in primary care.

Self-directed learning

Many Deaneries or their equivalent bodies organise courses for their GP specialty trainees on women’s health issues to supplement their local programmes and to ensure that those GP trainees who have not passed through a hospital-based placement in obstetrics and gynaecology are made aware of current management of women’s problems. All GP trainees will have the opportunity to discuss women’s health issues as part of their GP training programme’s educational sessions.

Learning with other healthcare professionals

Women’s health and sexual health problems, by their nature, are often exemplars of teamwork across agencies. Joint sessions with nursing colleagues provide you with multidisciplinary opportunities for learning about the wider aspects of women’s health, in both primary and secondary care. You should also find it fruitful to consider and discuss the roles of the various individuals who represent the many professional and non-professional groups involved in women’s healthcare.

Useful learning resources

Books and publications

- Guillebaud J. *The Pill and Other Forms of Hormonal Contraception* Oxford: Oxford University Press, 2004

**Web resources**

**Breast Cancer Care**

This is the UK’s leading provider of information, practical assistance and emotional support for anyone affected by breast cancer. Every year it is contacted by over 1,000,000 people with breast cancer or breast health concerns. It provides an excellent advice service for the public and healthcare professionals. [www.breastcancercare.org.uk/healthcare-professionals](http://www.breastcancercare.org.uk/healthcare-professionals)

**British Menopause Society**

This is a registered charity dedicated to: increasing awareness of post-menopausal healthcare issues and promoting optimal management through conferences, road shows and publications. Its website contains useful information and academic papers on the menopause. [www.thebms.org.uk](http://www.thebms.org.uk)

**Cancer Research UK**


**Domestic Violence**

This website provides information, advice and guidance about domestic violence. [www.domesticviolence.co.uk](http://www.domesticviolence.co.uk)
Faculty of Sexual and Reproductive Healthcare

This faculty of the Royal College of Obstetricians and Gynaecologists grants diplomas, certificates and equivalent recognition of specialist knowledge and skills in family planning and reproductive health care. It promotes conferences and lectures, provides members with an advisory service and publishes The Journal of Family Planning and Reproductive Health Care. The faculty website provides a wealth of information on sexual health and information about their Diploma Examination. The website also has information on ‘Global Maternal Health’ issues. www.fsrh.org

Foreign and Commonwealth Office (FCO)

Contact the FCO for further information on female genital mutilation (FGM) or if you are concerned that a patient is at risk of being taken abroad for this procedure. www.fco.gov.uk

FPA

Formerly the Family Planning Association, this is the only registered charity working to improve the sexual health and reproductive rights of all people throughout the UK. www.fpa.org.uk

Marie Stopes International UK

This is the country’s leading reproductive healthcare charity, helping over 84,000 women and men each year. It has nine specialist centres and a network of GP partners who provide services for patients seeking help and advice. www.mariestopes.org.uk

Menopause Matters

This is an independent, clinician-led website based at the Dumfries and Galloway Royal Infirmary and supported by experts in the field of menopause management. It provides accurate information about menopausal symptoms and treatment options, including hormone replacement therapy (HRT) and alternative therapies. www.menopausematters.co.uk

Royal College of General Practitioners

The e-GP Women’s Health course includes sessions on vaginal bleeding, pelvic pain, breast lumps and pain, the menopause and HRT, gynaecological cancers, urinary incontinence, domestic violence, and conception and pregnancy. www.e-GP.org

RCGP e-learning resources also include a course on Violence Against Women and Children, with modules on recognising, asking about and responding to violence. www.elearning.rcgp.org.uk/violenceagainstwomenandchildren

The RCGP website also includes additional resources on domestic violence and sexual abuse:

www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx
3.07 Men’s Health

Summary

- Across the UK there is a difference of over 14 years in male life expectancy, depending on where you live
- Under the Equality Act 2010, as a general practitioner (GP) you have a legal requirement to deliver services in such a way that they do not result in direct or indirect discrimination against one sex or the other
- Men are more likely than women to die prematurely; 42% of men die before age 75 compared to 26% of women
- Men are 67% more likely than women to die from those cancers that are not specific to one sex or the other. Men are also 56% more likely to develop those cancers and have poorer survival rates
- 76% of people who kill themselves are men
- Men’s mental and emotional health problems often emerge in different ways from women’s and are not always textbook cases; boys are four times more likely to be diagnosed as having a behavioural, emotional or social difficulty
- 65% of men are overweight or obese compared with 58% of women, but most weight-loss services attract mostly women
- Men tend to have less healthy lifestyles than women; for example, men are more likely to drink alcohol to excess, more likely to smoke, have a poorer diet, more sexually transmitted infections and higher HIV rates; they also take more illegal drugs and have more accidents
- GP services are used 20% less by men than women; pharmacy services are used even less by men

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Recognise that relationships with male patients may be different depending on the gender of the doctor, and intervene when this is adversely affecting the doctor–patient relationship, e.g. sexual advances from the patient
- Accept that your own gender experience may influence your decisions as a GP – although personal experience should not affect a doctor’s views, sometimes this does occur
Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Demonstrate a non-judgemental approach towards male health beliefs, and encourage the expression and modification of these beliefs, where appropriate

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Know that men may need more encouragement both to attend surgery and to articulate the full extent of their health problems during consultation
- Know that men may be both more reticent and less articulate about their health than women, and describe strategies to compensate for this during the consultation
- Know that men may present with more than one health problem at a time and that men may mask mental/emotional health problems with physical symptoms
- Describe the impact of gender on individual views and lifestyle, and formulate strategies for responding to this. For example, some men may have limited control over lifestyle choices, such as those from low socio-economic groups, or living with an addiction
- Know that men from different cultural backgrounds may have widely differing attitudes towards health and expectations of the doctor. They may also seem more dismissive about their symptoms than women, but be no less concerned
- Demonstrate a non-judgemental, caring and professional consulting style to minimise embarrassing male patients
- Utilise the consultation to help change behaviour so that male patients are confident in behaving differently on subsequent occasions; this will mean sharing information with the patient, adopting a shared decision-making style of consultation.

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.
This means that as a GP you should:

- Know that men consult less frequently but have poorer health outcomes for many conditions. This should lower the doctor’s threshold for suspicion of significant disease.
- Use knowledge of the relative prevalence of all medical conditions in men compared to women to assist diagnosis.
- Identify those non-male specific conditions that are found to be more prevalent or have a different presentation in men, such as depression.
- Understand that men’s presentation of symptoms for depression and other mental health problems are different from women’s.
- Know that erectile dysfunction is an early warning for many conditions including coronary vascular disease, diabetes, depression and lower urinary tract symptoms, occurring on average three years prior to the onset of such medical problems.\(^\text{17}\)
- Describe the potential impact of workplace health hazards on men.
- Know about overweight and obesity issues in men and where to refer them for weight management.

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Describe the indications for a prostate-specific antigen (PSA) blood test, explain its role in the diagnosis and management of prostate cancer and be familiar with the Prostate Cancer Risk Management Programme.
- Intervene urgently with suspected malignancy and have a low threshold for the referral of testicular lumps.

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Know that men currently tend to be poorer users of all primary care provision and that service providers have a statutory duty to achieve gender-equitable use of services where appropriate.

\(^{17}\) erectile dysfunction guidelines accessible on [www.bssm.org.uk](http://www.bssm.org.uk)
• Demonstrate knowledge and describe the management of the key male-specific medical conditions, while noting that the most serious non-sex specific health problems are more common in men and tend to occur earlier in the lifespan

• Manage primary contact with patients who have a male genito-urinary problem

• Know of conditions affecting men where there is a low index of suspicion such as breast cancer and osteoporosis

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

• Identify the patient’s health beliefs regarding illness and lifestyle, and either reinforce, modify or challenge these beliefs as appropriate

• Describe the impact of illness, in both the patient and his family, on the presentation and management, and of men’s health problems

• Use the male-targeted information (e.g. from the Men’s Health Forum) that is available to reinforce advice given during consultations and for general health promotion

• Know that healthcare provision for men can extend into other settings, thereby increasing opportunities to target men other than in the clinic, e.g. in the workplace or in leisure settings

• Know how to empower patients to recognise when they can self care safely and when they must visit the GP. This will require competence in sharing information and encouraging greater communication between patient and clinician.

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

______________________________

20 Kitty K, White A. Tackling men’s health – reflections on the implementation of a male health service in a rugby stadium setting Community Practitioner 2011; 84(4): 29–32
This means that as a GP you should:

- Identify the role of the practice nurse, health visitor and other surgery staff in delivering health care and health promotion for men
- Explain the indications for urgent referral to specialist services for patients with testicular lumps and suspected prostate cancer\(^\text{21}\)
- Use the practice’s patient communications (newsletters, websites) to provide men’s health information

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand that there are key statistical differences between the health of men and women\(^\text{22}\)
- Be aware that the evidence base for men’s different presentation of symptoms, particularly for mental health conditions, is still emerging and that postnatal depression in men is under-diagnosed\(^\text{23}, \text{24}\)

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Describe the particular difficulties that adolescent and young adult males have when accessing primary care services\(^\text{25}\)


\(^\text{24}\) Madsen SAa, Juhl T. Paternal depression in the postnatal period assessed with traditional and male depression scales Journal of Men’s Health & Gender 2007; 4(1):26–31

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Know the importance of the parental fathering role in family structures
- Describe the psychological, social, cultural and economic problems caused by unemployment amongst men
- Describe the health needs of gay, transgender and bisexual men (beyond sexual health) and their partners (e.g. you should understand their lifestyle and risk factors)\(^\text{26}\)
- Know the health needs of black and minority ethnic men (e.g. the differing disease prevalence in black and minority ethnic (BME) communities)
- Describe the social and cultural pressures that may be unspoken but which may underlie the reluctance of male patients to seek timely help and may inhibit male patients from expressing their health concerns (e.g. being seen in the surgery by a neighbour or close friend and having to explain why)
- Engage men in discussion about symptoms, and the link between lifestyle and health
- Promote well-being by applying health promotion and disease prevention strategies appropriately (e.g. safe sex)
- Use consultations with infrequent attendees opportunistically for health education
- Know the screening programmes available to men and be able to discuss these with patients

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Describe the features of a successful men’s health service, including cultural and social awareness
- Know how to evaluate the effectiveness of the primary care service you provide from the male patient’s point of view

\(^{26}\) King M, Semlyen J, Tai SS, \textit{et al.} A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people \textit{BMC Psychiatry} 2008; 8:70
• Understand equality legislation\textsuperscript{27}, such as the Health and Social Care Act 2012 in England that refers to tackling inequalities and the NHS Equality Delivery System\textsuperscript{28}, and the implications for you as a GP

• Develop practical means of engaging with men more effectively regarding their health

• Be able to review the role of well-man clinics in primary care

• Know that men’s presentation with aggressive behaviour could be a sign of psychological stress

• Know the local male-targeted health programmes or services for referral

• Recognise important variations in men’s health according to ethnicity, social class and geography e.g. being aware that male circumcision is important for several religious groups

• Describe the local demography, social deprivation and failings in service provision that may contribute to poor male health

**Case discussion**

Gerald Hinks is a 58-year-old former warehouseman who lost his job 12 months ago when his company had to make cuts. He has been married for 33 years and his two children have left home and live some distance away. His wife, Debbie, works part time in the local newsagent, which provides a very small income on top of the benefits that Gerald receives.

Gerald hasn’t really consulted much with you in the past ten years as he has only attended once to have his pandemic flu jab, which he needed because his elderly mother used to live with him until she unfortunately passed away four months ago.

You saw Debbie the other day in the local supermarket, when she mentioned to you that Gerald seemed quite tired recently and has been keeping her awake by getting up at night two or three times. She has found it hard to get up at five am for her job owing to the broken sleep she is getting. She asks you what might be wrong with Gerald. She also laughs out loud and says, ‘And Doc, he can’t keep me pleased any more either – get him sorted out will you.’ You make your excuses and leave Debbie contemplating which bottle of wine she is going to buy.

The next week you see Gerald’s name on your appointment list and welcome him to your consulting room but notice he has a slightly altered gait and that he has gained weight. He tells you that in recent months he has been needing to urinate more and more during the night and this has led him to feel very tired the day after. He also finds himself quite thirsty a lot of the time. He didn’t want to bother you but his wife had nagged him to come down. He has been decorating the front room recently and found he had a dreadful case of back pain, which won’t go away with pain killers.


You discuss the issues with him, check his blood pressure and weight, ask about his smoking and alcohol intake, and advise him that you would like to undertake a few tests to check out some of his symptoms. You find out that he is drinking two cans of strong lager each night, as well as three or four large whiskies – to try and help him sleep.

You ask him if there is anything else worrying or bothering him but he denies this. You arrange to see him again in two weeks’ time. After Gerald leaves you think about what he has told you and start typing into the computer the tests you need to order.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong>&lt;br&gt;This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td>What are my personal views about the use and abuse of alcohol that could influence my attitude to patients?&lt;br&gt;What are my personal preconceptions about men and the ‘male role’, and how might it influence my interaction with Gerald? How and why might my experience of this consultation differ if this patient was female?</td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong>&lt;br&gt;This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td>Would I have shared with the patient his wife’s concerns and if so what ethical dilemmas could it have presented?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong>&lt;br&gt;This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>How might I encourage Gerald to see me for follow up?&lt;br&gt;Do I feel I need to screen Gerald for any mental health issues? How might I raise this with him?&lt;br&gt;How do I broach the subject of erectile dysfunction with a man?&lt;br&gt;How do I handle the fact that I have already been given information about Gerald from Debbie? Should I involve Debbie in the management of Gerald’s poor health, given that she spoke to me originally?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong>&lt;br&gt;This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
<td>What aspects in the history are concerning, and what else do I need to do to explore any other red flags?&lt;br&gt;What clinical examination seems appropriate?&lt;br&gt;What investigations would I want to request?&lt;br&gt;How can I ensure that I do not run late whilst addressing all the issues?</td>
</tr>
</tbody>
</table>
| **Making decisions** | This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice. | Which, if any, of Gerald’s symptoms particularly worry me?  
How do I manage the presentation of undifferentiated illness and disease?  
What is my approach for managing uncertainty? |
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<tbody>
<tr>
<td><strong>Clinical management</strong></td>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
<td>Am I up to date with the guidelines for managing erectile dysfunction.</td>
</tr>
</tbody>
</table>
| **Managing medical complexity** | This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation. | How would I tackle the issues Gerald presents with in the consultation? How and what would I prioritise?  
Would I undertake health promotion in this consultation? |
| **Working with colleagues and in teams** | This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development. | Who else might I involve in Gerald’s assessment? |
| **Maintaining performance, learning and teaching** | This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity. | How can I ensure that I am up to date on the management of erectile dysfunction?  
What key national guidelines influence men’s health provision? |
| **Organisational management and leadership** | This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills. | How could I have reflected his wife’s concerns in his notes and should I have done it? |
Practising holistically and promoting health
This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>What has happened in Gerald’s life that could have an impact on his health? What social and cultural issues could be at play here?</td>
</tr>
<tr>
<td>How might Gerald’s financial and employment prospects affect his health?</td>
</tr>
</tbody>
</table>

Community orientation
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
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<tbody>
<tr>
<td>Why do men present less frequently to their GP – what factors should I take into account? What local initiatives am I aware of that address the issues of men’s health?</td>
</tr>
<tr>
<td>What services are available to support Gerald’s return to employment?</td>
</tr>
</tbody>
</table>

How to learn this area of practice

Work-based learning
In primary care and secondary care
The time you spend in general practice is ideal for gaining a better understanding of men’s health. Some practices offer ‘health check’ clinics specifically for men. The Men’s Health Forum promotes ‘National Men’s Health Week’, which takes place each June (since 2002). This is an ideal opportunity for the GP trainee to engage, perhaps helping to organise a practice event. Each year, the week focuses on an area of concern, e.g. in 2010 the focus was on men and physical activity, in 2011 it was men’s health and new technologies, in 2012 men and heart disease and in 2013 men and mental health. In June 2014, the focus will be men and work.

In secondary care
As a GP trainee you should take the opportunity during your hospital-based placements to attend outpatient clinics in specialties directly relevant to men’s health, such as urology outpatients. Sexual health clinics are also excellent environments to gain a better understanding of men’s health concerns and problems. It is important, however, to recognise that men’s health issues arise across all specialties that you encounter in the secondary care setting (including women’s health!).

Self-directed learning
The Men’s Health Forum has a website (www.menshealthforum.org.uk) that provides a number of informal resources that you will find useful. For GP trainees, your specialty training programme should offer case-based discussions where men’s health can be more fully explored (see below).

Learning with other healthcare professionals
Joint sessions with nursing colleagues provide multidisciplinary opportunities for learning about the wider aspects of men’s health, both in primary and in secondary care. For GP trainees, you should take the opportunity to accompany the occasional patient to hospital clinics to gain a better understanding of the ‘patient’s journey’ from a male perspective. The Royal College of General
Practitioners, in collaboration with the European Men’s Health Forum and the Men’s Health Forum runs occasional one-day training programmes on men’s health: see [www.rcgp.org.uk/courses-and-events/one-day-essentials.aspx](http://www.rcgp.org.uk/courses-and-events/one-day-essentials.aspx).

**Useful learning resources**

**Books and publications**

- Adler M. *ABC of Sexually Transmitted Diseases (5th edn)* London: BMJ Books, 2004
- Dolan A. 'You can’t ask for a Dubonnet and lemonade!': working-class masculinity and men’s health practices *Sociology of Health & Illness* 2011; 33(4): 586–601
- Martin LA, Neighbors HW, Griffith DM. The Experience of Symptoms of Depression in Men vs Women. Analysis of the National Comorbidity Survey Replication. *JAMA Psychiatry* 2013;70(10):1100–1106
**Web resources**

**British Society for Sexual Medicine (BSSM)**
For guidelines and membership [www.bssm.org.uk](http://www.bssm.org.uk)

**College of Sexual and Relationship Therapy (COSRT)**
For advice on psychosexual problems for both clinicians and patients. [www.cosrt.org.uk](http://www.cosrt.org.uk)

**The European Men’s Health Forum (EMHF)**
EHMF is a not-for-profit NGO. It is the only European organisation dedicated to the improvement of the health of men and boys in all its aspects and provides a platform for the collaboration of a wide range of stakeholder groups across Europe. Established in 2001, it has succeeded in raising the profile of men’s health through policy development, lobbying, campaigns, conferences and seminars, research and publications, and the provision of information directly to men. [www.emhf.org](http://www.emhf.org)

**Global Action on Men’s Health (GAMH)**
GAMH was established in 2013 by the EMHF as a collaborative project that brings together men’s health organisations, and others which share their objectives, in a new global network. GAMH’s mission is to create a world where all men and boys have the opportunity to achieve the best possible health and wellbeing wherever they live and whatever their backgrounds. [www.gamh.org](http://www.gamh.org)

**International Men’s Health Week**
Occurs annually and is synchronised around the world. [www.menshealthmonth.org/week/index.html](http://www.menshealthmonth.org/week/index.html)

**The International Society of Men’s Health**
The International Society of Men’s Health (ISMH) is the only international organisation dedicated to the rapidly growing field of men’s health. The comprehensive scope of men’s health brings together multiple disciplines such as urology, cardiology, endocrinology, oncology, gerontology, psychiatry, psychology, sexual and reproductive medicine, public health and others. It organises the biennial World Congress on Men’s Health. [www.ismh.org/en](http://www.ismh.org/en)

**Journal of Men’s Health (JMH: formerly Journal of Men’s Health & Gender)**

**The Men’s Health Forum (MHF)**
MHF is a charity that provides an independent and authoritative voice for male health in England and Wales and tackles the issues and inequalities affecting the health and well-being of men and boys. [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

They also run a ‘consumer’ website for men, with fast, free, independent advice [www.malehealth.co.uk](http://www.malehealth.co.uk)

**Trends in Urology and Men’s Health**
Content can be accessed online free of charge [www.trendsinurology.com](http://www.trendsinurology.com)
3.08 Sexual Health

Summary

- Sexual health is a UK government priority
- HIV continues to be one of the most important communicable diseases in the UK. The number of people living with HIV in the UK continues to rise and around 1 in 4 of those infected are unaware of their infection. General practice has a role in caring for patients with HIV and assessing the risk of having undiagnosed HIV
- Rates of sexually transmitted infection (STI) continue to rise, in some cases dramatically
- Teenage pregnancy rates in the UK remain high, as do abortion rates
- General practice has an important role in the management of sexual health problems, taking a holistic and integrated approach
- Sensitive, non-judgemental communication skills are essential

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Take a sensitive, non-judgmental and person-centred approach to handling sexual health problems
- Appreciate the definition of sexual health as being about the ‘enjoyment of the sexual activity you want without causing yourself or anyone else suffering or physical or mental harm. It is also about contraception and avoiding infections’
- Ensure that the doctor’s own beliefs, as well as moral or religious reservations about any contraceptive methods, abortion, sexual behaviour and practices, do not adversely affect the management of a patient’s sexual health

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29 [www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVData/](http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVData/)
Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Describe the ethical principles involved when treating patients who have sexual health concerns, e.g. contraception and abortion
- Understand the different cultural expectations regarding sexual behaviour and orientation
- Describe the importance of confidentiality, informed choice and valid consent
- Be aware of the legal aspects of providing contraception and sexual health in under-16s (including child protection issues)
- Be aware of the legal aspects relating to sexual health including termination of pregnancy and the methods used in the UK
- Ensure sensitivity to particular cultural beliefs and patient choice, e.g. the need for a female practitioner

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Take a sexual history from a male or female patient in a way that is private and confidential, non-judgemental, responsive to the reactions of the patient and avoids assumptions about sexual orientation or the gender of the partner(s), or assumptions related to age, disability or ethnic origin. (See also statements in 3.06 Women’s Health: communication and consultation.)
- Counsel patients with sexual problems including psychosexual issues related to contraception, sexually transmitted infection, HIV testing and patients who have an unplanned or unwanted pregnancy

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Be able to describe the functional anatomy of the male and female genital systems and the female reproductive physiology to aid diagnosis
• Apply the information gathered from the patient’s sexual history and examination to generate a differential diagnosis and formulate a management plan

• Understand the presentation of sexually transmitted infections that may present early and in an undifferentiated way, or may be present without symptoms

• Demonstrate a working knowledge of:
  o How to recognise HIV/AIDS and the presentations/complications: e.g. pneumocystis pneumonia, candidiasis, cryptococcus, Kaposi’s sarcoma, toxoplasmosis, lymphoma, hepatitis, tuberculosis
  o Conditions suggestive of immunosuppression

• Be able to describe common presentations of sexual dysfunction and of sexual violence and abuse, including covert presentations such as somatisation (physical symptoms)

• Perform a sexual health examination including digital and speculum examination, and assessment of the size, position and mobility of the uterus, and be able to recognise any abnormality of the pelvic organs. You should also be familiar with taking microbiology and virology swabs from the throat and ano-genital areas

• Demonstrate a working knowledge of:
  o The commonly used investigations in primary care: e.g. pregnancy testing, urinanalysis, approaches to the diagnosis of bacterial vaginosis
  o The limitations of these investigations and how to interpret them: e.g. blood tests for HIV, microbiology swabs, cervical screening (including HPV triage of low grade cytology and HPV test of cure management), and secondary care investigations like colposcopy

• Be aware of your competence to perform procedures, especially if you do not perform them regularly or have not had approved training

• Competently take a cervical screening test at the appropriate intervals

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Perform an appropriate risk assessment through history-taking

• Know when urgent intervention is needed in sexual health and, if necessary, refer appropriately, e.g. in the provision of emergency contraception or in severe pelvic inflammatory disease or in serious infections in the immune-compromised patient

• Be aware of the limitations of ‘watching and waiting’ because some serious infections, e.g. chlamydia and HIV, may also lapse back into being asymptomatic while still causing harm to the patient
Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Manage primary contact with patients who have sexual health concerns and problems
- Explain to patients the strategies for early detection of sexual health problems that may be present but have not yet produced symptoms
- Manage common as well as rare but important presenting signs and symptoms which will require subsequent examination, investigation, treatment and/or referral, as appropriate (e.g. genital skin/mucosal conditions, abnormal genital smell, discharge, presentations of pain, and vaginal bleeding)
- Recognise and use principles of treatment in relation to common as well as rare but important sexual health conditions in men and women (e.g. urinary tract and vaginal infections, tropical infections, sexual dysfunction/sexual addiction, conjunctivitis (neonatal and adult) and reactive arthritis)
- Demonstrate a working knowledge of:
  - Contraception: effectiveness rates, risks, benefits and appropriate selection of patients for all methods; safe provision of all methods of oral contraception, contraceptive patches and administration of depot medroxyprogesterone acetate (DMPA) injections, subdermal implants, intrauterine methods of contraception, sterilisation and natural family planning. Refer to the UK Medical Eligibility Criteria for Contraceptive Use
  - Abortion: methods and the legal procedures relating to referral for abortion
  - Principles of anti-retroviral combination therapy for HIV/AIDS, potential side effects and your role in their management in primary care
  - Gonorrhoea antibiotic resistance
- Manage sexual health emergencies (e.g. emergency hormonal contraception, emergency intrauterine contraception, post-exposure prophylaxis (PEP) in HIV prevention, referral for suspected Pneumocystis pneumonia (PCP), responding to early presentation of rape and sexual assault)

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.
This means that as a GP you should:

- Use the sexual history (including partner history and information on sexual practices including condom use) and other relevant information to assess the risk of sexually transmitted infection, unwanted pregnancy and cervical cancer
- Be able to teach the patient about male and female condom use
- Use risk assessment to tailor advice and care accordingly, including advice on safer sexual practices and hepatitis B immunisation/ HIV testing
- Understand which factors may indicate that a woman is at high risk of cervical cancer and the value of an opportunistic approach to screening in this group
- Know when to refer a patient with cervical screening abnormalities and what is involved in secondary care management
- Be able to describe the specific interventions for HIV prevention such as post-exposure prophylaxis and the prevention of mother-to-baby transmission

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Co-ordinate care and make timely, appropriate referrals to specialist services, especially to gynaecologists, sexual and reproductive health specialists, genito-urinary specialists, urologists, specialists in infectious diseases and specialists in sexual dysfunction – knowing the boundaries of what is reasonable and practicable in general practice

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Describe the key national guidelines that influence sexual healthcare provision
- Be able to describe the best-practice guidance on the provision of advice and treatment to young people under 16 years
Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Work in partnership with other members of the primary healthcare team to develop and update confidentiality policies related to sexual health
- Work in partnership with practice nurses, health visitors and other members of the practice team, including receptionists, to ensure patient services in sexual health are accessible and co-ordinated.

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Understand that sexual health problems have physical, psychological and social effects
- Understand and take into account cultural and existential factors that affect the patient’s risk of having sexual health problems and also their reactions to them
- Be sensitive to the social stigma that is often associated with sexual health problems, even for some healthcare professionals
- Promote sexual health and well-being by applying health promotion and disease prevention strategies appropriately
- Recognise factors associated with risky sexual behaviour including mental health problems, drug and alcohol misuse, and a history of sexual abuse
- Take into account the wider determinants of unplanned pregnancies and their impact on the individual and society
- Be aware of those whose sexual health needs may be inappropriately omitted by health professionals (those with physical or learning disabilities or the elderly)
- Understand the screening programmes in use in the UK and the benefits, limitations and need for informed consent (e.g. the Chlamydia Screening Programme and Cervical Screening Programme).

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• Be able to describe the different patient groups who are at greater risk of unplanned pregnancies and the value of an opportunistic approach for health promotion

• Examples of sexual health promotion opportunities in primary care include:
  o Health education and prevention advice – safe sex and risk reduction
  o Human papilloma virus (HPV) vaccination programme
  o Unplanned pregnancies
  o National screening programmes – cervical screening, chlamydia, antenatal HIV testing
  o Hepatitis B immunisation programme
  o Occupational risks – exposure to needle stick injuries

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Know the epidemiology of sexual health problems and how it is reflected in the local community
• Recognise that the prevalence of sexual health problems, including HIV, will be affected by the makeup of the local population
• Consider commissioning/provider issues for a locality need with a view to improving services, setting direction and managing services, e.g. religious circumcision provision and sexual health outreach for sex workers
• Know the principles of, and current guidance for, partner notification
• Provide patients with access to local sexual health services, including services for specialist contraceptive care; termination of pregnancy; STI diagnosis and management; HIV management; and services for relationship problems and sexual dysfunction
• Obtain specialist expertise, where necessary, through your local cytology and microbiology laboratories
• Describe the central role of you as a GP and your primary care team in the prevention of unwanted pregnancies; diagnosis and management of sexual problems; and prevention, diagnosis and management of sexually transmitted and other genital infections
• Be aware of the debate surrounding the effectiveness of the Chlamydia Screening Programme and suggestions to widen HIV testing to general practice new patient registration checks in high prevalence areas.

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Case discussion

Maria is a 26-year-old postgraduate student. She has moved to the UK from central Africa and has been registered with you for nearly two years. You note she attends infrequently but has had three abortion requests in this time. She has come to see you today because she has missed her last period and is requesting another abortion.

You try to explore her history but she seems reluctant to answer you and seems to be avoiding eye contact. You notice that she has not had a cervical screening test documented in her patient record and did not respond to her reminder letters. There is no evidence of any previous STI testing either. You recommend this to Maria but she declines this suggestion, saying she will arrange it another time and prefers just to have the abortion referral instead.

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How would my attitude towards Maria change if I learned she was a sex worker? Or a victim of sexual abuse?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td>What is the General Medical Council (GMC) guidance on Personal Beliefs and Medical Practice?</td>
</tr>
<tr>
<td></td>
<td>Do I have any personal ethical objections to dealing with sexual health matters such as abortion, repeated abortions or certain methods of contraception?</td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How might the guidance on entitlements to healthcare for overseas visitors affect my management?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td>What global health issues would I consider?</td>
</tr>
<tr>
<td></td>
<td>What are the legal issues regarding an abortion request?</td>
</tr>
<tr>
<td></td>
<td>What are the issues here regarding non-consensual sex or violence against women?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>What ‘phrases’ might I use to explore the sexual history?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>And what challenges might I face in ‘avoiding assumptions’ and making an appropriate ‘risk assessment’ in this case?</td>
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<td></td>
<td>Will Maria feel judged because of the unwanted</td>
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pregnancy or the abortion request? She is reluctant to answer questions – how do I determine if there are issues she feels unable to discuss today?

