RCGP NEWS

THE NEWSPAPER OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

MARCH 2010

GPs urged to have their say in landmark consultation on revalidation

The General Medical Council will launch its biggest consultation to date on revalidation on 1 March – with a plea to the UK's 50,000+ GPs to make their voices heard.

The consultation will explore a number of issues around the processes that need to be developed to support the revalidation of doctors across all medical specialties. Feedback will help the GMC to develop detailed policy around revalidation – and to work towards the practical steps needed to implement the system so that it is as fair and effective as possible.

Four main themes will be covered by the consultation:

- **How revalidation will work** This will consider some general questions about the GMC approach to revalidation, including the process by which a final recommendation will be made to the GMC by a designated 'Responsible Officer' (likely to be the medical director in a doctor's employing organisation). More specific issues, such as how revalidation will work for doctors in non-mainstream roles, including locum GPs, will also be considered.
- **What doctors and employers will be required to do** This will look at aspects of appraisal and assessment; the specialty standards developed by the Medical Royal Colleges and Faculties; the role of CPD in the context of revalidation and the principles and criteria for multi-source feedback.
- **How patients will be involved** Different ways in which patients can provide feedback to doctors on their performance and how this will be included in the revalidation process.
- **How and when revalidation will be introduced** GMC proposals for implementation across the four countries of the UK.

In order to encourage the widest feedback, the consultation has been structured to make it as manageable and user-friendly as possible – individual GPs need not respond to the whole questionnaire but can choose to give their views on specific sections.

RCGP Chairman Professor Steve Field stressed the importance of GP involvement. He said: "This consultation will provide the most insightful indication yet of doctors' views on revalidation. While it is aimed at colleagues in both primary and secondary care, it is crucial that as many GPs as possible take this opportunity to get involved and have their say.

"Revalidation is all about improving care for patients – and the professional development of GPs. It is crucial that the profession leads and takes control to ensure that the end system is as workable, robust and relevant as possible for GPs, regardless of their individual situation.

"It is no good sitting back on the sidelines and allowing things to happen. I hope that College Members and Fellows in their thousands will get behind this consultation and contribute their views to ensure that the voice of general practice is properly taken into account as the GMC develops its proposals and systems."

Professor Peter Rubin, Chair of the General Medical Council, said: "The first practical step towards the successful introduction of revalidation was completed in November 2009 when more than 200,000 doctors were given a licence to practise medicine in the UK. Now we are going to consult the profession, employers and patients on how we take this forward to create the right model.

"Each month I meet with frontline doctors who are delivering a quality service to patients every day across the UK. Revalidation will not mean they have to change the way they work but, by taking part in appraisal in the workplace, they will be providing regular assurance that they remain competent and fit to practise in the job they do everyday. We want to hear from doctors, employers and patients and I hope as many as possible to go to the General Medical Council website and contribute to the consultation and share their experience and expertise to help shape how revalidation will work."

The consultation will run until the end of May 2010, and GPs can respond via email, the consultation website or in writing.

■ *Full details will be available from 1 March on the GMC website at* www.gmc-uk.org/revalidation

Professor Steve Field: We must ensure the voice of general practice is properly taken into account

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Also seeking your views...

Influential think-tank the King's Fund is seeking the views of primary care professionals as part of its 18-month Inquiry into the Quality of General Practice in England.

It is running an opinion survey on current provision of high quality care and current approaches to quality improvement.

■ *More information is available at* www.surveymonkey.com/s/5KB3F63

The National Institute for Clinical Excellence has opened its second and final phase of topic suggestions for the 2012/13 Quality and Outcomes Framework.

An online facility allows you submit suggestions for new QOF indicators based on NICE guidance or other NHS Evidence accredited sources. Closing date for suggestions is 8 March 2010.

■ *See* www.nice.org.uk/aboutnice/qof/suggestion.jsp *and* www.nice.org.uk/media/995/C3/QOFTopicSuggestionUserGuidance.pdf *for further information.*

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2020 vision: Northern Ireland sets out 10-year plan for GPs and patients

Dr David Johnston
Chairman of RCGP Northern Ireland Council

The Royal College of General Practitioners, Northern Ireland, in partnership with the British Medical Association, has taken the first unique step forward in mapping out a 10-year strategy for general practice.

Looking ahead: Dr David Johnston, Chairman RCGP Northern Ireland Council; Dr Andrew McCormick, Permanent Secretary for the Department of Health Social Services and Public Safety; and Dr Brain Dunn, Chairman of GPC Northern Ireland

After a number of consultations with GPs, patient advocates and other medical professions, the RCGP in Northern Ireland is proud to be leading the way in setting a clear, coherent strategy, which will provide general practice with the confidence, tenacity and the vision to help build a patient centred healthcare service that is fit for purpose in the 21st century.

The document, entitled *The Future of General Practice: A 10-Year Strategy*, provides a strategic vision of how general practice can tackle future challenges within our healthcare system, whilst remaining focused on the future development of the profession. The strategy is the first attempt to highlight the issues to all concerned and offer solutions that will assist general practice, and therefore the whole health service, to thrive rather than just survive.

The main body of the strategy is centred on a 10-year action plan, which will help deliver on many key challenges facing general practice. The areas in which action must be taken include:

- Improving service and accessibility
- Resourcing general practice
- Addressing educational and training needs for general practice
- Monitoring the impact of medical regulations arrangements
- Improving leadership and management effectiveness within general practice
- Developing a framework for effective management of general practice
- Identifying and addressing competition issues
- Promoting the unique selling points of general practice
- Work with Trust and Commissioners
- Improving organisation within the infrastructure of general practice

The strategy could not be more timely. Against the backdrop of new political structures and institutions, the review of public administration, changing population demographics and resultant health needs and expectations – not to mention professional regulation and governance changes – GPs, more than ever, need a strategy which will make sense of all the issues affecting general practice.

We can empower general practice, GPs can rise to the challenges ahead and together we can build on all that has already been achieved or we can retreat, each ploughing our own little furrow, busy doing worthy things, no doubt, but never actually achieving our full potential either individually or as a service. We would be surviving but not thriving!

The document was officially launched at Stormont by Dr Andrew McCormick, Permanent Secretary for the Department of Health Social Services and Public Safety. Members and staff of the legislative Assembly, GPs and associates from the voluntary sector were very well represented at the event.

Also launched was an information leaflet for patients, *You and Your GP,* outlining the role of a GP, the services we offer and how GPs coordinate patient care. *You and Your GP* strongly conveys the message to patients that GPs deliver a very high quality service, provide great value for money and overall supply patients with an excellent experience.

Guests in attendance left Stormont with the strong message that 'if we are all to move forward and genuinely improve patient care in Northern Ireland we must recognise that general practice is not the stumbling block but the solution'.

GPs within Northern Ireland will receive a copy of both documents, and a number of information leaflets to display in their practices.

■ *For further information please contact Edward Hanna at* ehanna@rcgp.org.uk *or visit our website* www.rcgp.org.uk/councils__faculties/rcgp_northern_ireland.aspx

Primary care can make it happen, says Marmot

Angela Jones
Chair, RCGP Health Inequalities Standing Group

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

This review (entitled *Fair Society, Healthy Lives* but known to its friends as the Marmot Review) takes its place in history, following on from reports by Black in 1980 and Acheson in 1998 and was published on 14 February 2010.

As a document, the Marmot Review is long (over 200 pages), detailed and largely evidence based. It concentrates on the social determinants of health following, as it does, Professor Marmot's highly respected work on this topic for the World Health Organisation.

