RCGP NEWS

THE NEWSPAPER OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

JULY 2010

Revalidation still moving forward, says RCGP Chair

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

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

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

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

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

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

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

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

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

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

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

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

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

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

■ *Version Four of the* RCGP Guide to Revalidation *and Professor Pringle's webcast can be found at* www.rcgp.org.u k/revalidation

Also in this issue...

Change of plan for interim College

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

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

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

Dr Horder's historic edition

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

Dr John Horder CBE MA FRCP FRCGP joined the College as a Foundation Associate and went on to be a leader and pioneer in education. He was RCGP President from 1979-1982. Dr Horder was in general practice in London's Kentish Town between 1951 and 1982 and lives in Primrose Hill with his wife Elizabeth June, who was also his partner in general practice.

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

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

The print can be purchased by members and supporters of the College Copies are priced £90 plus £2.99 P&P and can be ordered from the RCGP online bookstore: www.rcgp.org.uk/bookshop

Changing with the times: The first three years of the MRCGP

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

KEY POINTS

- AKT to trial new question formats
- CSA to be marked on 13 cases
- New standard setting method for CSA
- CSA FAQs on web
- AKT FAQs available shortly

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

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

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

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

Sue Rendel: Looking to the future

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

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

The candidates' experience will be the same as before and should not affect the way in which they prepare for the examination. The cases will continue to be marked using the current three domains but instead of receiving the individual marks for each case the candidates will receive the total numerical score for all 13 cases and the pass mark which will have been set by the combined judgements of the examiners for that day.

The feedback statements have also been reviewed, taking into account comments from AiT representatives and CSA examiners. They have been clarified and the explanations that relate to them revised, with more information and advice on how to improve performance. Candidates will receive more feedback information than previously, with any areas of performance identified as deficient linked to the Curriculum Statements of the cases in question.

Further information about the new CSA standard setting method and that in use by the AKT will be available shortly in the form of Frequently Asked Questions (FAQs).

Invaluable resource: Professor Nigel Sparrow, Professor Sayeed Khan, Professor Dame Carol Black, Dr Debbie Cohen and Dr Bill Gunnyeon at the launch of Healthy Working UK

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

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

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

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

The Healthy Working UK website was initially funded though the Welsh Assembly Government working with Cardiff University and the Healthcare Learning Company. The site has now been extended to England and Scotland as well as Wales, through funding from the Department for Work and Pensions, who worked in Partnership with the RCGP, the Faculty of Occupational Medicine and the Society of Occupational Medicine.

RCGP Chairman Professor Steve Field said: "We welcome the development of any resources that improve the relationship GPs and primary healthcare professionals have with their patients, and that improve the quality of care that they receive.

"The Healthy Working UK resources are useful for both patients and professionals, and provide timely access to training, information and decision tools to support their daily practise."

Professor Field praised the success of a series of half-day RCGP health and work workshops, which have so far attracted over 1,400 GPs around the country. The workshops aim to increase GPs' knowledge, skills and confidence in dealing with clinical issues relating to work and health, and have recently been revised to include material on the 'fit note'.

Professor Field said: "I am delighted that there has been such an excellent response to the workshops and that so many grassroots GPs are finding the training relevant and useful."

- *To access the Healthy Working UK site please visit:* www.healthyworkinguk.co.uk
- *Visit* www.rcgp.org.uk *for further details of the next round of RCGP Health and Work workshops*

See page 6 for more news on online learning for GPs

Closing the gap: GPs urged to take the lead in creating a fairer society

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

The report, *How doctors can close the gap: tackling the social determinants of health through culture change, advocacy and education*, identifies how doctors can take account of social inequalities in all aspects of their work with the aim of improving wellbeing in healthcare and society in general.

Produced by the Royal College of Physicians, in partnership with the RCGP and other leading health organisations, the report was launched at a conference where speakers included Professor Sir Michael Marmot, RCGP Chairman Professor Steve Field, Professor Ian Gilmore, President of the RCP, and GMC Chair Professor Peter Rubin.

Focusing on three main strands – policy, the changing of professional cultures towards the social determinants of health and sustainability, and the implications for the education and training of doctors – its purpose was to encourage the sharing of ideas and best practice around the issues of health inequalities.

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

It defines the social determinants of health as 'the circumstances in which people develop and live affect their mental and physical well-being and life expectancy, and have been characterised as the causes of the causes of health (or ill health).

