Revalidation still moving forward, says RCGP Chair

We can learn more, particularly about the costs, and how we can make this as bureaucracy-light as possible. It will also give primary care organisations more time to sort out their clinical governance systems and appoint Responsible Officers.

Professor Steve Field

Revalidation is about professional development and we continue to listen to the concerns of grassroots GPs – that is the message of RCGP Chairman Professor Steve Field.

Professor Field has moved to reassure members on the future of revalidation in the wake of new Health Secretary Andrew Lansley’s call to the General Medical Council to extend piloting by a year in order to gain more evidence before the system is finally launched.

He said: “Regardless of what you read in the newspapers, revalidation is moving forward and I believe that the Secretary of State’s letter is a constructive addition to the debate.”

The Secretary of State announced his intentions in a letter to GMC Chair Sir Peter Rubin, citing a need to develop a clearer understanding of the costs, benefits and practicalities of implementation. Despite the delay, the plans to approve legislation that will result in the appointment of Responsible Officers in England continue, while in Wales they are already in place and in Scotland and Northern Ireland plans are also moving ahead.

Professor Field said he had always believed that revalidation was about professional development and that was why the College had been so open in the way that it developed its ideas – meeting GPs around the country, undertaking widespread inclusive stakeholder involvement and publishing its guide for GPs – so that the process could be developed with as wide an input from GPs as possible.

He said that delaying the introduction of revalidation was not a bad move because it would provide time to iron out any problems in general practice and especially in secondary care and the hospital specialties.

He said: “We have been told that there are concerns about the systems proposed in some of the hospital specialties about the standard that doctors will need to meet in order to revalidate, but in general practice we have always taken the view that revalidation is about professional development, and that for revalidation to be a success it will also depend on appropriate clinical governance systems in PCTs, appropriate funding and a solution to the question of remediation.

With extended piloting, we can learn more, particularly about the costs, and how we can make this as bureaucracy-light as possible. It will also give primary care organisations more time to sort out their clinical governance systems and appoint Responsible Officers. This is important in England because the structure of the NHS and even the future role of PCTs is uncertain.”

Meanwhile, the College has launched Version 4 of the RCGP Guide to Revalidation, giving advice on how GPs working in special circumstances can collect ‘equivalent portfolios’ of evidence to support them in their revalidation.

The guidance sets out how GPs such as those working as peripatetic locums or those working in remote rural practices or in small practices can collect the required level of evidence in different ways.

Professor Field said that it was important for GPs, whatever their working circumstances, to begin collecting evidence in order to make the process as straightforward and unbureaucratic as possible.

In addition to the launch of Version 4 of the Guide, the College has also published a new video webinar on revalidation for GPs working in special circumstances. It discusses how they can demonstrate that they are fit to practise, up to date and that they have the attributes of a good general practitioner.

In the film, Professor Mike Pringle, RCGP Medical Director of Revalidation says: “When it comes to significant events you can discuss outcomes with your colleagues, with locums and with your peer group. If you’re in a remote rural practice you can have people observing your practice, rather than doing a colleague survey, if that is better for you, and when it comes to audits you can collate evidence prospectively, looking at case studies in order to demonstrate that you reflect on your care and keep up to date.”

Version Four of the RCGP Guide to Revalidation and Professor Pringle’s webinar can be found at www.rcgp.org.uk/revalidation.

Change of plan for interim College

Plans for the RCGP to move into temporary premises at Commodity Quay (CQ) in London’s Tower Hill are being revised after the landlord changed the negotiating position at the eleventh hour.

The College sold the Princes Gate headquarters in April and has bought an imposing new building in Euston Square where we will relocate permanently in Summer 2012.

College Officers and the Senior Management Team have moved quickly to look at an equivalent and efficient cost effective solution for the College. As RCGP News went to press, the College was hoping to sign the lease on alternative and equally, if not more, effective accommodation in Cheapside, close to St Paul’s Cathedral.

Dr Horder’s historic edition

The College has commissioned a special limited edition reproduction of a beautiful painting of Princes Gate by Dr John Horder (right) to raise money for the College’s new headquarters in Euston, London.

Dr John Horder CB EM FRCP FRCS joined the College as a Foundation Associate and went on to be a leader and pioneer in education. He was RCGP President from 1970-1982. Dr Horder was in general practice in London’s Kentish Town between 1951 and 1982 and lives in Primrose Hill with his wife Elizabeth June, who was also his partner in general practice.

A talented writer, artist and musician, he kindly donated one of his watercolours depicting a view of the College from Hyde Park to mark the RCGP’s 40th anniversary in 1991. The original painting was presented to former RCGP President HRH Prince of Wales on the occasion of the first John Hunt Lecture. A limited edition of 200 prints was then made available to raise money for the College’s development fund in the early 1990s.