How might I approach taking a sexual health history generally in a sensitive and non-judgemental way for either gender?

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real-life practice, and demonstrating flexibility with regard to career development.

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- What is my plan for keeping up to date with current management of STIs and contraceptive choices?
- What evidence-based guidelines should I be aware of?

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- How do I record sensitive information in the notes? What read codes are commonly used?
- What is the local referral pathway for women requesting an abortion?

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- What might be the implications for Maria in relation to her future sexual health and her sexuality?
- What might be the psychological impact of repeated abortion on Maria?

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- If I was looking to evaluate and develop my local sexual health services how would I begin to do this?
- Does this case highlight an unmet need in the local community or health service?

### How to learn this area of practice

**Work-based learning**

**In primary care**

Primary care is the best place for a GP specialty trainee to learn how to manage sexual health problems because it is where the vast majority of patients present. The skill is in bringing the topic up if the patient does not do so. Patients will present their concerns and symptoms at varying stages of the natural history. As a trainee, critical and professional discourse with your trainer will aid you in developing an experience-based heuristic approach to problem-solving. Supervised practice will
engender confidence. Some general practices offer services in sexual health beyond what is considered core GP work. It would be beneficial to attend a session.

In secondary care

Some GP training programmes contain placements of varying length in obstetric and gynaecology units. These will give you exposure to patients with gynaecological and sexual health problems but it is important that as a specialty trainee you gain a broader understanding of sexual health than can be obtained in the gynaecology ward or clinics. By also attending sexual health clinics you will see concentrated groups of patients and learn about the issues involving women and men. Attendance at sexual health clinics (including family planning and genito-urinary medicine clinics) may be arranged for specialty trainees by their GP trainer or educational supervisor. Having a greater understanding of the access to/scope and limitations of sexual health provision in primary and secondary care will potentially give you a more patient-centred approach to offering sexual health care.

Self-directed learning

Many postgraduate deaneries provide their own courses on sexual health problems. Other providers include BASHH (British Association for Sexual Health and HIV) and the FSRH (Faculty of Sexual and Reproductive Healthcare). In response to the National Sexual Health Strategy, BASHH developed their two-day Sexually Transmitted Infection Foundation course (STIF) and more recently the STIF competency course, which is adapted from the Department of Health’s best-practice guidance Competencies for Providing More Specialised Sexually Transmitted Infection Services within Primary Care and complements the recommendations made in Standards for the Management of Sexually Transmitted Infections.

The RCGP offers a curriculum-based e-learning course on sexual health as part of the e-GP programme (www.e-GP.org) and an Introductory Certificate in Sexual Health (www.elearning.rcgp.org.uk). These resources provide a basic grounding in sexual health issues for GPs and practices nurses. To gain the certificate requires completion of the e-learning module followed by a one-day training event.

The FSRH also provide a comprehensive course consisting of e-learning modules, small group work and practical training, leading to an award of the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRH). Interested trainees can then progress to obtain letters of competence in subdermal implants (LoC SDI) and intrauterine techniques (LoC IUT). These serve to satisfy local clinical governance requirements for providers offering coil and implant fitting.

Learning with other healthcare professionals

Sexual health problems by their nature are often exemplars of teamwork across agencies and careful consideration and discussion of the roles of various individuals representing many professional and non-professional groups should be fruitful. As a specialty trainee it is essential that you understand the variety of services provided in primary care. Joint learning sessions with practice nurses and specialist colleagues in sexual health clinics will help you gain a greater understanding of both the services provided locally and the need for cross-agency communication and partnership working.
Useful learning resources

Books and publications

- BASHH/BHIVA. *Standards for the Management of Sexually Transmitted Infections*, 2010

Web resources

**British Association for Sexual Health and HIV**

This website provides guidelines on the treatment of sexually transmitted infections, as well as details about courses on genito-urinary medicine including the Sexually Transmitted Infection Foundation (STIF) course. www.bashh.org

**Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists**

Faculty of Sexual and Reproductive Healthcare (FSRH) grants diplomas, certificates and equivalent recognition of specialist knowledge and skills in family planning and reproductive health care. It promotes conferences and lectures, provides members with an advisory service and publishes *The Journal of Family Planning and Reproductive Health Care*. The faculty website provides a wealth of information on sexual health and information about its diploma examination. This website also offers the latest PDF versions of the UK Medical Eligibility Criteria for Contraceptive Use. www.fsrh.org
FPA

Formerly the Family Planning Association, the FPA is the only registered charity working to improve the sexual health and reproductive rights of all people throughout the UK. The FPA no longer runs family planning clinics, having handed them over to the NHS in 1974. After initiating and running family planning services for over 40 years, it successfully lobbied for its service to be provided free by the NHS. It provides an excellent website for patients and health professionals. [www.fpa.org.uk](http://www.fpa.org.uk)

International Planned Parenthood Foundation

Its directory of hormonal contraceptives (click on resources and information, then directory) is an excellent online resource to find out what is contained in 'foreign' brand pills. You can register as a user free of charge and download the whole directory. [www.ippf.org](http://www.ippf.org)

Marie Stopes International UK

The country’s leading reproductive healthcare charity, helping over 84,000 women and men each year. It has nine specialist centres and a network of GP partners that provide services for patients seeking help and advice. [www.mariestopes.org.uk](http://www.mariestopes.org.uk)

NICE

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Relevant NICE guidelines include:


NICE Public Health Guidance 34 – Increasing the Update of HIV testing among men who have sex with men 2011.

NICE Public Health Guidance 3 – Prevention of sexually transmitted infections and under age conceptions 2007

[www.nice.org.uk/](http://www.nice.org.uk/)

Relate

Relate is a national federated charity with over 70 years’ experience of supporting the nation’s relationships. Relate offers advice, relationship counselling, sex therapy, workshops, mediation, consultations and support face-to-face, by phone and through this website. [www.relate.org.uk/home/index.html](http://www.relate.org.uk/home/index.html)

Royal College of General Practitioners

e-GP Sexual Health modules

Experienced GP educators in sexual health have designed over 21 interactive and stimulating e-learning sessions which are underpinned by this RCGP curriculum statement including sessions on sexual history, contraception, STIs, HIV. [www.e-GP.org](http://www.e-GP.org)
Sexual Health in General Practice

This RCGP online course is part of the RCGP Introductory Certificate in Sexual Health (ICSH). You can also take it separately for self-directed learning.  www.elearning.rcgp.org.uk/sexualhealth

The Porterbrook Clinic

The Porterbrook Clinic, formerly known as the Marital and Sexual Problems Clinic, was established in 1974. The clinic has established itself as a centre of excellence, specialising in helping people with all kinds of sexual and relationship problems. The website provides useful downloadable patient information leaflets.  http://shsc.nhs.uk/service-a-z/porterbrook-clinic/leaflets/

Terrence Higgins Trust

The leading HIV and AIDS charity in the UK and the largest in Europe. It was one of the first charities to be set up in response to the HIV epidemic and has been at the forefront of the fight against HIV and AIDS ever since. The charity was established in 1982, as the Terry Higgins Trust. Terry Higgins was one of the first people in the UK to die of AIDS. A group of his friends wanted to prevent more people having to face the same illness as Terry and named the trust after him, hoping to personalise and humanise AIDS in a very public way. www.tht.org.uk
3.09 End-of-Life Care

Summary

- One of your essential roles as a GP is to help your patients die with dignity and with minimal distress
- Many terminally ill patients prefer the option of a death at home
- Most patients die of non-cancer/co-morbidity in old age
- GPs must be able to identify such patients in the last year of life
- GPs must be able to assess and make plans for future care needs
- Team working, interagency working and communication are fundamental

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Read the GMC’s document on end-of-life care with case examples
- Recognise that personal life events, such as deaths in the family, can make full clinical engagement a test of your professionalism

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Be aware of your cultural values and/or religious beliefs which might make it difficult for you to be non-judgemental about your patients’ decisions at the end of their life

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.
This means that as a GP you should:

- Communicate effectively with the patient, their family and carer(s) regarding difficult information about disease progression and prognosis.
- Describe how to provide and manage 24-hour continuity of care through various clinical systems.

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Describe palliative care emergencies and their appropriate management:
  - use of emergency drugs
  - major haemorrhage
  - spinal cord compression
  - anxiety/panic
  - dysphagia
  - bone fractures
  - hypercalcaemia
  - superior vena cava obstruction

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Apply the Gold Standards Framework in primary care
- Counsel and explain for patients and their carers:
  - symptom control
  - disease progression
  - processes around death and dying
  - advance care planning
  - normal and abnormal bereavement
Core Competence: Clinical management
This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.
This means that as a GP you should:

- Manage the full range of physical, social and spiritual needs of the patient, family and carer(s)
- Manage distressing symptoms, e.g. nausea, pain, shortness of breath and confusion.
- Use appropriate drug/nutrition delivery systems, e.g. a syringe driver
- Summarise suitable drugs combinations
- Describe the conversion of drugs from oral dosage to other appropriate delivery systems

Core Competence: Managing medical complexity
This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.
This means that as a GP you should:

- Summarise the principles of palliative care and end-of-life care and how these apply to cancer and non-cancer illnesses such as cardiovascular, neurological, respiratory and infectious diseases

Core Competence: Working with colleagues and in teams
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.
This means that as a GP you should:

- Function as both leader and member of end-of-life teams, as required

Core Competence: Maintaining performance, learning and teaching
This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.
This means that as a GP you should:

- Understand the evidence base for care at the end of life, while also acknowledging that it is less rigorous because there are very few trials available.
- Understand the difficulty of running double-blinded randomised controlled trials in patients who are dying

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Be aware of the many key national documents and policy statements that influence healthcare provision for cancer and palliative care. It is important that you are familiar with them

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Be aware of the spiritual needs of the patient and carer(s)
- Acknowledge the wide use of alternative therapies for the patient’s comfort rather than debating the lack of evidence
- Describe normal and abnormal grieving, and its impact upon symptomatology

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Summarise the social benefits and services available to patients and carer(s)
- Describe the current population trends in the prevalence of terminal illness in the community
- Explain the importance of the social and psychological impact of cancer on the patient’s family, friends, dependants and employers
Case discussion

Mr Singh is 82 years old and the head of a large Sikh family. He had a haemorrhagic stroke two months ago which left him with a reduced consciousness level and unable to communicate in any meaningful way. He did, however, retain the ability to swallow soft food. He is cared for at home by his daughters and granddaughters.

During the last week his consciousness level has declined a little more and he is now having difficulty swallowing. As his GP, you suspect that he has had further cerebral bleeding. Despite a concern about his swallowing, the family want to carry on at home, in line with their cultural practices and beliefs.

He deteriorates and you ask the palliative care consultant and her team to assess Mr Singh at home.

There are concerns about his hydration. An assessment is made to use a nasogastric tube or a drip, bearing in mind the family’s wishes. The family is still keen to care for him in his home.

After a discussion, including the risks, between the family and the clinical team they agree it should be possible to manage Mr Singh’s nutrition and hydration needs at home, with support from the palliative care team and careful monitoring.

Two weeks later, Mr. Singh is admitted to hospital with a chest infection caused by aspiration of food into his lungs. He is treated with IV antibiotics and a drip is inserted to provide hydration while further assessment of his condition is made. Further tests indicate that he has had more cerebral bleeding.

The team explains to Mr Singh’s family the factors they have weighed up in reaching a view that clinically assisted nutrition would not be of overall benefit for Mr Singh at this stage and that he should be transferred home in accordance with his and their wishes.

The family are reassured that they will receive support from the palliative care team to help them care for Mr Singh. His daughters agree that clinically assisted nutrition would not be of overall benefit at this stage and that the goals of care should focus on managing any pain and other symptoms, and ensuring that their father’s dignity and comfort will be maintained.

It is agreed that a drip will be continued to provide hydration. The consultant explains to the family that Mr Singh will need to be closely monitored and that the drip may need to be withdrawn if it is causing harm (for example, allowing secretions of fluid into his lungs).

A DNA CPR form is sensitively suggested by the doctor and agreed to. It is sent to the local ambulance service and the family take a copy home with them.

Mr Singh is transferred home, where he dies peacefully five days later.

(Source: This is a reduced and modified version of the GMC End-of-Life Care illustrative case.)

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:
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<th>Core Competence</th>
<th>Reflective Questions</th>
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| **Fitness to practise**                 | What are my personal feelings about advance care planning and adhering to my patient’s requests?  
| This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.  | How do we respect other people’s views and shared decision-making?                     |
| **Maintaining an ethical approach**     | What is the GMC’s advice on end-of-life care?                                          |
| This addresses the importance of practising ethically, with integrity and a respect for diversity. |                                                                                       |
| **Communication and consultation**      | How would I explain disease progression and processes around death and dying in this case? |
| This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters. |                                                                                       |
| **Data gathering and interpretation**   | In this context how far do I decide on the appropriateness of investigations?         |
| This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills. | To what extent will I act on the results?                                               |
| **Making decisions**                    | Which specific problem-solving elements are demonstrated in the case study?            |
| This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice. |                                                                                       |
| **Clinical management**                 | What other potential palliative care emergencies might arise in this situation and how would I manage them? |
| This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches. |                                                                                       |
| **Managing medical complexity**         | How do I involve patients in assessing risks and benefits when deciding on care at home for patients with complex clinical needs? |
| This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation. |                                                                                       |
| **Working with colleagues and in teams**| As the patient’s GP, where in this case study am I demonstrating my ability to function as both leader and member of end-of-life teams? |
| This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use |                                                                                       |
of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

**Maintaining performance, learning and teaching**
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.

What is the evidence-base for end-of-life care and what are the difficulties associated with research in this area?

**Organisational management and leadership**
This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

What is the importance of documenting issues such as care pathways and DNAR decisions?

**Practising holistically and promoting health**
This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

How could I manage the grieving process in Mr Singh's family?
On what occasions in this case study have the spiritual and cultural needs of my patient and his carers been identified and attended to?

**Community orientation**
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

What social benefits and services might be available to my patient and his carers?

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**How to learn this area of practice**

**Work-based learning**
There is no doubt that learning about end-of-life care happens best when you are actively involved in caring for a dying patient. Thus the best learning environment is where the patient and their carers are. This can be in the patient’s own home, or in a hospital, hospice or nursing home. You will find yourself surrounded by many health carers from whom you will learn how to become better at this very difficult and yet totally rewarding aspect of being a GP. Try if at all possible to follow a patient
through their end-of-life journey and build a case study with suitably anonymised clinical detail, accompanied by your reflections. Don’t forget to look after yourself. For GP trainees, working alongside your trainer can help in the day-to-day debriefing and emotional unloading. When death happens ask if you and your trainer can return to receive honest feedback from the family and carers about what they were feeling and their opinions on your performance. Do not try to defend your actions: listen and reflect and share with your colleagues. Training practices usually have regular meetings where deaths are discussed in detail with the caring teams.

Hospices usually have a community and holistic orientation and relating hospice care to GP care is straightforward. It is not so easy in the acute setting; however, it is important to remember it is the patient who is the focus of our care and the deliberate use of the Gold Standard Framework in end-of-life care is professionally and personally rewarding. Often in the acute setting you will find yourself having to use supportive leadership qualities to other team members who see dying as a failure of their care and ability to cure. These are the occasions for you to record often in your reflective journal. Don’t forget that poetry is a way to articulate feelings and tensions that retains freshness.

Self-directed learning
There are many formal learning events, especially in local hospices and courses run by the major charities. There is a growing body of e-learning to help consolidate and build on knowledge gained in the workplace. For GP trainees, your specialty training programme should offer case-based discussions where end-of-life care can be shared.

The arts cover dying and bereavement in great depth and in a variety of modalities: film, books, poetry, drama and painting. Fiction is as valid as non-fiction in helping you to understand yourself and your world.

Deaths in our own life can affect the way in which we manage the deaths of others. Be open about it with your supervisors.

Useful learning resources

Books and publications

- Buckman R. I Don’t Know What to Say: how to help and support someone who is dying London: Papermac, 1988
There are many novels and films that accurately portray the experience of dying from the patient’s, the carer’s and the professional’s perspective. They are valuable ways of understanding the human experience and can be used in groups to supplement case material.

Web resources

e-ELCA e-learning for end-of-life care

End of Life Care for All (e-ELCA) is an e-learning project for the NHS, commissioned by the Department of Health and delivered by e-Learning for Healthcare (e-LfH) in partnership with the Association for Palliative Medicine of Great Britain and Ireland. It was developed to support the implementation of the Department of Health's national End of Life Care Strategy. [www.e-lfh.org.uk/projects/end-of-life-care](http://www.e-lfh.org.uk/projects/end-of-life-care)

Gold Standards Framework for Community Palliative Care

Offers primary healthcare teams an evidence-based programme with the tools and resources to help improve the planning of palliative care for their patients in the community.

The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life. [www.goldstandardsframework.org.uk](http://www.goldstandardsframework.org.uk)

Palliative Care Guidelines Scotland

These Palliative Care Guidelines reflect a consensus of opinion about good practice in the management of adult patients with a life limiting illness. [www.palliativecareguidelines.scot.nhs.uk](http://www.palliativecareguidelines.scot.nhs.uk)

General Medical Council (GMC)

**NICE: End of Life Care Quality Standard**

This NICE quality standard defines clinical best practice within this topic area. It provides specific, concise quality statements, measures and audience descriptors to provide the public, health and social care professionals, commissioners and service providers with definitions of high-quality care. [http://guidance.nice.org.uk/QS13](http://guidance.nice.org.uk/QS13)

**Palliative Care Matters**

Palliative Care Matters is a website intended for health-care professionals working in palliative care or related fields.

Includes the *Palliative Care Handbook*.

[www.pallcare.info](http://www.pallcare.info)

**RCGP e-learning**

**RCGP End of Life Care Resources**

This webpage provides useful information and links to resources on end of life care [www.rcgp.org.uk/end_of_life_care/home.aspx](http://www.rcgp.org.uk/end_of_life_care/home.aspx)

**e-GP**

The e-GP Palliative Care course includes topics such as pain and symptom control, the final days, and ethical, psychosocial and medico-legal issues. [www.e-GP.org](http://www.e-GP.org)

**Charitable organisations**

Macmillan Cancer Support
Offer practical advice and support for patients and families affected by cancer. [www.macmillan.org.uk](http://www.macmillan.org.uk)

Marie Curie Cancer Care
Offer practical advice and support for patients and families affected by cancer. [www.mariecurie.org.uk](http://www.mariecurie.org.uk)

Hospice UK
Champions and supports the work of member organisations, which provide hospice care across the UK, so that they can deliver the highest quality of care to people with terminal or life limiting conditions, and support their families. [www.hospiceuk.org](http://www.hospiceuk.org)
### 3.10 Care of People with Mental Health Problems

#### Summary

- You should consider the mental health of a patient in every primary care consultation: 90% of people with mental health problems across the lifespan are managed in primary care.
- Mental health problems contribute to disability, unemployment and social exclusion.
- Depression and anxiety are common in people with long-term physical conditions, and increase the morbidity and mortality from these conditions.
- People with severe mental health problems have an increased risk of morbidity and mortality owing to cardiovascular disease and diabetes; as a general practitioner (GP) you have a significant role in prevention, detection and management of this physical co-morbidity.
- People with unexplained physical symptoms may have underlying psychological distress, but be aware of the dangers of medicalising distress. Repeated investigation is costly in terms of patient suffering and healthcare costs.
- Good communication skills, particularly listening skills, empathy, understanding and compassion, are key in managing people with mental health problems.
- An exploration of physical, psychological, social, cultural and spiritual issues should be integrated into both the consultation and the management of illness; cultural issues can impact on how mental health issues present and the acceptability of diagnosis.
- Offering alternative approaches and close working with the third sector (voluntary and community sectors) are important.

#### Knowledge and skills guide

**Core Competence: Fitness to practise**

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Understand the demands of working with people with mental health problems and the need to make sure you remain healthy; consider the need for supervision and support from your trainer, or peers.

**Core Competence: Maintaining an ethical approach**

This addresses the importance of practising ethically, with integrity and a respect for diversity.
This means that as a GP you should:

- Understand and reflect on how the need for confidentiality and informed choice may make you feel, always taking into account the patient’s perspective
- Understand how your own beliefs and value systems may influence your interactions with patients with mental health problems

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Enable people who are experiencing mental health problems to engage as much as possible in understanding their difficulties and negotiate appropriate, acceptable management
- Use communication skills that enable your patients who are distressed to feel comfortable enough to disclose their concerns
- Use assessment schedules in a patient-centred way
- Understand the concept of concordance, which is particularly important in mental health care:
  - You need to support patients in making choices about which treatment options may work best for themselves
  - You should understand that this ability to choose improves the likely effectiveness of the intervention
- Understand the range of psychological therapies available including cognitive behavioural therapies, mindfulness, counselling, psychodynamic, psychosexual and family therapy
- Provide opportunities for continuity of care for people with mental health problems
- Be aware of the need to promote hope and demonstrate compassion and their use as resources to aid healing

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Understand the epidemiology of mental health problems in general practice
- Know the prevalence of mental health problems and needs amongst your own practice population
• Understand the difference between depression and emotional distress, and avoid medicalising distress

• Understand the role of case-finding in identifying people at risk of developing mental health problems, using effective and reliable instruments where they are available

• Understand the place of instruments in case-finding for depression (the Whooley questions\textsuperscript{35}) and for assessment of severity of symptoms (GAD-7\textsuperscript{36} for anxiety and PHQ-9\textsuperscript{37} for depression)

• Ensure that you appropriately explore both physical and psychological symptoms, family, social and cultural factors, in an integrated manner

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Understand the roles and the power of emotions and their relevance in well-being and mental illness

• Recognise early indicators of difficulty in the psychological well-being of children and young people and respond quickly to concerns raised by parents, family members, early-years workers, teachers and others who are in close contact with the child or young person

• Understand specific interventions and guidelines for individual conditions using, where appropriate, best practice as described in the Scottish Intercollegiate Guidelines Network (SIGN) or NICE guidelines

• Be able to assess and manage risk/suicidal ideation

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

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\textsuperscript{35} This two-question case-finding instrument is a useful measure for detecting depression in primary care. The questions are: During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things? A positive response to either indicates that a person may be depressed and further assessment is needed.

\textsuperscript{36} The GAD-7 is a brief clinical measure for the assessment of Generalized Anxiety Disorder (GAD). This tool may serve as a case-finding instrument to identify probable cases of GAD, and the scale scores provide a measure of severity.

\textsuperscript{37} The PHQ-9 is a nine item depression scale of the Patient Health Questionnaire. It is a useful tool for assisting in diagnosing depression, assessing severity, as well as selecting and monitoring treatment.
This means that as a GP you should:

- Understand and empathise with people who are distressed and fully assess them (including risk) and offer appropriate support and management
- Understand the primary care management of patients with common mental health problems
- Understand the initial management of a patient with a suspected psychotic illness
- Manage people experiencing mental health problems in primary care, using alternative interventions where appropriate, including forms of talking therapy, medication and self-help
- Be able to co-create and implement an immediate safety plan with a suicidal patient

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Ensure that people with severe mental illness are screened for metabolic and cardiovascular risk factors and that such risks are minimised through appropriate lifestyle advice and management, including facilitating behaviour change
- Know how to use case-finding in people with physical illness who are at risk of mental health problems
- Understand the importance of recognising and treating depression and anxiety in people with long-term physical illnesses
- Understand the common mental health problems in older people and the importance of considering complex multi-morbidities in such patients
- Understand the psychological effects of trauma and war (e.g. post-traumatic stress disorder) and the needs of veterans
- Understand the range of mental health problems that people with learning difficulties may experience
- Recognise the increased risk of mental health problems in the perinatal period and demonstrate how to assess and manage these appropriately in general practice

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.
This means that as a GP you should:

- Understand how to access local health and social care organisations, both statutory and third sector, that are an essential component of managing people with mental health problems
- Understand your responsibilities for supporting children in difficulty, and know how to access support and advice from specialist Child and Adolescent Mental Health Services (CAMHS) and CAMH workers in primary care

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand the evidence base for care of people with mental health problems: evidence gathered through randomised controlled trials may not capture the complexities of working with people with mental health problems in primary care
- Be aware of the content, but also the limitations, of the key national guidelines that influence the provision of mental health services
- Be aware of:
  - The Mental Health Act
  - The Mental Capacity Act (or equivalent legislation)
  - The General Medical Services contract and Quality and Outcomes Framework and the reductionist approach to care

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Know how to use your practice registers for specific mental health conditions and record the required data as part of your General Medical Services contract
- Understand why some people find it difficult to access primary care and mental health services with their symptoms, and what you can do to increase equity of access to care
- Recognise how practice systems may reduce continuity of care, e.g. appointment systems that prioritise access may reduce patient continuity
Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Understand that a model of mental illness that creates an artificial separation between mind and body is often unhelpful – particularly in understanding psychosomatic complaints, psychological consequences of physical illness and medically unexplained symptoms
- Be aware of the impact that social circumstances such as poverty, debt, inequalities and upbringing can have on mental illness, and that recovery is contingent on the effective management of those social circumstances
- Understand that mental illness is culturally determined and depends on assumptions that may not be universal, e.g. that a psychological intervention may not be acceptable to some people who have alternative explanations for, and understanding of, their symptoms
- Be aware of the need for you to be culturally sensitive in your approach to all patients
- Understand the well-being agenda and the importance of mental health promotion and psychosocial interventions in preventing mental ill-health
- Demonstrate an understanding of the evidence base for the positive relationship between work and mental health, and the association between unemployment and declining mental health

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Understand the stigma that can be associated with the label of a mental health problem
- Understand how mental health problems contribute to (and are caused by) social exclusion, health inequalities and unemployment, and be aware of the contribution that you as a GP can make to support a patient
- Be able to work in partnership with other agencies to offer appropriate social interventions for individuals
- Be able to work in partnership with other agencies to secure wider public health for your local population
Case discussion

Bushra is 51 years old and rarely consults the practice. She works as a teaching assistant. Her husband, Imran, is 56, has diabetes and has just been made redundant from his job in a national IT company. Bushra attends your surgery complaining that she can’t settle, she feels ‘uptight’ and irritable, and finds it difficult to get to sleep. She is hot most nights and complains of palpitations. She stopped having periods about nine months ago. She is tearful in the consultation, but doesn’t feel that her mood is low all the time. She says she is ‘just about’ coping with school, but feels she is getting frustrated with her pupils. She is worried about her husband, who has stopped going to family events and only goes out to the job centre when he needs to. She says he recently came to an appointment at the practice with a different doctor. Bushra tells you that she is worried because Imran’s brother has a ‘mental problem’, which the family don’t talk about, and he is on some very strong tablets. He was admitted to hospital once, when he was 19, and the family are very ashamed of that.

The couple have four children; the youngest daughter, Safa, is 15 and Bushra describes her as ‘wayward’. She stays out late at night with friends from school, and Bushra thinks she might be smoking cannabis but hasn’t told her husband as he already always seems to be shouting at Safa. She worries about her daughter and wonders if she should confront her about her behaviour.

You spend some time in the consultation exploring Bushra’s concerns and think she is anxious. She scores 14 on the GAD-7 and you discuss with her the possibility that she has an ‘anxiety problem’ that might benefit from some treatment. You also suggest she has a blood test done to ‘check her thyroid’. She agrees to have the blood test but says she doesn’t want tablets – she thinks her husband might have been prescribed some, but she is not sure, and she feels that she should be able to sort things out for herself. She also feels that tablets are only for weak people.

You suggest that Bushra may wish to make contact with a South Asian women’s group held at the local library. She is not too sure and asks if there is anything else. You give her details of the local self-help services and explain that she needs to make contact with them herself. You also give her some written material about anxiety and panic and ask her to read it, and come and see you in two weeks.

Imran comes to see you later in the week saying that another doctor in the practice had prescribed some tablets because he said he was depressed. Imran disagrees and hasn’t taken the tablets. You explore how Imran is feeling and he starts to cry. He tells you that he feels worthless and feels that he has no function in the family. He admits that he does wish that he would not wake up, although he has not thought about harming himself. He denies any odd or unusual thoughts. You ask Imran what he thinks would help him and why he is reluctant to take the tablets. He describes his fear of becoming ill like his brother. You suggest that he might be depressed and perhaps discussing this would be helpful.