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

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

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

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

Engagement, prevention and sustainability are central to the new recommendations, and the report captures these three themes under the three E's of Engagement, Empowerment and Environment.

Professor Field said: "I am particularly pleased to see sustainability at the heart of this work. I am convinced that with the influence and support of the medical world driving it forward, this agenda can become as powerful as the anti-smoking movement started and led by doctors three generations ago."

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

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An innovative website of real-life patient experiences is the culmination of a life's work for its co-founder and RCGP Fellow Dr Ann McPherson.

The combination of her vision, energy and determination now provides a lifeline for thousands of patients and their families.

The people's practitioner

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

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

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

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

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

Even choosing general practice was thinking outside the box in those days. There was barely any training available and little kudos in the speciality. "What's a clever girl like you doing becoming a GP?" she was asked by one eminent tutor – a question she reminded him of at his 80th birthday recently. "He told me he still couldn't understand my choice," she says.

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

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

She observed that her own children as well as her young patients would benefit from knowing more about their bodies – "something about sore throats and threadworms, but I couldn't find anything".

An early idea was rejected by hundreds of publishers who said children wouldn't be interested. But a series of leaflets about different health topics written with a colleague, paediatrician Aidan McFarlane, became a cartoon illustrated book, *Mum I Feel Funny*, which won an information award from the *Times Educational Supplement*.

As her children became teenagers, she collaborated with McFarlane once again to write *Diary of a Teenage Health Freak* based on the life of 14-year-old hypochondriac, Pete Payne. As well as becoming a global best-seller, *Health Freak* was the subject of a six part Channel 4 TV series and was turned into a play in Rio de Janeiro.

But the web-based database of individual patients' experiences is undoubtedly her major contribution to health.

The idea came when she was diagnosed with breast cancer in 1995. "I wanted to know from other people's experiences what to expect physically and mentally'.

Driving home from an event with a friend, pharmacologist Professor Andrew Herxheimer who had just had a knee replacement, the conversation turned to their respective personal medical encounters – and what a revelation they had been.

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

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

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

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

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

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

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

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

The first project was on prostate cancer.

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

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

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

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

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

"It's an invaluable resource that will have a major influence on future generations of doctors into the curriculum," says the associate clinical dean, Dr Jonathan Silverman.

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

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

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

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

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

She remains very active from day to day. "My only regret is that so many questions that pop into my head during the long sleepless hours remain unanswered," she says.

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

Hugh Grant assisted: Healthtalkonline is supported by the actor and many other celebrities

DEBATE

ETHICS IN PRACTICE:

The first in an occasional series in which members of the RCGP Ethics Committee debate the tensions and moral dilemmas in everyday general practice to stimulate thought and debate

Is 'confidentiality' a con?

Stephen Pattison is Professor of Religion, Ethics and Practice at the University of Birmingham and a member of the RCGP Ethics Committee

Martin Marshall is Clinical Director of The Health Foundation, a practising GP in South London and Chair of the RCGP Ethics Committee

Stephen Pattison and Martin Marshall of the RCGP Ethics Committee kick off a new series on Ethics in Practice by questioning whether it is time for patients and GPs to cease worshipping at the shrine of 'confidentiality'.

Is confidentiality an essential component of effective patient care to be defended at all costs? Or is it a leaky and incoherent concept used to defend parternalism, which should be confined to the dustbin of history? A dangerous question, some would say, but an important one to help us unpick what is so often defended as a fundamental component of professional practice.

The word 'confidentiality' literally means 'with confidence'. The argument goes like this; effective care requires honesty between a patient and their GP. Honesty will only be forthcoming if it is underpinned by trust and this requires confidence that private or potentially damaging information divulged in the consultation will go no further. The belief that effective care therefore must be based on confidentiality has become an article of faith for many healthcare professions, general practice included.

But there is a big problem. The present practice of confidentiality is leaky and incoherent and the nature of modern society means that it is likely to become more so. When we move beyond the rhetoric, confidentiality is beset with theoretical and practical problems.

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

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

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

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

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

Realistically, we should probably assume that nothing about us is really private. And to know that is to know exactly where we stand – the facts are friendly, as therapist Carl Rogers said. If we accept the reality of non-confidentiality, then we are in a much better position about what information we may choose to disclose than if we hope that there is such a thing as the limited circulation of confidential information.