As the College prepares to leave its headquarters at Princes Gate, Dr Horder has produced another limited edition of the print. Only 200 are available and, unlike the initial edition, each print is individually signed and numbered by Dr Horder.

The print can be purchased by members and supporters of the College. Copies are priced £90 plus £2.99 P&P and can be ordered from the RCGP online bookstore: www.rcgp.org.uk/bookshop
Closing the gap: GPs urged to take the lead in creating a fairer society

Doctors must play a key role in leadership and advocacy in order to tackle the effects of social determinants of health, says a new report produced in partnership with the RCGP.

The report, How doctors can close the gap: tackling the social determinants of health through culture change, advocacy and education, identifies how doctors can take account of social inequalities in all aspects of their work with patients. It aims to improve working in healthcare and society in general.

Produced by the Royal College of Physicians, in partnership with the RCGP and other leading health organisations, it is the result of an international conference which included input from more than 80 guests and at a conference where speakers included Professor Sir Michael Marmot, RCGP Chair Professor Steve Field, Professor Ian Gilmore, President of the RCP, and GMC Chair Professor Peter Minute.

Focusing on three main strands – policy, the changing of professional cultures towards the social determinants of health and sustainability, and the implications for the education and training of doctors – the report seeks to create a culture change that encourages the sharing of ideas and best practice around the issues of health inequalities.

It makes a number of recommendations for action that apply to individual doctors, the wider NHS and local government, and is set against the background of the Marmot Review, Fair Society, Healthy Lives and the RCP curriculum statement Health People: promoting health and preventing disease.

It defines the social determinants of health as “the circumstances in which people are born, live and work and the policies and actions that shape the distribution of resources and opportunities in society”. The report notes that these factors can affect their mental and physical well-being and life expectancy, and have been characterised as “the causes of the causes of ill health” (or ill health).

Professor Steve Field said: “It’s shocking that we are in 2010, yet the health and life expectancy of our population are still largely determined by whether we are rich or poor, and that the divide between the two seems to be getting wider.”

The report calls on all doctors to use consultations as an opportunity to address factors affecting patient health beyond family history and presenting symptoms, something which Professor Field said GPs are uniquely placed to take advantage of.

He said: “GPs, more than any other health professionals, are in the privileged position of working at the heart of communities and being able to provide care to patients throughout their lifetime. We have a unique insight into the lives of our patients and are already making good progress in helping people live healthier lives and preventing them becoming ill, rather than trying to patch them up once they are ill.

“But we can all do more and this report really ups the ante. By working together, the medical professions can be a force for change and do much to improve the health outcomes for all our patients, wherever they fall in the socio-economic divide.”

Engagement, prevention and sustainability are central to the next round of RCGP, said Professor Field. “I am particularly pleased to see sustainability at the heart of this work. I am convinced that with the influence and support of the RCGP and the Faculty of Occupational Medicine and the Society of Occupational Medicine, this agenda can become as powerful as the anti-smoking movement started and led by doctors three generations ago.”

More information on the policy statement can be found at www.rcplondon.ac.uk

Sue Rendel: Looking to the future

Sue Rendel
Chief Examiner MRCGP
Mike Bewick
Chair, RCGP Assessment Committee

The MRCGP exam – having lost its ‘p’ prefix last year – is well established. It is the licensing exam, recognised by the General Medical Council, to indicate the satisfactory completion of GP training in the UK. Between two and three thousand candidates are taking the components of the exam each year. As with all such assessments they are continually evaluated. Content, context and standard setting mechanisms are reviewed to consider fairness to candidates and also patient safety.

Having led the field in adoption of computerised exams, the AKT (Applied Knowledge Test) has been a computer-based test since the inception of the new MRCGP in October 2007. Candidates have appreciated the convenience of being able to go to their local Pearson VUE test centre rather than travelling to major examination halls. The use of these centres has been so successful that the National Recruitment Office for GP Training is currently evaluating the same technology for selection into general practice training.

The AKT has maintained a high level of reliability in testing the knowledge base to underpin clinical general practice and many candidates have commented on it being fair and applicable to their work. The formats of Single best Answer and Extended Matching Questions apply to the majority of questions, with increasing use of graphics and photographs to enhance the topics.

The computer-based test can accommodate question formats such as free text answers, where the candidate can type in the answer rather than selecting from a list of options. It also gives an opportunity to use short videos or sound clips, and ‘hot spots’ where the candidate clicks on the graphic to indicate the site of a clinical sign, for example, tenderness. The AKT will pilot these new formats in the near future, and they will be included in the tutorial which precedes the exam.