The commissioners have reviewed the success or otherwise of current policies and targets and have come up with the following:

Two policy goals

1. To create an enabling society that maximises individual and community potential
2. To ensure social justice, health and sustainability are at the heart of all policies

Two underpinning policy mechanisms

1. Considering equality and health equity in all policies, across the whole of government, not just the health sector
2. Effective evidence-based interventions and delivery systems

Six new policy objectives

1. Give every child the best start in life
2. Enable all children, young people and adults to maximize their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

In terms of making this happen, primary care is acknowledged as having a role in a section which ends with the following recommendations:

- **The Quality and Outcomes Framework should be revised** to ensure that general practices are incentivised to provide 100 per cent coverage of the quality of care for all patients.
- **Primary care services should develop and adopt inclusive practice** that seeks to empower patients and develop their health literacy. Inclusive practice would also emphasise the facilitation of registration of disadvantaged groups who have difficulty in accessing health care.
- **General practices should be revitalised** to take a more systematic practice-based perspective, informed by QOF and other relevant data, to promote targeted prevention services.
- **General practices should scale up responses to occupational health** in line with the national initiative.
- **Primary care is well placed to act as a focus hub within local communities** and should be encouraged and incentivised to adopt this role as a contribution to integrating services and promoting healthier communities.

Many of these recommendations seem to have been in part inspired by the response sent to the Marmot team by the RCGP, authored by the Health Inequalities Standing Group (HISG). HISG supports wholeheartedly the calls for inclusive practice and for the re-establishment of primary care as a focus for local community development and preventive activity.

The issue of ending exception reporting for QOF, which would seem to be the thrust of the recommendation to incentivizing 100 per cent QOF coverage needs to be discussed, given the well-rehearsed concerns regarding the willingness of GPs to register more 'difficult' patients in this circumstance.

The comment on enhancing GPs' understanding of and involvement in the area of encouraging work and meaningful daily activity could be seen as an accolade for the current initiative on GPs and work, and perhaps an impetus to expand this area of work for the College. There is encouragement in other parts of the review for the concepts of social enterprise and of social prescribing.

Overall, the role suggested for primary care in this report is appropriate but disappointingly low profile. In my view, given impending financial constraints, I would have liked to have seen primary care given more credit for the mitigating effects it already has with respect to existing health inequalities, and the much greater effects it is capable of achieving, if integration of primary care, welfare and social care could be achieved more successfully on the ground

Unfortunately, GPs are seen by many, if not most, civil servants and officials as unwilling to do anything without charging a fee and it can be very difficult to convince the powers that be of the immense power of GP practices to plan, create and deliver real and cost-effective change in the health of the communities within which they work.

It is up to us to change that perception during the next years when loads of new money is not very likely to be forthcoming and we will have to think of new ways of working together to make things fairer for the people whom we serve.

■ *The RCGP response to Marmot is available online on the RCGP website.*

Harrogate 2010: Call for abstracts

Suggestions for ten-minute short papers or poster presentations at this year's RCGP Annual National Conference should be submitted online by 31 March.

As well as research and scientific papers, the RCGP welcomes papers that demonstrate good practice, education and new or innovative projects in primary care.

Papers will be accepted from a broad range of professionals including GPs, AiTs, practice managers, nurses, physicians assistants, students and other allied health professionals, agencies and organisations. Overseas submissions and examples of UK GPs working abroad are also invited.

Abstracts will be peer reviewed and authors contacted in May. Accepted authors will be required to register in full to attend and present their paper or poster at the Conference. Prizes for the best research and clinical/practice posters will be awarded at the Conference.

■ www.rcgpannualconference.org.uk/2010/call_for_papers.aspx

REGISTER NOW: Take advantage of the discounted early bird delegate rates by registering for the Conference before 28 June.

■ www.rcgpannualconference.org.uk/2010/register.aspx

New RCGP Fellow to develop CPD resources

Dr Miranda Wynne-Edwards has been appointed CPD Resources Development Fellow for the RCGP Online Learning Environment (OLE).

Dr Wynne-Edwards: Development role

Dr Wynne-Edward's role will focus on the development and quality assurance of RCGP e-learning packages. This will involve leading the development of specific e-learning packages; overseeing the authors commissioned to write content; coordinating, reviewing and quality assuring the authors' material, and working with the College's e-learning technical team to develop these materials into engaging and high quality online resources.

Other responsibilities will involve scoping the needs and possible approaches for blended learning, evaluating current online educational provision and working up new proposals for next stage development.

Dr Wynne-Edwards is currently working three days a week as a salaried GP at a semi-rural practice in Buckinghamshire. She also undertakes a session as a long term locum at an inner city practice in Oxford.

She said: "I am delighted to have now joined the OLE team as the CPD Resources Development Fellow. I applied for the post as I feel online learning is integral to the future of CPD and I wanted to be part of the RCGP team developing this. Since starting I have really enjoyed working with everyone and getting involved with the projects and becoming involved in the future of general practice on a wider scale."

Dr Wynne-Edwards will work under the guidance of RCGP Medical Director for e-Learning, Dr Ben Riley, and with Essential Knowledge Updates Development Fellow, Dr Dirk Pilat, to ensure integration with the College's CPD strategy.

■ www.rcgp.org.uk/cpd

Memory loss and dementia added to e-GP portfolio

Two new e-learning sessions covering memory loss in older people and dementia are now available to all primary care professionals via e-GP, e-Learning for General Practice.

The two sessions, *Memory Problems in Older People* and *Care of People with Dementia* are the latest additions to e-GP, a comprehensive programme of e-learning modules relevant to UK general practice. Written by experienced clinicians, the e-learning uses case studies, animation and interactive exercises. Each session takes around 20 minutes to complete.

Memory Problems in Older People looks at how to assess memory problems and the differential diagnoses. The session also advises learners on how to investigate memory problems and understand the role of memory enhancing medication.

Care of People with Dementia recognises the impact of dementia on the health of the nation. The session describes the issues particular to the management of people, from driving to end of life care. The session also provides guidance on the use of major tranquilisers for patients with advanced dementia.

The release of these two new sessions coincides with the first anniversary of the National Dementia Strategy. Launched in February 2009 the first ever National Dementia Strategy set out initiatives designed to increase awareness of dementia, ensure early diagnosis and intervention, and radically improve the quality of care that people with the condition receive.

Dr Ben Riley, Project Clinical Lead for e-GP said: "The UK has an ageing population and, going forward, the care of older people will make up a higher proportion of the general practitioner's workload. Caring for older people presents certain challenges and, in general practice, we have an important role to play in helping to improve the care of older people.

"These new e-GP sessions tackle some of the key issues that primary care professionals face when dealing with dementia and memory loss. The content has been written by subject specialists so learners can be confident they are benefiting from quality assured e-learning and the easy to use sessions can be easily fitted around busy working schedules."

e-GP has been developed by the Royal College of General Practitioners in partnership with e-Learning for Healthcare and is suitable for doctors in specialty training for general practice, general practitioners and general practice nurses and practice managers.

It now offers over 200 sessions covering a broad range of topics from child and adolescent health, safeguarding children and young people, evidence-based practice, women's health, sexual health, musculoskeletal problems and learning disabilities.

■ *For further information and details on how to access the e-learning visit* www.e-GP.org

Taking positive steps on care for older people

The RCGP is endorsing a one-day conference *Interface Geriatrics* with the British Geriatrics Society on 5 March to examine optimal models of care for older people.