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

To work on a principle of non-confidentiality then is to move from paternalistic protectionism to adult negotiation. I tell you what I want you to know. If I think that might be harmful to me, I withhold the information and if I fail to tell you something that restricts your ability to provide effective care, then that is up to me. The point is that we really talk about what confidentiality means and its impact on the contract between us. Patients then know exactly what is going on, instead of being in a blur of ostensible benevolence.

Confidentiality means everything and nothing. It is impossible to promise and to practice and continuing to pay ill-defined lip service to it may simply distract GPs from thinking about the need for a new, dynamic and more thoughtful, if more careful, ethical relationship with patients. Engaging in this kind of relationship on the assumption that information will be widely shared may well not damage the patient-doctor relationship. Indeed, it should deepen and clarify it.

■ *This article does not represent the views of the College or of the Ethics Committee but is intended to provoke discussion.*

NEWS

Better leaders, better doctors: Sign up now for RCGP Leadership Programme

The RCGP Leadership Programme is currently recruiting for the next cohort of candidates to start this October.

The College is looking for registrations by early September and interested GPs should visit www.rcgp.org.uk/leadership or call Julie Hargreaves at the University of Exeter Business School on 01392 723 770.

The programme is the only one of its kind built specifically around the leadership needs of GPs. As well as improving GPs' leadership skills within their own practices, it looks at how to influence the political agenda and contribute to the debate on the future of the NHS.

GP Foundation goes into action

The RCGP's newly established GP Foundation has announced two masterclasses tailored specifically towards the needs of Practice Managers and Practice Nurses.

The GP Foundation, which has recently begun to take registrations, is divided up into three specialities: Practice Managers, Physician Assistants and Practice Nurses, with a focus on education, networking, policy and practice consultations, and access to online journals and e-newsletters.

For only £59 a year, individuals can sign up for annual membership. Group registrations are now also available (www.rcgp.org.uk/gpf).

The workshops are a valuable opportunity to promote teamwork and explore the best way for Practice Managers and Practice Nurses to work together towards delivering services and achieving the practice's goals.

The first masterclass, a full day workshop, will take place in Birmingham on 7 September at Jury's Inn. The second is on 30 September in the conference centre at Perth Racecourse. Further details and a booking information is available from Stephanie Slade, Faculty Support Manager (stephanie.slade@nhs.net) 01224 558042.

The masterclasses will cover:

- Understanding how to ensure effective decision making
- Describe the core functions of leadership
- Understanding formal and informal sources of power in the practice
- Understanding your own motivators and demotivators and those of others in the team
- Understanding psychological contracts
- Describe the characteristics of a high-risk system
- Understand the differences between individual and organisational accidents
- The Swiss Cheese model – understanding hazards and losses in a system, how the hazards occur and how losses occur
- Understand the steps involved in managing risk in systems and how to apply them in the practice

A programme of individual events will soon be published aimed at Practice Managers with an additional programme for Practice Nurses. Further details at www.rcgp.org.uk/gpf

Sharing genetic information

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

Why might genetic information be considered different to other types of medical information when it comes to thinking about confidentiality? As genetic information about one person can reveal information about the probability of disease for other family members, and may therefore impact on those relatives' medical management.

Genetic information likely to be recorded in primary care includes pedigree information, which contains information about the family history, and genetic test results. Recording information about other people in a family in the form of a family history (and passing it onto other health professionals involved in the medical management of that patient) is permissible under the Data Protection Act without the explicit consent of all those shown on the pedigree – if this information is necessary for medical purposes. GPs are likely to receive copies of any genetic test results that their patients may have had and these results may be shared with other family members with the patients' explicit consent.

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

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

CONSIDER THE CASE of Sam, who is 28 years old. His father, Graham, died from bowel cancer at the age of 43 when Sam was only four years old. Sam and his mother have lost touch with Graham's family over the years, although members of the family are known to the practice.

It has recently come to your attention that Graham's sister, Janet, has been diagnosed with FAP (familial adenomatous polyposis). FAP is a multisystem disorder where individuals develop multiple adenomas of both the colorectum and duodenum with an associated risk of cancer.

As FAP is an autosomal dominant condition, and it is quite likely that this was the cause of Graham's cancer, there is a 50 per cent probability that Sam has inherited the altered FAP gene from his father. However, Sam is unaware that he is at risk of developing this condition and there is no record of Janet providing consent to share these results with family members.