The CSA (Clinical Skills Assessment) is also looking to the future and, following a rigorous review of the exam in the summer of 2009, we will be introducing some changes from September 2010. These changes are in line with suggestions made by PMETB (now GMC) at the time of the College’s approved submission to the curriculum and assessment systems in 2009.

Firstly we will be marking all of the 13 cases on the circuit, instead of 12, in order to enhance the reliability of the assessment. Secondly, we will no longer be creating a pass mark of eight cases out of 12. The pass mark will be set instead using the borderline group method. This is an established and robust standard setting method, approved by PMETB (now GMC), which will also allow us to deal with day to day variability in the difficulty of case mix.

The candidates’ experience will be the same and we should not affect the way they prepare for the examination. The cases will continue to be marked using the current three markers instead of the individual marking of marks for each case. The markers for each case will receive the total numerical score for all 13 cases and the pass mark will have been set by the combined judgements of the examiners for that day.

The feedback statements have also been reviewed, taking into account comments from AST representatives and CSA examiners. They have been clarified and the examiners have been trained, with more information and advice on how to improve performance. Candidates will receive more feedback information than previously, with any areas of performance identified as deficient linked to the Curriculum Statements as part of the feedback.

Further information about the new CSA standards and the topics which will be available shortly in the form of Frequently Asked Questions (FAQs).

Invaluable resource. Professor Nigel Stephenson, Professor Sayeed Khan, Professor Dame Carol Black, Dr Debbie Cohen and Dr Bill Gunnery at the launch of Healthy Working UK

One-stop shop for work and health is open for business

Professor Dame Carol Black, National Director for Health and Work, and Dr Bill Gunnery, Director, Health, Work & Wellbeing, Department for Work and Pensions, joined the RCGP to launch Healthy Working UK, a website providing a one-stop shop for GPs and other healthcare professionals about work and health.

The website offers news articles, decision aids, leaflets and guidance, as well as national and local contacts that could be of assistance during consultations for both professionals and patients. It is just one part of a programme of work which includes:

Health e-working for primary care: a modular e-learning package for primary care
Health e-working for secondary care: a modular e-learning package for secondary care
Health & Work in General Practice: a national education programme for GPs

The Healthy Working UK website was initially funded through the Welsh Assembly Government, working with Cardiff University and the Healthcare Learning Company. The site has now been extended to England and Scotland as well as Wales, through funding from the Department for Work and Pensions, who worked in Partnership with the RCGP. “The Fair Society, Healthy Lives report calls on all doctors to use consultations as an opportunity to address factors affecting health beyond family history and presenting symptoms, something which Professor Field said GPs are uniquely placed to take advantage of. He said: “GPs, more than any other health professionals, are in the privileged position of working at the heart of communities and being able to provide care to patients throughout their lifetime. We have a unique insight into the lives of our patients and are already making good progress in helping people live healthier lives and preventing them becoming ill, rather than trying to patch them up once they are ill. “But we can all do more and this report really ups the ante. By working together, the medical professions can be a force for change and do much to improve the health outcomes for all our patients, wherever they fall in the socio-economic divide.”

Engagement, prevention and sustainability are central to the next round of recommendations, and the report captures these three themes under the three ‘Es’ of engagement, Empowerment and Environment.

Professor Field said: “I am particularly pleased to see sustainability at the heart of this work. I am convinced that with the influence and support of the RCGP and the Faculty of Occupational Medicine, this agenda can become as powerful as the anti-smoking movement started and led by doctors three generations ago.”

More information on the policy statement can be found at www.rcplondon.ac.uk

RCGP News invites your letters or comments

Send your comments to The Editor RCGP News
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NEWS

One-stop shop for work and health is open for business

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One-stop shop for work and health is open for business
An innovative website of real-life patient experiences is the culmination of a life’s work for its co-founder and RCGP Fellow Dr Ann McPherson. The combination of her vision, energy and determination now provides a lifeline for thousands of patients and their families.

I HAVE BEEN described as one of the most exciting and successful medical breakthroughs of the last decade – “an idea whose implications for the future of medicine are as profound, in their way, as any since Hippocrates.”

The website www.healthtalkonline.org (originally known as Dipec, the Directory of Patients’ Experiences), and its more recent junior partner www.youthhealthtalk.org, which marks its tenth birthday this year, over 55 sections on different health problems and 2,000 interviews with ordinary people talking about their experiences are currently available online.

The website’s co-founder, retired Oxford GP Ann McPherson has been celebrated for her achievement in thinking outside the box – and for having the courage and energy to turn these thoughts into a successful and much praised enterprise, not least by patients themselves.

BORN IN 1945, the only daughter of a radical Jewish tailor, Ann was brought up in Golders Green, and was the first medic in her family.