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:
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<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
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<td><strong>Fitness to practise</strong></td>
<td>What are the boundaries of my involvement and responsibilities?</td>
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<tr>
<td>This concerns the development of</td>
<td>How do I maintain my own health as a GP?</td>
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<tr>
<td>professional values, behaviours and</td>
<td>What is meant by ‘resilience’?</td>
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<td>personal resilience and preparation for</td>
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<td>career-long development and revalidation.</td>
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<td>your own performance, conduct or health</td>
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<td>might put patients at risk, as well as</td>
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<td>taking action to protect patients.</td>
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<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How do I feel about patients consulting me with complex</td>
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<tr>
<td>This addresses the importance of</td>
<td>psychosocial and mental health problems?</td>
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<tr>
<td>practising ethically, with integrity and</td>
<td>How do I deal with my feelings about working with</td>
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<td>a respect for diversity.</td>
<td>patients who are distressed?</td>
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<td>What are the relevant sections from Good Medical Practice?</td>
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<td><strong>Communication and consultation</strong></td>
<td>How might mental health problems affect</td>
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<tr>
<td>This is about communication with patients</td>
<td>communication between doctor and patient?</td>
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<td>, the use of recognised consultation</td>
<td>How do I achieve empathy and understanding of mental</td>
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<td>techniques, establishing patient</td>
<td>health issues?</td>
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<td>partnerships, managing challenging</td>
<td>How do my own feelings affect my interactions?</td>
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<td>consultations, third-party consulting</td>
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<td>and the use of interpreters.</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What assessment tools are appropriate for use in Primary Care?</td>
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<tr>
<td>This is about interpreting the patient’s</td>
<td>What are the essential ‘red flag’ symptoms and signs?</td>
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<td>narrative, clinical record and biographical</td>
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<td>data. It also concerns the use of</td>
<td>How do I assess alcohol and drug misuse?</td>
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<td>investigations and examination findings,</td>
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<td>plus the adoption of a proficient approach</td>
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<td>to clinical examination and procedural</td>
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<td>skills.</td>
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<td><strong>Making decisions</strong></td>
<td>How do I differentiate between organic and psychological</td>
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<tr>
<td>This is about having a conscious,</td>
<td>symptoms?</td>
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<td>structured approach to decision-making;</td>
<td>Am I familiar with variations and patterns of</td>
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<td>within the consultation and in wider</td>
<td>presentations of common mental health conditions?</td>
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<tr>
<td>areas of practice.</td>
<td>How might time and continuity influence my decisions?</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>What are the important evidence based guidelines for</td>
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<tr>
<td>This concerns the recognition and</td>
<td>management of mental health issues in Primary Care?</td>
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<tr>
<td>management of common medical</td>
<td>When and how should I refer to specialist services?</td>
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<tr>
<td>conditions encountered in generalist</td>
<td>How do I manage continuity of care, response to</td>
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<tr>
<td>medical care. It includes safe</td>
<td>treatment, and regular monitoring?</td>
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<td>prescribing and medicines management</td>
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<td>approaches.</td>
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<tr>
<td><strong>Managing medical complexity</strong></td>
<td>How does pre-existing or comorbidity affect the</td>
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<tr>
<td><strong>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</strong></td>
<td>presentation of mental health problems?</td>
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<td>What conditions have most significant implications for medical management and drug treatment?</td>
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<td>What are the priorities for ensuring patient safety?</td>
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<td><strong>Working with colleagues and in teams</strong></td>
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<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
<td>What alternative interventions and therapies are available in Primary Care?</td>
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<td>How do we create seamless multi-disciplinary services in this field?</td>
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<tr>
<td>How do we define areas of responsibility and leadership in mental health services?</td>
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<tr>
<td><strong>Maintaining performance, learning and teaching</strong></td>
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<tr>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
<td>What are the best sources of updated information in Mental Health?</td>
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<td>What is the role of peer group support e.g. Balint groups?</td>
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<td>How can I audit the standard of care I provide?</td>
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<tr>
<td><strong>Organisational management and leadership</strong></td>
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<tr>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
<td>What additional risk factors should I screen for in patients with mental health problems?</td>
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<td>What systems do I need to be in place to ensure safe and consistent monitoring?</td>
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<tr>
<td>How do we develop services to provide ready access to marginalised and stigmatised members of society?</td>
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<tr>
<td><strong>Practising holistically and promoting health</strong></td>
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<tr>
<td>This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</td>
<td>What are the important determinants and influences on mental health?</td>
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<td>How does my role extend beyond the medical model?</td>
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<td>How well equipped am I to explore cultural and spiritual factors in patients’ lives?</td>
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<tr>
<td><strong>Community orientation</strong></td>
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<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based,</td>
<td>How can I ensure equity of access to mental health services?</td>
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<tr>
<td>What community resources are available for my patients with mental health problems (including the third sector)?</td>
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<td>How do I ensure that I understand and recognise the</td>
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How to learn this area of practice

Work-based learning

In primary care

Primary care, both inside and outside the practice, is the ideal environment for you to learn about the care of people with mental health problems. As a GP specialty trainee you should become familiar with the assessment schedules you can use in consultations to aid diagnosis and guide your management of patients with mental health problems. GP trainees should learn from patients and carers by offering health reviews and participating in their training practices’ mental health activities.

As a GP trainee you should take the opportunity to gain a better understanding of the role of the primary care mental health teams, specialist teams, referral criteria and care pathways. Attend any liaison meetings that are held in the practice with members of the specialist team. Attending clinic appointments with patients will help you better understand the patient’s journey and the partnership across the primary/secondary interface. As a trainee you should also take the opportunity to learn how to adopt a shared-care approach to primary care mental health with the community mental health teams and intermediate care mental health teams.

Teamwork learning resource

There is a toolkit specifically designed for primary care teams to evaluate the extent to which they and their practices promote mental health. It is available from d.p.c.tomson@ncl.ac.uk or maryanne.freer@pcpartners.org, or from NIMHE.

In secondary care

Some GP training programmes contain placements of varying length in psychiatry units. These will give you exposure to patients with mental health problems but it is important that as a GP specialty trainee you gain a broader understanding of mental health than can be obtained in the psychiatry ward or clinics. Learn from community mental health teams about how referrals are assessed, which patients are cared for by both primary and specialist care, and understanding their physical health needs. There should also be opportunities to learn from graduate mental health workers/psychological practitioners (and other primary care mental health service providers, including the third sector) about which resources are available locally and how to create a local practice resource directory.

Self-directed learning

Many postgraduate deaneries and RCGP Faculties provide courses on mental health problems.

The RCGP offers e-learning courses on a number of mental health topics (such as older people’s mental health; improving access to psychological therapies; substance misuse) as part of the e-GP programme (www.e-GP.org).
Learning with other healthcare professionals
Managing patients with mental health problems often requires teamwork across health and social care, and the third sector. Careful consideration and discussion of the roles of various individuals representing the many professional and non-professional groups should be fruitful. As a GP specialty trainee it is essential that you understand the variety of services provided in primary care. Joint learning sessions with psychiatry trainees and mental health practitioners will help you gain a greater understanding of both the services provided locally and the need for cross-agency communication and partnership working.

Useful learning resources

Books and publications
- Age UK. Promoting Mental Health and Well-being in Later Life, 2011
- Beech R and Murray M. Social engagement and healthy ageing in disadvantaged communities Quality in Ageing and Older Adults 2013; 14(1): 12-24
- Cole-King A, Lepping P. Suicide mitigation: time for a more realistic approach British Journal of General Practice 2010; 60: 3-4
- Department for Work and Pensions (DWP). Caseloads for employment and support allowance and incapacity benefits Administrative Data Tabulation Tool 2010


• Henderson DC. Atypical anti-psychotic-induced diabetes mellitus: how strong is the evidence? *CNS Drugs* 2001; 16: 1–13


• Mental Health Foundation. *Starting today: the future of MH services. Final enquiry report* Sept 2013


Web resources

AMP – Improving access to Mental Health in Primary Care

A guide to delivering good quality health services to people with mental health problems from under-served groups [www.amproject.org.uk](http://www.amproject.org.uk)

The Mental Capacity Act Code of Practice


Mental Health Act


NHS Wales NSF Mental Health

This website provides information and links to the National Service Framework for Adult Mental Health Services in Wales [www.wales.nhs.uk/sites3/home.cfm?orgid=438](http://www.wales.nhs.uk/sites3/home.cfm?orgid=438)

NIMHE National Early Intervention Programme

The Early Intervention in Psychosis IRIS Network supports the promotion of EI in psychosis. Their website includes links to resources. [www.iris-initiative.org.uk](http://www.iris-initiative.org.uk)

Northern Ireland Association for Mental Health

Niamh, (the Northern Ireland Association for Mental Health), is an independent charity focusing on mental health and wellbeing services in Northern Ireland. [www.niamh.co.uk](http://www.niamh.co.uk)

Royal College of General Practitioners (RCGP)

There are a number of mental health courses on the online learning environment. [www.elearning.rcgp.org.uk](http://www.elearning.rcgp.org.uk)

The Primary Care Mental Health Forum (2009-12) developed a number of factsheets which are still available on the RCGP website. [www.rcgp.org.uk/clinical-and-research/clinical-resources/mental-health.aspx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/mental-health.aspx)

Royal College of Psychiatrists (RCPsych)

This website provides a number of useful resources including:

Improving physical and mental health
[www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh.aspx](http://www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh.aspx)

[www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx](http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx)
3.11 Care of People with Intellectual Disability

Summary

As a general practitioner (GP) caring for adult patients with intellectual disability, you should:

- Recognise the importance of the principle of fairness and equality, irrespective of the innate abilities of each patient
- Recognise that in every consultation you must make the effort to identify, monitor and review the progress of all patients who have difficulties with communication, social relationships and managing their own affairs
- Recognise that respect for diversity may involve challenging the values of the local community and society in general
- Be aware of the atypical morbidity and mortality prevalent in patients with intellectual disability and the atypical presentation of acute and chronic physical and psychiatric disorders
- Be aware of the additional skills of diagnosis and examination needed in patients unable to describe or verbalise symptoms and where to obtain specialist advice and help
- Be aware of the effects intellectual disability has on the life history of the patient and family, particularly at times of transition
- Be aware of the effects intellectual disability has on the aging process, particularly in the development and recognition of dementia
- Understand the value of conducting regular (annual) health checks
- Appreciate the role of your own patients in the evolution of services for patients with intellectual disability. All mainstream services should offer patients with intellectual disability professional resources and facilities that are appropriate and tailored to their needs.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Be aware of your own feelings and attitudes to disability
- Be aware of your own feelings and attitudes to difficult decisions in the care of adults with intellectual disability
Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Respect the equal rights of all citizens to health care, health information and health promotion
- Appreciate that inclusion begins with and depends on commitment to the development of a fully accessible service
- Show respect for the patient’s right to make decisions about some aspects of their lives in accordance with the Mental Capacity Act 2005 in England and Wales, common law in Northern Ireland and the Adults with Incapacity (Scotland) Act 2000

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Be aware of residential situations and daytime activities available locally to adults with intellectual disability, including those provided by the voluntary sector
- Be aware of how communicating via carers may affect the doctor–patient relationship
- Optimise communication through the use of consulting skills and communication aids
- Be aware of the issues of capacity and consent, and the mechanisms by which these can be determined

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Describe how psychiatric and physical illness may present atypically in patients with intellectual disability because of sensory, communication and cognitive difficulties
- Demonstrate the necessary skills to conduct a physical and mental state assessment in a patient with intellectual disability with regard to the higher prevalence of some problems, such as respiratory conditions and epilepsy
- Understand the need to use additional enquiry, appropriate tests and careful examination in patients unable to describe or verbalise symptoms
• Understand the significance and prevalence of oropharyngeal disorders and dysphagia in people with intellectual disability and its relevance to the high prevalence of respiratory disorders in these patients

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Be aware of the concept of diagnostic overshadowing when a person's presenting symptoms are put down to the disability, rather than the doctor seeking another, potentially treatable cause

• Understand the psychiatric disorders prevalent in the adult with intellectual disability and how their diagnosis, detection and management differ particularly with regard to –
  o emotional and behavioural disorders
  o bereavement reactions
  o anxiety and depression
  o schizophrenia
  o bipolar affective disorder
  o Alzheimer’s disease
  o Autism and autistic spectrum conditions

• Understand developmental disability and the neurologically based disorders that originate before birth and affect the patient throughout life. In particular, you need to understand the diagnosis and management of patients with autistic spectrum conditions

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

• Understand the need to support adolescents with intellectual disability as they become adults and no longer have the multidisciplinary support of community paediatricians

• Create and maintain a register of adults with intellectual disability in the practice and correlate this to the shared local health and social services registers

• Understand the importance of the annual health check to an adult with intellectual disability

• Manage and undertake annual health checks within the primary care team and arrange the necessary referrals and follow-up of conditions detected by tailoring chronic disease management to the particular needs of this group of the practice population
• Understand your role in ensuring equal access to mainstream services, ensuring those services make ‘reasonable adjustment’ to the needs of patients with intellectual disability, whenever required

• Provide more time in the consultation in order to deal more effectively with people with intellectual disability

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

• Be aware of likely associated conditions, the high mortality, the high morbidity and the difference in morbidity in people with intellectual disability compared to the rest of the population

• Understand how patients with borderline intelligence have difficulty coping with complex executive mental functions and how this can affect their behaviour

• Understand how health promotion can be overlooked in the care of patients with intellectual disability and the importance of tailoring health promotion to the needs of this special group particularly with regard to the difficulties of routine screening, such as cervical cytology, mammography, abdominal aortic aneurysm and bowel cancer screening

• Understand how adults with intellectual disability are subject to poly-pharmacy and how this can be made safer

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.
This means that as a GP you should:

- Understand the technical and ethical difficulties of designing research studies using bio-medical models
- Have an awareness of the evidence regarding the health needs of people with intellectual disability
- Understand the evidence regarding the effectiveness of routine health interventions, including annual health checks
- Understand the importance of developing and maintaining continuing learning of physician-based issues that are barriers to healthcare, including:
  - a lack of specialist knowledge about the health issues of people with intellectual disability
  - a lack of awareness of appropriate specialist support services (behavioural support teams or psychiatric or neurological assessment) and their availability

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Understand the impact of the doctor’s working environment on the care provided to patients with intellectual disability, e.g. access, atmosphere in the waiting area, the measures taken to compensate for sensory impairment

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Understand the impact of intellectual disability on family dynamics and the implications for physical, psychological and social morbidity in the patient’s carers
- Understand that by the time the patient with intellectual disability has reached adulthood the parents have gone through a different series of transitions to other parents and subsequently if their child dies they may go through a bereavement process that differs from those whose child without intellectual disability dies (see also 3.09 End-of-Life Care)
- Understand the emotional and sexual needs of adults with intellectual disability and how they can be expressed
• Demonstrate the use of screening tests for adults with intellectual disability to detect neurological and psychiatric problems such as dementia and depression

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Recognise the risk to adults with intellectual disability of physical, sexual, financial, institutional, discriminatory and emotional abuse

• Be aware of the sometimes negative response of the community to the presence of adults with intellectual disability, especially in the area around communal homes, such as ‘hate crimes’

• Offer consultations at times which provide optimal care of the patient by ensuring access to key workers and services

• Describe the roles of carers, respite care and voluntary and statutory agencies, and demonstrate an ability to work in partnership with these so that there is co-operation without duplication based on a free flow of communication which, when necessary and possible, maintains confidentiality

**Case discussion**

Amy lives in a residential home with 40 other residents, supported by a staff some of whom are permanent and experienced and some of whom are employed by an agency for periods of weeks or months. She has moderate intellectual disability and attends a local training centre five days each week. Her parents live near the home and they visit her regularly – every other weekend she returns home and stays overnight.

She is 41 years old and the staff bring her to see you saying that recently her behaviour has changed. She is accompanied on this occasion by a carer who has looked after her for years and relates a detailed history, together with her concerns:

• Amy has become aggressive, especially at meal times. During a meal with the other residents she can lash out and hit a member of staff or someone sitting next to her

• Her appetite has decreased and there is concern she has lost weight

• Whereas before she used to be the first ready to go to the training centre every morning, she is now rarely ready and needs help with dressing before she goes

• She used to recount to her parents what she had made and done each day but now remains quiet when they visit

You ask about her general health:

• She frequently wets herself

• Her periods are no problem now – she has not had one for seven months
- Her sleep is disturbed and she wanders from her room at least once each night
- Her bowels open every day as before but she has become incontinent of faeces

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>Do I have any preconceptions about intellectual disability?</td>
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<tr>
<td>This concerns the development of</td>
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<td>professional values, behaviours</td>
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<td>and personal resilience and</td>
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<td>preparation for career-long</td>
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<td>development and revalidation.</td>
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<td>It includes having insight into</td>
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<td>when your own performance,</td>
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<td>conduct or health might put</td>
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<td>patients at risk, as well as</td>
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<td>taking action to protect</td>
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<td>patients.</td>
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<td><strong>Maintaining an ethical approach</strong></td>
<td>What does patient autonomy mean for this patient?</td>
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<td>This addresses the importance of</td>
<td>What would be my reaction to an adult without</td>
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<td>practising ethically, with</td>
<td>intellectual disability who presents with the same</td>
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<td>integrity and a respect for</td>
<td>behaviour problems?</td>
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<tr>
<td>diversity.</td>
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<td><strong>Communication and consultation</strong></td>
<td>What are the difficulties in obtaining a history of</td>
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<td>This is about communication with</td>
<td>behaviour change in an adult with intellectual disability?</td>
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<td>patients, the use of recognised</td>
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<td>consultation techniques,</td>
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<td>establishing patient</td>
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<td>partnerships, managing</td>
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<td>challenging consultations, third-</td>
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<td>party consulting and the use of</td>
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<td>interpreters.</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>Who else could I ask to provide further information?</td>
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<td>This is about interpreting the</td>
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<td>patient's narrative, clinical</td>
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<td>record and biographical data.</td>
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<td>investigations and examination</td>
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<td>findings, plus the adoption of a</td>
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<td>proficient approach to clinical</td>
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<td>examination and procedural skills.</td>
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<tr>
<td><strong>Making decisions</strong></td>
<td>What is my differential diagnosis, and how would I explore it?</td>
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<td>This is about having a conscious,</td>
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<td>structured approach to decision-</td>
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<td>making; within the consultation</td>
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<tr>
<td>and in wider areas of practice.</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>If no social cause was present, what are the alternative</td>
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<td>This concerns the recognition and</td>
<td>causes of behaviour changes?</td>
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<td>management of common medical</td>
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<td>conditions encountered in</td>
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<td>generalist medical care. It</td>
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<td>includes safe prescribing and</td>
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<td>medicines management approaches.</td>
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<tr>
<td><strong>Managing medical complexity</strong></td>
<td>What is the legal situation of an adult with intellectual</td>
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<td>This is about aspects of care</td>
<td>disability residing in a supported home whose parents</td>
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<td>beyond</td>
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<td>Topic</td>
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<td>Managing straightforward problems. It includes multi-professional</td>
<td>visit at least weekly?</td>
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<td>management of co-morbidity and poly-pharmacy, as well as uncertainty</td>
<td>How does the practice co-ordinate health promotion for patients living</td>
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<td>and risk. It also covers appropriate referral, planning and</td>
<td>in residential care?</td>
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<td>organising complex care, promoting recovery and rehabilitation.</td>
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<tr>
<td>Working with colleagues and in teams</td>
<td>Who are the other members of this patient’s care team of which I am a</td>
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<td>This is about working effectively with other professionals to</td>
<td>member?</td>
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<td>ensure good patient care. It includes sharing information with</td>
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<td>colleagues, effective service navigation, use of team skill mix,</td>
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<td>applying leadership, management and team-working skills in real-life</td>
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<td>practice, and demonstrating flexibility with regard to career</td>
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<td>development.</td>
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<tr>
<td>Maintaining performance, learning and teaching</td>
<td>What are the difficulties of getting research evidence about the</td>
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<tr>
<td>This is about maintaining performance and effective CPD for</td>
<td>management of patients with intellectual disability?</td>
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<td>oneself and others. This includes self-directed adult learning,</td>
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<td>leading clinical care and service development, participating in</td>
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<td>commissioning*, quality improvement and research activity.</td>
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<tr>
<td>Organisational management and leadership</td>
<td>How can a practice prepare for acute episodes of illness in adults with</td>
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<tr>
<td>This is about the understanding of organisations and systems, the</td>
<td>intellectual disability?</td>
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<td>appropriate use of administration systems, effective record keeping</td>
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<td>and utilisation of IT for the benefit of patient care. It also</td>
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<td>includes structured care planning, using new technologies to access</td>
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<td>and deliver care and developing relevant business and financial</td>
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<td>management skills.</td>
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<tr>
<td>Practising holistically and promoting health</td>
<td>What does the bio-psycho-social model mean for patients with intellectual</td>
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<tr>
<td>This is about the physical, psychological, socioeconomic and cultural</td>
<td>disability?</td>
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<td>dimensions of health. It includes considering feelings as well as</td>
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<td>thoughts, encouraging health improvement, preventative medicine,</td>
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<td>self-management and care planning with patients and carers.</td>
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<tr>
<td>Community orientation</td>
<td>What are the community resources available to this patient in my practice</td>
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<td>This is about involvement in the health of the local population. It</td>
<td>area?</td>
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<td>includes understanding the need to build community engagement and</td>
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<td>resilience, family and community-based interventions, as well as</td>
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<td>the global and multi-cultural aspects of delivering evidence-based,</td>
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<td>sustainable healthcare.</td>
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RCGP Curriculum: Professional and Clinical Modules 18 May 2015
How to learn this area of practice

Work-based learning

In primary care

Primary care, both inside and outside the practice, is the ideal environment to learn about the care of people with intellectual disability. GP specialty trainees should take the opportunity to gain a better understanding of the practice’s patients who are looked after in partnership with the specialist team and other agencies.

In secondary care

As a GP trainee you should spend time during your GP training placement with your local intellectual disability specialist and attend specialist clinics to gain a better understanding of the care of patients with intellectual disability. You should also actively assist in the annual health checks.

Self-directed learning

The care of people with intellectual disability is an excellent subject for discussion with your GP trainer and in groups with other specialty trainees. As a GP trainee, discussing issues with patients and carers will help you gain valuable insights into the health and social care needs of those with intellectual disability. Postgraduate deans are responsible for the training of intellectual disability specialists as well as GPs. The local deanery will have a variety of learning opportunities that specialty trainees can attend if they want to learn more.

Learning with other healthcare professionals

The care of people with intellectual disability is a multi-agency activity that involves the patient, his or her carers and professionals from health and social care. Your learning with other professionals is, therefore, very important to gain a better understanding of their roles and how best care may be delivered.

Useful learning resources

Books and publications

- Ali A and Hassiotis A. Illness in people with intellectual disabilities is common, under-diagnosed and poorly managed British Medical Journal 2008; 336: 570–1
- Cooper S-A, Melville C, Morrison J. People with intellectual disabilities. Their health needs differ and need to be recognised and met British Medical Journal 2004; 329;; 414–15
- Danielsson S, Gillberg IC, Billstedt E, Gillberg IC. Epilepsy in young adults with autism: a prospective population-based follow-up study of 120 individuals diagnosed in childhood Epilepsia 2005; 46(6):918–23
• Kerr M. Improving the general health of people with learning disabilities *Advances in Psychiatric Treatment* 2004; 10: 200–6
• Lindsay P (ed). *The Care of the Adult with Intellectual Disability in Primary Care* Oxford: Radcliffe Press, 2011
• Lindsay P and Burgess, D. Care of patients with intellectual or learning disability: no more funding so will there be any change? *British Journal of General Practice* 2006; 56(523): 84
• Martin G. Support for people with learning disabilities: the role of primary care *Primary Care and Community Psychiatry* 2005: 10(4):133–42
• Martin G and Lindsay PJ. Dying and living with learning disability: will health checks improve the quality of life? *British Journal of General Practice* 2009; 59(564): 480–1

• Morgan CL, Scheepers MIA, Kerr MP. Mortality in patients with intellectual disability and epilepsy *Current Opinion in Psychiatry* 2001; 14: 471–5

• National Patient Safety Agency. *Understanding the patient safety issues for people with learning disabilities*, 2004, [www.nrls.npsa.nhs.uk/resources/?EntryId45=92328](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92328)


• Sir F, Smith LK, McGrother CW. Mortality in adults with moderate to profound intellectual disability: a population-based study *Journal of Intellectual Disability Research* 2007; 51(7); 520-527

• Straetmans JMJAA, van Schrojenstein Lantman-De Valk HMJ, Schellevis FG, Dinant G-J. Health problems of people with intellectual disabilities: the impact for general practice *British Journal of General Practice* 2007, 57; 64–66

• Sutherland G, Couch MA, Iacono T. Health issues for adults with developmental disability *Research in Developmental Disabilities* 2002; 23: 422–45

• van Schrojenstein Lantman-De Valk HMJ, Metsemakers JFM, Haveman MJ, Crebolder HFJM. Health problems in people with intellectual disability in general practice: a comparative study *Family Practice* 2000; 17(5); 405-7

• van Schrojenstein Lantman-De Valk HMJ. Health in people with intellectual disabilities: current knowledge and gaps in knowledge *Journal of Applied Research in Intellectual Disabilities* 2005; 18: 325–33

• Whitaker S and Read S. The prevalence of psychiatric disorders among people with intellectual disabilities: an analysis of the literature *Journal of Applied Research in Intellectual Disabilities* 2006; 19; 330–45

Web resources

**British Institute of Learning Disabilities (BILD)**

BILD aims to improve the lives of all people with an intellectual disability. [www.bild.org.uk](http://www.bild.org.uk)

**The Challenging Behaviour Foundation**

A resource on information on challenging behaviour in people with intellectual disability and resources available to support them. [www.challengingbehaviour.org.uk/](http://www.challengingbehaviour.org.uk/)

**Down’s Syndrome Association**

A useful resource on people with Down’s Syndrome and support for them and their families. [www.downs-syndrome.org.uk/](http://www.downs-syndrome.org.uk/)

**Down Syndrome Medical Interest Group**

This site provides information for healthcare professionals on ‘best practice’ medical care for people with Down syndrome in the UK and Ireland. [www.dsmig.org.uk](http://www.dsmig.org.uk)
Easyhealth
This website has downloadable easy-to-read information leaflets and books about health issues for people with an intellectual disability.  www.easyhealth.org.uk

GMC Learning Disabilities website
This site aims to help doctors provide better care for people with learning disabilities by identifying the issues, highlighting patient perspectives, and showing how to put GMC guidance into practice. It includes interactive learning sessions.  www.gmc-uk.org/learningdisabilities

gptom
This site has a toolkit to support GP staff to deliver the Department of Education and Skills (DES).  www.gptom.com

Improving Health and Lives
The Public Health Learning Disabilities Observatory.  www.improvinghealthandlives.org.uk

Intellectual Disability
A useful learning resource for medical, nursing and other healthcare professionals, who are required to support equal access to their services for all disabled people.  www.intellectualdisability.info

Mencap
Mencap works with people with intellectual disability to fight discrimination.  www.mencap.org.uk

National Autistic Society
The National Autistic Society website includes information for professionals  www.autism.org.uk

Oxleas NHS Foundation Trust
Oxleas NHS Foundation Trust provides community health, mental health and intellectual disability services. See the website for downloadable health check information and resources for GPs.  www.oxleas.nhs.uk/gps-referrers/learning-disability-services

Respond
An organisation that provides counselling services to people with intellectual disability who have experienced trauma in their lives.  www.respond.org.uk/

Royal College of General Practitioners (RCGP)
The RCGP website has a specific section on intellectual disability including downloadable material to support annual health checks.  www.rcgp.org.uk/clinical-and-research/clinical-resources/learning-disabilities.aspx

There is also an e-GP course on Intellectual Disability, including sessions on demographic characteristics and hidden history, access, effective communication, working with carers, sensory issues, syndromes and pathology, epilepsy, and health checks.  www.e-gp.org
Intellectual disability resources in the online learning environment (OLE) include a course on autism in general practice [http://elearning.rcgp.org.uk/](http://elearning.rcgp.org.uk/)

**Seeability**

This site provides information about vision and hearing, including eye and hearing checks, and promotes positive lifestyles for people with intellectual disability. [www.seeability.org](http://www.seeability.org)

**Signpost Sheffield**

A PCT information website about the Joint Learning Disabilities Service in Sheffield, designed for service users, families, carers and staff. This website has a downloadable GP resource pack for health checks. [www.signpostsheffield.org.uk](http://www.signpostsheffield.org.uk)

**Society for the Study of Behavioural Phenotypes**

This is a useful site for the non-specialist when encountering a patient with a rare syndrome. [www.ssbp.org.uk](http://www.ssbp.org.uk)

**Valuing People**

3.12 Cardiovascular Health

Summary

- Cardiovascular problems are an important cause of morbidity and mortality
- Managing the risk factors for cardiovascular problems is an essential part of health promotion activity in primary care
- As a general practitioner you should be competent in the management of cardiovascular emergencies in primary care
- Accurate diagnosis of symptoms that may potentially be caused by cardiovascular causes is a key competence for general practice

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Ensure that personal opinions regarding risk factors for cardiovascular problems (e.g. smoking, obesity, exercise, alcohol, age, ethnicity) do not influence your management decisions

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Recognise that non-concordance is common for many preventative cardiovascular medicines and respect your patient’s autonomy when negotiating management

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.
This means that as a GP you should:

- Communicate the patient’s risk of cardiovascular problems clearly and effectively in a non-biased manner
- Utilise disease registers and data-recording templates effectively for opportunistic and planned monitoring of cardiovascular problems to ensure continuity of care between different healthcare providers
- Consider involving the patient in self-monitoring and self management (for instance of hypertension)

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Identify your patient’s health beliefs regarding cardiovascular problems and either reinforce, modify or challenge these beliefs as appropriate
- Demonstrate an understanding of the importance of risk factors, including chronic kidney disease, in the diagnosis and management of cardiovascular problems

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Intervene urgently when patients present with a cardiovascular emergency, e.g. myocardial infarction, stroke and critical ischaemia
- Demonstrate a reasoned approach to the diagnosis of cardiovascular symptoms (e.g. chest pain) using history, examination, incremental investigations and referral. Investigations you will be expected to understand and utilise include:
  - blood pressure measurement
  - 12-lead electrocardiogram
  - 24-hour ambulatory blood pressure measurement and ECG monitoring
  - venous dopplers and ankle brachial pressure index (ABPI) measurement
  - echocardiogram
  - secondary care investigations and treatment
Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Manage primary contact with patients who have a cardiovascular problem
- Make an initial diagnosis to elicit the appropriate signs and symptoms, and subsequently investigate and/or refer patients presenting with symptoms (below) that might be cardiac in origin, noting that in each case there will be a non-cardiac differential diagnosis:
  - chest pain
  - breathlessness
  - ankle swelling
  - symptoms or signs thought to be caused by peripheral vascular disease (arterial and venous)
  - palpitations and silent arrhythmias
  - signs and symptoms of cerebrovascular disease
  - dizziness and collapse
- Be able to manage cardiovascular conditions, including:
  - coronary heart disease
  - heart failure
  - arrhythmias (atrial fibrillation is by far the commonest)
  - other heart disease (valve disease, cardiomyopathy, congenital problems)
  - peripheral vascular disease (arterial and venous)
  - cerebrovascular disease
  - thromboembolic disease (PE and DVT)
- Describe strategies for early detection of cardiovascular problems that may already be present but have not yet produced symptoms

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Prioritise interventions for multiple risk factors and symptoms of cardiovascular problems, according to their severity and prognostic risk
- Advise your patients appropriately regarding lifestyle interventions, according to their cardiovascular risk and level of disability
• Consider whether other co-morbidities are present and manage these appropriately

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

• Co-ordinate and commission care with other primary care health professionals, cardiologists and other appropriate specialists, leading to effective and appropriate acute and chronic disease management – including prevention, rehabilitation and palliative care for those with end-stage cardiac failure

• Make timely appropriate referrals on behalf of patients to specialist services, especially to rapid-access chest pain, stroke/TIA and heart failure clinics

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

• Be able to describe the key research findings that influence management of cardiovascular problems (e.g. Heart Protection study, Framingham study and Interheart; plus see the reading list below)

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

• Describe and be able to implement the key national guidelines that influence healthcare provision for cardiovascular problems
Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Appreciate the importance of the social and psychological impact of cardiovascular problems on the patient, their family, friends, dependants and employers
- Recognise the impact cardiovascular problems have on disability and fitness to work
- Recognise the cultural significance that people attach to the heart as a seat of emotions
- Promote cardiovascular well-being by applying health promotion and disease prevention strategies appropriately

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Recognise social determinants of health and the importance of population interventions
- Advise patients appropriately about driving, according to their cardiovascular risk and Driving and Vehicle Licensing Agency (DVLA) guidelines
- Be able to describe current population trends in the prevalence of risk factors and cardiovascular disease in the community
- Be able to describe the key government policy documents that influence healthcare provision for cardiovascular problems

Case discussion

Example adapted from C. Heneghan in *Cardiovascular Disease in Primary Care - a guide for GPs*, RCGP Publications, 2010.