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

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

■ *For further information about sharing genetic information please refer to:*

- General Medical Council. *New guidance – confidentiality.* Oct 12, 2009. www.gmcuk.org/guidance/news_consultation/confidentiality_guidance.asp
- Joint Committee on Medical Genetics, Royal College of Pathologists. C*onsent and confidentiality in genetic practice: guidance on genetic testing and sharing genetic information.* April 2006. www.rcpath.org/resources/pdf/GeneticsConsentAndConfidentiality-JCMGreportJul06.pdf
- Lucassen, A and Parker, M (2010) Confidentiality and sharing genetic information with relatives. *The Lancet* 375:1507 - 1509

■ *For further information about genetics please visit* www.geneticseducation.nhs.uk

Now you can electrify your learning on dementia

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

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

In 2009, the RCGP successfully launched its new e-learning resource with a wide range of learning modules available for GPs. April 2010 saw the publication of two modules on dementia care in primary care; timely dissemination as it is one year since the launch of the National Dementia Strategy for England which aims to improve the quality of care received by people with dementia and their families [1].

Professor Robinson: GPs admit to difficulties in diagnosis and management

Dementia care in primary care: current service provision and evidence

Dementia is one of the main causes of disability in later life. In terms of Global Burden of Disease, it contributes 11.2 per cent of all years lived with disability, higher than stroke (9.5 per cent), musculoskeletal disorders (8.9 per cent), heart disease (5 per cent) and cancer (2.4 per cent). One in 14 people aged over 65 has a form of dementia, rising to one in six of those over 85.

In the UK, there are currently approximately 700,000 people with dementia but this is estimated to rise to 1.7 million by 2050, an increase of over 150 per cent[2]. The total cost of caring for people with dementia in the UK is estimated at £17-18 billion a year, more than heart disease (£4 billion), stroke (£3 billion) and cancer (£2 billion)[2].

Currently around two-thirds of people with dementia live in private households, with the majority of their care provided by family supporters and primary and community care. There is consistent evidence that the standard of dementia care in the UK is in urgent need of improvement, with frequent failure to deliver services in a timely, integrated or cost-effective manner to support people with dementia to live independently for as long as possible[3].

Within primary care, GPs admit to difficulties in both dementia diagnosis and common areas of dementia management[3]. Currently a GP with an average list size may only diagnose a handful of new cases of dementia per year. However, due to our rapidly ageing population and greater public awareness of dementia through initiatives like the National Dementia Strategy[1], the number of older people with possible cognitive impairment seen by GPs will increase.

As the majority of GPs, old and young alike, will not have received much training in this area, diagnosing dementia and caring for people with dementia in primary care have been identified by the RCGP as areas in need of attention. The recommendation to develop further training for GPs has also been highlighted in the National Audit Office report on Dementia[3] and the National Dementia Strategy for England[1]. This has certainly a challenge for the RCGP Clinical Champion for Ageing and Older People.

RCGP e- modules on dementia

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

A project, led by Simon Plint in Oxfordshire, is exploring this area in detail and results will be available in 2011. However, two international review papers have recently been published[4,5] which consider the role of the GP in dementia care. These, together with the NICE guidance on dementia care[6], have informed our development of two RCGP e-modules on dementia.

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

The RCGP e-modules are problem-based and focused on typical patients presenting to a GP surgery. In addition, we have developed a key factsheets on:

1. *Dementia: diagnosis and early intervention in primary care* and
2. *Care of people with dementia in primary care* to accompany each e-module, which summarise key learning points from the two modules.

An important area of dementia care for primary care is the management of agitation and behavioural problems in dementia. A recent review of anti-psychotic drugs prescribed for people with dementia revealed inappropriate over-prescribing of these drugs to people with dementia in the community as a means of controlling disruptive and distressing behaviours[7].

NICE guidelines recommends non-pharmacological approaches before pharmacological methods in the management of such behaviours[6]. In practice, however, this can be difficult to achieve due to the limited access of primary care teams to specialist services such as challenging behaviour nurses and psychological support.

We acknowledge that the community management of behavioural problems in dementia is a particularly challenging area and that the sections in the dementia e-module only touch the surface of this.