She studied at Kings College and then at St George’s where she says the message from her best tutors was “the importance of communicating with patients – that you get a diagnosis by listening to the patient rather than by doing hundreds of tests. And communicating well was important – if bad news has to be broken, the consultant should do it.”

Even choosing general practice was thinking outside the box in that way. There were barely any training available and little kudos in the specialty. “What’s a clever girl like you doing being a GP?” she was asked by one eminent tutor – a question she reminded him of at his 80th birthday recently. “He told me he could never understand my choice,” she says.

By 1968, she was married to the epidemiologist Alan McPherson, who persuaded her of the importance of evidence-based medicine “long before it was fashionable”. They had three children in five years and she is now a grandmother of five.

As a mother who wanted to have as much time as possible with her children, she fought for part-time training, eventually gaining a partnership in an Oxford practice in 1979.

She observed that her own children as well as her young patients would benefit from knowing about their bodies – “something about medicine and the way the body worked – but he wanted human stories as well. And we thought – how can we get this working? How can we do this?”

“He was also a doctor, and knew a great deal about medicine and the way the body worked – and what a revelation they had been.”

He was also a doctor, and knew a great deal about medicine and the way the body worked – but he wanted human stories as well. And we thought – how can we get this working? How can we do this?

“We both twigged to the prodigious possibilities of recording and analysing the experience of large numbers of patients in a systematic way.

The practicalities of fundraising and recruiting staff proved daunting but Ann brushed off all opposition aside.

“You should always stick with what you really believe in, even though it may not always make you popular,” she says. “People shouldn’t be afraid to say what they think. If you really believe in something you should go for it.”

FROM THE START, the aim was to create something that was research-based.

“We found that if you talk to people you get so much more than a questionnaire. So that’s what we did, finding that in order to get a good sample we needed at least 40 or 50 people.”

The arrival of broadband with its capacity to transmit videos of interviews helped shape the site. “Stick someone in front of a camera and invite them to talk, they do so fluently,” she says.

“We felt that web-based video was going to be the thing of the future – and it was the ideal way to hear people’s stories about illness.”

The first project was on prostate cancer. We had 50 men from all over the country with different backgrounds, experiences and disease stages and we could sort the dialogues into 25 key themes: getting a diagnosis, making treatment choices, telling your family. We put a summary of each theme on the website, illustrated with a mixture of clips.

Today there are 55 conditions including cancers, heart disease, arthritis, depression and traumatic issues, such as termination for a congenital defect.

An important factor is the lack of political correctness. “People do admit to awful feelings, and are not always touchy feely. People benefit from knowing about the bad times, from hearing about how other people wanted to kill their parent with Alzheimer’s – rather than hearing how people cope marvellously when faces are smeared on the wall.

It was rather like me with breast cancer. Doctors tend to put the best gloss on things and I was given to expect that I’d be back in surgery pretty well straight after chemo. And that wasn’t the case at all.

Academics are also impressed with the response. The School of Clinical Medicine at Cambridge is one of several medical schools that uses the website for teaching purposes.

“An invaluable resource that will have a major influence on future generations of doctors into the curriculum,” says the associate clinical dean, Dr Jonathan Silverman.

Knowing the value of involving those who are prominent in the public eye, Ann has also drawn together a host of celebrities to support and raise awareness of the site and some have even contributed their own experiences.

The author Philip Pullman is a devotee and news broadcaster Jon Snow is another key supporter, chairing launches of the new sections as well as being a major online presence.

In the last year, the actor Hugh Grant has become the site’s patron and donor as well as becoming her good friend since Ann wrote to him asking for his support, after he talked about his mother’s death from pancreatic cancer.

As to the future, she says the team is desperate to do a site for asthma, chronic obstructive pulmonary disease, and multiple sclerosis – but fundraising is a struggle. Plans are well advanced to establish a Health Experiences Institute at Oxford University – an international centre of excellence with a research team committed to making “a real impact on health policy and practice on a global scale”.

But time is running out for Ann herself due to a recurrence of pancreatic cancer. She has supported the campaign on assisted dying – not assisted suicide, she insists – and as part of the “excellent” palliative care she is receiving, wants the option of medical assistance should she choose to end her life.

She remains very active from day to day. “My only regret is that so many questions that pop into my head during the long sleepless hours remain unanswered,” she says.
Stephen Patterson and Martin Marshall of the RCGP Ethics Committee kick off a new series on Ethics in Practice by questioning whether it is time for patients and GPs to cease worshipping at the shrine of ‘confidentiality.’

