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Editor's choice

Child protection will always be a difficult area for doctors, and we welcome any strategy to increase their ability and readiness to act on concerns.¹

Doctors on the front-line of care play a key role in identifying signs of child abuse or neglect, and also have a broader responsibility for the health and welfare of the families they treat. As every practitioner knows, though, this is a delicate and sensitive area and there can be an understandable fear about 'getting it wrong' and damaging relationships with parents or even being the subject of a complaint. For these reasons and others, it is crucial that doctors have the confidence to raise concerns and feel they have the support to be able to act promptly and effectively.

To support doctors with these challenges, we published comprehensive new guidance in 2012.² It includes advice on recording child protection concerns, working with families who need extra support, and approaching potentially distressing conversations with parents when there are concerns about the welfare of their child.

Doctors who take action will always be justified, if the concerns they have raised are honestly held and reasonable, and they have acted to protect children through the appropriate channels — and this will be justified even if it turns out that the child or young person is not at risk.

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A letter to Jeremy Hunt

It's the middle of the night. I can't sleep. The time has come to put pen to paper. What good will it do? Probably very little. At least it will make me feel that I have done my bit to save the profession I love so dearly.

Let's start with this whole 7-day-a-week working; in your words, as part of '21st century medicine'. You mentioned in the RCGP Conference that *'if a patient wakes up on a Saturday morning with a problem, they want it sorted that day ...'* What problem, might I ask you, needs sorting that day by a GP? The sore throat that developed that morning? The headache they have from the Friday night out? The inconvenient spot that has appeared on their nose before a big party? These people, all of whom I've seen in urgent out-of-hours clinics, need education not access.

We are currently swamped with patients that actually need us. The housebound, vulnerable ageing population that are often only too apologetic to be 'troubling you doctor'. The chronic diseases that used to be dealt with by hospitals, that are (quite rightly) being pushed into the community for us. These are the people who need us and who we should be focusing on, not pandering to the worried well whose ailment is merely an inconvenience to them on a Saturday or Sunday morning.

Moving on to negativity in the media: where do I start? I don't know a single GP who would ever intentionally 'miss' a cancer. We see over 250 patients a week — I see more than five patients a day with a headache — would you like me to send them all for a CT scan? After all, nearly every person who comes to me with a headache is worried that they may have a brain tumour. Should I send every patient with chest pain to hospital to exclude a heart attack? Every child I see with constipation to a paediatrician? The NHS would buckle to its knees overnight. Please stop fuelling the negativity and support us. Believe me when I say that we all do the best we can. We are all affected when our patients get cancer; we always look back and wonder if we could have picked it up sooner.

As for recruiting 5000 new GPs? Fantastic! But where do you intend to find them? Our training posts are empty right now. People just don't want to go into general practice

and can you blame them? I work in a small rural practice. Patients are at the forefront of our priorities and we provide a fantastic service with continuity of care with your own preferred GP. I'm physically unable to be at my surgery 12 hours a day, 7 days a week. If I am at another surgery on a Saturday and Sunday then I am not going to be there on Monday morning to see those who truly need me.

Please, I beg you, let us manage our practices and our patients as we see fit. We know our patients and we know what they need. The needs of practices do vary and we can't all be shoehorned to fit one model. For those people who wake up with a sore throat or a pimple on their nose on a Saturday morning, educate them about self-limiting illness, tell people about pharmacies, and for goodness sake, let's please make people take some responsibility for their own health.

For the minority who need to see a GP over a weekend, they can ring 111 and have an appointment within hours. You may be surprised to hear that those who actually need us are happy with us, and the fantastic service that we as GPs provide. As always it's the happy ones that are the silent ones who don't speak out: until it's too late.

I publicly invite you, Mr Hunt, to come and spend time at our practice, to meet our patients, and to see for yourself what general practice is all about.

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RCGP Annual Conference

I have just returned from this year's RCGP Annual Conference where the positive effects of bringing colleagues together was evident in the 'buzz' at break times and extended discussion of topics on social media; however, this buzz was very much dominated by recent concerns over recruitment to the profession, workload, and clinician burnout. In his plenary

address, Jeremy Hunt announced that there would be a review of the workforce needs of general practice. This was met with a mixed response, as the feeling on the ground seemed to be that the time for a review was past as the issues are clear. Indeed, those concerning the workforce were evident some 10 years ago when, as a result of a local analysis of the Wessex GP workforce,¹ we estimated that 1.5–2 GPs would be needed to replace each GP retiring due to changing working patterns and a growing trend in early retirement.² What we could not have anticipated at that time was the changing political culture the NHS would come to exist within and the increasing complexity of the cases to be managed on a daily basis. Expanding the number of places in training for general practice is a step, although a potentially fruitless one if the career itself is unattractive due to the intensity and complexity of the work. Further, in addition to expansionist solutions, time might be well spent in learning what might retain senior clinicians to the profession. Thus for me, the 'take home messages' from the conference

are questions for reflection:

- How can we better understand the complexity and intensity of clinical work, the impact of this on clinicians, and the implications for the business model of general practice?
- What factors are leading established GPs to consider leaving the profession and what would retain them?