Mr Black is a 58-year-old man who presents to your clinic with a history of central chest pain radiating to the left arm. This occurs on exertion and is relieved by rest. It started about one month ago and has not got any worse.

He has no history of hypertension, diabetes or hyperlipidaemia that you are aware of, but he rarely visits the practice. He smokes. There is no family history of ischaemic heart disease but his mother developed diabetes from the age of 65.
On examination, he is comfortable. His blood pressure is 155/95 with a pulse rate of 85 b.p.m. regular. His BMI is 32 kg/m².

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How important is it for me to model healthy living for my patients?</td>
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<tr>
<td>This concerns the development of</td>
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<td>professional values, behaviours</td>
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<td>and personal resilience and</td>
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<td>preparation for career-long</td>
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<td>development and revalidation.</td>
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<td>It includes having insight into</td>
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<td>when your own performance,</td>
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<td>conduct or health might put</td>
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<td>patients at risk, as well as</td>
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<tr>
<td>taking action to protect patients.</td>
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<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How might cardiovascular disease prevention vary in different cultures and sexes?</td>
</tr>
<tr>
<td>This addresses the importance of</td>
<td>Should overweight smokers be offered open access to treatment if they do not lose weight or stop smoking?</td>
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<tr>
<td>practising ethically, with</td>
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<td>integrity and a respect for</td>
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<tr>
<td>diversity.</td>
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<tr>
<td><strong>Communication and consultation</strong></td>
<td>How would I go about explaining cardiovascular risk to this patient?</td>
</tr>
<tr>
<td>This is about communication with</td>
<td>How could I influence a change in Mr Black’s lifestyle?</td>
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<td>patients, the use of recognised</td>
<td>How would I explore this patient’s ideas, concerns and expectations?</td>
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<td>consultation techniques,</td>
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<td>establishing patient partnerships,</td>
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<td>managing challenging consultations,</td>
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<td>third-party consulting and the</td>
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<tr>
<td>use of interpreters.</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What additional information do I need?</td>
</tr>
<tr>
<td>This is about interpreting the</td>
<td>If I have access to same day ECG, how confident am I at interpreting it?</td>
</tr>
<tr>
<td>patient’s narrative, clinical</td>
<td>Would blood tests be useful? Which ones?</td>
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<tr>
<td>record and biographical data.</td>
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<tr>
<td>It also concerns the use of</td>
<td></td>
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<tr>
<td>investigations and examination</td>
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<td>findings, plus the adoption of</td>
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<td>a proficient approach to clinical</td>
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<tr>
<td>examination and procedural skills.</td>
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<tr>
<td><strong>Making decisions</strong></td>
<td>What is my differential diagnosis?</td>
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<tr>
<td>This is about having a conscious,</td>
<td>What drug treatment might I prescribe for Mr Black?</td>
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<tr>
<td>structured approach to</td>
<td>How does prevalence of cardiovascular disease vary in the UK population?</td>
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<td>decision-making; within the</td>
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<td>consultation and in wider areas</td>
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<td>of practice.</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>What are the national guidelines for diagnosis and longer-term treatment in this case?</td>
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<tr>
<td>This concerns the recognition and</td>
<td>What would be the key features of my safety-netting</td>
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<td>management of common medical</td>
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<td>conditions encountered in</td>
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<td>generalist medical care. It</td>
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<td>includes safe prescribing</td>
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and medicines management approaches.  

| and medicines management approaches. | conversation with Mr Black? 
What advice would I give him about smoking cessation? |
|-------------------------------------|--------------------------------------------------|
| **Managing medical complexity**    | How would I manage his multiple risk factors at this initial consultation? 
What can I do to help manage the risk in this patient? 
What are the criteria for referral to secondary care and what would I include in my referral letter? |
| This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation. |
| **Working with colleagues and in teams** | How might other members of the practice team be involved in the care of this patient? 
What rapid access clinics are available locally? |
| This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development. |
| **Maintaining performance, learning and teaching** | What quality improvement could I consider for patients with Ischaemic Heart Disease at my practice? |
| This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity. |
| **Organisational management and leadership** | How do I record cardiovascular risk on my IT system? |
| This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills. |
| **Practising holistically and promoting health** | What is Mr Black’s job? How might this be relevant? 
What are his home circumstances? What would I advise him about having sex? 
What patient information resources are available? |
| This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers. |
Community orientation
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

What community resources are available for cardiovascular disease prevention in my area?

How to learn this area of practice

Work-based learning

In primary care

- Primary care is a good place for you to learn how to manage cardiovascular problems because of the wealth of clinical material. Patients will present with various symptoms, at varying stages in the natural history of their illness. Critical, professional discourse with a trainer will aid specialty trainees in developing heuristics to help in problem-solving. Supervised practice will also give trainees confidence.

- In particular, the GP specialty trainee should be able to learn about risk factor management and gain experience in the management of cardiovascular problems as they present (acute and chronic), including emergencies. Primary care is also the best place to learn about chronic disease management (angina, post-myocardial infarction (MI), heart failure, stroke, peripheral vascular disease).

In secondary care

- Some GP training programmes have placements of varying lengths with cardiologists. The acute setting is the place for you to learn about the immediate management of acute coronary syndrome (ACS), MI, stroke and aortic aneurysms. As a specialty trainee you will also learn about the invasive management of cardiovascular problems: angioplasty, coronary artery bypass grafts, transplantation, other forms of vascular surgery (carotid endarterectomy, vascular bypass). Outpatient or clinic settings are ideal places for seeing concentrated groups of patients with cardiovascular problems. They provide you with opportunities to learn about secondary care investigation of cardiovascular problems (exercise tests, radionucleotide scans, MRI/CT, carotid dopplers, angiography and echocardiography).

- Vocational training programmes should offer you the opportunity to attend cardiovascular clinics when working in other hospital posts and you should also consider attending specialist clinics during your general practice-based placements.

Self-directed learning

- Many postgraduate deaneries provide courses on cardiovascular problems. Other providers include universities and the Royal College of General Practitioners. There is a growing body of e-learning to help you consolidate and build on the knowledge you have gained in the workplace.

Learning with other healthcare professionals

- Chronic disease management in primary care is a multidisciplinary activity. As a specialty trainee it is important for you to attend nurse-led cardiovascular disease annual review assessments in practice and gain an understanding of the follow-up of hypertensive patients in the practice’s clinics that are often led and delivered by a practice nurse. It is also important to understand the role of district nurses in the assessment and management of leg ulcers or ankle oedema by
attending their clinics or home visits. You should also take the opportunity to observe cardiovascular rehabilitation programmes led by physiotherapists.

Useful learning resources

Books and publications


Interesting papers -

**Acute coronary syndrome**

- Hoenig MR, Aroney CN, Scott IA. Early invasive versus conservative strategies for unstable angina and non-ST elevation myocardial infarction in the stent era. *Cochrane Database of Systematic Reviews* 2010 Mar 17; 3: CD004815

**Angina**


**Cardiac rehabilitation**


**Heart disease statistics**

- The best source of these can be downloaded as both PDF and Excel spreadsheets from the British Heart Foundation ‘Heart Stats’ website: [www.bhf.org.uk/heart-health/statistics.aspx](http://www.bhf.org.uk/heart-health/statistics.aspx)

**Heart failure**

- Paulus WJ. Novel strategies in diastolic heart failure *Heart* 2010 96(14): 1147–53
Patient’s perspective

  www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0046124

Peripheral vascular disease


Risk factors for CHD


Self-management


Stroke

- Mant J, McManus RJ, Hare R. Applicability to primary care of national clinical guidelines on blood pressure-lowering for people with stroke: cross- sectional study British Medical Journal 2006; 332: 635–7

Venous thromboembolism

• McManus RJ, Murray E, Taylor CJ, Fitzmaurice DA. Thromboembolism in Clinical Evidence London: BMJ Online, updated yearly
• Tovey C and Wyatt S. Diagnosis, investigation, and management of deep vein thrombosis British Medical Journal 2003; 326(7400): 1180–4

Web resources
British Cardiac Society www.bcs.com
British Heart Foundation www.bhf.org.uk
British Hypertension Society (lists of validated BP monitors) www.bhsoc.org
Long Term Conditions resources from RCGP www.rcgp.org.uk/policy/rcgp-policy-areas/long-term-conditions.aspx

NHS Evidence Health Information Resources [Note: additional information on a wide variety of topics]
Chest Pain: www.evidence.nhs.uk/topic/chest-pain
Stroke: www.evidence.nhs.uk/topic/stroke
Hypertension: www.evidence.nhs.uk/topic/hypertension
Chronic Kidney Disease: www.evidence.nhs.uk/topic/chronic-kidney-disease

National Institute for Health and Care Excellence (NICE – for copies of guidelines including heart failure, hypertension, post MI, cardiovascular risk, chest pain.) www.nice.org.uk

Personal experiences of illness and health (multimedia) www.healthtalk.org
South Asian Health Foundation www.sahf.org.uk
The Stroke Association www.stroke.org.uk
3.13 Digestive Health

Summary

- Digestive problems are common in general practice
- As a general practitioner (GP) you have a central role in the diagnosis and management of digestive problems in primary care
- Dyspepsia, gastro-oesophageal reflux disease (GORD) and Irritable Bowel disease (IBS) are common conditions, affecting a significant proportion of the population
- Prevention and early treatment of colorectal cancer are priorities for the Department of Health
- A national programme of screening for colorectal cancer is now in place, with plans for the possible addition of flexible sigmoidoscopy. Primary care has an important role, even though recruitment of patients and follow-up are centrally co-ordinated
- New treatment approaches are emerging for patients with hepatitis B and C

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Be aware of your own attitudes to gastrointestinal illness and accept that these can influence the way you respond to individuals with digestive disorders

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Be aware of the many issues relating to embarrassment and social and cultural factors which influence presentation to primary care, and how you can have a constructive approach to these
- Appreciate the complex issues around drug and alcohol misuse, the ways these impact on digestive disorders and the management problems they are associated with, demonstrating a non-judgemental approach to individuals with, for example, chronic gastrointestinal symptoms, drug and alcohol problems
Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Recognise that it is difficult for some patients to discuss digestive symptoms, through factors such as embarrassment and social stigma
- Demonstrate a non-judgemental, caring and professional consulting style to minimise the embarrassment of patients with digestive problems

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Understand that digestive symptoms are often multiple and imprecise, and frequently linked to emotional factors
- Understand the many cultural and social factors which can influence the way patients interpret symptoms and the manner in which this influences their expectations of medical management
- Be aware of the sensitive nature of GI symptoms and some GI examinations (such as rectal examination) – and do everything possible to put the patient at ease, including the offer of a same-sex doctor if appropriate
- Understand the need to provide an environment where abdominal and rectal examination are easy to perform with dignity and under chaperoned conditions

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Intervene urgently when patients present with an acute abdomen
- Be cautious with telephone advice when the abdomen has not been examined
- Understand the risks associated with various symptoms which may indicate GI cancer, and refer with appropriate levels of urgency
• Demonstrate a structured, logical approach to the diagnosis of abdominal pain, e.g. to enable a positive diagnosis of irritable bowel syndrome to be made, rather than making the diagnosis by exclusion

• Understand dietary factors associated with various GI conditions and offer appropriate dietary advice (e.g. in weight loss, irritable bowel syndrome and primary cancer prevention)

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

• Be able to manage primary contact with patients who have a digestive problem
  o Understand the epidemiology of digestive problems as they present in primary care\(^\text{38}\) and their often complex aetiology
  o Know how to interpret common symptoms in general practice, including dyspeptic symptoms (epigastric pain, heartburn, regurgitation, nausea, bloating), abdominal pain, nausea, vomiting, anorexia, weight loss, haematemesis and melaena, rectal bleeding, jaundice, diarrhoea and constipation, and dysphagia

• Demonstrate a systematic approach to investigating common digestive symptoms, taking into account the prevalence of these symptoms in primary care and the likelihood of conditions such as peptic ulcer, oesophageal varices, hepatitis, gastrointestinal cancers and post-operative complications

• Understand that digestive symptoms are frequently linked to psychosocial factors and empathise with individuals who are psychologically distressed
  o Explore gastrointestinal symptoms and psychological and social factors using an integrated approach
  o Understand the range of gastrointestinal problems associated with alcohol and drug usage (see also module 3.14 Care of People who Misuse Drugs and Alcohol)

• Understand the indications for urgent referral for suspected GI cancer
  o Be aware of the cancer risks associated with various symptoms and symptom complexes\(^\text{39}\)
  o Understand the National Institute for Health and Care Excellence (NICE) referral guidelines for suspected cancer

• Use an evidence-based approach to management and prescribing for common symptoms such as dyspepsia, and be familiar with contemporary developments around drug treatment options for hepatitis B and C\(^\text{40}\)

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\(^{38}\) Hellier MD, Williams JG. The burden of gastrointestinal disease: implications for the provision of care in the UK Gut 2007;56:165–6, doi:10.1136/gut.2006.102889

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Identify patients’ attitudes and beliefs about digestive symptoms and disease, and how they might influence patterns of presentation
- Advise patients appropriately regarding lifestyle interventions that have an impact on gastrointestinal health, such as advice on diet and on stress reduction
- Know the gastrointestinal side effects of common medicines
- Modify the form or modalities of treatment to cater for the patient’s GI function and preferences
- Have strategies to respond to patients who attend frequently with unexplained GI symptoms, e.g. strategies might include educational and supportive counselling approaches
- Have a good understanding of the impact of GI symptoms and illness on patients, their families and their wider networks
- Support people to self care, particularly those with chronic symptoms (such as those typically associated with irritable bowel syndrome)

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Have a good understanding of the availability of endoscopic services for upper and lower GI symptoms/diseases

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

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40 Feller R, Strasser S, Ward J, Deakin G. *Primary care management of chronic viral hepatitis* | ASHM, 2010
This means that as a GP you should:

- Understand the epidemiology of gastrointestinal symptoms and disorders in primary care, and the evidence on the risks for cancer and other serious diseases associated with various symptoms and symptom complexes
- Use contemporary management approaches to individuals with hepatitis B and C, and understand the dynamics for screening for colorectal cancer and its influence on individual patient management
- Understand the evidence base for the national guidelines on screening and management of common and important gastrointestinal conditions
- Understand the evidence underpinning the national bowel cancer screening programme, and the public health implications of the programme

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Champion the availability and appropriate use of direct-access endoscopy and imaging for primary care practitioners
- Recognise the place in cost-effective management of simple therapy and expectant approaches (in which active treatment is deferred) while the patient's condition is adequately monitored

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Recognise the effects psychological stress can have upon the gastrointestinal tract, especially with functional disorders, e.g. non-ulcer dyspepsia, irritable bowel syndrome, abdominal pain in children
- Recognise the impact of social and cultural diversity, and the important role of health beliefs relating to diet, nutrition and gastrointestinal function
- Holistically manage psychological symptoms and conditions which have associated GI issues, e.g. it may be appropriate to refer the patient to a support group or counsellor
• Acknowledge the importance of the full array of psychosocial, cultural and other determinants on the presentation of gastrointestinal disorders and ensure that the practice is not biased against recognising these

• Understand screening programmes for colorectal cancer, and the role of primary care in information provision and dealing with symptoms amongst screening invitees

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Understand the high prevalence of GI symptoms in the community and the implications for primary care

• Be aware of community-based services in areas such as drug and alcohol rehabilitation, both of which are implicated in gastrointestinal disease

Case discussion

Beverley Chalmers is a 62-year-old librarian. She is married with two grown up children and three grandchildren. She says her marriage has been going through a particularly ‘difficult patch’ since her husband lost his job two years ago and markedly increased his alcohol consumption. She would like to retire but is concerned over finances. She consults you with symptoms of weakness and fatigue. She has lost 5kg in the last six months with no obvious cause.

You ask about Beverley’s gastrointestinal (GI) symptoms: she has had constipation on and off for a number of years, with occasional bloating which she attributes to ‘wind’. She saw you 12 months ago with a single episode of rectal bleeding and you noticed a small external haemorrhoid. The bleeding settled after conservative treatment. Beverley is stressed by changes at her library (a new supervisor is ‘making life difficult’ for her) and by the relationship difficulties in her marriage. She is also concerned about her 12-year-old granddaughter’s behaviour – she is missing school and not telling her parents where she is.

Over the last three months Beverley has become a little breathless – she first noticed this when climbing the stairs at work. She has mild rheumatoid arthritis. A doctor in the practice recently prescribed her some temazepam (as she was sleeping poorly). She also takes a regular dose of a non-steroidal anti-inflammatory drug (NSAID). She has had a normal mammogram within the last 12 months. She has had two invitations, at age 60 and 62, to undertake a faecal occult blood test (FOBT) as part of the screening programme; the first was negative and she declined the second. There is no family history of note. Beverley has never smoked, and drinks only on rare social occasions.

On examination she has mild clinical signs of anaemia. Her BP is 130/70, lungs are clear. Abdominal examination is essentially normal. You perform a rectal examination which is also normal, and there is no sign of the haemorrhoid you previously diagnosed.
Initial investigations, including an Hb of 7.3 gm/DL, suggest she has iron deficiency anaemia and you commence iron replacement therapy. When you see her on a follow-up visit her tiredness appears to have worsened. She also appears anxious and is very concerned about her poor sleeping. She thinks the iron tablets are making her more constipated. She has lost a further kilogram in weight which she can’t understand. You need to give thought to the next steps you will take in investigating and managing Beverley’s symptoms.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
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</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How does Beverley’s complex presentation make me feel and why? How would I take account of this in my management of the situation?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
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</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How would I deal with my concerns about the 12 year old grand-daughter?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td>What ethical principles do I know that might help me with this case?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>How can I acknowledge the wide range of psychosocial issues in the history?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>What techniques would I use to work flexibly and efficiently within the allotted time?</td>
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<td></td>
<td>Would I want to see other members of her family? Why?</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What other tests might I request in order to explore the differential diagnosis? Could she have a serious illness?</td>
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<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
<td>How sensitive and specific are the bowel screening programmes?</td>
</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>What is my strategy for investigating this combination of symptoms and factual information (e.g. weight loss, anaemia, weakness/fatigue, psychological issues)?</td>
</tr>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
<td>What criteria would I use for prioritizing my decisions?</td>
</tr>
<tr>
<td>Clinical management</td>
<td>What are my next steps?</td>
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<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
<td>Would I refer Beverley and if so, to whom?</td>
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<td>Would I expect a colonoscopy at this point?</td>
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</table>

<table>
<thead>
<tr>
<th>Managing medical complexity</th>
<th>How will I address Beverley’s current concerns while being diligent in investigating her for serious illness?</th>
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<tbody>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
<td>How can I involve Beverley in thinking about planning the different strands of her care?</td>
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</table>

<table>
<thead>
<tr>
<th>Working with colleagues and in teams</th>
<th>What are the referral guidelines for 2 weeks suspected cancer referrals? What information should be included in any referral letter?</th>
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<tbody>
<tr>
<td>Working with colleagues and in teams</td>
<td>Who else in the team might be appropriate to involve in thinking more about Beverley’s current concerns?</td>
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</table>

<table>
<thead>
<tr>
<th>Maintaining performance, learning and teaching</th>
<th>What sources of information can I identify to ensure I am up to date with the investigation of lower GI symptoms?</th>
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<tbody>
<tr>
<td>Maintaining performance, learning and teaching</td>
<td>How does my practice record and follow up patients who have not attended for the bowel screening programme?</td>
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<td></td>
<td>What can my practice do to improve the uptake of screening programmes?</td>
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<td>What’s the most appropriate way to record the multiple aspects of this patient’s presenting complaint?</td>
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<thead>
<tr>
<th>Organisational management and leadership</th>
<th>How could Beverley’s wider concerns influence her presentation?</th>
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<td>What other aspects of her social and cultural background would I like to enquire about?</td>
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Community orientation
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

How do people respond to invitations for FOBT screening? What influences this?

What community services might be available to help Beverley and her family?

How to learn this area of practice

Work-based learning

In primary care
Primary care provides tremendous opportunities for you to gain a broad-based understanding of digestive illness. Virtually all gastrointestinal diseases present initially with symptoms in primary care. There is a high prevalence of gastrointestinal symptoms in the community and one of the fascinating challenges in primary care is to interpret these symptoms and identify those patients with problems which warrant further and/or urgent investigation. As a GP trainee it may be possible for you to spend time in community-based endoscopy facilities – these are sometimes led by primary care doctors with an interest in gastrointestinal disease. You should also take the opportunity to discuss screening programmes with patients in eligible age groups and check on their understanding of the screening process and how it relates to symptom-based diagnosis.

In secondary care
As a GP trainee you should ideally take the opportunity of spending time in outpatient clinics, in both general and specialised areas – for example, hepatitis management, liver disorders, endoscopy clinics etc. There is a very broad spectrum of activity in which you could potentially get involved and the opportunities will depend to some extent on individual hospital environments.

Self-directed learning
You will find many case-based discussions within GP speciality training programmes on gastrointestinal disorders. These cases are often challenging because patients with gastrointestinal diseases often follow unpredictable diagnostic journeys. Trainees with a particular interest might consider attending meetings of the Primary Care Society for Gastroenterology Society (see under Learning Resources).

Learning with other healthcare professionals
Trainees should take the opportunity of discussing gastrointestinal disorders with practice nurses and nurses in the hospital environment. Some practices have community nurses dealing specifically with drug and alcohol problems and it would be helpful to spend time discussing gastrointestinal disorders in relation to intravenous drug use and excessive alcohol consumption. It would also be helpful for you to accompany patients in investigations such as helicobacter breath testing and endoscopic procedures.

Formal learning
As a trainee you should be aware of the range of RCGP courses, many of them based on e-modules. For example, the RCGP certificate in the detection, diagnosis and management of hepatitis B and C in primary care: www.rcgp.org.uk/courses-and-events/online-learning/ole/hepatitis-b-and-c.aspx
Useful learning resources

Books and publications

- Delaney BC. 10-minute consultation: dyspepsia *British Medical Journal* 2001; 322: 776
- Hay DW (ed). *Blackwell’s Primary Care Essentials: gastrointestinal disease* John Wiley and Sons Ltd, 2002

Web resources

Primary Care Society for Gastroenterology

The Primary Care Society for Gastroenterology has a good website with lots of helpful guidance on common gastrointestinal conditions in primary care. [www.pcsg.org.uk](http://www.pcsg.org.uk)
3.14 Care of People who Misuse Drugs and Alcohol

Summary

- People with drug and alcohol problems are often stigmatised by society and professionals.
- Drug and alcohol misuse are common problems in the community and need to be treated with compassion.
- As a general practitioner (GP) you are ideally placed to identify people with drug or alcohol problems and need to be aware of the extent and consequences of these problems.
- All general practitioners have a responsibility for providing general medical care to people registered with them who have drug or alcohol problems.
- Primary care-based interventions for drug and alcohol problems can be very effective in reducing physical, psychological and social harm, for both the patient and the community.
- Helping people with drug and alcohol problems can be very rewarding for the doctor and life changing for the patient.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Understand that a difficult past experience of people with drug and alcohol problems should not influence your attitude to the next person.
- Understand that there may be personal barriers such as your lack of suspicion of misuse that may make enquiry less likely, particularly in certain age or ethnic groups (e.g. people from religious groups that normally abstain from alcohol may still have alcohol problems).
- Agree that as a doctor you are there to treat people and not to make non-clinical judgements about their lives.

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.
This means that as a GP you should:

- Understand that GPs do not need to know everything about everything and the patient will often know more – there is no need to be anxious about this
- Be aware that addiction affects us all, either personally or through its impact on family and friends, the community and the culture in which we live
- Understand that addiction is not a lifestyle choice – although it could have started off that way. It needs proper treatment
- Be aware that as a GP you can make a significant difference even if you do not have a special interest in drug and alcohol problems
- Understand that, even if you have to say ‘no’, if you treat people with compassion and competence they will usually respect you and your service

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Treat each patient as an individual and not a stereotype
- Assess each patient’s awareness of their drug and alcohol use (including addiction-related problems) and the consequences to them and others
- Assess their motivation for seeking help and how they want things to change
- Not blame the patient for barriers or failings in the systems of care
- Instil hope for the future and the concept of recovery from addiction
- Understand the stress that managing such patients can cause in the consultation and use techniques such as setting priorities, housekeeping and time management to maintain personal health and motivation
- Recognise that each patient will interpret ‘recovery’ in relation to his or her unique context and that this interpretation may vary over time, using this understanding to tailor your approach accordingly

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.
This means that as a GP you should:

- Take an adequate drug and alcohol history including the physical, mental, social and legal aspects
- Use screening tools to assess alcohol and/or drug use, when appropriate (both planned and opportunistically)
- Be aware of common long-term effects of drug and alcohol misuse including reasons for drug-related deaths
- Recognise the widespread use and associated health impacts of “Performance- and Image- Enhancing Drugs” (PIEDs), such as anabolic steroids, and newly synthesized drugs, such as “legal highs”

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Always be aware of possible drug- or alcohol-related problems with almost any presenting problem or prescribing issue
- Understand the varying degrees of drug and alcohol use and their implications for future management
- Be aware of urgent and important issues of safety including risks to self or others and the need for urgent medical or psychiatric care

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Appreciate that drug and alcohol use is common the community and that harmful use is often unrecognised and can take a range of forms (including excessive use, binges, risk-taking behaviours or dependency)
- Understand that for risky drinking, appropriate screening and brief interventions (SBI) can be effective
- Understand the presenting signs and symptoms of drug/alcohol misuse, as well as the signs and symptoms of withdrawal
- Provide evidence-based screening, brief interventions and effective primary care treatments for these patients, where appropriate
- Make sure that repeat prescriptions are monitored for long-term prescribing of addictive drugs and appropriate action taken if this is happening
• Work in partnership with the wider primary healthcare team including pharmacists, specialist services, the voluntary and criminal justice sectors
• Recognise that older adults can have unrecognised alcohol or drug problems

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Address potential drug and alcohol misuse through prevention strategies with individuals and communities
- Perform a ‘brief intervention’ for people who are drinking over the recommended safer limits or engaging in harmful drinking behaviour
- Recognise that people with drug and alcohol problems often have significant co-morbidity, both mental and physical
- Understand the home and family circumstances of the patient and look for hidden harm to children or vulnerable adults
- Know the forensic (legal) history of the patient and any current issues such as court cases, probation or drug/alcohol treatment orders
- Be aware of the patient's housing needs and if necessary direct them to the relevant service

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Refer to and liaise with local specialist and secondary care services, as appropriate, to make a comprehensive treatment plan work

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41 Brief interventions are usually ‘opportunistic’ – that is, they are administered to a patient who has not attended a consultation to discuss their drinking. They offer information, advice and encouragement to the patient to consider the positives and negatives of their drinking behaviour, plus support and help if the patient decides they do want to cut down on their drinking. For further information, see www.ncl.ac.uk/ihs/engagement/documents/trainingsession1.ppt
• Discuss with and refer to social services, if appropriate
• Direct patients, where appropriate, to mutual aid organisations such as Alcoholics Anonymous/Narcotics Anonymous and SMART Recovery (see also under Learning Resources below)

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:
• Implement the evidence-based treatments for opiate substitution
• Use resources such as the Substance Misuse Management in General Practice (SMMGP) network and courses to keep up to date (see under Learning Resources below)

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:
• Recognise the special needs of patients with drug and alcohol problems, who often have very difficult lives and are frequently marginalised by society
• Ensure that patients with drug and alcohol problems have equal access to care in your practice and are treated with compassion
• Act as an advocate for your patient when they are being denied proper health or social care services because they have a drug or alcohol problem

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:
• Realise that people with drug and alcohol problems often have chaotic lives and conflicting pressures which do not help their reliability
• Understand that the causes of drug and alcohol problems are multifactorial, as are the propagating factors that hinder recovery

• Appreciate the importance of social and family support as well as the difficulties faced in families and communities

• Be aware of hidden harm to children in chaotic and dysfunctional households and be ready to contact social services if you are concerned

• Not forget to advise about the dangers of drink/drug driving as well as the patient’s legal responsibilities, and be ready to take appropriate action if necessary

• Offer screening to patients with a history of drug misuse for blood-borne viruses and hepatitis immunisation

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Know what services are available both in acute crises and for longer-term treatment locally, and how to access them

• Understand that money spent on treating drug and alcohol problems saves considerably more in the whole economy than the actual cost of treatment

• Be aware that people with drug and alcohol problems often do not get the help they need from the community because of prejudice and preconceptions

• Appreciate that people with drug and alcohol problems are often victimised and targeted for abuse, especially if they are vulnerable

• Know that you may be the first person in the community to really try and help the patient and take their problems seriously

• Appreciate that giving appropriate care to people with drug/alcohol problems will have a positive effect on their family and wider community

• Be aware of the developing government policy on drug and alcohol treatment

• Understand how the Misuse of Drugs Act (1971) affects drug users

• Understand how legislation on drink and drug driving applies in a clinical situation

• Understand how courts may impose supervision and treatment orders and what probation involves

• Understand how safeguarding procedures for children and vulnerable adults must shape your decisions and behaviour
Case discussion

Julie is a 25-year-old single mother who lives with her two children, aged four and two years. She comes to see you complaining of fatigue. You notice that she is underweight and appears pale and stressed; she has noticeable needle marks on her forearms. On further enquiry, she admits to using heroin and crack cocaine; she feels she is now addicted to both. She has very little money, allows her house to be used by other people to take drugs and is occasionally working as a prostitute to finance her addictions. She has wanted to get off drugs for some time but was afraid her children would be ‘taken away’ if she mentioned it to a doctor. She has fallen out with her mother because of her drug use and lifestyle. She also reveals that she was sexually abused as a child, but has never told anyone about this.