Is confidentiality an essential component of effective patient care to be defended at all costs? Or is it a leaky and potentially indefensible concept that we need to guard against at all costs? And, if we defend parternalism, which should be confined to the dustbin of history? A dangerous question, some would say, but an important one to help us unpack what is so often defended as a fundamental component of professional practice.

The word ‘confidentiality’ literally means ‘with confidence’. The argument goes like this; effective care requires honesty between a patient and their GP. Honesty will only be forthcoming if it is underpinned by trust and this requires confidence that private or potentially damaging information divulged in the consultation will go no further. The belief that effective care therefore must be based on confidentiality has become an article of faith in many healthcare professions, as evidenced by policy and training. But there is a big problem. The present practice of confidentiality is leaky and incoherent and the nature of modern society means that it is likely to become more so. When we move beyond the rhetoric, confidentiality is beset with theoretical and practical problems.

For example, the nature and scope of the term is seldom discussed. Everyone thinks they know what it is and agrees with its importance. But what are its limits and nature? Where does information sharing begin and end? In practice, this tends to be very variable.

Confidentiality is often poorly understood in a conceptual sense with many different meanings that may even be at variance with each other. Whose confidentiality are we talking about in any particular situation? And is your confidentiality (sharing with the health care team) the same as mine? You must not tell another living soul! Tight, clear meanings are not often agreed in advance, and patients can change the understanding and practice of confidentiality.

Loose theory and understanding is then embodied in loose practice. In reality, lots of people can know things that they do not need to know about others, and they even talk about them in public places, hoping that they are not overheard. The problem is exacerbated by the growth of information technology which opens up potential access to personal information even further. This is added to by increasing demands to link up information systems.

Put simply, it is not really possible any longer to argue that the way in which we practised confidentiality, its whatever version, narrow or broad, in the past is realistically possible. It is a delusion. And if we continue to propagate and support this delusion, we may be deceiving ourselves and our patients.

Confidentiality is leaky and inadvertently give out and leave about all sorts of personal and potentially damaging information about themselves, their friends and recent stories about Facebook illustrate. Arguably, we live in a society where many people perceivably understand that there is really no such thing as privacy. Credit agencies that we have never heard of, or dealt with, have information about us. We may be selling ourselves if we do not think that it is quite easy possible for complete strangers to find out most things about us within a few hours if they wish to do so.

For example, we should probably assume that nothing about us is really private and to know that is to know exactly where we stand – the facts are, as therapies, that Carlot Rogers said. If we accept the reality of non-confidentiality, then we are in a much better position about how information we may choose to disclose than if we hope that there is such a thing as the limited circulation of ‘confidential information’.

If patients know exactly where they stand and that there is no such thing as real, let alone absolute, privacy or confidentiality, this will necessitate an honest conversation with their doctor about the do’s and don’ts and terms and conditions of their relationship.

To work on a principle of non-confidentiality then is to move from paternalistic protectionism to adult autonomy. I tell you what I want you to know. If I think that might be harmful to me, I withhold the information and if I fail to tell you something that restricts your ability to provide effective care, then that is up to me. The point is that we are being challenged to re-define confidentiality as a means and its impact on the contract between us. Public perceptions of confidentiality, on the other hand, seem to be deeply entrenched, instead of being in a blur of ostensibly benevolent confidentiality.

Confidentiality means everything and nothing. It is impossible to promise and to define confidentiality in advance. It is not as simplistic an issue as it may seem.

Sharing genetic information

Michelle Bishop
Education Development Officer (Medicine)
NHS National Genetics Education and Development Centre

Why might genetic information be considered confidential? Is confidentiality something that varies depending on when it comes to thinking about confidentiality? As genetic information about one person can reveal information about the probability of disease for other family members, and may therefore impact on the medical management of that person, genetic information likely to be recorded in primary care includes pedigree information, which contains information about the family history, and genetic test results. Recording information about other people in a family in the form of a family history (and passing it onto other health professionals involved in the medical management of that patient) is permissible under the Data Protection Act without the explicit consent of all those shown on the pedigree – if this information is necessary for medical purposes. GPs are likely to receive copies of any genetic test results that their patients may have had and this information should be shared with other family members with the patients’ explicit consent.

In most cases individuals are more than happy for their pedigree information and genetic test results to be available to other family members and professionals to assist in diagnosis and medical care. However it is good practice for the health professional who collects the information to ask for and record consent that the family history and genetic test results may be shared.

If asked to release information, it is good practice to review the pedigree to try to ensure that only information relevant to the clinical purpose is released. If, for any reason, consent is not provided, the General Medical Council’s guidelines state that doctors must make a judgement whether their duty to make the care of the patient [their] first concern is greater than [their] duty to help protect the other person [patients’] confidentiality.

CONSIDER THE CASE of Sam, who is 28 years old.