RCGP Vice-Chair Dr Clare Gerada and Professor Louise Robinson, RCGP Clinical Champion for Ageing & Older People's Health and Wellbeing, will be co-presenting a session on geriatric care in general practice as part of 'Perspectives from the Coal Face'. The event provides six hours of CPD accreditation.

■ *For more information on the conference visit* www.bgs.org.uk *or* www.rcgp.org.uk/bgscourse

BETHANY CLARKE

Breaking down the barriers: Phoebe Caldwell's work gains recognition in Times/Sternberg award

e-Learning contributor receives top award

A 76-year-old grandmother of nine who contributed to the RCGP e-Learning module on caring for people with learning difficulties has had her achievements recognised with a prestigious national award.

Phoebe Caldwell, who has more than 30 years' experience working with people with severe learning difficulties, won the £5,000 Times/Sternberg award for her work with people with autism, their families, schools, psychologists, therapists and the NHS.

Mrs Caldwell has been involved with the RCGP's e-Learning module *Care of People with Learning Disabilities*, contributing to Jo Corbett's session on breaking down the barriers in communication.

In an average GP list of 2,000 patients there will be 40 patients with a learning disability. The RCGP Learning Disabilities task group has released interactive e-learning sessions to help GPs better understand this complex area and improve the services offered to patients.

Mrs Caldwell uses a method called Intensive Interaction – first introduced in the UK by psychologist Geraint Ephraim in the 1980s to aid communication with non-verbal people with learning difficulties, particularly those with severe autism.

The method is based on adapting to an individual's behaviour. It is a way of working with the child (or adult's) brain using familiar signals that do not need elaborate processing to build up emotional engagement.

She said: "It's more than just copying body language; it uses their whole behavioural repertoire to build up non-verbal conversation. What you're looking at is not just what they're doing, but 'how' they're doing it in order to understand how they are feeling.

"We use empathy in our responses. As soon as the brain picks up that if they make a sound or movement they will get a significant response, they will pay attention. However, if you just copy, you'll get attention, but there is a danger of habituation. But if we add variations, the brain will pass from attention to engagement, and they will come back for more.

"What is interesting is that when you do this, they visibly relax. Eye contact and social responsiveness improve and normally, distressed behaviour decreases."

Intensive Interaction is not a cure for autism but it does allow for closer inter-personal relationships. Mrs Caldwell said the process was largely successful and described the technique as incredibly easy to pick up.

"Parents, particularly mothers, pick it up very quickly as it's based on the infant-mother paradigm. What we have to do is give people permission to do it: they feel that with adults it may be age-inappropriate, but what matters is what works for the person in question: using a method of communication that the brain understands helps to calm and interest a child or adult."

The Times/Sternberg award, in its second year, is recognition of the achievements of people aged 70 or over who have done most for society and good causes.

Mrs Caldwell said that she was very honoured to receive the award, at a ceremony at 11 Downing Street, and said that winning would generate much needed publicity for the Intensive Interaction method.

She said: "It's something that GPs can try, and encourage the families of people with autism to try."

In conjunction with Dr Zeedyk of Dundee University Psychology department, films of the technique have been analysed frame by frame.

■ *For references of empirical analyses and more information on papers, books and training films by Phoebe Caldwell or on Intensive Interaction, visit* www.phoebecaldwell.co.uk

Setting the record straight

The new RCGP e-learning course on Improving Access to Psychological Therapies is available from www.elearning.rcgp.org.uk on the College's Online Learning Environment and not from www.e-GP.org as published in the February edition of *RCGP News*.

The RCGP Online Learning Environment (www.elearning.rcgp.org.uk) hosts the Essential Knowledge Updates and CPD online courses which are provided free to College members.

The e-GP website is a separate project run by the Department of Health's e-Learning for Healthcare in partnership with the RCGP. It covers the GP training curriculum and is free to the whole NHS.

The mistake was a production error and we apologise for any confusion caused.

The RCGP Leadership Programme takes GPs from all parts of the profession who are eager to expand their expertise and develops them into future leaders. This thought-provoking programme is keen to hear from GPs who want to join the next cohort.

Generation Next – developing the GP leaders of the future

"What we do is help them find a leadership style that works for them," says Course Director Valerie Iles. "Whether they want to improve systems and relationships within the practice, challenge the way other services are offered, or influence on a wider stage. It enables them to be more effective on so many different levels.

"The course is also entirely independent of NHS management structures, so it allows GPs the opportunity to think for themselves about the best ways forward for their patients and their profession."

Starting each September, the course takes around 40 people a year. The cohort is divided into tutor groups of five or six candidates; each group is coached on seminar days by a tutor who also provides individual personal support. Each participant has a confidential relationship with their tutor from whom they can expect to receive frank and supportive feedback.

"I developed a much clearer idea of what I need to do, and an understanding that the road is rarely straight," says Dr Elizabeth Barrett, a past course participant. "Since finishing the course I have tackled some personal devils – especially the fear of ridicule."

Run over a 12 month period, the course involves attendance on four weekends (Friday/Saturday) and five seminar days of intensive classroom work with tutorial support, and online study with the chance to reflect on participants' learning built around their own time. Those undertaking the course are also expected to put in four to five hours a week of private study time.

Residential weekends introduce and close the four phases of the programme. The weekends also provide an opportunity for participants to meet and debate with nationally and internationally known figures from the world of health care and beyond, as well as to meet their tutors.

The seminar days – seen as an opportunity to reflect on experience and consolidate learning – often help to ensure everything slides into place and boost participants' confidence over the relatively short period of learning.

'SHA leaders' get to grips with the grim realities of spending cuts at the recent simulation weekend

In between these days, students are provided with a programme of reading and visits. They also have access to a process of 'supported learning' in the form of online coaching.

"This combination of learning approaches ensures they are supported over the whole 12 month period and that their learning is consolidated and integrated so that it becomes part of their everyday behaviour," says Valerie Iles.

Candidates learned first-hand about some of the stresses and successes of being a leader at a recent Health System Negotiation Simulation weekend, organised as part of the RCGP Leadership Programme.

Over a 24-hour simulation period, 32 candidates met at a hotel in Lancashire and were tasked with staying 'in-character' as they took on unique roles in a PCT, Acute Trust, Mental Health Trust, Local Authority and in the media.

By the end of the second day candidates needed to have reached an agreement on how to reduce spending by £20m over the next three years, taking into account annual increases to drug bills, and to show how they could achieve this while abiding by the NHS Operating Framework for 2010/11, various commissioning rules, and the NHS Quality Improvement, Performance and Prevention agenda.

Candidates had been informed of their role around six weeks before the simulation took place and were encouraged to contact their local real-life equivalents to get as many tips as possible in preparation – and to also act as an icebreaker for future networking opportunities.

Given that they only had a finite amount of time, work had to move at an extremely busy pace. Key first steps were agreed by each team 30 minutes into the simulation and meetings were already taking place an hour later.

"If you feel that you really don't know what's going on – you won't be the only one; it's all part of the learning process," Julia, one of the facilitators, reassured the candidates at the start.

Real-life leaders attended to observe the various meetings and provide input where necessary. These included Jane Cummings, Director of Performance, Nursing and Quality, NHS North West; Mike Deegan, CEO of Central Manchester University Hospitals NHS; Joe Rafferty, CEO Central Lancashire PCT; Alan Yates, CEO of Mersey Care NHS Trust and Paul Hodgkin, CEO of Patient Opinion.