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Best practice for child safeguarding

Jenny Woodman has done well to highlight the fact that a GP's role in child safeguarding can be vast, stretching far beyond that of simply sentinel (or, indeed, case-conference-report-writer).¹

However, as 'best-practice models of GP child safeguarding' are considered and developed, I would suggest that it is imperative that health visitor input is incorporated into these, with 'best-practice models of primary care child safeguarding' perhaps being considered as an alternative.

Having participated in the child protection inter-agency discussion process for a number of years, it is clear that health visitors often know the members of a family better than their GP, with them having easy access to the home environment itself as

well as a better understanding of relationship dynamics as a result.

Despite some health visitors being recently relocated away from GP practices, safeguarding models must include them. This will have to involve general practice championing their cause and testifying to the value they bring, rather than quietly becoming resigned to the fact that they are not around as much as they used to be and subsequently re-writing models of care without their input.

I believe that children will benefit as a result.

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Authors' response

We agree with Dr Meldrum about the critical role of health visitors and his helpful suggestion of using the phrase 'best practice models of primary care safeguarding' to move forward in this area.

Qualitative research with professionals consistently highlights that health visitors are necessary for bringing wider information to GPs, for following-up GP concerns with a home visit and for acting as a conduit of information between children's social care and GPs; see for example our study of GPs, health visitors, and practice nurses in England.¹

With reduced co-location, one way of bringing together GPs and health visitors for child safeguarding is to have regular meetings to discuss families who have been identified as vulnerable or who raise child protection concerns. These meetings are recommended by the RCGP in their Child Safeguarding Toolkit.² However, there is little guidance about how they should best be implemented and there remain many unanswered questions, such as: who should attend? Should social care or education colleagues be invited? How often should meetings take place? Who should be discussed and for what purpose? Who should follow up on the meetings and how?

How can the meetings be funded and/or attendance incentivised? Do these meetings help support better child safeguarding practice in primary care, and, crucially, make things better for children and families?

These meetings are of great interest to us and our preliminary research suggests that the potential of the meetings is not yet being realised even when they take place.³ This is an area of practice that we wish to develop through good-quality evaluative research and in conjunction with primary care teams.

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Response to 'Burnt out or fired up' and 'The Tao of family medicine'

In what is perhaps an example of Jung's 'wounded healer', Alastair Dobbin in his excellent article 'Burnt out or fired up' shows the two-way nature of this relationship.¹ As Gautama Buddha recognised, being a doctor hopefully leads to a deeper understanding of

the human condition and, ultimately, leads to the healing of the physician as well as the patient.

Nigel Mathers in his James Mackenzie Lecture 2013 emphasises the importance of the intuitive side of general practice, of experiencing a sense of 'flow', to 'be' rather than 'do'.²

But I find that when I have to keep one eye on the patient (who may have four or five pressing problems), one eye on the computer (which has a long list exhorting us to focus on the minutiae irrelevant to the consultation), and possibly my intuitive 'third eye' on the clock, the sense of 'flow' is more akin to being swept along on a raging torrent, trying desperately to prevent oneself being dashed against the rocks.

And it's very hard to 'be' when one is being given increasingly bizarre things to 'do' (unplanned Admissions DES, anyone?), which leaves us no time to 'be' anything at all, with our patients, staff, or even families.

To continue the Eastern theme of these two articles I quote Swami Vivekananda who said, 'it is an insult to a starving man to teach him metaphysics'.

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Antipsychotics and osteoporosis: current awareness and practice in primary care

As part of health surveillance in mental illness, GPs are increasingly being asked to check prolactin on those taking antipsychotics. Risperidone, amisulpride, and older antipsychotics raise prolactin and this in turn is a cause of osteoporosis.^{1,2} The level of awareness and current practice of antipsychotic-induced hyperprolactinaemia in primary care is unknown.

To find answers 28 GP practices were surveyed. In the first survey (13 practices, 59 GPs) we asked, 'Are you aware of any guidelines around the management of hyperprolactinaemia?' Nineteen (32%) responded and all said no. Most would seek specialist advice and were unaware of its management. In the second survey (15 practices, 54 GPs) we asked, 'Have you been aware of any associations between hyperprolactinaemia and osteoporosis?' Fifteen (28%) responded and three (20%) were aware.