• For further information about sharing genetic information see:…
  - Genomics Consensus document: www.rcpath.org/resources/pdf/…
  - Consultation/Confidentiality_guidance.asp

In this situation, you would have to weigh up the possible harm to Janet in breaking her confidentiality against the potential harm to Sam of not informing him he may be at risk of a condition that could be detected through colonooscopy and treated. Decisions like this take time and consideration, and may require the input from other medical colleagues, such as those from the Regional Genetics Centre.

Contact details are available from the British Society for Human Genetics: www.bshg.org.uk

...
Now you can electrolyte your learning on dementia

Professor Louise Robinson
Newcastle University
RCGP Clinical Champion for Ageing and Old People.

Dr Emma Vardy
NHIR Clinical Lecturer in elderly medicine
Honorary Specialist Registrar
Manchester University.

In 2009, the RCGP successfully launched its new e-learning resource with a wide range of learning modules available for GPs. During 2010, we have developed two new modules on dementia care in primary care; time for a look at this area as it is one year since the launch of the National Dementia Strategy for England which aims to improve the quality of care received by people with dementia and their families1-8.

Dementia care in primary care: current service provision and evidence

Dementia is one of the main causes of disability in later life. In terms of diagnosis, it contributes 11.2 per cent of all years lived with disability, highest only by cardiovascular (16.7 per cent), musculoskeletal disorders (8.9 per cent), heart disease (5 per cent) and cancer (2.4 per cent). If left alone, one in 14 people aged over 65 has a form of dementia, rising to one in six of those over 85.

In the UK, there are currently approximately 700,000 people with dementia but this is estimated to rise to 1.7 million by 2050, an increase of over 150 per cent (2). The total cost of caring for people with dementia in the UK is estimated at £17.1 billion a year, more than heart disease (£12.5 billion) or stroke (£3 billion) and cancer (£2 billion) (2). Currently around two-thirds of people with dementia live in private households, with the majority of their care provided by family supporters and primary and community care. There is consistent evidence that the standard of dementia care in the UK is in urgent need of improvement, with frequent failure to deliver services in a timely, integrated and cost-effective manner to support people with dementia to live independently for as long as possible (3).

Within primary care, GPs admit to difficulties in both diagnosing dementia and caring for people with dementia in primary care have been identified by the RCGP as areas in need of attention. The recommendation to develop further training for GPs has also been highlighted in the National Audit Office report on Dementia (1) and the National Dementia Strategy for England (6). This has been highlighted as a challenge for the RCGP Clinical Champion for Ageing and Older People.

RCGP e-modules on dementia

In order to develop educational resources in this area, it is important to identify what role(s) the GP undertakes in diagnosing and caring for people with dementia.

A project, led by Simon Flint in Oxfordshire, is exploring this area in detail and results will be available in 2011. However, two international review papers have recently been published (4,5) which consider the role of the GP in dementia care. These, together with the NICE guidance on dementia care (8), have informed the development of two RCGP e-modules on dementia.

The first module is focused on assessing memory problems in primary care, while the second covers key aspects of dementia relevant to primary care, including drug prescribing, ethical and legal issues, behavioural problems and end of life care.

The RCGP e-modules are problem-based and focused on typical patients presenting to a GP in order to develop educational resources in this area, it is important to identify what role(s) the GP undertakes in diagnosing and caring for people with dementia.

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Rheumatoid arthritis: the importance of early diagnosis