Former programme candidate Dr Matthew Wordsworth said: "I thought long and hard about signing up to the commitment of a year-long course. I knew I needed support and education for my leadership roles but also to meet others whom I wouldn't normally meet in my role as a GP and company director.

"The support, education and mentoring I am accessing is happening more now than ever before and a lot of this is a direct result of attending the course. I can thoroughly recommend this course; it's the best education I've ever participated in."

■ *The course is incredibly popular with a rush for places each summer in time for the new cohort in the autumn. To register your interest in this coming year's course, visit* www.rcgp.org.uk/leadership
A limited number of bursaries are also available to help towards programme fees. For more information contact leadershipprogramme@rcgp.org.uk

Business as usual as PMETB merges with GMC

Professor Stuart G Macpherson
Chairman, Postgraduate Medical Education and Training Board (PMETB)

As the PMETB staff and operations move over to the General Medical Council offices in Euston Road this April, our message to colleagues and partners is that it will be business as usual for postgraduate medical education and training.

The merger has been widely welcomed as the right thing to do. It ushers in a new era for the medical profession. For the first time we will have one body, the GMC, to oversee the whole of medical education regulation in the UK.

The merger will bring a sense of security and stability following several years of significant change for training in all specialties, including general practice. Although for the most part this change has been for the greater good, it has come about through a great deal of hard work for all concerned.

Following the merger, the GMC will be the single point of responsibility for all stages of medical education and training, providing one point of contact for doctors, educators, potential employers and indeed anyone with an interest in UK medical training.

We have worked hard to 'lift and shift' the functions and operations that have been developed, progressed and improved at PMETB to ensure service standards are maintained. As such, contact details aside, there will be no discernible difference to certification when this moves to the GMC.

From the application processes, to the assessment of applicants for CCT/CESR/CEGPR certificates and the arrangements with Royal Colleges for processing applications, it will be business as usual. Application fees will remain frozen at the rates set in 2009 until 2010/11.

Quality assurance of specialty training (including GP) will also continue as planned. The National Training Surveys, now in their fourth year, will be delivered concurrently for the first time. This at once maximises the surveys' synergies and helps reduce the workload of deanery colleagues who work so hard to help us deliver these. The views we hear from trainers and trainees through the surveys are a crucial part of the Quality Framework and the quality assurance of training. The surveys remain unaffected by the merger and are on track to pass smoothly over to the GMC in time for the launch of this year's surveys at the beginning of April.

We have made it our priority not to lose sight of the benefits PMETB has brought to postgraduate training and to ensure that the GMC can build on the progress PMETB has made. The Quality Framework, launched in 2007, has brought about the promise of much greater consistency for quality assurance of postgraduate medical education and training. Its surveys, visits and reports are designed to ensure training meets the rigorous standards that have been set for the good of all involved with training and trainees.

The introduction of standards for training and published curricula for all specialties and sub-specialties has been a substantial undertaking for all concerned. College colleagues have worked alongside PMETB to ensure the structures this work has created will remain not simply as a legacy of PMETB but as a solid foundation for specialty, including GP, training for many years to come.

The launch of equivalence routes to certification has engendered entry onto the Specialist and GP Registers for over 4,000 doctors, who without accredited training, formerly had no such opportunity. Thanks to the robust systems, processes and principles introduced by PMETB, these doctors, with their years of experience over formal training, now have a measure for this and a rightful place as a fully qualified specialist or GP.

The Future Doctors' Review opened up new channels of dialogue with patients, trainees, the service and colleagues within regulation about the real issues that matter to specialty training. Through an expansive series of workshops, seminars and consultation work over the past three years, the review has helped build a picture of what we need to do to make training fit for purpose and deliver against the expectations we have in the next five, ten or, indeed,15 years. The resulting Future Doctors' Policy Statement has fed into Lord Patel's Review of the Future Regulation of Medical Education and, more importantly, provides a framework for the GMC to work from, following the merger.

The GMC's priority will be to build on the successes and gains made. Along with John Jenkins and John Smith, I will join the GMC's Postgraduate Board, bringing with us our experience and knowledge of postgraduate medical education and training. The outcomes of Lord Patel's review, currently available for consultation, will help ensure the benefits of the merger are fully realised.

However our work is not yet done. We need continued support in cascading our merger messages on to ensure we reach all who need to know.

In summary, the key merger messages are:

- From 1 April 2010, all regulation of medical education will be dealt with by the GMC
- All certification matters should be directed via the GMC's Registration team
- Contact your PMETB contact to discuss specific specialty or GP training issues
- Beyond the change of name, expect business as usual for specialty and GP training matters
- For the latest news on the merger, go to www.pmetb.org.uk and www.gmc.org.uk

Few can dispute the wisdom of a single regulator which will bring with it a seamless approach to doctors' careers and, moreover, a sense of consistency of expectations and standards throughout the profession.

PMETB has done much to change the face of postgraduate medical education and training. With processes and standards for training now firmly in place and with the continued support of our stakeholders, PMETB's operations are on track to make a seamless transition to the GMC.

The merger in brief:

- In April 2010, the Postgraduate Medical Education and Training Board (PMETB) will merge with the General Medical Council (GMC). The GMC will acquire all legal functions formerly performed by PMETB.
- Appeals against certification currently being processed will not be affected. Please redirect appeals to the GMC after 1 April 2010. There will be changes to the process after this date. Anyone considering this course of action should check the GMC website, www.gmc-uk.org
- *Visit* www.gmc.org.uk *for up-to-date information about the merger.*
- *Surveys information is available at:* www.pmetbtrainingsurveys.org

A one-stop approach to gynaecology services

An innovative approach to gynaecological services is improving the lives of patients in South London.

The Croydon Intermediate Gynaecology Clinic has been running for two years and is the brainchild of RCGP Fellow Dr Kalpesh Shah and the late Dr John Ogeah. It aims to see all patients within two weeks of referral from their GP in line with government guidelines.

The idea for a one-stop service came about when a PCT survey revealed that patients were frustrated with the state of their gynaecological services. Communication problems between primary and secondary care, and waiting times of between eight to ten weeks for specialist consultations were among patients' complaints.

Following a successful pilot in December 2007, and £25,000 of PCT funding to buy an ultrasound scanner, the service now operates on two sites – the Norbury Medical Centre, and the Shirley Clinic in central Croydon.

Dr Shah said the popularity of the service stems from the comprehensive one-stop patient experience: "In terms of communication, diagnostics and delivery of a treatment plan, it's really a one-stop clinic which is of direct benefit to the patient: they are seen within two weeks, they have an opinion from a consultant and a management plan in their hand. They know what to expect next before they leave the clinic."

The treatment plan is faxed to the patient's GP before they leave the clinic, and this immediate communication between service providers is one of the many ways in which the clinic reduces waiting times.

Dr Shah said: "As a practising GP one of the biggest frustrations is encountering a patient who has received secondary care with no communication. Because of the difficulties patients often experience in accessing secondary care, patients come to their GPs confused about their future treatment plan.

"We see so many problems in terms of communication between primary and secondary care – currently there is a gap where patients have been through the secondary care system but letters don't arrive and the GPs do not receive the patients' treatment plans. So much time is wasted chasing up patient information. What we have created addresses this issue, and benefits the patients and the clinicians alike."

The clinic runs on Wednesdays until 7pm and on Saturday afternoons to minimise disruption to the lives of the women who use it. Dr Shah said: "Many of our patients work, or have families, so they find it difficult to come in during normal surgery hours."