You explain to Julie that you will do your best to help her and her children. You take a targeted history, perform a relevant examination and consider immediate risk management and safeguarding for her and her children. Following this, you make an urgent referral to social services and the local drug and alcohol team, and also give her contact information for the local women’s refuge. You make a further appointment with Julie a few days later to continue your assessment. In the meantime, you review the medical records of the two children to look for any evidence that their mother’s problems are having a detrimental effect on their physical and emotional development.

At the second appointment, you advise Julie about harm reduction, contraception, blood-borne virus screening, immunisations and the services available to support her. You suggest she may consider specialist counselling for her previous abuse and give her information on this. Julie requests medication ‘to help with sleep’. You decline to prescribe anything at this time, but she understands when you explain why this would not be the best thing for her at the moment. You notice she smells of alcohol and remember you have forgotten to ask her about her alcohol intake. She is drinking up to two bottles of cheap wine daily and using street diazepam when she runs out of wine. You give her more harm reduction advice about alcohol and drugs. You feel a bit helpless, given her complex situation, but you explore her physical, psychological and social problems and formulate a plan for each. The local drug and alcohol team meet with Julie and, in view of her polydrug and alcohol use and home circumstances, recommend an inpatient stay for titration and stabilisation on to a prescribed opiate regime, as well as a detoxification from alcohol and diazepam. Social services are actively involved with the family now and arrange to re-house them when Julie gets out of inpatient treatment. In the meantime, Julie’s mother has agreed to look after the children.

You catch up with Julie a month after discharge – she is much brighter and tells you she has remained off alcohol and street drugs, has a new house, is stable on methadone and is feeling a lot more healthy, both physically and mentally. You are asked to continue her methadone as part of a shared care scheme and contact her key worker and discuss how you will liaise regularly and help Julie together. The children are doing well and she is having regular visits from social services, who have advised her on benefits and other support. Julie is very grateful to you for getting her the help she needed and for continuing to look after her. You notice that compared to a few months ago, her life is completely different and transformed; she has hope and stability and a clear plan for the future.
**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
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<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>As a GP, what responsibility do I have to ensure Julie gets the right treatment? How do I feel about Julie? Compassion? Anger? Sadness? Despair? How do I feel about what has happened to Julie’s children, and will this affect my relationship with Julie?</td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How do I try to ensure that the patient’s children are safe and that her mother is adequately supported? What legal issues might influence my decisions or constrain my practice?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>How would I address her disclosure of sexual abuse in childhood? How do I ensure that Julie feels supported and is involved in the decision-making and planning?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What other investigations might Julie need as a result of her drug/alcohol misuse? What other issues must be considered?</td>
</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>What are the implications of Julie’s drug/alcohol misuse for managing her care?</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>As a GP, how do I prioritise the actions needed to address issues raised by this case? Which investigations and/or referrals are needed immediately?</td>
</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>What issues can I deal with – and which do I need help to manage? What risks do Julie’s drug and alcohol use pose to her health?</td>
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<tr>
<td>Topic</td>
<td>Questions</td>
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<tr>
<td><strong>appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</strong></td>
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</table>
| **Working with colleagues and in teams**  
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development. | What other local services or team members might I involve in Julie’s care?  
Who is the safeguarding lead in my team? |
| **Maintaining performance, learning and teaching**  
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity. | What is the evidence for the effectiveness of the different approaches that might be taken to manage and support Julie?  
How might I contribute to the improvement of local drug and alcohol services for patients like Julie? |
| **Organisational management and leadership**  
This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills. | How do I record this consultation in the children’s records?  
What is the practice policy regarding recording safeguarding concerns? |
| **Practising holistically and promoting health**  
This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers. | What background issues might be affecting Julie?  
How will I ensure that I act as advocate for the patient?  
Have I considered Julie’s physical, emotional, psychological and social needs? |
| **Community orientation**  
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare. | Which support services are available in my area to help patients and families where drug and alcohol are involved? |
How to learn this area of practice

Work-based learning

In primary care

There is no substitute for actually working with patients with drug and alcohol problems to learn how to provide good treatment in a sometimes pressurised situation. As a GP specialty trainee you should be able to spend time observing a more experienced GP and then take on patients of your own to manage during your placement under proper supervision. By doing so you will come into contact with a broad range of teams of service providers and develop an understanding of how the treatment system should work in a seamless and timely manner – and also how often it doesn’t. It would also be good to visit other providers including those from non-statutory agencies and independent sector providers to get a broad overview of services available.

In secondary care

A placement in a specialist drug or alcohol service, either residential or in the community, would be useful for you as a GP specialty trainee and would provide valuable experience for your whole career. Unfortunately, as there are not many placements of this type available a normal placement in general adult psychiatry should give you some exposure to drug and alcohol problems, as well as invaluable general psychiatric training.

Self-directed learning

You will find it informative to visit mutual aid groups such as Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery when they hold open meetings. Local and regional groups of doctors with a special interest in addictions also exist, which you may find useful to attend. Trainees should be able to bring interesting and complex cases to tutorials and peer group meetings. Some regions have regular organised clinical update meetings for GPs – these should include drug and alcohol issues during their programmes. As mentioned above, the SMMGP (Substance Misuse Management in General Practice) network is a great resource providing newsletters, conferences and a useful website (see under Learning Resources below for further information).

Learning with other healthcare professionals

The certificate courses mentioned below are multidisciplinary and so provide an excellent insight into other professionals and workers in the field. The RCGP yearly conference on Substance Misuse Management in Primary Care is very well attended by many different professionals, workers and service users and is well worth attending at least once. Some regions have multidisciplinary learning meetings which are also worth attending.

Formal learning

The RCGP Part 1 Certificate in the Management of Drug Misuse in Primary Care is well worth doing even if you don’t envisage developing a special interest in this field. The Part 2 certificate is especially useful if you wish to develop a special interest, become a GP with a Special Interest (GPwSI) and/or participate in local shared care schemes and enhanced services. The Certificate in the Management of Alcohol Problems in Primary Care is also valuable for all GPs. Details are on the RCGP Online Learning Environment website (http://elearning.rcgp.org.uk). New courses of relevance to this curriculum are often added to this resource.
Useful learning resources

Books and publications

- Royal College of General Practitioners (RCGP). *Guidance for the Use of Buprenorphine for the Treatment of Opioid Dependence in Primary Care* London: RCGP & SMMGP, 2004
- Royal College of General Practitioners (RCGP). *Guidance for Working with Cocaine & Crack Users in Primary Care* London: RCGP & SMMGP, 2004
- Royal College of General Practitioners (RCGP). *Guidance for the Use of Methadone for the Treatment of Opioid Dependence in Primary Care* London: RCGP & SMMGP, 2005
- Royal College of General Practitioners (RCGP). *Guidance on Prescribing Benzodiazepines to Drug Users in Primary Care* London: RCGP, 2005
- Royal College of General Practitioners (RCGP). *Guide to the Management of Substance Misuse in Primary Care* London: RCGP, 2005

Web resources

**Alcoholics Anonymous (AA)**

Provides information for professionals and patients, and lists where to find local meetings. Also offers a 24-hour helpline, seven days a week. [www.alcoholics-anonymous.org.uk](http://www.alcoholics-anonymous.org.uk)

**Bandolier**

This is an independent journal about evidence-based healthcare, written by Oxford scientists. There is plenty about drug and alcohol problems here and it is a useful resource for evidence-based practice. [www.medicine.ox.ac.uk/bandolier/index.html](http://www.medicine.ox.ac.uk/bandolier/index.html)
Cochrane Library

The famous Cochrane database of reviews – look for the Cochrane drug and alcohol group section.  
http://onlinelibrary.wiley.com/o/cochrane/cochrane_clsysrev_crglist_fs.html

Drink and Drugs News

This looks at current issues in the drug and alcohol field and has many contributors from various backgrounds.  www.drinkanddrugsnews.com

Driver Vehicle Licensing Authority (DVLA)

This site gives access to the medical standards for fitness to drive and includes alcohol and drug problems.  www.dft.gov.uk/dvla/medical/ataglance.aspx

Drug Driving:

This site provides useful information about drug driving  http://drugdrive.direct.gov.uk

Government information and policies:


Narcotics Anonymous

Provides information for professionals and patients, and lists where to find local meetings.  www.ukna.org

National Treatment Agency for Substance Misuse (NTA)

The National Treatment Agency for Substance Misuse aimed to increase the availability, capacity and effectiveness of treatment for drug misuse in England. It has now been incorporated into Public Health England (PHE). It can still be accessed on:  www.nta.nhs.uk

RCGP Online Courses and Certifications

The RCGP provides a number of certification courses on alcohol and drug-related health issues. The e-learning component can be taken independently for self-study or can be combined with a classroom-based workshop to lead to a formal certification:

- RCGP Harm Reduction and Wellbeing of Substance Users
- RCGP Management of Drug Misuse in Primary Care (Parts 1 and 2)
- RCGP Management of Alcohol Problems in Primary Care

Available at: http://elearning.rcgp.org.uk

e-GP also includes a course on alcohol misuse from the DH Alcohol Improvement Programme
www.e-GP.org
RCGP Substance Misuse and Associated Health

This is what it ‘says on the tin’ with access to the various RCGP certificates, guidelines and web links. [www.rcgp.org.uk/clinical-and-research/clinical-resources/substance-misuse-resources-for-gps.aspx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/substance-misuse-resources-for-gps.aspx)

SIGN

The Scottish Intercollegiate Guidelines Network (SIGN) have produced guidelines for ‘The Management of Harmful Drinking and Alcohol Dependence in Primary Care’. [www.sign.ac.uk/guidelines/fulltext/74/index.html](http://www.sign.ac.uk/guidelines/fulltext/74/index.html)

Smart Recovery UK

Self-help for addiction recovery and alcohol abuse with free weekly meetings, locally and online. [www.smartrecovery.org.uk](http://www.smartrecovery.org.uk)

Substance Misuse Management in General Practice (SMMGP)

Substance Misuse Management in General Practice is a network that supports GPs and other members of the primary healthcare team who work with substance misuse in the UK. The project team produces the Substance Misuse Management in General Practice newsletter, Network, and organises the annual conference, ‘Managing Drug Users in General Practice’. You can access details of the certificates in substance misuse and alcohol treatment through the site and take part in online forum discussions. [www.smmgp.org.uk](http://www.smmgp.org.uk)

Talk to Frank

FRANK is a national drug education service jointly established by the Department of Health and Home Office. It is a good source of information for practitioners and patients about the different drugs, their appearance, street names, mode of use, effects and dangers. [www.talktofrank.com](http://www.talktofrank.com)
3.15 Care of People with ENT, Oral and Facial Problems

Summary

- 15% of consultations in general practice involve the upper respiratory tract or head and neck\textsuperscript{42}
- Guidelines for appropriate management are widely available but not always used
- Knowledge of normal anatomy and examination techniques makes diagnosis easier
- Variable training in ear, nose and throat (ENT) at undergraduate level means that trainees and trainers have to review current knowledge and skills
- Head and neck cancer rates are increasing and outcomes depend on early diagnosis

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Ensure that a patient’s hearing impairment or deafness does not prejudice the information communicated or your attitude as a doctor towards the patient

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Demonstrate empathy and compassion towards patients with ENT symptoms that may prove difficult to manage e.g. tinnitus, facial pain, unsteadiness

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

\textsuperscript{42} Griffiths E. Incidence of ENT problems in general practice \textit{Journal of the Royal Society of Medicine} 1979;72:740–2
This means that as a GP you should:

- Be able to communicate effectively with patients with hearing impairment and deafness, or speech impairment, some of which may occur together

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Understand how to recognise rarer but potentially serious conditions such as oral, head and neck cancer
- Know the epidemiology of head and neck cancers, including the risk factors, and identify unhealthy behaviour
- Identify symptoms that are within the range of normal and require no treatment such as small neck lymph nodes in healthy children and ‘geographic tongue’

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Carry out appropriate examination including more detailed tests where indicated, e.g. audiological tests and the Dix–Hallpike test to help diagnose benign paroxysmal positional vertigo (BPPV)
- Know the skills which can be used in primary care to effect a cure when indicated, e.g. nasal cautery and the Epley manoeuvre

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

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43 Head and neck fast-track referral guidance:
This means that as a GP you should:

- Manage primary contact with patients who have a common/important ENT, oral or facial problem, e.g. vertigo or tinnitus
- Understand when watchful waiting and the use of delayed prescriptions are indicated

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Understand the relationship between factors in the patient’s environment, such as smoking or noise levels, and the cause and management
- Appreciate that pathology in other systems may lead to ENT-related symptoms. Examples include gastro-oesophageal reflux disease (GORD) and cerebrovascular accident (CVA)
- Understand that ENT pathology can lead to developmental delay, e.g. ‘glue ear’ can impair a child’s learning
- Understand that systemic disease such as haematological, dermatological and gastrointestinal problems may present with oral symptoms, e.g. glossitis caused by iron deficiency anaemia
- Empower patients to adopt self-treatment and coping strategies where possible for conditions such as allergic rhinitis, minor epistaxis and tinnitus

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Understand when urgent (or semi-urgent) referral to secondary care may be indicated, e.g. in trauma, epistaxis, quinsy (peritonsillar abscess), severe croup or stridor
- Be aware of the need to refer patients with oral disease to appropriate specialist services in oral medicine or oral and maxillofacial surgery
- Be aware that dental practitioners have knowledge and experience of diagnosing and managing common (benign) oral conditions in primary care
Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Recognise that your training in ENT, oral and facial problems might need to be supplemented
- Demonstrate knowledge of the scientific backgrounds of symptoms, diagnosis and treatment of ENT, oral and facial conditions
- Demonstrate an evidence-based approach to antibiotic prescribing
- Understand and implement the key national guidelines that influence healthcare provision for ENT problems

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Ensure that your working environment is equipped to ease communication with patients who are hard of hearing and does not create barriers to accessing your services

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Appreciate the impact of hearing loss on quality of life and understand the community and cultural attitudes to deafness
- Understand that patients in poorer socio-economic situations (including the homeless) have higher rates of head and neck malignancy
- Know how community-specific aspects of oromucosal disease may be related to lifestyle (e.g. chewing paan, tobacco, betel nut, khat/qat, or reverse smoking)
- Know that certain ENT, oral and facial symptoms may be manifestations of psychological distress, e.g. globus pharyngeus, atypical facial pain, burning mouth syndrome
• Demonstrate effective strategies for dealing with parental concerns regarding ENT conditions such as recurrent tonsillitis or otitis media with effusion, e.g. explain why antibiotics are not always indicated

• Understand the significant quality-of-life impairment that may arise from common ENT and oral complaints, e.g. snoring, rhinosinusitis, persistent oral ulceration and dry mouth

• Know the national screening programme for hearing loss

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

• Avoid a negative attitude towards homeless patients, which can lead to less vigilance in early detection of head and neck cancer in this group

• Understand that certain services are highly specialised and regionally based such as the provision of cochlear implants

• Know the community services that may be available, e.g. for audiological assessment

• Refer patients with dental or gingival problems to their general dental practitioner or local community dental services

• Ensure the practice welcomes patients from low socioeconomic classes and is active in reducing risk factors for head and neck malignancy

Case discussion

Mark Johnson is a 25-year-old trainee solicitor who presents with persistent nasal obstruction, runny nose, watery eyes and regular sneezing. The problem is perennial and has been getting worse for years. He also has asthma. He has moved into a flat and has adopted a cat. The use of steroid sprays and antihistamines only marginally improves things and he tells you he is ‘fed up with his symptoms’ and says ‘there must be something else that can be done’. He requests an immediate referral to a specialist. Your examination reveals some form of swelling in the nose, more noticeable on the right than the left.

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:
<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How do I feel when say ‘there must be something that can be done...’?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>Do I consider his symptoms to be an appropriate use of medical consulting time?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td>How far should I take further investigations and treatments?</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>How do I feel about his demand for referral? How will I manage those feelings in the consultation?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td>How might I deal with his frustrations and anger?</td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>How can I determine if Mark has been compliant with treatment?</td>
</tr>
<tr>
<td>This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
<td>How effective is allergy testing (PRIST, RAST or skin tests)?</td>
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<td></td>
<td>What triggers his symptoms?</td>
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<tr>
<td><strong>Making decisions</strong></td>
<td>How do I determine whether the swellings in the nose are nasal turbinates or polyps or part of the normal nasal cycle?</td>
</tr>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
<td>How could the history help to determine the cause of his symptoms?</td>
</tr>
<tr>
<td><strong>Clinical management</strong></td>
<td>What is the optimal treatment (drug and dosage)?</td>
</tr>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
<td>What are the current guidelines for reducing exposure to house dust mite?</td>
</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>How might his asthma and nasal symptoms be linked?</td>
</tr>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
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</tr>
<tr>
<td>Working with colleagues and in teams</td>
<td>Who else might I involve in the management of this patient?</td>
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<tr>
<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
<td>If I refer him, what key features should go in the referral letter?</td>
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<td>Where can I direct Mark to further information about his condition?</td>
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</table>

<table>
<thead>
<tr>
<th>Maintaining performance, learning and teaching</th>
<th>Do I have sufficient knowledge of nasal anatomy to allow me to detect any abnormality? If not, how could I improve my knowledge?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
<td>What is the evidence for effectiveness of common ENT treatments?</td>
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<td></td>
<td>What other resources do I need in my area?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisational management and leadership</th>
<th>How would I know from my IT system whether Mark has had a recent asthma review? What recall systems are in place?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Practising holistically and promoting health</th>
<th>How might these symptoms affect Mark’s ability to work and study, and his social life?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</td>
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</table>

<table>
<thead>
<tr>
<th>Community orientation</th>
<th>What are the resource issues relating to providing care for allergies in our health economy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
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44 The real issue here is the fact that allergy is very common and it is accepted that it is under-resourced in the UK. This is outlined in a Royal College of Physicians document *Allergy: the unmet need*, [www.bsaci.org/pdf/allergy_the_unmet_need.pdf](http://www.bsaci.org/pdf/allergy_the_unmet_need.pdf)
How to learn this area of practice

Work-based learning
In primary care and secondary care

As a GP specialty trainee you will find the frequency of ENT-related symptoms in primary care makes this the ideal environment for you to learn the basics of history-taking and examination (including identifying what is ‘normal’). It is not uncommon for a clinician (GP or other healthcare professional) to have developed additional expertise in ENT, and working alongside such an individual can be very beneficial. Local ENT departments are usually very willing to have trainees sitting in outpatient clinics, and taking time to arrange a regular session in such a clinic will provide you with invaluable experience. The experience will be enhanced if you can see patients initially and then discuss examination findings and potential management with your supervising colleague. The extensive use of endoscopes and microscopes will greatly facilitate your understanding of ENT pathology. In both scenarios always ask for feedback on cases and look to use formal assessment tools (available online) to document your learning.

The frequency of common oral-related symptoms in primary care and the limited undergraduate training in this area make it worth your while attending specialist clinics in oral medicine and oral and maxillofacial surgery. In these clinics you will learn how to examine the mouth, recognise and provide initial management of common oral conditions and appreciate the presenting features of oral cancer and pre-cancerous lesions.

Self-directed learning

It is not uncommon to come across friends and relatives with ENT conditions and this can give you an insight into the impact on quality of life of what may be regarded as ‘trivial conditions’. Examples include general upper respiratory tract infections, allergic and non-allergic rhinitis, snoring and deafness. Indeed, as a primary care physician it is essential that you understand the effect of a significant hearing loss on an individual’s way of life. It is also important that you understand its isolating effect and appreciate the statement that ‘blindness separates an individual from objects; deafness separates an individual from people’.

Learning with other healthcare professionals

As a GP trainee, gaining experience in other medical specialities will give you insight into dealing with common ENT, oral and facial problems. In particular:

- Paediatrics – many children have ENT-related conditions which affect their general well-being and may compromise their education
- Medicine of the Elderly – deafness and balance disorders are common
- Immunology – it is not uncommon for systemic allergy to present with symptoms and signs in the ear, nose, oral cavity or throat
- Dermatology – skin conditions affecting the face and scalp, and otitis externa, may present to skin specialists
- Respiratory medicine – it is important to understand that both the upper and the lower airway often need to be treated together
- Oral medicine and oral and maxillofacial surgery – understand that oral signs and symptoms may be a manifestation of underlying systemic disease
- Hearing loss clinics in the high street – these increase access to a range of services
During your training, spending time with nurses who have ENT experience can be very rewarding. Dental surgeons also have training and experience in managing common oral conditions as well as dental disease, and their opinion is often helpful.

**Useful learning resources**

**Books and publications**
- Bull T and Almeyda J. *Colour Atlas of ENT Diagnosis (5th edn)* Thieme, 2009
- Coley AN and Kay NJ. *ENT for Primary Care (2nd edn)* Churchill Livingstone, 1998
- Milford C and Rowlands A. *Shared Care for ENT* ISIS Medical Media Ltd, 1999
- Scully C. *Oral and Maxillofacial Medicine: the basis of diagnosis and treatment (3rd edn)* Churchill Livingstone (Elsevier), 2013
- Robb P, Watson A. *ENT in Primary Care* RILA publications 2007

**Web resources**

**British Association of Oral and Maxillofacial Surgery (BAOMS)**

National association for oral and maxillofacial surgery. [www.baoms.org.uk](http://www.baoms.org.uk)

**British Society for Oral Medicine (BSOM)**

National association for oral medicine. The website contains information about the specialty and location of units in the UK. Patient information and other links can also be found. [www.bsom.org.uk](http://www.bsom.org.uk)

**Cancer Research UK**

The following links provide information on mouth cancer and referral guidelines.


**Clinical Knowledge Summaries**

A reliable source of evidence-based information and practical 'know how' about the common conditions managed in primary care. [http://cks.nice.org.uk/#?char=A](http://cks.nice.org.uk/#?char=A)

**e-GP**

*e-GP* includes ENT sessions on audiology, including ear examinations. To access the e-GP courses, visit [www.e-GP.org](http://www.e-GP.org)
ENT UK – British Association of Otorhinolaryngologists, Head & Neck Surgeons

National association for ENT. The website contains wide-ranging information about the specialty, advice, information leaflets, documents, videos and links etc. www.entuk.org
3.16 Care of People with Eye Problems

Summary

- Visual loss is a significant cause of physical and psychosocial morbidity, which is a barrier to accessing healthcare. This can be overcome by appropriate rehabilitation for the visually impaired.
- The general practitioner (GP) has a key role as part of the primary healthcare team in coordinating access to community and secondary care services.
- As part of opportunistic health screening, GPs are well placed to ensure that patients have regular eye tests and are referred appropriately and in a timely manner.
- The GP should be able to examine, diagnose and treat common eye conditions and know when to refer to secondary care.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Understand your role in balancing the autonomy of patients with the need to address visual problems and public safety

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Recognise that patients with visual impairment may have difficulty receiving written information and accessing healthcare services, and your role in implementing measures to overcome these obstacles to effective health care

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.
This means that as a GP you should:

- Understand the importance of exploring the ideas, concerns and feelings of patients who are threatened with sight loss
- Know how to communicate with a visually impaired person and their carers, and help them to participate fully in planning the management of their problem

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Recognise ophthalmic emergencies and refer appropriately, e.g. new visual distortion in wet age-related macular degeneration, sudden loss of vision
- Recognise ocular manifestations of neurological disease, e.g. hemianopia, nystagmus

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Understand the use of medications for eye problems including mydriatics, topical anaesthetics, corticosteroids, antibiotics and glaucoma agents, and be able to explain these to your patient
- Be able to diagnose and manage common conditions causing red eye and lid problems, such as blepharitis, chalazion and conjunctivitis

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Manage primary contact with all patients who have an eye problem
- Understand the common eye conditions in primary care and manage them appropriately
- Manage superficial ocular trauma, including assessment of foreign bodies, abrasions and minor lid lacerations.
- Understand the importance of diabetic retinopathy screening and regular eye tests in the context of preventable sight loss
Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Understand the implications of the certificate of visual impairment, and the role of specialist social workers
- Promote a healthy lifestyle for your patients and manage co-morbidity in an attempt to reduce the prevalence of blinding eye conditions
- Manage the underlying systemic disease to reduce further complications, e.g. diabetes, vascular disease, connective tissue disorders and infections such as herpes
- Understand the significance of visual impairment for a patient’s ability to self-manage other chronic illness

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Make timely, appropriate referrals on behalf of patients to specialist and community eye services

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand and implement the key national guidelines that influence the provision of eye healthcare including prevention and management of eye problems, visual impairment and blindness
- Be aware of major advances in therapy for eye conditions

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes
structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Recognise your responsibility to facilitate access to the services you provide, including the practice environment

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Appreciate the importance of the social and psychological impact of eye problems on the patient
- Understand the significant psychological impact of sight loss for the patient and their family
- Understand the impact eye problems may have on co-morbidity/disability and fitness to work, and on independent living
- Understand what influences the patients in your practice to take up regular eye examinations to prevent sight loss

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Understand the role of the community optometrist and NHS entitlement
- Know the DVLA driving regulations for people with visual problems, and your role in relation to your patients
- Facilitate patients’ access to sources of social and charity support for visually impaired adults and children
- Be aware of the Royal National Institute of Blind People Access to Work scheme
- Develop your understanding of how you might organise screening for eye problems in your practice, e.g. six-week baby check, checks for diabetic retinopathy, glaucoma, squint
Case discussion

It’s Monday morning and your second patient is Mr John Smart who is 75 years old. He was last seen six months ago following problems with sleeping. He has lived alone since his wife died suddenly from a stroke three years earlier.

He is accompanied by his daughter, whom you have not met before. She tells you that her dad has asked her to come along as he is a bit upset since his visit to his optometrist last week. Mr Smart states, ‘It was not the girl I usually see at the opticians. This man flashed a lot of lights in my eyes then said I had a major problem with my vision and should come to see you about going to the hospital. What’s worse is that he said I shouldn’t drive my car.’ His daughter adds, ‘Dad was so upset he didn’t even ask what was wrong. His car is his lifeline. I went back with him to the opticians and they told me he probably has something called ARMD – he wrote it down for me. He said you would be able to sort it out, and he would be writing to you.’

You look at his past medical history before calling him in. There appears to be no relevant previous history. He is on no medication, and comes in regularly for his ‘flu jab and health checks with the nurse. On direct questioning he admits that he has noticed his vision was deteriorating but assumed this was because he needed new glasses, and that was why he went for an eye check. He admits that he has not been for an eye check since well before his wife died. He says, ‘She used to sort those things out. I don’t go out at night anymore as I can’t see well enough. I also noticed a funny thing – I can see the television better when I look from the side rather than from the front.’

Your receptionist finds that a letter from the optometrist has arrived this morning. The optometrist noted a marked loss of visual acuity since his last eye examination and feels that this is likely to be due to age-related macular degeneration. Visual acuity testing in your surgery reveals that Mr Smart can only see the top line of the Snellen chart at 6 metres and this does not improve with a pin hole.

You advise Mr Smart that you will refer him to the local eye department. You tell him that they may refer him on to the Low Vision Service based at the local NHS Treatment Centre near your practice. You also print off some information regarding eye charities in large print in order that Mr Smart can read them himself and seek support and advice while he awaits his appointment.