Dr Jonathan Botting
RCPG Clinical Champion for Minor Surgery

Please imagine the following scene. You are waiting at the airport for your flight to leave, talking to your companion about your family and your holiday on board. An announcement comes over the public address system. Ladies and gentlemen we have a problem. There are too many of you all on the aircraft, but here is the good news: we have laid on a second flight for you all today...” I assume you would all decline the offer of a trip to Derry-Air? Any person with UK doctors are providing surgical activity in exactly the same way as our enthusiastic amateur. “See one, do one, teach one,” was passed down to many doctors’ training in the past but the world has moved on to DOPs and COTs and CEX and CIBDs. Today’s doctors are asked to produce evidence in existence of their skills and of their continuing professional development. Those GP’s suggesting to provide surgical activity as part of a specialist interest are required to meet accreditation requirements which include a number of observed procedures, case-based discussions and reflective practice. Patients being referred to such services not only benefit from care closer to home but also from specialist care. A training scheme that ensures the practitioner has evidence of their skills and knowledge. The outcome of such a training process is not being delivered by clinicians who have been advised in such a training process. With out peer review, observed procedures, CPD or the requirement to regularly audit surgical activity, histological results, much of primary care surgery is an unknown quantity. Unfortunately, when it becomes the subject of criticism, the outcomes can be associated with considerable delay in the diagnosis of ankylosing spondylitis. The trial. This has been conducted on a number of occasions to protect and promote this service to meet these audit requirements there is a natural and understandable reluctance to undergo any form of test or evaluation, especially for an activity that may have been provided for a number of years. Evaluation may be for the purposes of funding and with an educational and formative aim it facilitates the goal of lifelong learning. In addition, validation of this service to is in our interests to show evidence of this approach, especially if we are providing any activity that expected within the NHS. Evidence for recording surgical skills. There is at least one of the rheumatoid arthritis has a significant impact on the economy. More than two-thirds of the population are affected with rheumatoid arthritis. It was launched at the BSR Conference in April, supported by an educational video podcast. The key points are to remind doctors that the SFACTOR gives doctors an opportunity to intervene therapeutically. There is a natural and understandable reluctance to undergo any form of test or evaluation, especially for an activity that may have been provided for a number of years. Evaluation may be for the purposes of funding and with an educational and formative aim it facilitates the goal of lifelong learning. In addition, validation of this service to is in our interests to show evidence of this approach, especially if we are providing any activity that expected within the NHS. Evidence for recording surgical skills. There is at least one of the rheumatoid arthritis has a significant impact on the economy. More than two-thirds of the population are affected with rheumatoid arthritis. It was launched at the BSR Conference in April, supported by an educational video podcast. The key points are to remind doctors that the SFACTOR gives doctors an opportunity to intervene therapeutically.
Headache in children and the elderly

This is the fifth and final factsheet written by RCGP Clinical Champion Dr David Kernick to support the diagnosis and management of headache in primary care. The factsheets are available on www.rcgp.org.uk/circ and are also published by GP newspaper.

**BACKGROUND**

Headache is the most frequent neurological symptom, and commonest manifestation of pain in children. Diagnosis is often more difficult and the patient less likely to articulate their problems and seek help. Twenty per cent of children report headaches that trouble them at least weekly. Migraine is the most common type of headache with a peak incidence at the age of 15 years in girls and ten years of age in boys. Headache in children sits within a complex biopsychosocial framework and has an impact at school and home.

**MANAGEMENT**

- **Trigger factors** can be subtle and children have a lower threshold to stress, missing meals, irregular sleep patterns, dietary irregularities, especially missed meals and lack of hydration. A high fibre regular cereal snack, a regular intake of fluid and avoidance of caffeinated drinks is helpful.
- For the acute attack, effective pain relief is important.
- **Systemic disease**, eg anemia, and hypocalcaemia, can be triggers and may be associated with migraines.
- **Drug usage** is common and should be considered as a trigger.
- **Associated symptoms** include nausea, vomiting, photophobia or phonophobia. These are not always present.
- **Pressure** or band-like pain is not always present.
- **Aura** is less common.
- **Frequently prevents normal activity** is not always present.
- **Sufferer usually able to continue with normal activities**

**DIAGNOSIS**

Migraine differs in children when compared with adults (see table on the right). In many cases there is an overlap between migraine and tension-type headache that does not occur so frequently in adults.

**Other syndromes are associated with migraine**

The associations remain unclear, but there is often a family history of migraine.

- Cyclic vomiting. Recurrent severe nausea and vomiting associated with pallor, lethargy +/- autonomic symptoms. Symptoms often begin in the middle of the night. Girls more affected than boys. Begins at approximately five years of age and resolves by puberty. Conventional migraine preventative effective in reducing attacks frequency.
- Abdominal migraine. More common in children aged seven to 13 years with a family history of migraine. Recurrent, episodic, attacks of abdominal pain lasting one hour up to three days. Abdominal pain has a full character usually in a per umbilical location but can be more diffuse. Pain is sufficiently severe to affect daily activities. Treatment is with conventional migraine preventative medication.
- Benign paroxysmal vertigo of childhood. More commonly affects young children. Attacks begin suddenly, last minutes only and may occur in clusters lasting days to weeks. Paroxysmal, recurrent, untriggered, attacks of severe vertigo +/- gait unsteadiness without warning.

**INVESTIGATING THE CHILD WITH HEADACHE**

- The risk of a tumour in a child who presents to a GP with headache is 0.03%, a third of the adult level.
- Indications for investigation are the same as for adults (see Fact File 2). Unexplained deterioration in school work or headache in the very young are additional causes of concern.
- The rate of incidental abnormalities is higher. Rates up to 20 per cent have been quoted.