The quality of care patients visiting the clinic receive is due to the combined efforts of all medical and administrative staff. He added that the fact patients are able to see a senior, specialist consultant so soon after referral is beneficial not only in terms of diagnostics and treatment planning, but also in reassuring patients at what can be an anxious time.

Dr Shah: The scheme offers peace of mind to the patient and the clinician

He said: "Abnormal bleeding disorders can cause a great deal of anxiety for both the patient and the clinician; if the patient is displaying symptoms and the clinician is not sure of the cause, having to wait for eight to ten weeks to determine whether something is seriously wrong can be a terribly worrying time.

"So to be seen within two weeks, and to have diagnostics and a treatment plan in hand, we can offer both the patient and the clinician peace of mind."

With plans for further expansion this year to offer a similar satellite service to South Croydon, Dr Shah believes that the success and growing popularity of the scheme mark it out as a model for replication around the UK.

"There has been a lot of interest nationally in replicating the clinic, and we've had fantastic feedback from our visitors. The model is right – we just need people to replicate the scheme so that a similar service can be provided to patients up and down the country."

■ *For more information please visit* www.norburymedicalpractice.co.uk

Confronting the not-so-silent killer: Professor Mike Richards and Professor Steve Field

Joining forces to take action on ovarian cancer

March is Ovarian Cancer Awareness Month and the RCGP is supporting the charity Ovarian Cancer Action in its work to help GPs and patients with the *Remember the Symptoms* campaign.

Each GP may only see one confirmed case of ovarian cancer in every five years of practice but the disease is diagnosed in 6,800 women in England every year.

RCGP Chairman Professor Steve Field co-chaired a Department of Health summit with Professor Mike Richards, National Clinical Director for Cancer, to look at ways of improving early diagnosis of ovarian cancer – erroneously described as the 'silent killer'.

The meeting brought together various groups committed to increasing the knowledge base of the cancer and raising awareness of symptoms at an earlier stage. Participants included Ovarian Cancer Action, Ovacome, Target Ovarian Cancer, Cancer Research UK, BMJ Learning and Macmillan Cancer Support.

BMJ Learning will shortly release a free online learning module for all GPs, practice nurses and physician assistants. The learning tool has been developed with the input of Dr Willie Hamilton, GP and Consultant Senior Lecturer at the University of Bristol. Dr Hamilton's work has been instrumental in highlighting the key symptoms to look out for and when to consider ovarian cancer as a diagnosis.

Professor Field said: "Early diagnosis is key and GPs need to familiarise themselves with the possible symptoms. Although ovarian cancer is a less common cancer, it is not a silent cancer and early diagnosis may save more lives."

Evidence of the following three symptoms, if they occur on most days, can suggest ovarian cancer:

- Persistent pelvic and abdominal pain
- Increased abdominal size/persistent bloating (not bloating that comes and goes)
- Difficulty eating and feeling full quickly

Ovarian Cancer Action has also produced a web-based 'symptom diary' which can be downloaded for women to record their own observations

■ *More information on Ovarian Cancer Awareness Month can be found at* www.ovarian.org.uk. *The symptom diary for patients is available from* www.ovarian.org.uk/pdf/diaryGP.pdf

■ *Key messages for health professionals can be downloaded from the Department of Health website at* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110534

Launch of online support for coping with traumatic death

Patient experience website Healthtalkonline has launched a new section to support people coping with bereavement due to traumatic death.

Healthtalkonline was created by RCGP Fellow Dr Ann McPherson and colleagues from the DIPEx Health Experiences Research Group at the University of Oxford.

The latest section of the award-winning website is based on in-depth interviews with 40 people bereaved by traumatic death such as car crash, murder, manslaughter, fire bombing or pedestrian incident.

As well as helping those who have been bereaved, the resource will also be used to teach police liaison officers, coroners' officers, counsellors and other professionals to deal with such situations.

Richard Taylor – father of Damilola Taylor – has added his endorsement and said he hoped that the experiences of such a wide variety of people would provide comfort and support to others.

"We all have different ways of remembering the one we lost – such as through memorials, writings or music. Many of us do voluntary work to try to prevent other senseless violence.

"Those who have lost family members through car or rail crashes often campaign to make the roads and railways safer places. We set up a charity in memory of Damilola to support Government youth projects against knife crime."

The website www.healthtalkonline.org and its sister site www.youthhealthtalk.org contain people's experiences of almost 50 different illnesses and health conditions. The websites are based on in-depth qualitative research and are aimed at patients, their carers, family and friends, doctors, nurses and other health professionals.

Illnesses covered include cancer, heart disease, neurological conditions (Parkinson's, epilepsy and autism) chronic health issues (HIV, diabetes, rheumatoid arthritis) and mental health. Young people's experiences include epilepsy, sexual health and teenage cancer. A new section on leukaemia will be launched later this month.

The project is funded by the Department of Health and the latest section can be found at www.healthtalkonline.org/Dying_and_bereavement/bereavement_due_to_traumatic_death

Support network: Dr Ann McPherson, Medical Director, DIPEx Health Experiences (centre) at the launch with (l-r) Keith Hawton FRCPsych, Professor of Psychiatry, University of Oxford and Consultant Psychiatrist with Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust; Detective Chief Superintendent Ian Kennedy, West Yorkshire Police; Sian Rees, Senior Policy Advisor, Department of Health; and Alison Chapple, Senior Research Fellow, Department of Primary Health Care, University of Oxford

The College has teamed up with *GP* newspaper to publish a series of five factsheets to support the diagnosis and management of headache in primary care.

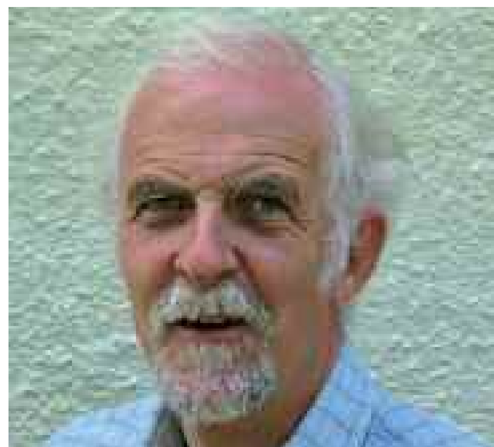
New RCGP factsheets to improve headache care in general practice

Headache has been nominated as a clinical priority area by the RCGP and the five factsheets are just one of a number of initiatives being developed to improve the management of this condition.

Twenty per cent of both adults and children suffer from headache that impacts upon their quality of life. Migraine alone is in the top 20 of the World Health Organisation causes of disability with major impact at home and in the workplace both during and in between attacks. Despite this high level of impact, the needs of the majority of sufferers go unmet – fewer than half of migraine sufferers have ever seen their GP and the majority self medicate.

Cluster headache is arguably one of the most painful conditions known to medicine but it takes many years before a diagnosis is made and then treatment is invariably suboptimal. One study found that over 70 per cent of headache presentations in primary care did not achieve a diagnostic threshold even when followed up for over a year.

The new factsheets cover classification of headache; history, examination and investigation of the headache; migraine; cluster headache; and headache in children and the elderly. Each factsheet is presented in a concise format that can be downloaded and printed off for reference. The series is supported by an in-depth video discussion between the RCGP Clinical Champion for Headache Dr David Kernick and Professor Peter Goadsby, a leading headache specialist, available from the *GP* website: www.healthcarerepublic.com/go/rcgp



Dr Kernick: Provides video discussion support

FACT FILE 1: CLASSIFICATION OF HEADACHE

Headache was first formally classified in 1986 and revised 2004. The brain has no sensory fibres. Intracranial pain arises from invasion, stretching, pressure on or inflammation of meninges. The two main classifications of headache are primary and secondary.