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
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<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
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<tr>
<td>This concerns the development of</td>
<td>How do I feel about telling Mr Smart he must not drive</td>
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<tr>
<td>professional values, behaviours and</td>
<td>his car?</td>
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<td>personal resilience and preparation</td>
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<td>for career-long development and</td>
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<td>revalidation. It includes having</td>
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<td>insight into when your own</td>
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<td>performance, conduct or health might</td>
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<td>put patients at risk, as well as</td>
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<td>taking action to protect patients.</td>
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<tr>
<td>Module Title</td>
<td>Questions</td>
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</tr>
<tr>
<td>Maintaining an ethical approach</td>
<td>What would I do if he drives the car against my advice?</td>
</tr>
<tr>
<td>Communication and consultation</td>
<td>How can I explore the psychological impact of visual loss in the consultation with Mr Smart? How would I explain the likely outcome of his condition? What do I think might be the obstacles to Mr Smart having regular eye tests? How would I explore all those issues?</td>
</tr>
<tr>
<td>Data gathering and interpretation</td>
<td>Why should I use a pin hole when assessing visual acuity? When is an Amsler grid useful in assessing a patient? What lifestyle factors would I record in the notes?</td>
</tr>
<tr>
<td>Making decisions</td>
<td>What other blinding eye conditions present with gradual onset?</td>
</tr>
<tr>
<td>Clinical management</td>
<td>Which of my patients are entitled to free eye tests under the NHS? How easy is it to arrange for my patients to receive an eye test at home?</td>
</tr>
<tr>
<td>Managing medical complexity</td>
<td>What co-morbidities are common with sight loss? What are the risk factors for age-related macular degeneration (ARMD/AMD) and how common is it? What role has his bereavement played in this scenario?</td>
</tr>
<tr>
<td>Working with colleagues and in teams</td>
<td>How urgent is this hospital referral? What role does an optician play in caring for patients with eye conditions? How can I collaborate with local opticians to provide a better service for my patients? Can I read GOS letter and understand what the different terms mean?</td>
</tr>
<tr>
<td>Maintaining performance, learning and teaching</td>
<td>What are the current issues around treating age-related macular degeneration?</td>
</tr>
</tbody>
</table>
**How to learn this area of practice**

**Work-based learning**

**In primary care**

Eye problems account for 1.5% of general practice consultations in the UK with a rate of 50 consultations per 1000 population per year. Primary care is an ideal setting for you to learn how to manage eye problems within the limited time and resources available. You should also take the opportunity to find out about other agencies, both statutory and voluntary, that provide support for patients with chronic eye disorders in the community. (See also Web Resources below.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do I keep myself updated about ophthalmological conditions?</td>
<td>This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
</tr>
<tr>
<td>How confident am I at using an ophthalmoscope?</td>
<td></td>
</tr>
<tr>
<td>How should I ensure that my patients are not ‘lost to follow-up’?</td>
<td>Organisational management and leadership This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
</tr>
<tr>
<td>What does the practice provide to support visually impaired patients?</td>
<td>Practising holistically and promoting health This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</td>
</tr>
<tr>
<td>How will I manage the psychological impact of sight loss in Mr Smart?</td>
<td>Community orientation This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
</tr>
<tr>
<td>Why do I think Mr Smart did not seek help earlier for the problems with his vision?</td>
<td></td>
</tr>
<tr>
<td>What do I know about Mr Smart’s living accommodation? Will he need additional support at home?</td>
<td></td>
</tr>
<tr>
<td>What social benefits and services might be available to this patient and his carers if he is certified visually impaired?</td>
<td></td>
</tr>
<tr>
<td>Where do I find the DVLA rules on sight impairment and who is required to inform the DVLA? (see also case illustrations in statements 3.17 Care of People with Metabolic Problems and 3.18 Care of People with Neurological Problems)</td>
<td></td>
</tr>
<tr>
<td>What other health professionals in the community could help in managing his vision problems?</td>
<td></td>
</tr>
</tbody>
</table>
In secondary care

As a GP specialty trainee you should be able to attend secondary care-based ophthalmology clinics and/or eye casualty to learn about both acute and chronic conditions. It is also useful for you to attend an operating session to gain an understanding of cataract surgery, perhaps by accompanying a patient on his or her journey.

Self-directed learning

There are a number of online and classroom-based courses which may help you with your learning in this area. This includes the e-GP course on Eye Problems (www.e-GP.org).

Learning with other healthcare professionals

Optometrists are key members of the primary healthcare team and are increasingly involved in working in partnership with GPs in the management of diabetic patients and in screening for glaucoma and other eye problems. Partnerships provide an excellent opportunity for discussing the impact of chronic eye problems, and issues of screening and prevention. As a GP trainee you should attend your local optometrist to gain a better understanding of their skills and their contribution to primary care teams.

Formal learning

Find out about specific workshops. For example, the North & West London RCGP Faculty runs a Primary Care Ophthalmology Workshop covering ‘all you need to know to provide eye care in the community’.

Useful learning resources

Books and publications


Web resources

Driver and Vehicle Licensing Agency (DVLA)

At a Glance downloadable booklet with DVLA guidelines on the current medical standards for fitness to drive. www.dft.gov.uk/dvla/medical/ataglance.aspx

eye learning

A very useful site for trainees, developed by a GP with previous experience in ophthalmology. http://eyes.gp-surgery.com/

International Glaucoma Association

Provides readable material for patients. It also aims to raise public awareness of glaucoma and support those who already have the condition. www.glaucoma-association.com
Macular Society

The Macular Society aims to build confidence and independence for those with central vision impairment. They are the only UK charity dedicated to helping people with macular degeneration. [www.macularsociety.org/](http://www.macularsociety.org/)

National Institute for Health and Care Excellence (NICE) guidelines


Type 2 diabetes: the management of type 2 diabetes (CG87), 2009. [www.nice.org.uk/guidance/cg87](http://www.nice.org.uk/guidance/cg87)


Royal College of Ophthalmologists (RCOphth)

A useful resource for press releases on topical subjects in ophthalmology. [www.rcophth.ac.uk](http://www.rcophth.ac.uk)


NHS Choices

Information about entitlement to free eye tests

Royal National Institute of Blind People (RNIB)

The RNIB is the UK’s leading charity, helping anyone with a sight problem. The RNIB has worked with blind and partially sighted people for over a century with the specific aims of improving lives, increasing independence and eliminating preventable sight loss. [www.rnib.org.uk](http://www.rnib.org.uk)

Royal College of General Practitioners

The e-GP Eye Problems course includes topics such as screening and prevention of eye disease, eye examination, eye problems in children, supporting people with visual impairment, and sessions on specific eye conditions.

To access the e-GP courses, visit [www.e-GP.org](http://www.e-GP.org)

The RCGP webpage on eye health includes information and links to resources [www.rcgp.org.uk/eyehealth](http://www.rcgp.org.uk/eyehealth)

The UK Vision Strategy

The UK Vision Strategy is a VISION 2020 UK initiative led by the RNIB to develop a unified plan for action on all issues relating to vision, across the four countries of the UK. The UK Vision Strategy has brought together people with sight loss, users of eye care and eye health services, and social care
professionals and statutory and voluntary organisations for the very first time, to set the direction for eye health and sight loss services across the UK. The strategic outcome areas identified in the UK Vision Strategy are improving the eye health of the people of the UK, eliminating avoidable sight loss and delivering excellent support for people with sight loss, as well as inclusion, participation and independence for people with sight loss. [www.vision2020uk.org.uk/UKVisionstrategy](http://www.vision2020uk.org.uk/UKVisionstrategy)
3.17 Care of People with Metabolic Problems

Summary

- The prevalence of overweight and obesity, together with their associated complications including diabetes mellitus and non-alcoholic fatty liver disease (NAFLD), is increasing.
- As a general practitioner (GP) you should have an understanding of how common endocrine or metabolic disorders such as diabetes mellitus, thyroid or reproductive disorders can present. You must also be aware of rarer and important disorders such as Addison’s disease, which can be potentially life-threatening if missed.
- Biochemical tests can be diagnostic and often necessary for monitoring metabolic and endocrine diseases, so it is important for GPs to know which tests are useful in a primary care setting and how to interpret these tests and understand their limitations.
- GPs should appreciate the health and medical consequences of obesity including malnutrition, increased morbidity and reduced life expectancy, and have an understanding of the social, psychological and environmental factors underpinning obesity.
- GPs should understand the role of good diabetes management in prevention and/or postponement of associated morbidity and mortality.
- All GPs should be competent in the recognition and primary care management of metabolic and endocrine emergencies.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Recognise your central role as a primary care physician in managing diabetes mellitus and hypothyroidism.

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

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This means that as a GP you should:

- Ensure that the patient’s weight does not prejudice your decisions
- Ensure that the risks of complications from obesity or diabetes are not overstated in order to coerce a patient into complying with treatment

**Core Competence: Communication and consultation**

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Be aware that non-concordance is common for chronic metabolic conditions, e.g. diabetes, and respect the patient’s autonomy when negotiating management
- Communicate with patients clearly and effectively about the risk of complications from obesity and diabetes mellitus
- Develop a flexible approach to health promotion which reflects that certain groups with obesity and diabetes mellitus require different approaches, e.g. children, adolescents and young adults (see also statement 3.04 Care of Children and Young People), pregnant women, ethnic minorities
- Negotiate a programme of weight-reduction sensitively with patients, giving appropriate health promotion advice regarding diet, exercise and pharmacological therapies
- Recognise the potential for abuse of thyroxine and propose strategies to reduce dosage

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Recognise that patients with metabolic problems are frequently asymptomatic or have non-specific symptoms and that diagnosis is often made by screening or recognising symptom complexes and arranging appropriate investigations
- Understand the need for early recognition and monitoring of complications in diabetes mellitus

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.
This means that as a GP you should:

- Intervene urgently when patients present with a metabolic emergency, e.g. hypoglycaemia and hyperglycaemic conditions
- Demonstrate a logical, incremental approach to investigation and diagnosis of metabolic problems

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Manage appropriately primary contact with patients who have a metabolic problem
- Understand the role of particular groups of medication in the management of diabetes, e.g. anti-platelet drugs, ACE inhibitors, angiotension-2 receptor antagonists, lipid-lowering therapies, GLP-1 agonists
- Understand the use and main limitations of tests commonly used in primary care to investigate and monitor metabolic or endocrine disease, e.g. fasting blood glucose, HbA1c, urinalysis for glucose and protein, urine albumin: creatinine ratio, ‘near patient testing’ (point of care testing) for capillary glucose, lipid profile and thyroid function tests, and uric acid tests
- Recognise the risk of co-morbid mental health problems in people with metabolic problems such as diabetes and obesity, and the effect of these on morbidity and mortality

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Recognise that patients with diabetes mellitus often have multiple co-morbidities such as neuropathy, nephropathy and cardiovascular disease, and consequently polypharmacy is common
- Develop strategies to simplify medication regimes and encourage concordance with treatment
- Advise patients appropriately regarding lifestyle interventions for obesity, diabetes mellitus, hyperlipidaemia and hyperuricaemia
Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Co-ordinate care with other primary care and secondary care professionals with diabetes as a focus
- Know the indications for referral to an endocrinologist, metabolic medicine specialist or nephrologist for investigation of suspected endocrine disease, management of complex metabolic problems, or diabetic renal complications respectively
- Understand the systems of care for metabolic conditions including the roles of primary and secondary care, shared-care arrangements, multidisciplinary teams and patient involvement

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand and implement the key national guidelines that influence healthcare provision for cardiovascular problems associated with metabolic problems such as diabetes, e.g. NICE guidelines, British Hypertension Society Joint Committee recommendations, national frameworks and quality markers
- Know the key research findings that influence management of metabolic problems, e.g. Diabetes Control and Complications Trial (DCCT), United Kingdom Prospective Diabetes Study (UKPDS), Action to Control Cardiovascular Risk in Diabetes Trial (ACCORD), and the ADVANCE trial in diabetes and cardiovascular disease (see also Learning Resources below)

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.
This means that as a GP you should:

- Utilise disease registers and data-recording templates effectively for opportunistic and planned monitoring of metabolic problems to ensure continuity of care between different healthcare providers
- Understand the key government policy documents and the way they influence healthcare provision for your patients with metabolic problems
- Case find for depression and manage appropriately

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Recognise the psychosocial impact of diabetes mellitus and other long-term metabolic problems, e.g. the risk of depression, sexual dysfunction, restrictions on employment and driving for diabetes
- Recognise the stigma associated with obesity
- Empower patients to self-manage their condition, as far as is practicable

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Recognise that environmental and genetic factors affect the prevalence of metabolic problems, e.g. diabetes mellitus is more prevalent in the UK in patients of Asian and Afro-Caribbean origin, hyperuricaemia is more common in prosperous areas and is associated with obesity, diabetes, hypertension and dyslipidaemia
- Recognise that public health interventions are likely to have the largest impact on obesity and diabetes mellitus, and be able to signpost patients to such programmes where possible, e.g. exercise on prescription
- Know the exemptions from prescription charges for patients with metabolic conditions
- Understand how obesity and overweight can impact directly and indirectly on a wide variety of disease areas and thus why there is a need to consider obesity in the commissioning of a wide range of health services
Case discussion

Mrs Jones is 46 years old and has struggled with her weight for many years. Despite numerous diets, she has never managed to achieve sustained weight loss and is obese with a BMI of 36. She has a history of hypertension and hyperlipidaemia, and type 2 diabetes mellitus was diagnosed three years ago. Annual checks have identified background retinopathy but no evidence of nephropathy or neuropathy. Six months ago she was started on insulin by the diabetes specialist team as her glycaemic control was poor on maximal oral hypoglycaemic therapy and she was due to undergo a cholecystectomy. Unfortunately, her glycaemic control has deteriorated further since starting insulin. Her HbA1c has increased from 91 mmol/mol Hb (DCCT 10.5%) six months ago to 102 mmol/mol Hb (DCCT 11.5%). The practice nurse has been unable to check this result against the patient’s home monitoring record because Mrs Jones has not been testing her blood glucose levels but monitoring her urine glucose instead. When her urine test is negative she has been omitting her insulin dose. You note that her blood pressure, cholesterol and triglycerides are elevated and that her weight has increased by a further 3 kg over the last six months.

As her GP, you are aware that Mrs Jones is divorced and is a single parent to her two young children. She also looks after her elderly parents and holds down a full-time job at a local bank. You are concerned that she is not prioritising her health and is not coping with insulin injections. She admits that she has not been prioritising her diabetes, she resents being on insulin and has also been forgetting to take her oral medications. On exploration of her health beliefs, she expresses her fear of having a hypoglycaemic episode. She has been eating larger amounts of carbohydrate regularly to run high blood glucose levels as she had one ‘hypo’ several months ago which frightened her. She has stopped driving since then and this is making life more stressful. Following discussion with Mrs Jones and the diabetes consultant, an urgent review with the diabetes clinical team is arranged.

The result of this multidisciplinary team (MDT) work is that more time is spent teaching her how to test and manage her blood glucose. She is informed of targets to aim for and a concordant agreement is reached regarding the number of blood glucose measurements and the number of insulin injections per day. Her obesity is discussed sensitively. It becomes clear that she has developed a number of eating behaviours that have contributed to her weight gain. She agrees to enrol on a structured education programme for type 2 diabetes and to be referred to the psychology service for support to change her eating behaviours. GLP-1 agonist therapy is initiated to assist weight loss and insulin is down-titrated. To support her making long-term significant changes to her lifestyle you signpost her to sources of information on local facilities for exercise and weight management.

Six months later, she has lost 12kg and is reaching glycaemic, lipid and blood pressure targets. She remains on the GLP-1 agonist and no longer requires insulin.

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

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46 Diabetes Control and Complications Trial (DCCT) aligned units for HbA1c – see also Examples of Relevant Texts and Research below
<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>What are my own feelings about overweight and obesity? How might my attitude, as well as societal attitudes, influence my care of patients who are overweight? What are the social implications of obesity?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>As Mrs Jones’ GP, what is my legal responsibility in relation to her fitness to drive with diabetes? What is the GMC’s advice? (see also case illustrations in 3.16 Care of People with Eye Problems and 3.18 Care of People with Neurological Problems and Web Resources below)</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td></td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>Have I explored Mrs Jones’ ideas, concerns and expectations? Does this case demonstrate respect for Mrs Jones’ autonomy?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td></td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What potential emergencies may arise in this situation? How would I recognise a diabetic emergency? What other factors may affect the validity of the Hba1c value?</td>
</tr>
<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
<td></td>
</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>How confident am I to add medications in the care of diabetic patients?</td>
</tr>
<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical management</strong></td>
<td>How can I demonstrate my ability to act as a team leader and a team member in this case?</td>
</tr>
<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
<td></td>
</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>How would I explain to Mrs Jones the importance of managing her blood glucose, blood pressure, lipids and weight?</td>
</tr>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
<td></td>
</tr>
<tr>
<td><strong>Working with colleagues and in teams</strong></td>
<td>How are the diabetics managed in my practice? Who follows them up? What are the shared care protocols?</td>
</tr>
<tr>
<td>This is about working effectively with other professionals to ensure good patient care.</td>
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<tr>
<td>Area</td>
<td>Question</td>
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</tr>
<tr>
<td>It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
<td>How do I liaise with the diabetes specialist nurse and the local diabetologist?</td>
</tr>
<tr>
<td><strong>Maintaining performance, learning and teaching</strong>&lt;br&gt;This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
<td>What is the evidence base for current glycaemic, lipid and blood pressure targets in diabetes?</td>
</tr>
<tr>
<td><strong>Organisational management and leadership</strong>&lt;br&gt;This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
<td>How would I audit the diabetic care in my practice? What standard and criteria would I use and why?</td>
</tr>
<tr>
<td><strong>Practising holistically and promoting health</strong>&lt;br&gt;This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</td>
<td>How does an awareness of social and psychological factors help the management of this patient?</td>
</tr>
<tr>
<td><strong>Community orientation</strong>&lt;br&gt;This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
<td>What is the local strategic approach to tackling overweight and obesity in my area, including non-NHS partners?</td>
</tr>
</tbody>
</table>

**How to learn this area of practice**

**Work-based learning**

**In primary care**

As a GP specialty trainee, primary care is the best place for you to learn how to manage common metabolic problems such as diabetes because it is where the vast majority of patients present and
are managed. There is no substitute for clinical experience, supported by your GP trainer and experienced members of the primary healthcare team.

Particular areas of learning include risk factor management, ‘motivational interviewing’\textsuperscript{47} to help people change health behaviours, acute and emergency management of metabolic problems as they present in primary care, and chronic disease management including surveillance for and early diagnosis of complications.

Some GP practices offer level 2 services in diabetes or obesity. Other arrangements may include intermediate diabetes care clinics. You will find it beneficial to attend some sessions.

**In secondary care**

Secondary care is the best place for you to learn about patients with uncommon but important metabolic or endocrine conditions such as Addison’s disease and hypopituitarism, as well as about patients with complex needs or with complications of the more common metabolic conditions.

Some GP training programmes include placements of varying duration with diabetes or endocrinology specialists, giving trainees exposure to patients with serious diabetes or endocrine problems in the acute setting. Most specialist care is, however, provided in outpatient clinic settings and you should take the opportunity to attend specialist diabetes, endocrine and obesity clinics when working in other hospital posts. You should also consider attending specialist clinics during your general practice placements.

Particular areas of learning include how to recognise metabolic or endocrine disorders that may be life-threatening if missed, which groups or types of patients are best followed up by a specialist team and when patients who are usually managed in primary care should be referred to a specialist team, including the timing and route of such referrals.

**Self-directed learning**

An e-learning programme for practitioners in the NHS and local authorities working in weight management has been developed by the Department of Health obesity team in partnership with the Department of Health e-learning for Healthcare (www.e-lfh.org.uk).

As part of the e-GP programme (www.e-GP.org) the RCGP offers two curriculum-based e-learning modules on metabolic problems (Diabetes; Endocrine and Metabolic Problems). There are also sessions on obesity in adults and children (in the Promoting Health & Preventing Disease module and the Children and Young People module). These are interactive and reflective e-learning sessions that enhance GP training and support preparation for appraisal and revalidation.

**Learning with other healthcare professionals**

The achievement of good outcomes in the care of chronic metabolic conditions such as diabetes or obesity requires well-organised and co-ordinated services that draw on the knowledge and skills of

\textsuperscript{47} Motivational interviewing (MI) is an evidence-based technique for producing behavioural change by helping patients explore and resolve ambivalence towards change. It uses a patient-centred, supportive and goal-directed approach which is collaborative rather than ‘coercive’ (see also Examples of Relevant Texts and Research below)
health and social care professionals across primary and secondary care. As a specialty trainee it is important for you to attend nurse-led diabetes annual review assessments in practice and gain an understanding of the follow-up of diabetic patients in primary care. It is also important to understand the role of district nurses in the management of diabetic leg ulcers. You should also take the opportunity to sit in with colleagues such as specialist diabetes or obesity nurses, dieticians and psychologists in a secondary or intermediate care setting to learn from and appreciate the contribution of these professional groups.

**Formal learning**

Some higher-education institutions provide postgraduate certificate courses in diabetes and metabolic problems. The Intercollegiate Group on Human Nutrition is a group of the Academy of Medical Royal Colleges whose main objective is to provide courses and education on nutrition primarily for medical practitioners. For example, the Intercollegiate Course on Human Nutrition is suitable for general practitioners wishing to develop a special interest in nutrition [www.aomrc.org.uk/intercollegiate-group-on-nutrition/icgn-courses.html](http://www.aomrc.org.uk/intercollegiate-group-on-nutrition/icgn-courses.html).

**Useful learning resources**

**Books and publications**

- United Kingdom Prospective Diabetes Study – UKPDS 33. Intensive blood glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes Lancet 1998; 352: 837–53
- United Kingdom Prospective Diabetes Study – UKPDS 34. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes Lancet 1998; 352: 854–65
• Gadsby R. *Diabetes and Endocrine Disorders in Primary Care* London: RCGP Publications, 2009
• Miller WR and Rollnick S. *Motivational Interviewing: preparing people for change* New York, NY: Guilford Press; 2002

**Web resources**

**Association for the Study of Obesity (ASO)**

The UK's foremost charitable organisation dedicated to the understanding and treatment of obesity. [www.aso.org.uk](http://www.aso.org.uk)

**Diabetes in Scotland**

*The Scottish Diabetes Framework* published in April 2002 sets out the first steps of a 10-year programme to address the problem of diabetes. This website provides a record of what has been achieved as well as a means of sharing information and ideas about the challenges and opportunities ahead. [www.diabetesinscotland.org.uk/Publications.aspx](http://www.diabetesinscotland.org.uk/Publications.aspx)

**Diabetes UK**

The leading charity working for people with diabetes, funding research, campaigning and helping people to live with the condition. [www.diabetes.org.uk](http://www.diabetes.org.uk)

**Driver and Vehicle Licensing Agency (DVLA)**

DVLA guidelines for doctors regarding driving licences for patients with medical disorders. [www.dft.gov.uk/dvla//medical.aspx](http://www.dft.gov.uk/dvla//medical.aspx)

**International Diabetes Federation**

A non-governmental organisation working with the World Health Organisation (WHO) and the Pan American Health Organisation (PAHO) to promote diabetes care, prevention and research into a cure. [www.idf.org](http://www.idf.org)

**International Association for the study of obesity (IASO)**

The International Association for the Study of Obesity (IASO) is an umbrella organisation for 53 national obesity associations, representing 55 countries.
SCOPE (Specialist Certification in Obesity Professional Education) is IASO’s official obesity education programme, designed for all health professionals and is comprised of 5 different workstreams including e-learning and live training courses. [www.iaso.org/scope/about-scope/](http://www.iaso.org/scope/about-scope/)

**Malnutrition Task Force**

A number of guides on implementing nutritional care in hospital and community settings, as well as some brief summary information for commissioners are available on this website [www.malnutritiontaskforce.org.uk](http://www.malnutritiontaskforce.org.uk)


**Diabetes National Service Framework (Wales)**

The Diabetes NSF standards were published in England in December 2001 and have been adapted for use in Wales. The Diabetes NSF Standards (Wales) were published on 29 April 2002. The Delivery Strategy was launched in Wales in Spring 2003. The website provides information on key documents [www.wales.nhs.uk/sites3/home.cfm?orgid=440](http://www.wales.nhs.uk/sites3/home.cfm?orgid=440)

**National Institute for Health and Care Excellence – NICE Guidelines: Clinical Guidance (CG) and Public Health Guidance (PH)**

- Behaviour change at population, community and individual levels (PH 6), 2007
- Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease (CG 67), 2008
- Identification and management of familial hypercholesterolaemia (CG 71), 2008
- Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (CG 43), 2006
- Preventing type 2 diabetes – population and community interventions in high-risk groups and the general population (PH 35), 2011
- Type 2 diabetes: prevention and management of foot problems (CG 10), 2004
- Nutrition support in adults (CG 32)
- Type 2 diabetes: the management of type 2 diabetes (CG 66), 2008
- Type 2 diabetes: newer agents (CG 87). 2009
- Weight management before, during and after pregnancy (PH 27), 2010
- QS6 Diabetes in adults quality standard, 2011
- Obesity - working with local communities (PH42) 2012Managing overweight and obesity among children and young people (PH47) 2013
- Acute kidney injury: Prevention, detection and management of acute kidney injury up to the point of renal replacement therapy (CG169) [www.nice.org.uk](http://www.nice.org.uk)

**National Obesity Forum**

An independent organisation set up to raise awareness of the emerging epidemic of obesity and its impact on both individuals and the NHS. Resources are designed to help prevent and treat obesity in adults. [www.nationalobesityforum.org.uk](http://www.nationalobesityforum.org.uk)
Obesity Learning Centre

A website developed by the National Heart Forum with the support of the Department of Health and Department of Education to support people who work either directly or indirectly in promoting a healthy weight and tackling obesity. www.ncdlinks.org/olc

Primary Care Diabetes Society

This group represents all healthcare professionals involved with primary care diabetes, not only general practitioners and practice nurses but also GPSIs (GPs with a Special Interest) and clinical assistants. It has built a database of key opinion leaders working in primary care as well as forged close links with leading bodies in diabetes. www.pcdsociety.org

Royal College of General Practitioners

e-GP includes two curriculum-based e-learning modules on metabolic problems (Diabetes; Endocrine and Metabolic Problems), a number of sessions on obesity in adults and children, and a session on the examination of a patient with symptoms of an overactive thyroid www.e-GP.org

RCGP Nutrition resource

This provides essential information under four separate topics obesity, malnutrition and nutritional deficiency, food allergy and eating disorders. www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition.aspx
3.18 Care of People with Neurological Problems

Summary

- The management of epilepsy in primary care is a key competence for general practice
- All general practitioners (GPs) should be competent in the management of neurological emergencies
- Many neurological conditions can be managed in primary care. When making referrals, you need to be aware that there is a shortage of neurologists in the UK
- As a GP you play an essential role in the management of chronic neurological disability in the community

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Ensure that a patient’s neurological disability does not prejudice your attitude towards, or the information communicated to, the patient

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Be able to describe the ethical principles which you apply when treating an ‘incompetent’ patient (e.g. an unconscious patient) and when treating a patient who is unable to communicate (e.g. because of aphasia (partially or totally unable to communicate) or anarthria (total loss of speech))
- Be conversant with the Mental Capacity Act (and its equivalents in other UK countries) and its local application

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.
This means that as a GP you should:

- Communicate prognosis, including any uncertainties, truthfully and sensitively to patients with disabling neurological conditions such as Parkinson’s disease and multiple sclerosis
- Demonstrate empathy and compassion towards patients with disabling neurological conditions
- Understand the importance of continuity of care for patients with chronic neurological conditions

**Core Competence: Data gathering and interpretation**

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Know the epidemiology of common and/or important neurological conditions such as epilepsy, headache and facial pain syndromes, brain infections, neurological causes of vertigo, spinal cord disease, spinal root compression/irritation, peripheral neuropathies, multiple sclerosis, motor neurone disease, Parkinson’s disease and common and/or important movement disorders, brain tumours, and common and/or important inherited and congenital conditions
- Know the functional anatomy of the nervous system relevant to diagnosis
- Perform and understand the limitations of a screening neurological examination

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Demonstrate a structured, logical approach to the diagnosis of ‘difficult’ symptoms with multiple causes, e.g. headache, dizziness
- Demonstrate an understanding of the relevance to management and effective use of special investigations such as EEG, CT, MRI and nerve conduction studies

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.
This means that as a GP you should:

- Be able to demonstrate how you manage primary contact with patients who have a neurological problem, including headache, dizziness, tremor, numbness and tingling, weakness, abnormal movements, blackouts and loss of consciousness, and coma
- Understand principles of treatment for common conditions that are managed largely in primary care including epilepsy, headaches, vertigo, neuropathic pain, mononeuropathies, essential tremor and Parkinson’s disease
- Manage the acute presentation of meningitis and meningococcal septicaemia and people presenting with collapse, loss of consciousness or coma
- Co-ordinate care with other primary care health professionals to enable chronic disease management and rehabilitation
- Know the indications for referral to a neurologist for chronic conditions that require ongoing specialist management and conditions that require early treatment to avoid permanent deficit

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Offer vaccination for meningococcal disease where relevant
- Advise on the avoidance of triggers and prophylaxis for migraine
- Offer counselling about investigating people with a family history of genetic neurological disease
- Counsel patients appropriately regarding epilepsy medication including drug interactions, side effects and contraceptive and pregnancy advice

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Know the indications for referral of people with other neurological emergencies, e.g. spinal cord compression, cauda equina
Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Know the key national guidelines (e.g. NICE guidelines) that influence healthcare provision for neurological problems
- Understand how to access up-to-date information on the management of neurological conditions

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Be able to apply the national policy documents and patient information about many neurological disorders

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Recognise that neurological conditions often affect patients during their working lives and consequently have a large impact on the family’s social and economic well-being
- Recognise the stigma associated with neurological disease and disability, and how this may differ in different communities and cultures
- Offer health education and accident prevention advice for people with epilepsy and other chronic neurological disorders

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.
This means that as a GP you should:

- Know the current medical standards of fitness to drive for neurological conditions
- Understand the sources of help and support that are available in the local community for people with neurological disabilities

**Case discussion**

Mr Trevor Scott, a 32-year-old manager in a haulage company, presents with a history of a blackout at home, witnessed by his wife. The history given by his wife suggests a generalised tonic–clonic seizure. Trevor recalls that a year previously he had had a blackout while away on business which was un-witnessed but was associated with a period of amnesia and urinary incontinence. Trevor says he will lose his job if he can’t drive and maintains that the event was a stress-related faint.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>If he continues to drive, what should I do?</td>
</tr>
<tr>
<td>This concerns the development of</td>
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<tr>
<td>professional values, behaviours and</td>
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<td>personal resilience and preparation</td>
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<td>for career-long development and</td>
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<td>revalidation. It includes having</td>
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<td>insight into when your own</td>
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<td>performance, conduct or health</td>
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<td>might put patients at risk, as well</td>
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<td>as taking action to protect patients.</td>
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<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>What will I tell Mr Scott about driving?</td>
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<tr>
<td>This addresses the importance of</td>
<td>What should I be saying to the DVLA?</td>
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<tr>
<td>practising ethically, with integrity</td>
<td>(see also Web Resources below and case illustrations in statements 3.16 Care of</td>
</tr>
<tr>
<td>and a respect for diversity.</td>
<td>People with Eye Problems and 3.17 Care of People with Metabolic Problems)</td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>What explanation of the problem will I give Mr Scott?</td>
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<tr>
<td>This is about communication with</td>
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<tr>
<td>patients, the use of recognised</td>
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<td>consultation techniques, establishing</td>
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<td>patient partnerships, managing</td>
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<td>challenging consultations, third-party</td>
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<td>consulting and the use of</td>
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<tr>
<td>interpreters.</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What are the essential details in history and examination that will determine his</td>
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<tr>
<td>This is about interpreting the patient’s</td>
<td>management?</td>
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<tr>
<td>narrative, clinical record and</td>
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<tr>
<td>biographical data. It also concerns</td>
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<td>the use of investigations and</td>
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<td>examination findings, plus the</td>
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<td>adoption of a proficient approach</td>
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<tr>
<td>Module</td>
<td>Question</td>
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<tr>
<td>Making decisions</td>
<td>What examination will I perform and what tests does he need?</td>
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<tr>
<td>Clinical management</td>
<td>How will I manage this problem in general practice?</td>
</tr>
<tr>
<td>Managing medical complexity</td>
<td>How would poorly controlled epilepsy or polypharmacy impact on him as he gets older?</td>
</tr>
<tr>
<td>Working with colleagues and in teams</td>
<td>What is the role of the CNS in providing support?</td>
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<td></td>
<td>What is the role of the specialist versus the generalist?</td>
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<tr>
<td>Maintaining performance, learning and teaching</td>
<td>What is the evidence about starting treatment for seizures?</td>
</tr>
<tr>
<td>Organisational management and leadership</td>
<td>What are the rules regarding driving and neurological conditions?</td>
</tr>
<tr>
<td>Practising holistically and promoting health</td>
<td>What precautions should I suggest in his everyday life?</td>
</tr>
</tbody>
</table>
socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

**Community orientation**
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

If the epilepsy continues and becomes disabling, how will this affect his family’s wellbeing?