Neither the National Institute for Health and Care Excellence nor the Royal College of Psychiatrists have published guidelines. There are very few local guidelines but the Maudsley recommendations are widely recognised within secondary care.^{3,4} High prolactin is a known cause of premature osteoporosis and high prolactin is common on antipsychotics. Men are probably at risk as much as women are since prolactin is an independent factor.⁵ These health risks are clearly important but there is confusion as to who should oversee its surveillance

and management. With the ever-increasing demands on primary care there is a view that management of high prolactin from antipsychotics falls outside their remit. Local or national guidelines would at least make it less threatening. As it stands, prolactin monitoring has been done in primary care when asked but its management is seen as a secondary care responsibility. All parties should cooperate to address this gap in health care since a significant proportion of young people with mental illness will generate health and financial burdens of premature osteoporosis.

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IPCR research: any offers?

Some years ago I developed a system that I found to be a most useful consultation tool:

'Immediate Post Consultation Reflection' (IPCR). To the best of my knowledge this was my invention. At the end of each consultation spend a few seconds and ask yourself: *Have I covered all the topics raised during the consultation? Have I applied my learning points? Have any intuitive ideas emerged and evaporated from my non-dominant hemisphere during the consultation?* I found that by employing this technique, fleeting (but often important ideas) came flooding back to me while the patient was still in the consulting room. IPCR will be perceived by the patient as a natural silence, or for what it is, a period of contemplative reflection. It is not the same as 'summing up', which is a recap of the important points covered in the doctor/patient dialogue. It takes only a few seconds and is time well spent. I retired from general practice some 3 years ago. Would anyone out there be interested in evaluating the efficacy of this potentially valuable consultation tool?

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Improving telephone access to general practice reduces time to diagnose cancer

There has been much speculation about the use of telephone consultations over recent months and their effectiveness compared with face-to-face consultations.¹ There has also been public criticism of alleged delays within primary care related to the recognition and diagnosis of malignancy.²

Our practice, in north Worcestershire, has an average consultation rate of 10 per patient each year, a high proportion of elderly patients and a higher than national average disease prevalence. Three years ago we found a large proportion of our patients were choosing to wait several weeks to see a doctor of their choice rather than accessing another doctor within 48 hours. We therefore changed our appointment system to one where all patients requiring a consultation from a doctor have an initial telephone consultation as a first contact. On average three out of four patients are effectively

managed on the telephone and are satisfied with outcomes.

As expected, we experienced a reduction in our practice's A&E attendances, but in addition we decided to measure a marker of quality: the time between first patient contact with the surgery to referral into secondary care and time to a definite diagnosis of a malignancy.

Our data indicate that the average time of first contact in primary care to diagnosis was previously 53 days. This was reduced to 43 days in the first year and reduced further to 37 days in the second year, this being due a reduction in time between first contact with the surgery and a referral being made. This has fallen from 26 days to 10 days with 14 out of 17 patients within the past year being referred within the first week of their first contact. The average time from date of referral to a diagnosis being made in secondary care has remained the same.

We believe this supports the fact that GPs are skilled at recognising malignancy and how prompt access to GPs enables us to facilitate speedier diagnosis of malignancy in our communities. If the traditional systems of patients booking face-to-face appointments via reception or the internet are to be continued, this must be alongside securing adequate resources to allow GPs to provide both prompt access and quality of clinical care. If resources are not forthcoming, both the general population and healthcare providers need to be open minded about adapting to different models of healthcare delivery.

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National Review of Asthma Deaths (NRAD)

While I agree with David Jewell that GPs are generalists, I don't agree with the way he has apparently written off the recommendations, and I would urge against complacency with regard to the findings of the National Review of Asthma Deaths (NRAD).¹ He suggests the report and recommendations emanated from specialists: this was clearly not the case. To clarify, the process of the NRAD involved collaboration of a multidisciplinary steering committee with representatives from the Royal Colleges, respiratory societies (primary and secondary care), respiratory and allergy charities, as well as patient representatives.

I was the Clinical Lead, and am a practising GP (with 37 years of experience, 15 years as a single-handed doctor). The 174 confidential inquiry panel members were primary and secondary care doctors and nurses; they made 1000 recommendations based on close scrutiny and discussion of the 276 sets of medical records of people who were certified as having died from asthma. Furthermore, the final report was a collaborative effort, with input from over 20 representative groups, including the Primary Care Respiratory Society who made 13 recommendations for change within a separate chapter in the report.

I understand clearly that we are working under extremely difficult, under-resourced conditions in the current economic climate. Nonetheless, the findings and recommendations applied to care provided by primary and secondary care. Preventable factors in over two-thirds of asthma deaths have been repeatedly identified in studies for over 50 years; and it is really time to take appropriate action and change the way care is being provided.

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