PRIMARY HEADACHE

No underlying cause demonstratable: 90 per cent of GP presentations.

Migraine: 85 per cent of GP presentations. *(See Fact Sheet 3.)*

- Severe episodic pain with or without aura associated with nausea, photophobia and phonophobia.
- Five per cent chronic migraine, >15 days each month. Usually history of episodic migraine.

Tension type headache: Ten per cent of GP presentations but high population prevalence. Poorly understood. If occurs in migraine sufferer probably part of migraine spectrum.

- Dull, pressing pain usually bilateral with no nausea, photophobia or phonophobia.
- Episodic or chronic. Reassurance and amitriptyline first line approaches.

Cluster headache and other autonomic cephalalgias: Less than one per cent of GP presentations

- Very severe unilateral pain with autonomic features rarely with nausea, photophobia or phonophobia. *(See Fact Sheet 4.)*

SECONDARY HEADACHE

Underlying cause demonstratable: Five per cent of GP presentations. Some important headaches listed below. See www.i-h-s.org for full list.

Headache attributed to vascular disorder

- Subarachanoid haemorrhage. 85 per cent due to aneurysmal bleed. Characterised by thunderclap headache. (Worst headache ever rising to a maximum within a minute.) Ten per cent of thunderclap headaches are due to SAH. Medical emergency with high mortality. Sentinel headaches may be recognised in retrospect.
- Temporal arteritis. Occurs over the age of 50. Forty per cent will have polymyalgia rheumatica. Can be systemically unwell. May have jaw claudication. Raised ESR or CRP in 97 per cent of cases. Temporal artery biopsy may be necessary to confirm diagnosis. Treat with steroids 1mg per kilogram, maximum of 60mg a day and reduce to a maintenance dose.
- Carotid/vertebral artery dissection. Can radiate anywhere in face and neck. Can have an associated Horner's syndrome. Can occur after trauma, eg RTA. Collagen disease is a risk factor.
- Stroke. Non-specific headache can be associated with stroke.
- Cerebral venous thrombosis. Can mimic any headache. Watch cancer, prothrombotic states, pregnancy, infection of facial structures. Can be fatal.
- Hypertension. Apart from malignant hypertension, the contribution of hypertension to headache is over-rated and in practice negligible.

Headache attributed to space occupying lesions

- Tumour. Primary tumour: 70 per cent glioma – prognosis poor; 30 per cent meningioma – 80 per cent five-year survival. Secondary tumour particularly breast, lung, prostate. Although headache is common during course of illness, only ten per cent of tumours present with isolated headache. Pain usually featureless.
- Non-malignant space occupying lesions, eg AV malformations, cysts.

Disorders of intracranial pressure

- Idiopathic intracranial hypertension. Commoner in young obese women. Headache and papilloedema often with pulsatile tinnitus. Can lead to permanent loss of vision. Refer.
- Intracranial hypotension. Occurs due to CSF volume depletion as a result of leakage. Headache is worse on standing and alleviated by lying down. Classically post lumbar puncture but spontaneous leaks can occur. Refer.

Headache attributed to head trauma

- Can come on up to seven days after trauma. Intensity of pain may not be related to degree of trauma. Most resolve < six months but 25 per cent can go on for longer. Watch for development of depression.
- Headache can be part of a post-concussive syndrome associated with other non-specific symptoms.
- Treatment difficult but amitriptyline drug of choice. Watch medication overuse headache.
- Underlying aetiology unknown but watch for secondary causes – haematoma, low CSF pressure due to dural tear, carotid or vertebral artery dissection.

Headache referred from other structures

- Cervico-genic pain most common. Probably over-rated as cause of headache. Neck pain often part of migraine process.
- Eyes (refractive errors, glaucoma), tempero-mandibula joint, teeth, sinus (85 per cent of diagnosed chronic sinusitis is migraine) are all possible but overestimated as causes of headache.

Headache associated with activity

- Sexual activity. Pre orgasmic – dull, gradually increases with sexual activity. Orgasmic – sudden severe at orgasm. Needs investigation. Treatment of both pre-emptive (indomethacin) or preventative (betablocker).
- Exercise induced headache. May be a co-existing primary headache induced by exertion, eg migraine but cause of most exercise headache unknown. Need to exclude an underlying pathology. Treatment as for sex headache.

Headache attributed to infection

- Meningitis, encephalitis, systemic infection, HIV, brain abscess, TB.

Headache attributed to metabolic causes, disorders of homeostasis or drugs

- Obstructive sleep apnoea. May be due to CO_2 retention or poor sleep exacerbating primary headache. Reversible with treatment of problem.
- Carbon monoxide. Still fatalities each year.
- Alcohol, drugs including prescribed drugs.
- Renal failure, thyroid disease, raised calcium.
- Medication overuse headache. Up to three per cent of population. Occurs with regular analgesia or triptan use. (More than three days a week). All analgesics and NSAIs implicated, particularly codeine compounds. Non-specific, dull pain but usually starts from an underlying primary headache. (Enquire for previous headache history). Abrupt cessation of analgesics rather than gradual withdrawal after starting relevant preventative medication. Steroids useful to cover withdrawal symptoms. High relapse rates.

Cranial neuralgias

- Trigeminal neuralgia most common. Burning or stabbing pain lasting less than two minutes. Often provoked by mild pressure or other triggers. Vascular compression of nerve most common cause.
- Glossopharyngial nerve less common involving tongue, throat, jaw ear.
- Treatment with carbamazepine or lamotrigine.
- Trigeminal neuralgia may be confused with idiopathic stabbing headache particularly with co-existing migraine. Seconds, 'jabs and jolts' anywhere in head.

Nomination of Members to serve on College Council for 2010 – 2013

Six new nationally-elected members are needed to serve on RCGP College Council for the three-year term 2010-2013. Any Fellow or Member of the College may propose another for election to one of the six vacancies.

Nomination forms and further details may be obtained on application to the Returning Officer, 14 Princes Gate, London SW7 1PU or by email to: jcheong@rcgp.org.uk. Tel: 020 7344 3157
Please note all nomination forms must be returned no later than noon **31 March 2010**.

Ballot of members

In the event there are more nominations than places to be filled, a ballot will be held. Voting papers* for the ballot will be sent to all Fellows and Members during April 2010. A single transferable vote system will be used for the election. The result of the ballot and names of the six successful candidates will be declared at the June 2010 Council meeting and subsequently published in the *British Journal of General Practice*.

(* The ballot of Members & Fellows may be conducted electronically.)

At-a-glance guide to general practice

The third edition of the Oxford *Handbook of General Practice* is now available from the RCGP Bookshop.

A lifeline for busy GPs since the first edition was published in 2002, the *Handbook* covers the entire spectrum of general practice, gives hands-on advice from experienced practitioners and provides rapid access to information to help with day-to-day problems.

The latest edition has been revised to include:

- New sections on the GP contract, foundation level doctors and training in general practice
- New guidelines and current best practice
- New chapters on pregnancy and contraception/sexual health.
- Quick reference management boxes for the treatment of paediatric and elderly patients.
- A colour plate section of dermatology and ophthalmology images.