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**How to learn this area of practice**

**Work-based learning**

**In primary care**

In general practice, patients present with various neurological problems at varying stages of the natural history. As a GP specialty trainee, critical professional discourse with your trainer will aid you in developing ‘heuristics’, i.e. strategies for problem-solving in the cases you see. Supervised practice will also give you greater confidence.

Following up cases during your training period allows you to observe for yourself the natural history of neurological diseases and how they develop. Such clinical experience during training will be supported by your GP trainer and experienced members of the primary healthcare team such as the physiotherapist, occupational therapist and district nurse.

Some areas offer a specialist neurology outpatient service, based in primary care. This is a good opportunity for you to observe practice and be involved in the formal and informal conversations between GPs and specialists.

Many patients with chronic neurological conditions are resident in accommodation provided by voluntary organisations within the community. They usually have an appointed GP and it is important that you gain experience for caring for patients in this environment. This might require working with another practice if your training practice does not look after such a ‘home’.

**In secondary care**

Some GP training programmes contain placements of varying length with neurologists and/or general physicians and physicians for elderly people that give exposure to patients with serious neurological problems in the acute setting. However, most specialist care is provided in outpatient or clinic settings. These are ideal places for you to see concentrated groups of patients with neurological problems. They provide opportunities to observe many of the common conditions, as well as treatments for conditions such as migraine, epilepsy, stroke and Parkinson’s disease. Many chronic neurological conditions are also present in patients who are in mental health facilities.
Vocational training programmes should give you the opportunity to attend neurology clinics when working in other hospital posts. You should also consider attending specialist neurology clinics during your general practice-based placements.

**Self-directed learning**

Many postgraduate deaneries provide courses on neurological problems. Other providers include universities and the Royal College of General Practitioners (see Web Resources below).

**Learning with other healthcare professionals**

Neurological problems by their nature are often exemplars of teamwork and the multidisciplinary approach across agencies, so take the opportunity to consider and discuss the different roles with the many professional and non-professional groups who work as a team within both primary and secondary care. Physiotherapists, occupational therapists and district nurses, in particular, have important expertise in the management of neurological disease and rehabilitation. You will also find that specific case conferences are often held to organise and focus efforts in the provision of care.

**Useful learning resources**

**Books and publications**


**Web resources**

**Driver and Vehicle Licensing Agency (DVLA)**

DVLA guidelines for doctors regarding driving licences for patients with neurological disorders. [www.dft.gov.uk/dvla//medical.aspx](http://www.dft.gov.uk/dvla//medical.aspx)

**National clinical guidelines for stroke**

The guidelines are published by the Clinical Effectiveness and Evaluation Unit of the Royal College of Physicians (RCP), in collaboration with the Intercollegiate Stroke Working Party. They are available from the RCP website. [www.rcplondon.ac.uk/resources/stroke-guidelines](http://www.rcplondon.ac.uk/resources/stroke-guidelines)
National Institute for Health and Care Excellence (NICE)

For NICE clinical guidance (CG) on epilepsy, see CG137 – The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care. www.nice.org.uk/guidance/CG137

Patient resources

You will find a wealth of useful information about neurological problems (and many other chronic conditions) in resources specifically prepared to inform patients and carers, in sites such as NHS Shared Decision Making (http://sdm.rightcare.nhs.uk), NHS Choices (www.nhs.uk) and Patient (http://patient.info/).

You may also find helpful material in your local hospital departments or on the websites of neurological disease charities such as:
- Epilepsy Society - www.epilepsysociety.org.uk
- Multiple Sclerosis Trust - www.mstrust.org.uk
- Motor Neurone Disease Association - www.mndassociation.org
- Parkinsons’s UK - www.parkinsons.org.uk

Royal College of General Practitioners

RCGP resources include an online course on multiple sclerosis www.elearning.rcgp.org.uk/ms

The Rare Diseases programme of the RCGP includes resources on Motor Neurone Disease www.rcgp.org.uk/clinical-and-research/clinical-resources/rare-diseases.aspx
3.19 Respiratory Health

Summary

- Respiratory diseases are amongst the most common long-term conditions affecting patients in the UK
- The identification, assessment, diagnosis and treatment of most respiratory diseases is a primary care issue
- Socio-economics, ethnicity, age and gender have a significant impact on both the development of respiratory disease and its impact
- The impact of respiratory disease on patients, families, health services and society is significant
- When dealing with respiratory patients there are key skills you need as a general practitioner (GP) to interpret investigations, identify co-morbidity and effectively manage resources
- Respiratory disease affects patients of all ages. It also brings specific challenges in the diagnosis and treatment of various groups including children, some occupational and ethnic groups, those with social and mental health challenges, and those nearing the end of their life

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Be aware of your own experience of respiratory symptoms or disease

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Understand your attitude towards 'lifestyle' disease and towards diseases where interventions may have real but limited benefit
Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Understand the potential impact of the patient’s family history, lifestyle and occupation on the subsequent development of respiratory disease
- Explain, encourage and support self-management strategies for different respiratory diseases, according to the differing wishes and expectations of patients
- Be able to explain to patients (and their carers) why they are breathless, the progression of their disease, benefits and limitations of treatments and how to recognise and treat exacerbations

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Know the key points in your history-taking and examination with respect to specific respiratory diseases, e.g. in relation to occupation, smoking, ‘red flag’ symptoms, family history, clubbing, lymphadenopathy
- Know how to interpret lung function measurements as performed in primary care, e.g. peak expiratory flow (PEF), spirometry, pulse oximetry, and know the expected impact of bronchodilators on such measurements

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Ensure that patients can use the inhaled medication they are prescribed, both routinely and in an emergency

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.
This means that as a GP you should:

- Know the diagnostic and treatment guidelines for common respiratory diseases (asthma, COPD, lung cancer) in primary care
- Know the boundaries of primary care management and the role of specialist services in supporting the patient

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Recognise the risk of co-morbid mental health problems in people with long-term respiratory problems, such as asthma and COPD, and the effect of these on morbidity and mortality
- Understand the importance of lifestyle changes (particularly smoking) and pulmonary rehabilitation
- Recognise the impact of co-morbidity such as muscle wasting, osteoporosis, anxiety, cardiovascular disease or bronchiectasis

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Be able to function as both diagnostician and respiratory team leader

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Understand the evidence base for different respiratory diseases and for different parts of the care pathway
• Recognise the difficulties of blinded research using inhaled agents

• Be aware of the evidence base that demonstrates the impact of culture and beliefs on the management of respiratory problems

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

• Be aware of your surgery’s location, parking, appointment times, stairs and the impact this has for the way you work with these patients

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

• Seek to identify patients who, for complex personal reasons, often tend to present late in the progress of their condition

• Be able to support patients who perceive that they have brought their illness upon themselves

• Help patients whose illness can have a significant impact on their life choices

• Be able to support patients with different cultural or ethnic perceptions of what are acceptable forms of treatment (e.g. inhalers)\(^{48}\)

**Core Competence: Community orientation**

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

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\(^{48}\) Davidson E, Liu JJ, Sheik A. The impact of ethnicity on asthma care *Primary Care Respiratory Journal* 2010; 19(3): 202–08. This is a superb review article specifically about asthma and ethnicity that also makes reference to the relevant sections of the Global Initiative for Asthma (GINA) guidelines and to some Cochrane reviews
This means that as a GP you should:

- Understand the current population trends for lung disease with respect to age, ethnicity, occupation and socio-economic status
- Know about the support available to your patient and their carers from health, social services and specific respiratory charities (see also Web Resources below)
- Appreciate the importance of exercise, and the benefits of peer group support in all types of lung disease

**Case discussion**

Mrs Evelyn James is a 49-year-old woman who presents in your surgery complaining of increasing breathlessness over the past year. She is a smoker, having started smoking when she was 15 years old, although she gave up during her three pregnancies. She usually smokes one pack of cigarettes per day. She works part-time as a spinner in a local textile mill and is the primary carer for her mother, who has emphysema.

On further discussion, she describes deteriorating dyspnoea, to the point where she can no longer keep up with her husband when walking on the flat. She has also had chest infections during the last two winters, for which she received antibiotic treatment. During these events she had increasing breathlessness and mucopurulent sputum production.

On examination you assess her cardiorespiratory system, as well as looking for peripheral signs of respiratory disease. You find that she has a BMI of 31, normal cardiovascular signs, but widespread low-pitched rhonchi throughout both lung fields. She has no lymphadenopathy. Her peak expiratory flow rate (PEFR) is 200 litres per minute and her pulse oximetry (Sp O₂) is 95%. You arrange for your practice nurse to perform spirometry, which shows acceptable technical quality and an obstructive FEV₁/FVC ratio of 61%, and an FEV₁ of 49% against predicted. Her chest x-ray reports that the heart is enlarged and the lung fields are hyperinflated, with widespread signs of airways inflammation consistent with chronic bronchitis. There are no obvious focal lesions.

On the basis of your findings so far, you confirm a diagnosis of chronic obstructive pulmonary disease (COPD). You discuss her treatment options with the practice nurse, who also sees Mrs James and later confirms that the patient’s inhaler technique with the two devices you propose to give her is satisfactory. Mrs James says she is hoping to stop smoking with the help and support offered to her.

When you review Mrs James three months later, she tells you she hasn’t smoked since last seen and describes some improvement in managing activities of daily living, although she is still too breathless to keep up with her friends when out walking. You decide to refer her for pulmonary rehabilitation at the local community centre.

The next winter, Mrs James is brought to the surgery by her husband. She is distressed, breathless, cyanosed and tachycardic, with an Sp O₂ of 89%, having been unwell for the previous five days. Her husband tells you she didn’t want to bother anyone and thought she could ride out this episode using her inhalers. You admit her to hospital, where she does very well, returning home with the support of the Hospital at Home team and the practice-attached community nurses.
## Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>What are my personal feelings about smoking-related illnesses?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>If health inequality, occupation, smoking and illicit drug use influence respiratory illness and its treatment, how does patient autonomy influence my joint decision-making?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
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</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>What are the challenges facing me as a GP in delivering effective care in this case?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
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<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>On what occasions in Mrs James’ case could her worries and responsibilities have been addressed, and by whom?</td>
</tr>
<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
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<tr>
<td><strong>Making decisions</strong></td>
<td>What are the specific indications for the various treatments and how can I monitor their effectiveness?</td>
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<tr>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
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<tr>
<td><strong>Clinical management</strong></td>
<td>What specific knowledge of clinical assessment and data interpretation do I need for managing patients with respiratory disease?</td>
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<tr>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
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<tr>
<td><strong>Managing medical complexity</strong></td>
<td>What are the common co-morbidities associated with respiratory disease?</td>
</tr>
<tr>
<td>This is about aspects of care beyond managing straightforward problems. It</td>
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<tr>
<td>Topic</td>
<td>Question</td>
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<tr>
<td>includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
<td>How do co-morbidities or systemic problems impact on respiratory illness or its treatment?</td>
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<td></td>
<td>What impact does the patient’s lifestyle, ethnicity, education and occupation have on their respiratory health and their future treatment?</td>
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<tr>
<td>Working with colleagues and in teams</td>
<td>Are there any local protocols for managing COPD?</td>
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<td>How are COPD patients looked after in my practice?</td>
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<td></td>
<td>What role do nurses and other PHCT members play in their management?</td>
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<td></td>
<td>What is the role of the generalist and the specialist in diagnosis and management?</td>
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<tr>
<td>Maintaining performance, learning and teaching</td>
<td>What is the evidence base for the early identification of patients with chronic lung disease and subsequent health education or therapeutic interventions?</td>
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<td>Do I know when to introduce additional treatment?</td>
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<tr>
<td>Organisational management and leadership</td>
<td>What templates should I use during consultation with patients with asthma and COPD?</td>
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<td></td>
<td>How would I monitor quality of care for COPD patients?</td>
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<tr>
<td>Practising holistically and promoting health</td>
<td>What is the impact of respiratory disease on patients, physically, psychologically and socially (including occupation and employability)?</td>
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<td></td>
<td>What impact does respiratory disease have on families?</td>
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<tr>
<td>Community orientation</td>
<td>What is the impact of health and social inequality on respiratory disease prevalence, diagnosis, prognosis and treatment?</td>
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<tr>
<td></td>
<td>What support services might be available to Mrs James and her carers?</td>
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<td></td>
<td>How relevant are social, ethnic and gender issues in the</td>
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</table>
How to learn this area of practice

**Work-based learning**

As a GP specialty trainee, the principal component of your work-based learning around respiratory disease involves meeting, assessing and helping to manage patients with respiratory disease. Learning from the training team, and specifically from the respiratory lead GP and practice nurse, as well as colleagues within the practice is also important.

Specific learning around the performance and interpretation of lung function testing, as commonly performed in general practice, should reflect the needs and responsibilities of the generalist, and should cover:

- patient selection and preparation
- health and safety
- infection control
- equipment selection and calibration
- interpretation of results for validity and clinical patterns
- the role of bronchodilators in lung function testing
- the limits of lung function assessment in patient management, and the value of other available patient-related outcome measures.

With respect to patients with respiratory disease, the modern GP should learn the roles and responsibilities of the primary care team, in its widest sense, including community staff and secondary care outreach, charities and self-help groups, physiotherapists and exercise trainers. In addition, as the impact of the patient’s environment on their disease and their ability to manage it effectively is important, you will find it useful to visit schools and workplaces.

You should understand the importance of organising care within the practice for both acute and chronic presentations, as well as the risks and benefits of ‘at risk registers’ and the tools needed to provide effective 24-hour care for patients. You should also look for opportunities to learn from local respiratory consultants, physiotherapists and multidisciplinary groups.

**Self-directed learning**

There are a number of disease-specific learning modules available for learning about respiratory disease from organisations such as RCGP online learning, Education for Health and Respiratory Education UK. These include updates, diplomas and degree modules.

Other organisations offering education and support include: Asthma UK, British Lung Foundation, British Society of Allergy and Clinical Immunology, British Thoracic Society, and the Primary Care
Respiratory Society UK. (See Web Resources below for further information on all these organisations.)

Look out too for the range of clinical conferences, both regionally and nationally, that offer clinical education and the opportunity to present your own work.

Useful learning resources

Books and publications


Web resources

British Society of Allergy and Clinical Immunology

Professional society of allergy and clinical immunology specialists, dedicated to improving allergy management. www.bsaci.org

British Thoracic Society (BTS)

For guidelines on the management of asthma. www.brit-thoracic.org.uk/guidelines-and-quality-standards/asthma-guideline


Charitable organisations

Asthma UK

The Asthma UK website provides a wealth of information and resources about asthma. www.asthma.org.uk

British Lung Foundation

The aims of the British Lung Foundation include supporting people affected by lung disease and promoting greater understanding of lung disease. www.lunguk.org
Chest Heart & Stroke Scotland (CHSS)

The Chest Heart & Stroke Scotland website provides a range of resources for healthcare professionals. [www.chss.org.uk](http://www.chss.org.uk)

Education for Health

Education for Health is a charity focussing on the education of health professionals as a key factor in improving patient health and quality of life. They are a specialist provider of pioneering cardiovascular and respiratory education and training courses. [www.educationforhealth.org](http://www.educationforhealth.org)

Healthcare Improvement Scotland (HIS) Standards for COPD and Children’s Asthma Scotland


National Institute for Health and Care Excellence (NICE)


Primary Care Respiratory Society

The Primary Care Respiratory Society UK (PCRS-UK) represents primary care health professionals interested in delivering the best standards of respiratory care. The website includes a range of resources. [www.pcrs-uk.org](http://www.pcrs-uk.org)

Respiratory Education UK

Respiratory Education UK (REUK) is an educational charity promoting excellence in respiratory care for patients and professionals across both primary and secondary care settings. [www.respiratoryeduk.com](http://www.respiratoryeduk.com)

RCGP

Online course in respiratory health

This comprehensive e-learning course, developed in partnership with the Primary Care Respiratory Society and Education for Health, has been designed to cover many of the key outcomes and primary care topics identified in this curriculum statement, including the assessment and investigation of patients with respiratory symptoms, the diagnosis and management of commonly encountered conditions such as asthma and COPD, and the role of the GP in the management of less common respiratory conditions. It is available on the RCGP Online Learning Environment (OLE). [www.elearning.rcgp.org.uk/respiratory](http://www.elearning.rcgp.org.uk/respiratory)
Respiratory care resources

This section of the website includes resources to support care of patients with respiratory disease. 
www.rcgp.org.uk/clinical-and-research/clinical-resources/respiratory-care.aspx
3.20 Care of People with Musculoskeletal Problems

Summary

- Each year 20% of the general population consult a GP with a musculoskeletal problem.  
- Research evidence supports the effectiveness of simple positive approaches for many patients, and general practitioners (GPs) should encourage appropriate self-care. 
- Common musculoskeletal conditions such as back pain and osteoarthritis are the dominant cause of chronic pain, disability and work loss in the UK. 
- As a GP, understanding the psychological and social dimensions of chronic pain and disability is fundamental to your management of musculoskeletal conditions. 
- Taking an effective history and making a simple, focused examination in general practice is likely to be more important than imaging and serology, which on their own may be falsely reassuring. 
- Early diagnosis and treatment of inflammatory arthritis, such as rheumatoid arthritis, has a major impact on long-term outcome. Urgent referral to specialist care is indicated if there is clinical suspicion of inflammatory arthritis.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Be aware of your own attitudes to patients presenting, for example, with modest back pain and seeking time off work.

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Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Communicate health information effectively to promote better outcomes, e.g. use positive terms such as ‘wear, flare and repair’ and avoid unhelpful terms like ‘crumbly spine’ and ‘ruptured disc’
- Explore the perceptions, ideas or beliefs the patient has about the condition and whether these may be acting as barriers to recovery or return to usual activity or work
- Use simple techniques and consistent advice to promote activity in the presence of pain and stiffness, e.g. GPs play an essential role in promoting the message that when it comes to long-term musculoskeletal health patients need to ‘use it or lose it’ and stay active within their individual capabilities
- Agree treatment goals and facilitate supported self-management, particularly around pain, function and physical activity
- Assess the possibility that musculoskeletal symptoms can be compounded by psychological causes
- Recognise the frustrations that chronic, painful but non-fatal conditions, with few spectacular cures, can have on both patients and the general practitioner

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

- Assess the importance and meaning of the following presenting features:
  - pain: nature, location, severity, history of trauma
  - variation of symptoms over time
  - symptoms which help distinguish inflammatory from non-inflammatory conditions
  - loss of function – weakness, restricted movement, deformity and disability, ability to perform usual work or occupation
  - systemic manifestations of rheumatic disease
- Understand that reducing pain and disability rather than achieving a complete cure could be the goal of treatment
• Understand indications and limitations of plain radiography, ultrasound, CT and MR scan

• Understand the limitations of blood tests for diagnosing musculoskeletal conditions where ‘negative’ tests may not rule out disease and where diagnostic criteria are often not clear-cut. This is particularly the case with inflammatory arthritis (e.g. rheumatoid arthritis) where early referral should be initiated on clinical suspicion rather than based on the results of tests.\(^{53}\)

• Identify ‘red flags’ that relate to infection (e.g. septic arthritis or osteomyelitis); cancer (e.g. bony metastases and osteogenic sarcoma); fracture (e.g. fragility fracture in osteoporosis); neurological compromise (e.g. cauda equina syndrome); and inflammatory arthritis (e.g. rheumatoid arthritis, ankylosing spondylitis)

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Be aware of the concept of ‘yellow flags’ in musculoskeletal disease and the tools that can be used to stratify those at risk of progression to long-term pain and disability.\(^{54,55}\)

• Use decision-making tools such as iRefer, the Royal College of Radiologists (RCR) imaging referral guidelines (see learning resources)

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

• Identify and manage acute systemic inflammatory conditions that are appropriately treated in primary care such as gout and polymyalgia rheumatica

• Diagnose common, regional soft-tissue problems that can be managed in primary care (e.g. tennis elbow, trigger finger)

• Diagnose and manage the common, regional pain syndromes such as osteoarthritis, back pain and fibromyalgia


• Understand the issues and debates about use of complementary therapy and opiate analgesia for chronic pain

• Identify those patients at risk of bone disorders, such as osteoporosis, and understand the principles of primary and secondary prevention of fragility fractures

• Consider rare conditions such as connective tissue diseases (e.g. lupus) which may present with non-specific symptoms and affect extra-articular organs such as blood vessels, skin and kidneys

• Identify musculoskeletal conditions in children, the ages at which they commonly present and how pathology is differentiated from variations of normality, e.g. ‘bow legs’ (varus appearance) is a normal variant and usually resolves by age three

• Be aware of how musculoskeletal problems may be a manifestation of injury not only from trauma but also abuse

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

• Know the problems that can be caused by the treatment of musculoskeletal disorders and explain their primary and secondary prevention (e.g. NSAIDS and gastrointestinal bleeds, cardiovascular disease risk and renal impairment)

• Identify and treat depression to improve clinical outcomes for patients with musculoskeletal conditions

• Be aware of increased cardiovascular risk in patients with inflammatory arthritis, connective tissue diseases and gout

• Be aware of increased fracture risk in patients with rheumatoid arthritis

• Be aware of the burden of treatment for patients with long-term musculoskeletal conditions like osteoarthritis, many of whom will be attending the GP surgery regularly for appointments about other long-term conditions

• Know what resources are available locally and nationally and how to access them, e.g. patient information material from Arthritis Research UK and patient support organisations such as Arthritis Care (see also Web Resources below)

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying
leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Understand the challenge that many musculoskeletal conditions might be better and more confidently managed by other healthcare personnel rather than GPs because they do not fit neatly into the biomedical model of pathological diagnosis and cure, and because most GPs do not gain the necessary treatment skills during their training
- Refer those conditions which may benefit from early referral to an orthopaedic surgeon (e.g. internal derangement of the knee, ruptured achilles tendon, massive rotator cuff tear)
- Apply local shared-care guidelines for safe prescribing and monitoring of disease-modifying anti-rheumatic drugs (DMARDs)

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Describe the key national guidelines that influence healthcare provision for musculoskeletal conditions and the potential problems in applying these guidelines based on local availability of services
- Recognise the difficulty with developing and measuring outcomes in musculoskeletal conditions where diagnoses are often not clear-cut and response to treatment is related to symptoms rather than ‘hard’ outcomes such as improvements in blood tests or other disease markers

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Examine what systems are in place at your workplace to help prevent practice staff developing common problems such as back pain
- Think about how your workplace facilitates return to work for staff with musculoskeletal problems
- Think about how your workplace facilitates access for people with disabilities
Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Consider the physical, psychological, social, occupational and financial impact of musculoskeletal conditions on individuals and their carers (e.g. problems with fatigue, altered body image, work, impact on family relationships and sexual issues)
- Be aware of cultural differences in the expression of emotional distress and how this may present as pain and loss of function
- Incorporate a bio-psycho-social approach to assessment and management of chronic musculoskeletal conditions that is tailored to the diagnosis. e.g. addressing the patient’s worrying thoughts around experience of pain and providing a consistent message regarding activity and return to work

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Be aware of the potential effect on the health of patients where services are deficient and frequently have long waiting times
- Understand the huge impact on the community of incapacity for work caused by musculoskeletal conditions, and how you can facilitate a patient returning to work by giving consistent advice and the use of ‘fit notes’

Case discussion

Susan Andrews, a 45-year-old care assistant in a local residential home for older persons, presents in surgery complaining of worsening pain in her lower back during the past four weeks. The pain is confined to her back and does not radiate down her leg. It becomes worse in the course of a day and sometimes wakes her at night. She also has some pain in her neck and right shoulder, and pain, longstanding but occasional, in her left knee when walking.

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She dates her back pain to an episode in her workplace where she had to lift a patient off the floor unassisted. She offers the information that staff illness and absence rates in her workplace have been higher than usual in recent months, with change of personnel in the senior management of the home. ‘It’s not like it used to be – it’s more stressed – there are not the people around to help with lifting and moving like before – but I still like the place.’

On questioning, Susan says her appetite and weight have been steady but she now wakes at night, has started to feel a bit low, and she gets more tired than before towards the end of the day. She has had episodes of back pain in the past but it has never lasted this long. She reports no fever, and no significant neurological symptoms or history of malignancy. She lives with her husband, a local council gardener, and her one child is enjoying work as a nurse in a town 20 miles away. She expresses her concern that she might be developing a long-term problem which will make her work difficult.

On examination, she looks generally well and is moderately overweight; there is some curvature in the lower spine which disappears when she bends down to touch her toes – she can almost reach her toes but slowly and with some difficulty. She has some difficulty putting her hands behind her head.

You advise Susan about work and physical activity and provide an advice leaflet explaining the simple messages around back pain and how to protect the back when lifting and doing heavy work. You suggest that she tries to lose some weight with the objective of reducing the strain on her back. You recommend simple but regular analgesics, especially at night.

Some elements of Susan’s history raise your concerns about a possible poor prognosis for improvement and associated increased risk for time off work.

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>What is my own attitude towards people who I believe are falsifying or exaggerating their musculoskeletal symptoms?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
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</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>What further information would prompt me to raise concerns about the local residential home?</td>
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<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
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<tr>
<td><strong>Communication and consultation</strong></td>
<td>How might I negotiate any conflict over time off work? (E.g. if Susan requests ‘a sick note for a few weeks until I feel better.’)</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient</td>
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</table>
| Partnership, managing challenging consultations, third-party consulting and the use of interpreters. | Data gathering and interpretation  
This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills. | What aspects of Susan’s case cause me concern?  
What is the likely prognosis?  
Would investigations be useful? If so, which ones? |
| --- | --- | --- |
| Making decisions  
This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice. | What are the differential diagnoses for Susan’s symptoms? What is the diagnosis likely to be? | |
| Clinical management  
This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches. | What options do I have in treating this problem?  
What follow-up arrangements would I make? | |
| Managing medical complexity  
This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation. | How might I manage Susan’s ‘yellow flags’? | |
| Working with colleagues and in teams  
This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development. | Who else might be involved in the management of Susan’s back pain? | |
| Maintaining performance, learning and teaching  
This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity. | What barriers might I face in providing the ‘best’ care for my patients as defined by national guidelines?  
What tools are available to stratify those at risk of developing chronic low back pain?  
What tools are available to measure pain and loss of function caused by musculoskeletal problems? | |
| Organisational management and leadership  
This is about the understanding of organisations and systems, the appropriate use of administration systems, effective | What would be the key points of this consultation that should go in the patient’s record? | |
record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

<table>
<thead>
<tr>
<th>Practising holistically and promoting health</th>
<th>What would help Susan to stay at work?</th>
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<tbody>
<tr>
<td>This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</td>
<td>What self-care and health promotion advice might I provide to Susan on this occasion?</td>
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<td>What steps could I take to facilitate continuity of care for Susan?</td>
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<td>How might Susan’s problem impact upon the health of her family?</td>
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<tr>
<th>Community orientation</th>
<th>What are the advantages of a local back pain service?</th>
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<tr>
<td>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</td>
<td>How might I go about establishing one?</td>
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<td>What other options might I have in managing musculoskeletal disease in the community?</td>
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<td>What provision might my practice make for patients and staff with musculoskeletal disorders?</td>
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### How to learn this area of practice

#### Work-based learning

#### In primary care

Given the number of patients with musculoskeletal problems that present to their GP, you will have no shortage of clinical exposure during your time in primary care. You will see a wide range of conditions and it is worth keeping a log of the cases – to demonstrate that you are becoming confident in managing the conditions as you become more experienced.

Musculoskeletal problems offer the opportunity for you to develop clinical skills and reflect upon the utility of investigations in managing uncertainty and complexity.

The management of long-term musculoskeletal conditions is often criticised for not being aligned with national guidelines and standards of care. There are few indicators for musculoskeletal conditions in the Quality and Outcomes Framework (QOF) to incentivise systemised care, but no shortage of national guidelines and standards of care which can be used to improve the outcomes for musculoskeletal patients in alignment with accepted best practice. Take the opportunity to reflect on the care that you deliver patients with musculoskeletal problems with tools such as audit, reviews of referral activity and use of investigations. Guided examples of high impact activity that you can take to improve patient care can be found at [www.arthritisresearchuk.org/health-professionals-and-students/impact-toolkit.aspx](http://www.arthritisresearchuk.org/health-professionals-and-students/impact-toolkit.aspx).
The first contact with a patient is crucial and one of the great things about general practice is time and the opportunity for continuity of care. Following your patients up can provide a very useful insight into the natural course of musculoskeletal problems and give valuable clues in the clinical conundrums we all face.

Listen to the language your patients use to describe how their ‘brittle bones’, ‘crumbly spines’, ‘grinding’, ‘worn-out’ joints are affecting them; how they feel their bodies have let them down. And see how positive language can influence the perception of their pain and improve both how you feel about what you can do to help and the outcome for the patient. So when a patient states that ‘all I need is a new pair of knees, Doc’, ask yourself whether you have done what you can to help, using pharmacological and non-pharmacological interventions to help with pain and to improve function as recommended in the NICE guidance.