**FACT FILE 5a: HEADACHE IN CHILDREN**

**BACKGROUND**

Headaches with higher prevalence in the elderly:
- Co-morbidities and drug usage are more common both of which can cause headache.
- Space occupying lesions. Increasing risk with age of primary and secondary tumour.
- Temporal arteritis. Always consider over the age of 50, which can include jaw claudication and constitutional symptoms (see Fact File 2).
- Neuralgia: trigeminal, post herpetic.
- Systemic disease, eg anaemia, hypocalcaemia, hypotension, renal failure, hypoxia or hypercapnia.
- Cerebral vascular disease: thrombotic and embolic stroke (headache in 20% per cent); intracerebral haemorrhage; subarachnoid haemorrhage.
- Cervical spondylosis leading to cervicogenic headache.
- Fever.
- Hypnic headache. Occurs only during the night, wakes from sleep and frequently at the same time lasting up to three hours. Indomethacin, caffeine and lithium are treatment options.

**DIARY DATES**

- **JULY**
  - 27 ‘Preparing for appraisal’ support group
  - 19:00 – 21:00 University of Nottingham
  - **FREE**
- **AUGUST**
  - 26 Let’s innovAiT
  - 09:30 – 18:00 The Audrey Emerton Centre, Brighton
  - **FREE**
- **SEPTEMBER**
  - 23 Dealing with difficult people (aimed at practice staff)
  - 09:30 – 12:30 RCGP, Edinburgh
  - **Price: £45**
- **OCTOBER**
  - 13 Perspectives on mental health in primary care
  - 19:00 – 21:00 Chancellors Hotel Manchester
  - Members: £20
  - Non-members: £45
  - **FREE**
  - **MRCGP for trainers: helping your registrar through the exams**
  - 9:00 – 21:00 RCGP Assessment Centre, Croydon
  - Members: £150
  - Non-members: £175
  - **FREE**
  - **ANAPHYLAXIS: the essential update**
  - 19:00 – 21:00 Royal College of Physicians, Edinburgh
  - Members: £20
  - Non-members: £45

**FACT FILE 5b: HEADACHE IN THE ELDERLY**

**BACKGROUND**

In particular, migraine prevalence reduces with age but rarely can develop after the age of 50. (In this group 10 per cent will have an abnormality on imaging and should be investigated.) Triptans are underused over the age of 65 but often benefit will be greater than potential risks providing there are no particular contraindications and an ECG may be advisable.

**DIAGNOSIS**

Migraine is the most common type of headache with a peak incidence at the age of 5 years in girls and ten years of age in boys. Migraine in children sits within a complex biopsychosocial framework and has an impact at school and home.

**MANAGEMENT**

- **Trigger factors** can be subtle and children have a lower threshold to stress, missing meals, irregular sleep patterns, dietary irregularities, especially missed meals and lack of hydration. A high fibre regular cereal snack, a regular intake of fluid and avoidance of caffeinated drinks is helpful.
- For the acute attack, effective pain relief is important.
- **Systemic disease**, eg anemia, and hypocalcaemia, can be triggers and may be associated with migraines.
- **Drug usage** is common and should be considered as a trigger.
- ** Associated symptoms** include nausea, vomiting, photophobia or phonophobia. These are not always present.
- **Pressure** or band-like pain is not always present.
- **Frequently prevents normal activity** is not always present.
- **Sufferer usually able to continue with normal activities**

**MAIN FEATURES OF MIGRAINE IN ADULTS AND CHILDREN AND TENSION-TYPE HEADACHES**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>DOSE UNDER 12 YEARS</th>
<th>DOSE 12-18 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pizotifen</td>
<td>0.5-1.0mg/day</td>
<td>1.5-3.0mg/day</td>
</tr>
<tr>
<td>Propranolol</td>
<td>Max 4.0mg/kg/day</td>
<td>Max 160mg/day</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Up to 50mg/night</td>
<td></td>
</tr>
<tr>
<td>Topiramate</td>
<td>2-3mg/kg/day</td>
<td>Gradual increase to target dose</td>
</tr>
</tbody>
</table>

**DRUGS USED IN THE PREVENTION OF MIGRAINE**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Dose (mg)</th>
<th>How to use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pizotifen</td>
<td>0-1.0</td>
<td>Add as needed</td>
</tr>
<tr>
<td>Propranolol</td>
<td>20-40</td>
<td>Add as needed</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>0.2-0.5</td>
<td>Add as needed</td>
</tr>
<tr>
<td>Topiramate</td>
<td>0.2-0.5</td>
<td>Add as needed</td>
</tr>
</tbody>
</table>

**CLINICAL UPDATE**

- **RCGP News** • Jul 2010
Sustainable Primary Care

Growing healthy partnerships

Annual Primary Care Conference 2010

7-9 October 2010
Harrogate International Centre

Have you registered yet?

www.rcgpannualconference.org.uk