The Handbook of General Practice *can be purchased online from* www.rcgp.org.uk/bookshop *or by phone on 020 7344 3198. RCGP Members receive an automatic 15 per cent discount and pay £28.04 per copy.*

GPs called to battle against blindness

The UK Vision Strategy is the UK response to Vision 2020, a global initiative that aims to eliminate all avoidable blindness by the year 2020, and GPs can play a significant role in achieving this.

The aim of the UK Vision Strategic Advisory Group is to bring together different members from the healthcare sector, the charity sector and patient groups in order to put together a plan to address Vision 2020 objectives. The three core objectives are to prevent avoidable blindness; to improve the quality of services available to vision-impaired people; and to improve the training available to those professionals providing advice and services.

The RCGP speciality training curriculum for general practice includes a module on the care of patients with eye problems. All GP trainees should have covered the objectives in this module by the end of their training programme.

The UK Vision Strategy is aimed at all primary care professionals. Dr Andrew Partner, the RCGP's representative on the Strategic Advisory Group, said that GPs can play a vital role in achieving these objectives, but often do not feel armed with adequate eye care training to offer detailed advice to their patients.

Increasing GP training from three to five years, Dr Partner said, would make it easier for deaneries to offer more intensive eye care training to those who wish to learn, but he also stressed that in the shorter term, improvements could be made to the 'notoriously poor' eye education at medical school.

He said: "I only had about two weeks on eye care at medical school, and even then it was every other day. The sessions are very few and, as a result, most GPs don't really remember any decent eye training at medical school. And when that's all they've had in total, the result is that their skills are very, very poor.

"I would like to see GP eye skills really improve because I think we can do a lot better."

Dr Partner said that it is important that GPs are aware of the 'at risk groups' – the groups of people most likely to become blind – so that they can advise them appropriately. He said that communication between GPs and opticians would be particularly useful for one such group – patients over 40 with a family history of glaucoma – as if a GP is aware that there is a family history, he or she is better armed to look out for eye problems.

He added: "Certain ethnic groups too, including those patients of Afro-Caribbean and Asian origin, are less likely to go for an eye test. GPs working in those communities should be especially keen in encouraging their parents to go for an eye test."

It is among the last group, people over 60, Dr Partner said, where blinding eye conditions find real prevalence, and stressed that all patients over 60 should have an eye test every two years.

Patients are entitled to a free sight test, paid for by the NHS, if they:

- Are under 16 years of age
- Are 16, 17, or 18, and in full-time education
- Are 60 or over
- Have been diagnosed with diabetes or glaucoma
- Are 40 or over, and their mother, father, brother, sister, son or daughter has been diagnosed with glaucoma
- Have been advised they are at risk of glaucoma by an ophthalmologist
- Are registered as blind or partially sighted
- Are prescribed complex lenses (with a power of 10 dioptres or more, or prism controlled bifocal lenses)
- Have sight tests that are usually done through a hospital eye department, as part of their care for an existing eye condition, or
- Are a war pensioner and need the sight test because of a disability for which they get a war pension

Patients are entitled to full help with health costs, including sight tests, if they or their partner receive:

- Income Support
- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance, or
- Pension Credit Guarantee Credit

The surgery, too, was somewhere that the needs of blind and visually-impaired patients needed consideration, Dr Partner said. "We should be trying to improve communication, and ensuring the voice of the visually impaired is heard when planning services. I'd like to see surgeries in general practice set up our so that visually impaired people can find their way around. The ideal situation would be that signs and patient information are in Braille.

"Certainly in the first instance we should be giving information to sight impaired patients in big print. Most sight impaired people can't read Times New Roman in 12 point but they might be able to read it in 18 point. Patients will know what they can read, so it's actually about GPs getting into the habit of finding this out."

Achieving the UK Vision Strategy objectives is not the sole responsibility of GPs, and Dr Partner said that simply by improving communications between general practice and organisations in

Dr Partner: It is important that GPs are aware of 'at risk' groups

the visual impairment sector could lead to enormous improvements in the provision of eye care to patients.

He said: "I would like opticians to always send a notification to the patient's GP when they have had an eye test. If GPs have a record, then in the future we'll be able to establish diary entries that remind us when a patient should have had an eye test, and remind the patient if they've forgotten."

One of the most important factors of improving eye care in the UK, he said, was making patients aware of their entitlements to eye care.

"There are a huge number of people who are entitled to free eye care. I saw a patient who was 76 who has not had an eye test for ten years and he had no idea he could have free eye tests. Everyone over 60 gets free eye tests. There is a whole list of free eye test entitlements *(see panel)*, which many patients and GPs are completely unaware of.

"As GPs we are the patient advocates and we should be trying to improve communication. The fact that 99 per cent of the population is registered with a GP means we can be there to pick up these avoidable causes of sight loss early on, but also have, at the forefront of our mind, the knowledge of how important eye tests are to the at risk groups."

How mindfulness can help patients

Andrew McCulloch
Chief Executive, Mental Health Foundation

Since 2004, NICE guidelines have recommended Mindfulness Based Cognitive Therapy (MBCT) as an effective treatment to offer people with recurrent depression, but few GPs and patients are aware of its existence, and mindfulness therapy is not generally commissioned within the NHS. A new report by the Mental Health Foundation reveals that only one in five GPs say they can access the treatment for their patients and only one in 20 refer people to MBCT.

What is MBCT and how does it work?

MBCT is based on meditation techniques and offers a set of simple and effective self-management strategies that patients can use to help protect themselves against further episodes of depression, as well as to improve their mental health more generally.

MBCT teachers work to help people develop their ability to identify their thoughts and recognise the impact that they can have on their feelings and emotions. By accepting the impact, a person may be more likely to be able to let the difficult thoughts or feelings pass, thereby enabling them to get on and enjoy the present moment.

An MBCT course is normally taught over an eight-week period in a group setting. Once the course is completed, a person is encouraged to adopt the principles into everyday life for long-term benefit. Studies have shown that when people practice mindfulness, visits to the GP reduce and feelings of general health and well-being increase [1].

MBCT has been shown to cut relapse rates in half for those who experience more than two episodes of depression [2]. Recurrent depression is extremely common, with 50 per cent of sufferers having more than one episode. After the second and third episode, the risk of relapse rises even higher to 70 per cent and then 90 per cent .

Several clinical trials have demonstrated the effectiveness of MBCT. In a study of 145 patients with recurrent depression who were in remission, only 37 per cent of patients who took part in an MBCT course relapsed over the following year, compared with 66 per cent in a control group [3]. A recent trial found that MBCT was more effective in preventing relapse than maintenance antidepressant treatment alone, and better at improving quality of life [4].

Mindfulness meditation has been shown to affect the workings of the brain and even its structure. Compared with non-meditators, it has been shown that people who practice Mindfulness meditation for 40 minutes a day have greater cortical thickening in areas of the right pre-frontal cortex and right anterior insula. These areas have been associated with decision-making, attention and awareness [5]. People undertaking mindfulness training have shown increased activity in the area of the brain associated with positive emotion – the pre-frontal cortex – which is generally less active in people who are depressed [6].

Are there other mindfulness-based therapies?

As a GP, you may have heard about other mindfulness-based approaches such as Mindfulness Based Stress Reduction (MBSR). The Mental Health Foundation's *Be Mindful* report discusses the potential of such approaches for the treatment and management of many other mental health problems, including eating disorders, anxiety problems and psychosis. Mindfulness has also been shown to be effective in managing symptoms of physical health problems such as cancer and HIV, but more research is needed to develop this promise into clinical interventions.

McCulloch: Clinical trials show the effectiveness of MBCT

How can patients access a mindfulness course?