In secondary care

Few GPs in training will get significant exposure to a core musculoskeletal specialty during their time in secondary care but many of the patients you will see during your training, especially the elderly, will have significant musculoskeletal problems. So take time for a brief, focused examination of a painful joint, and ask about mobility issues, work problems and function around the home, in order to get a feel for the impact that musculoskeletal conditions can have on the individual.

During placements in A&E you will see plenty of common musculoskeletal problems, including acute back pain. Think about whether you would be confident in managing these patients in the GP surgery setting and whether these patients might be more effectively managed in primary care.

Try to spend some time with specialty nurses and pharmacists engaged in shared-care prescribing of disease-modifying anti-rheumatic drugs (DMARDs). Can you think of some of the benefits and potential pitfalls of shared-care prescribing? What issues do the nursing team have? How are problems communicated to all involved? Think how you would, as a GP, ensure a safe service for your patients in the community.

Consider attending an orthopaedic clinic and explore the decision to undertake a joint replacement for osteoarthritis. What factors influenced the decision? Were they the same factors for each patient you saw? Were Patient Decision Aids being used?

Many areas have interface or tier 2 musculoskeletal services in the community or hospital setting. The GPs with a Special Interest (GPwSI) or Extended Scope Physiotherapists who work in these services may be able to help you improve your clinical skills, and the patients are a rich resource of common musculoskeletal problems. Think of the factors that may have influenced the decision to


58 Patient Decision Aids are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and patients need help in deciding which option will be best for them. Research shows that PDAs are effective in helping patients make informed choices about their healthcare and increase patients’ awareness of the expected risks, benefits and likely outcomes. See also http://sdm.rightcare.nhs.uk/pda/
refer patients to these services. What might the advantages and disadvantages be for GPs and patients of such services?

Time spent in a local chronic pain service can give a valuable insight into the multidisciplinary approach to managing patients with chronic musculoskeletal and other pain. Pause to reflect on the barriers that patients face to getting back to normal functional levels and also the factors that may have contributed to the development of chronic problems. Were there missed opportunities that may have presented to address their problems earlier – perhaps preventing progression to a more chronic problem?

**Self-directed learning**

It’s highly unlikely that you will go through the duration of your specialist training and not experience musculoskeletal aches and pains of one sort or other, from the minor through to the more significant. Perhaps you are involved in sport and have noticed some new ache or pain when you are training. How does it make you feel? Are you worried that the pain will get worse? What if you can’t do the things you enjoy? What about work? How would you cope if your pain and disability prevented you following your chosen career path?

Reflecting on such issues provides a valuable insight into how your patients may be feeling when they come to see you. Asking about such worries forms part of the thorough assessment of a patient. If you do not address these concerns, you are less likely to help that person and may miss acting on cues that could prevent the patient from developing a chronic problem.

**Learning with other healthcare professionals**

It is worth spending time with allied health professionals including physiotherapists, occupational therapists and podiatrists to see how their methods of assessment differ from yours. In particular, time with physiotherapists learning clinical skills and improving your ‘handling skills’ will be well spent and will also help your understanding of what patients should expect when they are referred to physiotherapists.

You may be surprised by the number of patients who have paid to see a ‘complementary’ therapist before coming to see you. Osteopaths, chiropractors, acupuncturists and massage therapists may play a role for some patients. Find out what these practitioners do and whether they have registered governing bodies. Would you recommend them to patients?

Other members of the practice team, including nurses and healthcare assistants, spend the most time with patients with chronic diseases. They have valuable insights into how patients are getting along. Find out if their assessment includes asking patients about pain and level of function and which validated tools can be used to measure this.

Carers, both professional and informal, may be the best-placed individuals to inform how a person is coping at home and in the community. You often get a very limited view of the stoical patient within the confines of the surgery.

All GPs have a role in advising patients about fitness for work. How this advice is communicated has a significant effect on the future of that individual’s working life. Discussion with occupational health physicians involved in Department of Work and Pensions work-capability assessments can help you understand how decisions regarding work fitness are made and how you as a GP can facilitate patients to stay in work, for example by delivering a consistent message around back pain.
Formal learning
There are many e-learning resources available and the RCGP online learning environment has a module on musculoskeletal care (www.elearning.rcgp.org.uk/msk). This module consists of seven lessons and focuses on a primary care approach to assessment of patients with a musculoskeletal problem. It covers diagnosis, investigations and treatment. Specific conditions frequently encountered by GPs are described in more detail, including back pain, gout, inflammatory arthritis, polymyalgia rheumatica and osteoarthritis. The final session looks at musculoskeletal problems which can be exclusively managed within primary care and features useful exercises for patients.

Look out for core musculoskeletal skills courses, aimed at GPs, which offer the opportunity to develop your consultation and examination skills, as well as keeping you up to date with the latest evidence and opinion on best practice.

You may also consider attending courses offering joint injection training. But remember that, while injection skills can be very helpful, you should not run before you can walk – the core skill for GPs is competent assessment of patients with musculoskeletal problems and, as a general rule, if you don’t know the diagnosis you shouldn’t be injecting the patient. A fundamental skill is knowing what not to inject as well as what to inject.

Useful learning resources

Web resources

Arthritis Research UK

Arthritis Research UK is the charity that is leading the fight against arthritis. This website is a resource for patients and professionals on all musculoskeletal conditions.

In the primary care area you will find all the resources for GPs and the primary care team in one place, including publications, the Core Skills in Musculoskeletal Care programme, GP trainee prizes and training bursaries for GPs. www.arthritisresearchuk.org/health-professionals-and-students/information-for-gps.aspx

Resources available from Arthritis Research UK include:

**Hands On and Synovium**

Each issue of *Hands On* contains practical advice about managing musculoskeletal problems within primary care. *Hands On* also aims to inform GPs about current relevant topics within rheumatology and musculoskeletal medicine. *Synovium* presents a digested overview of current hot topics and research in musculoskeletal conditions. www.arthritisresearchuk.org/health-professionals-and-students/reports.aspx

**Clinical Assessment of the Musculoskeletal System: a guide for medical students and healthcare professionals**

This handbook covers 50 core competencies in musculoskeletal examination. The guide is accompanied by video clips demonstrating the widely used GALS (gait, arms, legs, spine) screening
examination and a detailed regional examination of the musculoskeletal system (REMS).
www.arthritisresearchuk.org/health-professionals-and-students/video-resources/remm.aspx

**Paediatric gait, arms, legs, spine (pGALS) assessment**

Short videos and supporting text that demonstrate a simple, quick and effective way to screen the musculoskeletal system in school-aged children. www.arthritisresearchuk.org/health-professionals-and-students/video-resources/pgals.aspx
www.arthritisresearchuk.org/~/media/Files/Education/Hands-On/HO15-June-2008.ashx

**Expert Patients Programme**

The Expert Patients Programme (EPP) is a self-management programme for people who are living with a chronic (long-term) condition. The aim is to support people who have a chronic condition by increasing their confidence, improving their quality of life and helping them manage their condition more effectively. www.nhs.uk/Conditions/Expert-patients-programme-/Pages/Introduction.aspx

**FRAX**

The FRAX® tool has been developed by the World Health Organisation to evaluate the fracture risk of patients. It is based on individual patient models that integrate the risks associated with clinical risk factors, including rheumatoid arthritis, as well as bone mineral density (BMD) at the femoral neck.
www.shef.ac.uk/FRAX

**QRISK**

QRISK® 2-2013 is a cardiovascular disease risk calculator adjusted for rheumatoid arthritis and SLE
http://qrisk.org

**QFracture**

QFracture® -2012 is an osteoporotic fracture risk calculator adjusted for rheumatoid arthritis and SLE.
www.qfracture.org

**Royal College of General Practitioners**

The RCGP and Arthritis Research UK have jointly produced the Core Skills in Musculoskeletal Care programme with free e-learning lessons, clinical and consultation skills workshops and an impact toolkit to help GPs demonstrate improved patient care from their learning. More details on the course can be found on: www.elearning.rcgp.org.uk/msk

The e-GP Rheumatology and Musculoskeletal Problems course includes back pain, joint pains, arthritis, connective tissue disease, osteoporosis and various problems in children. The e-GP course also includes sessions on a variety of musculoskeletal physical examinations. www.e-GP.org
Work and employment resources

Healthy Working UK brings together a range of resources to support GPs in helping patients stay at or return to work. It includes a Fit Note guide, e-learning, decision aids and an advice line for general and patient related health and work issues.  [www.healthyworkinguk.co.uk](http://www.healthyworkinguk.co.uk)

There are a number of patient and professional organisations’ websites which you will also find useful, including:

Arthritis Care [www.arthritiscare.org.uk](http://www.arthritiscare.org.uk)

Arthritis and Musculoskeletal Alliance [http://arma.uk.net](http://arma.uk.net)

BackCare

National charity for back health. [www.backcare.org.uk](http://www.backcare.org.uk)

British Association of Occupational Therapists/College of Occupational Therapists [www.cot.co.uk](http://www.cot.co.uk)

British Chiropractic Association [www.chiropractic-uk.co.uk](http://www.chiropractic-uk.co.uk)

British Institute of Musculoskeletal Medicine [www.bimm.org.uk](http://www.bimm.org.uk)

The British Orthopaedic Association [www.boa.ac.uk](http://www.boa.ac.uk)

The British Pain Society [www.britishpainsociety.org/](http://www.britishpainsociety.org/)

The British Society for Rheumatology [www.rheumatology.org.uk/](http://www.rheumatology.org.uk/)

British Sjögren’s Syndrome Association [www.bssa.uk.net](http://www.bssa.uk.net)

The Chartered Society of Physiotherapists [www.csp.org.uk](http://www.csp.org.uk)

Children’s Chronic Arthritis Association (CCAA) [www.ccaa.org.uk](http://www.ccaa.org.uk)

London College of Osteopathic Medicine [www.lcom.org.uk](http://www.lcom.org.uk)

Lupus UK [www.lupusuk.org.uk](http://www.lupusuk.org.uk)

National Ankylosing Spondylitis Society [www.nass.co.uk](http://www.nass.co.uk)

National Osteoporosis Society [www.nos.org.uk](http://www.nos.org.uk)

Osteoporosis resources for primary care [www.osteoporosis-resources.org.uk](http://www.osteoporosis-resources.org.uk)

National Rheumatoid Arthritis Society [www.nras.org.uk](http://www.nras.org.uk)

Paget’s Association [www.paget.org.uk](http://www.paget.org.uk)

Pain Community Centre [www.paincommunitycentre.org](http://www.paincommunitycentre.org)

The Society of Podiatrists and Chiropodists [www scpod.org/about-us](http://www scpod.org/about-us)

Polymyalgia Rheumatica and Giant Cell Arteritis (PMR-GCA) Scotland [www.pmrandgca.org.uk](http://www.pmrandgca.org.uk)
Primary Care Rheumatology Society [www.pcrsociety.org](http://www.pcrsociety.org)
The Psoriasis Association [www.psoriasis-association.org.uk](http://www.psoriasis-association.org.uk)
RSI Action (National repetitive strain injury charity) [www.rsiaction.org.uk](http://www.rsiaction.org.uk)
Scleroderma Society [http://sclerodermauk.org](http://sclerodermauk.org)
Society of Musculoskeletal Medicine [www.sommcourses.org/about-somm](http://www.sommcourses.org/about-somm)
3.21 Care of People with Skin Problems

Summary

- Around 24% of the population consult their general practitioner (GP) with a skin problem in any 12-month period.\textsuperscript{59}
- About 14% of consultations with a GP are for the management of diseases of the skin. Maintaining competence in this area of medicine, is therefore essential for any GP.\textsuperscript{60}
- There is variable (and generally limited) training in dermatology at undergraduate level which means that GP trainees should review their current knowledge and skills.\textsuperscript{61}
- Currently about 90% of diseases of the skin are managed exclusively in Primary Care. Most skin disease can and should still be appropriately and efficiently managed in primary care.
- Skin disease can impact significantly on quality of life for patients and their families. GPs are in the ideal position to recognise this and help.
- Skin cancer rates are increasing and outcomes depend on early diagnosis. GPs have a critical role in early diagnosis.

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Ensure that skin problems are not inappropriately dismissed as trivial or unimportant by healthcare professionals.

\textsuperscript{59} RCGP Birmingham Research Unit. \textit{Weekly Returns Service Annual Report 2006}

\textsuperscript{60} Kerr OC, Benton EC, Walker JI \textit{et al} Dermatological workload: primary versus secondary care. \textit{British Journal of Dermatology} 2007: 157 (suppl. 1). Looked at burden of dermatological disease presenting across 13 general medical practices in Scotland, serving a population of 100,000, over a two week period. Skin complaints accounted for 14% of all consultations in this study.


See also \texttt{www.ncbi.nlm.nih.gov/pubmed/19410336}

Chiange Y \textit{et al} (including C Griffiths & S Burge) Undergraduate dermatology education: a survey of UK medical students \textit{British Journal of Dermatology} 2008: 159 (Suppl.1)

\textsuperscript{62} Information from Hospital Episode Stats (2008) \texttt{(www.statswales.wales.gov.uk)} and data extrapolated from Birmingham RCGP Research Unit prevalence data 2006 in fact gave a figure of 6.1% of consultations for a skin problem resulting in a referral to secondary care.
Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Empower patients with chronic skin problems, including managing the effects of disfigurement

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Identify symptoms that are within the range of normal and require no medical intervention, e.g. age-related changes such as dry skin/hair loss and innocent moles
- Appreciate the feelings engendered by skin disease, which include fears about contagion (the ‘modern-day leper’) and concerns about malignancy
- Empower patients to adopt self-treatment and coping strategies, where possible, in such conditions as mild eczema and mild acne
- Appreciate the quantities of cream/ointment/lotion that should be prescribed to enable patients to treat their skin condition appropriately, and when to use each vehicle
- Whilst respecting dignity and observing appropriate hygiene measures, demonstrate that examining the skin and touching affected areas is acceptable
- Describe a skin lesion or rash using dermatologically accurate terms

Core Competence: Data gathering and interpretation

This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Recognise the importance of skin-specific symptoms, e.g. itching and rash distribution
- Appreciate the importance of the social and psychological impact of skin problems on the patients’ quality of life (sleep, disfigurement, messy treatment regimens etc.)
- Recognise the spectrum of patterns and distributions of rashes of different skin disorders

[See www.changingfaces.org.uk/home]
• Understand how to carry out more detailed tests where indicated, including skin scrapings and the use of Wood’s light

• Be prepared to carry out appropriate examination of the skin, including:
  o Addressing the need to undress the patient sufficiently but with sensitivity to dignity
  o ‘Difficult areas’ such as the flexures, genitalia and mucous membranes

**Core Competence: Making decisions**

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

• Understand the ‘alarm symptoms and signs’ for skin cancers that necessitate fast-track referral

• Understand the different indications for patch and prick testing, and when these are appropriate

• Understand the role of histopathology and when to recommend incision or excision biopsy

• Know the indications for curettage, cauterity and cryosurgery

• Be aware of likely scenarios for contact dermatitis, where patch testing may be needed

• Be able to distinguish benign from malignant skin conditions and make appropriate referrals

**Core Competence: Clinical management**

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

• Demonstrate appropriate history-taking for patients with skin problems, including past personal history, family history, chemical contacts, occupation and drug usage

• Understand how to recognise common skin conditions in primary care, e.g. eczemas, psoriasis and infections, and instigate appropriate treatment

• Recognise rarer but potentially important conditions and know when to refer to secondary care, e.g. bullous disorders and vasculitis

• Recognise emergency skin conditions, e.g. erythroderma, anaphylaxis and herpetic eczema, and act appropriately

**Core Competence: Managing medical complexity**

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also
covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Appreciate that pathology in other systems may lead to skin changes, e.g. skin manifestations of internal disease
- Know the association between psoriasis and arteriosclerosis
- Be able to advise regarding risk of long-term exposure to ultraviolet and sunburn, especially in children
- Be aware of inheritance of common skin diseases, such as eczema or psoriasis

**Core Competence: Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Be aware of primary care resources and when to refer to secondary care so that patients receive appropriate treatment (such as light therapy, biological therapies or immunosuppressant therapy)
- Be aware of local, alternative referral resources such as GPs with a Special Interest (GPwSIs) or specialist nurse practitioners
- Provide patients with information on referral options, if appropriate (GPwSI clinic/Expert Patients Programme (EPP)/specialist nurse/secondary care)
- Know about shared care protocols with secondary care for the follow up of patients with skin cancer/lichen sclerosis et atrophicus and, where negotiated with the secondary care provider, those on isotretinoin
- Consider the help of ‘expert patients’ for conditions like severe childhood atopic eczema or psoriasis
- Value the role of other members of the primary healthcare team (e.g. specialist health visitors for eczema and wet wrapping, district nurses/nurse practitioners for leg ulcers and wound management)

**Core Competence: Maintaining performance, learning and teaching**

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.
This means that as a GP you should:

- Be aware of the major advances in therapy, including biological treatments such as TNFalpha blockers and monoclonal antibodies, for severe disease that has failed to respond to standard second-line therapies
- Understand and implement the key national guidelines that influence healthcare provision for skin problems

**Core Competence: Organisational management and leadership**

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Consider reviewing all referrals to establish whether the input of secondary care is ‘value added’ and to establish any learning points for similar cases (i.e. meeting doctors’ educational needs (DENS))

**Core Competence: Practising holistically and promoting health**

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Understand the significant quality-of-life issues regarding common skin complaints, which can also impact on the entire family. You should also be aware of:
  - Sleep disturbance from itching, especially for children with eczema (which can also cause disturbed, restless nights for parents and interfere with education)
  - Isolation and loss of confidence, especially in young people with acne or disfigurement (e.g. vitiligo)
- Recognise how disfigurement (including problems like acne which can be seen by doctors as apparently clinically ‘trivial’) and cosmetic skin changes fundamentally affect patients’ confidence, mood, interpersonal relationships and even employment opportunities
- Appreciate the impact of skin disease on family, friends and dependants, and on employers and employment (i.e. career choices)
- Empower patients to self-manage their skin condition as far as practicable
- Give advice on maintaining ‘healthy skin’, e.g. avoiding unnecessary chemicals and overexposure to sun
Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Understand the effect of a patient’s environment/occupation on skin conditions
- Know how to refer to rapid access clinics in secondary care where appropriate
- Understand that services other than the traditional secondary care, consultant-led service may be available, such as camouflage service and other patient support groups, and refer appropriately
- Recognise the evolving trends in disease demographics, e.g. the increasing incidence of skin cancers, an aging population and the increase in ethnic minorities
- Recognise how the cultural differences of your patient population might affect not only the spectrum of skin conditions but also their management
- Recognise the huge prevalence of skin disease in the community and its impact on patient’s lives and healthcare resources
- Be aware of locally determined health service priorities, e.g. restrictions on prescribing oral terbinafine/Vaniqa®/topical immunomodulators

Case discussion

Mrs Jane Smith is 36 years old. She is a teacher and married to a computer engineer. They have two daughters, aged ten and eight. Apart from psoriasis she says she enjoys good health, apart from borderline hypertension (not currently on treatment) and a high BMI.

She has had psoriasis since her early teens. Initially this presented with guttate psoriasis after a sore throat, but that soon evolved into chronic stable plaques of psoriasis on the back of her elbows, front of her knees and scattered plaques on her torso – some quite small, others up to the size of the palm of her hand. From time to time she has less scaly, almost shiny, sore areas under her breasts and in her groin and umbilicus. In her scalp she has areas of very thickened scale, and she has a few plaques of psoriasis on the nape of her neck and behind her ears. She keeps her hair long to hide these. Her face, hands and feet are clear. Her nails are ‘quite brittle’ with a few areas of heaped-up scale under a few of them (especially her right index and middle fingers). She denies any joint pain or stiffness.

In the past she has noticed a significant deterioration in her psoriasis after a sore throat, and she continues to have a bad sore throat at least four or five times a year. Both Mrs Smith and her husband smoke up to 20 cigarettes a day. She rarely has any alcohol. She is on no medication other than the mini pill (her BMI is 31), which she continues, largely as it has stopped her periods.

She previously had about five courses of light therapy (as a teenager PUVA, but subsequently UV-B). The last course was at least five years ago.

She has tried steroids creams (up to Betnovate® strength), which have helped. More recently she has been using a vitamin D analogue ointment, but she says she finds this quite ‘irritant’ and so has
abandoned it. She tells you that a further course of light therapy would be very inconvenient as she works all week. During the holidays she needs to be with the children.

As her GP you are aware that their marriage has been unhappy from time to time. Mrs Smith recently told you they were now sleeping in different bedrooms. They have not had a family holiday for some years.

You ask her how having psoriasis makes her feel and she bursts into tears. ‘No one has ever asked me that before,’ she says. She goes on to say it makes her feel dirty, uncomfortable and she is desperately embarrassed about it. It looks awful and she is aware she leaves a trail of skin scales wherever she goes. She refuses to take her daughters swimming and the idea of a beach holiday (which her daughters have been begging for) appals her. She is so unhappy about exposing her body that she cannot even get undressed in front of her husband. They have not made love for years. Recently she struggled to hide her tears when her daughter said, ‘Why do you never wear pretty skirts like my friend Kirsty’s mum?’

**Reflective questions**

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Core Competence</th>
<th>Reflective Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness to practise</strong></td>
<td>How hard should I work to help her if she seems unmotivated?</td>
</tr>
<tr>
<td>This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining an ethical approach</strong></td>
<td>How can I balance my patients’ needs with the availability of commissioned services?</td>
</tr>
<tr>
<td>This addresses the importance of practising ethically, with integrity and a respect for diversity.</td>
<td></td>
</tr>
<tr>
<td><strong>Communication and consultation</strong></td>
<td>Are there any lifestyle or complementary therapies that she might ask me about?</td>
</tr>
<tr>
<td>This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.</td>
<td></td>
</tr>
<tr>
<td><strong>Data gathering and interpretation</strong></td>
<td>What tools could I use to measure severity (DLQI / PDI)?</td>
</tr>
<tr>
<td>This is about interpreting the patient’s narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings,</td>
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64 The best access to the Dermatology Life Quality Index (DLQI) and Psoriasis Disability Index (PDI) is via [www.dermatology.org.uk/quality/quality-life.html](http://www.dermatology.org.uk/quality/quality-life.html)
<table>
<thead>
<tr>
<th>Topic</th>
<th>Question/Task</th>
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<tbody>
<tr>
<td>plus the adoption of a proficient approach to clinical examination and procedural skills.</td>
<td>Am I confident I can diagnose psoriasis and distinguish it from other common skin conditions?</td>
</tr>
<tr>
<td><strong>Making decisions</strong></td>
<td>This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.</td>
</tr>
<tr>
<td>What topical treatments might I prescribe for the various affected areas?</td>
<td>How would I approach discussions about the inheritance of psoriasis?</td>
</tr>
<tr>
<td><strong>Clinical management</strong></td>
<td>This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.</td>
</tr>
<tr>
<td>Should I consider referring her for consideration of oral second-line therapies (e.g. methotrexate / ciclosporin)?</td>
<td>If so, what advice would I give (note she is a smoker and has borderline hypertension)?</td>
</tr>
<tr>
<td>How will I approach discussions about the inheritance of psoriasis?</td>
<td>If her treatment is going to be topical, how is she going to treat her back?</td>
</tr>
<tr>
<td><strong>Managing medical complexity</strong></td>
<td>This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.</td>
</tr>
<tr>
<td>What resources might be available in the primary health care team to help me manage this patient?</td>
<td></td>
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<tr>
<td><strong>Working with colleagues and in teams</strong></td>
<td>This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</td>
</tr>
<tr>
<td>What do I know about ‘complete emollient therapy’ and its place in the management of psoriasis?</td>
<td>What advice would I give regarding the use of topical steroids in psoriasis (refer to NICE / SIGN guidelines 2012)</td>
</tr>
<tr>
<td><strong>Maintaining performance, learning and teaching</strong></td>
<td>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</td>
</tr>
<tr>
<td>What advice might I give about a pre-payment prescription?</td>
<td>How can I record the distribution of her skin condition on the computer software?</td>
</tr>
<tr>
<td><strong>Organisational management and leadership</strong></td>
<td>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</td>
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Practising holistically and promoting health
This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

What are her priorities for treatment?
Mrs Smith is a smoker. Should I use this opportunity to discuss this with her?

What is the additional risk of chronic, moderate or severe psoriasis accelerating atherosclerosis? How will I discuss CVS risk factors?
Psoriatic arthritis is often unrecognised, but it is essential to manage this actively, as it is common and destructive (NICE / SIGN guidelines). How would I evaluate the presence of this in Mrs Smith’s case?

Community orientation
This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

Do we provide sufficient support in the community for lifelong dermatological conditions?

How to learn this area of practice

Work-based learning
In primary care
Skin diseases are common and many are chronic. They will therefore necessarily form a large part of your work as a GP. The patient is very likely to be an expert on their own skin and can often tell you a lot about their condition. One of the advantages of working in primary care is the ability to develop a ‘longitudinal consultation’ by inviting the patient to come back to discuss their skin problem. That provides a great opportunity to look up their condition in the meantime.

It is very easy to fall into the trap of dismissing many skin diseases as trivial (acne, for example), but patients tell us that although they have difficulty raising the issue of their skin problem or discussing it, even with a health professional. The truth is that it can have a considerable impact on their lives. Recognising this and treating the condition well makes an enormous difference.

Be prepared to ask difficult questions (e.g. ‘Does your skin condition cause you any problems or embarrassment in your relationships or at work?’) and always try to examine and feel skin rashes or lesions (usual hygiene measures of course). For a patient, the ‘laying on of hands’ by a healthcare professional dispels concerns of contagion and being ‘untouchable’, as well as helping them to believe you understand what they are experiencing.

Consider discussing with practice members all referrals that are made to dermatology specialists by yourself and your partners to establish what exactly you and your patients are hoping to achieve from the referral – in what way will it be value added? Review your referral again after the patient
has been seen to decide whether the same benefit might have been achieved from resources available in primary care.

Consider arranging a Patient Satisfaction Questionnaire (PSQ) for patients with eczema or psoriasis in order to review your delivery of care. An annual Dermatology Life Quality Index (DLQI) assessment takes less than a minute to complete and would demonstrate to your patient that you are interested in the possible detrimental effect of their disease on their quality of life.

Also consider regularly auditing your patients who are on repeat prescriptions for psoriasis treatments. Have you considered whether they might have psoriatic arthritis, that they have previously dismissed as ‘wear and tear’?

In secondary care

Attending community-based and GPwSI clinics both give you valuable learning opportunities for general practice. You can also reflect on each case and ask yourself: ‘Why was referral deemed necessary and what value-added input has the specialist provided?’

Self-directed learning

Dermatology is high on the learning needs of most professionals working in primary care. As a result, you will find that talks on the subject are regularly included in many continuing education programmes. The Primary Care Dermatology Society (PCDS) mission is to educate and disseminate high standards of dermatology in the community. They run a regular series of ‘Essential Dermatology’ days up and down the country, as well as education events on minor surgery and dermoscopy (i.e. skin surface microscopy for increasing the accuracy in diagnosing both pigmented and non-pigmented lesions).

The British Association of Dermatologists, together with CRUK have recently produced a web-based resource for lesion recognition in Primary Care (www.doctors.net.uk/client/cruk/cruk_skin_toolkit_b09)

On a personal level, your friends and relations will also experience skin problems and talking to them about their experience can be very enlightening.

Learning with other healthcare professionals

Experienced GPs will have seen a lot of skin disease, so ask them for their thoughts. Our nursing colleagues too are a remarkable reservoir of knowledge, approaching patients with skin disease differently from GPs. Specialist health visitors or district nurses are also worth talking to, as of course is the specialist dermatology nurse practitioner.

Remember that your annual appraisal provides an opportunity to reflect on your particular learning needs and plans.

Formal learning

The Cardiff Diploma in Practical Dermatology (DPD) (www.dermatology.org.uk) and the Barts Diploma in London (www.londondermatology.org/index.html) are each largely distance, internet-based learning courses (three terms over a year) with a summative exam and qualification at the end.
Useful learning resources

Books and publications
A key resource is:


Other useful texts and resources include:


Web resources

**British Association of Dermatologists**

More designed for secondary care, but this is an excellent resource for patient information leaflets (e.g. on phototherapy or isotretinoin). [www.bad.org.uk](http://www.bad.org.uk)

**Cardiff University Dermatology Department**

Good patient information resource. Also gives details of the Diploma in Practical Dermatology (DPD). [www.dermatology.org.uk](http://www.dermatology.org.uk)
Changing Faces

Patients who may benefit from ‘skin camouflage’ for scarring or disfiguring skin conditions can be referred to this service. Trained volunteers teach patients to cover and lessen disfigurements using specialist creams and powders. www.changingfaces.org.uk/Home

DermIS

Includes a photo library with a search function. www.dermis.net

Dermnet NZ

Good search engine. Excellent library of pictures and descriptions of diseases (including the uncommon), which can also be used for creating patient information leaflets. www.dermnetnz.org

DermQuest

This is an excellent picture library with news on clinical and research updates available for all. Other parts of the website can only be accessed by DermQuest members. www.dermquest.com

eGuidelines


e-Learning for Healthcare

The e-LfH e-dermatology resource provides an excellent series of over 100 tutorials. You will need your GMC number and an NHS email address in order to be allowed access. www.e-lfh.org.uk/projects/dermatology/register.html

Medscape


National Psoriasis Foundation

This site includes photos and short descriptions on psoriasis. www.psoriasis.org

National Rosacea Association

Includes patient education materials and information for physicians. www.rosacea.org

Primary Care Dermatology Society

This is the best web-based resource out there. It gives really good practical advice on managing the common skin problems seen in primary care (see clinical guidance section) and has excellent pictures. www.pcds.org.uk
Royal College of General Practitioners

RCGP resources include minor surgery information. www.rcgp.org.uk/clinical-and-research/clinical-resources/minor-surgery.aspx