There are a number of privately-run courses across the UK and a growing number available within some PCTs, though availability on the NHS is currently limited. Greater availability could offer significant economic, social and health benefits to society. The expansion of MBCT services could be usefully led through the existing Improving Access to Psychological Therapies (IAPT) programme, whose stated principal aim is 'to support Primary Care Trusts in implementing NICE guidelines for people suffering from depression and anxiety disorders' [7].

You can also refer patients to www.bemindful.co.uk where they can search for privately-run courses or clinical trials taking place in their area. The website also suggests books written by psychologists and mindfulness experts that provide a helpful introduction to mindfulness, as well as some simple techniques.

How can I raise awareness of mindfulness in my practice?

The Mental Health Foundation has developed a surgery toolkit that includes promotional items to be put on display. The toolkit directs people to www.bemindful.co.uk where they can find information, local courses and hear from people who have benefited from mindfulness-based therapy. Visit www.bemindful.co.uk to purchase the toolkit.

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Pride of Scotland: Deputy First Minister of Scotland and Cabinet Secretary for Health and Wellbeing Nicola Sturgeon and GP turned MSP Dr Richard Simpson join Dr Dean Marshall (far left) and Dr Ken Lawton, Chair of RCGP Scotland (right) to celebrate National General Practice Week

Celebrating the best of general practice in Scotland

RCGP Scotland joined forces with the BMA's Scottish General Practitioners Committee (SGPC) to mark National General Practice Week in Scotland.

A series of events were organised to raise awareness of the range of services provided to patients by GPs and their teams and encourage politicians to value NHS General Practice. The Scottish Parliament building provided the backdrop for a debate, exhibition and reception, and *The Scotsman* newspaper ran a special supplement featuring good news stories on general practice. The week also saw the launch of the document *General Practice in Scotland: The Way Ahead* on which RCGP Scotland worked closely with the SGPC.

Head for Harlow

RCGP Essex Faculty holds its third annual conference in Harlow on 11 March 2010.

Chaired by Dr Sati Ariyanayagam, speakers include RCGP President Dr Iona Heath and Professor Mike Pringle on revalidation for GPs.

Workshops will look at issues ranging from Practice Based Commissioning to Safeguarding of Vulnerable Adults. Cost is £50 and participants will be issued with a CPD certificate.

- *For further information and to book, contact Gerald Walsh on 020 7173 6076 or e-mail* essex@rcgp.org.uk

Eric Gambrill Fund

Applications are invited for two Eric Gambrill Travelling Fellowships, worth £3,000 each.

The Awards are open to fully trained and practising UK GPs. The successful applicants will be expected to undertake a study or project as part of their professional career development. Closing date is 31 March 2010.

- *Application forms and further information from*: www.ericgambrillmemorialfund.ac.uk *e-mail* vanessambmason@aol.com *or call* 01428 609570.

RCGP Audit Committee Vacancy for College Member

We are seeking a College Member to fill a vacancy on the RCGP Audit Committee, a sub-committee of the College's Trustee Board.

The role of the Audit Committee is to ensure there is an appropriate framework of scrutiny, accountability, review and control of all matters financial and otherwise, including risk analysis and management, and to ensure the College is complying with all aspects of the law, relevant accounting and other regulations, and best practice. The Committee also ensures that all the College's activities are undertaken with probity, integrity and in the best interests of the College and its membership, and to offer expert advice to the Trustee Board, Council and its members.

This post may be of particular interest to faculty treasurers, but all members are welcome to apply. The appointment will be for a period of two years in the first instance, to coincide with that of the Trustee Board, which is running as a two-year pilot. (Normally the appointment would be for a three-year term, renewable for a further period of three years.)

If you are interested in being considered for this role or require further information, please contact jcheong@rcgp.org.uk

The deadline for responses is noon, Friday 19 March.

Applicants should provide a statement of not more than 250 words setting out their interest, experience, and the skills they can bring to the work of the Audit Committee, together with a current brief CV.

Interviews for this post will take place on 1 April 2010.

Professor Kieran Sweeney MA MPhil MD FRCGP

KIERAN SWEENEY came from a medical family in the West of Scotland and he and one of his brothers, Brendan, followed their father as general practitioners. He gained arts and medical degrees from the University of Glasgow and then went to Exeter for his vocational training. He spoke French so well that he satisfied the French authorities and extended his training as a doctor for a year in France – earning usefully by playing the piano in the evenings. In Exeter, he made several lifelong friends and met his wife Barbara with whom he had four children. Kieran was very much a family man and enjoyed many family holidays in Cornwall.

He was the first British GP to be awarded a Harkness Travelling Fellowship and spent several months with his family in the USA. This experience fired him up. He achieved a master's degree by research from the University of Exeter as a full-time GP and became a part-time Lecturer in General Practice there.

As a full-time GP at the St Leonard's Practice in Exeter he started to write. His first-authored article on the use of warfarin[1] noted three per cent recruitment and cast doubt on the validity of what had previously been seen as a 'landmark' trial[2]. This led to more trials in general practice. He co-authored two editorials in the *BMJ* and wrote challenging articles there. He thought his essay in *The Lancet* in 1998 on 'Personal Significance' [3] was his most important contribution and it marked his central interest in personal doctoring and the role of medical generalists.

An RCGP Occasional Paper on the Human Side of Medicine[4] linked him to Martyn Evans, which led to a rich partnership. He was author or co-author of four books, of which *The Human Effect in Medicine*[5] is the best known. This sets out much evidence for the importance of human interaction in medicine.

In 2000 he was appointed to the Commission for Health Improvement in London. He gained much experience there but left when this body metamorphosed into another. He later returned to general practice in Exeter to make a success of an experimental practice with a clinical nurse.

With Adrian Freeman he described why GPs do not follow evidence in a *BMJ* article[6] which attracted 246 citations. As his reputation grew, he delivered the McConaghey Memorial Lecture in the UK and a major lecture for the New Zealand College of Family Physicians[7].

He wrote his MD thesis in his fifties and became an Honorary Senior Lecturer in the Peninsula College of Medicine and Dentistry. He enjoyed teaching a special study module on the humanities and held senior appointments with the local PCT and NHS network.

Kieran Sweeney brought great breadth to his thinking and writing, and emerged as a leading exponent of the role of the medical generalist. He became increasingly critical of reductionist thinking in medicine and to counter this he developed the idea of complexity as an alternative model. He wrote articles and two books on this[8/9].

His profound thoughts and extensive experience made him a valued clinical opinion for colleagues, especially in a local long-running Balint Group. His appointment as director of the RCGP leadership course was inspired and many on that course have much to thank him for.

The increasing academic output and the quality of his scholarship led to his promotion to professor in 2008, only the second general-practice professor in Devon and Cornwall – a remarkable achievement for one who never followed a traditional career in university departments. Sadly, at much the same time, he received the devastating news that he had mesothelioma, knowing it was a death sentence.

In 2009, he and his wife went on holiday to Italy and also revisited their favourite places in Paris. Even as he weakened, he wrote. First a piece[10] with his medical student son and also, with two colleagues, a moving final article in the *BMJ*[11], describing his experience as a patient, seeking to improve what is now called the 'patient experience'.

His friends and colleagues visited him frequently, poignantly seeking to give some comfort as his precious time ran out. As one of his partners for 14 years, and a friend and colleague for 30, I owe him much for sustained support. He will be hugely missed.

He died, aged 58, at home on Christmas Eve 2009, with his wife Barbara and four children at his side.

Denis Pereira Gray

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