However, more detailed guidance on this topic, especially the pharmacological management of behavioural problems in dementia, can be accessed via the Royal College of Psychiatrists' website:
ww.rcpsych.ac.uk/mentalhealthinfo/olderpeople.aspx

■ *The factsheets will be featured in subsequent issues of* RCGP News *and will shortly be available from* www.rcgp.org.uk/circ

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Five goes live: The latest version of EKU is online

Dr Dirk Pilat
EKU Development Fellow

The fifth edition of Essential Knowledge Updates (EKU) is live and available for GPs to access.

Now in its third year, EKU provides GPs with a six-monthly focused update on selected items of new and changing knowledge central to everyday practice. For the latest version, the Editorial Board picked a broad spectrum of important topics from 150 identified sources to be featured as major items:

- Emergency management of anaphylaxis in children and young people
- When to suspect child maltreatment
- Management of sexually transmitted infections in children and young people
- Impaired glucose regulation
- Diagnosis and management of syncope
- Management of community acquired pneumonia in adults
- Management of asthma – adults
- Management of asthma – children

The briefings cover a similarly broad range of issues:

- Administration of influenza vaccine in children allergic to egg
- Paracetamol and ibuprofen for the treatment of fever in children
- Interaction between St John's Wort and hormonal contraceptives?
- Guidance for the HIV testing of children with HIV-positive parents
- Postnatal sexual and reproductive health
- Brief interventions for depression in primary care
- Diagnosis and management of chronic insomnia in primary care
- Aspirin in the primary and secondary prevention of vascular disease
- First-line drugs for hypertension
- Alarm symptoms and identification of non-cancer diagnoses in primary care
- Corticosteroids for pain relief in sore throat
- Guidelines for referral to audiology of adults
- Clopidogrel and proton pump inhibitors: interaction
- Probiotics in the treatment of IBS
- Migraine and cardiovascular disease
- Non-steroidal anti-inflammatory drugs for the common cold
- Upper limb disorders
- Guidelines for the management of contact dermatitis
- Reference guide to consent for examination or treatment
- Consensus guideline for the management of anal fissure in primary care

To broaden the appeal of EKU for clinicians more comfortable with a traditional style of teaching, the first seminar-style EKU event was held in February by Severn Faculty under the chairmanship of Dr Martyn Hewett. This was a well-received event with excellent feedback from the packed auditorium. More events are planned for the remainder of the year, and it will be interesting to see how these evolve.

Since the introduction of the five star instant feedback within EKU's content management system we have been able to evaluate the numeric feedback users have been giving us.

With EKU 4 getting the highest average rating, it is reassuring that our users share our impression that EKU is getting better from update to update.

Three new e-learning courses

Three new e-learning courses have been launched on the RCGP Online Learning Environment.

Supporting Couple Relationships in General Practice is a short online course to help GPs recognise relationship issues in patients and the potential impact these can have on health.

The course recommends appropriate sources of support, including online resources, self-help guides and useful information and services for patients.

It has been developed in partnership with One Plus One, the UK's leading relationship research organisation.

Management of Drug Misuse (incorporating *Harm Reduction and Treatment Planning*) and *Sexual Health in General Practice* have been redesigned to fit into the College's online learning platform and make up the e-learning sections of the Part 1 certificate in the Management of Drug Misuse and RCGP Introductory Certificate in Sexual Health.

All e-learning courses are freely available to all GPs.

Six new health and work sessions now in e-GP

Six new e-learning sessions supporting primary care professionals with patient issues relating to work and health are now available in e-GP.

The sessions cover subjects such as how a patient's occupation links with their health, advising on fitness for work, completing the new 'fit note', the implications of the Disability Discrimination Act and worklessness and unemployment.

The Health e-Working e-learning sessions have been developed by the Faculty of Occupational Medicine in partnership with the RCGP, the Society of Occupational Medicine and the Department of Health's e-Learning for Healthcare.

Debbie Cohen, Clinical Project Lead for Health e-Working said: "Enabling people to return to work is good for their long term health, however, many patients need active support from their GP or other healthcare professionals.

"Health e-Working helps develop the knowledge, skills and confidence of GPs, trainees, primary care nurses and practice managers in dealing with the clinical issues relating to work and health. Designed in a flexible and engaging way, Health e-Working will help GPs and their teams provide the best possible patient care."

Health e-Working is now available to GPs, trainees and other primary care professionals in the 'Healthy People' section in e-GP.

e-GP is a free and comprehensive learning resource for doctors in specialty training for general practice, general practitioners and other primary care professionals. The e-learning is explicitly linked to the RCGP curriculum and covers a broad range of primary care topics.

■ *To register for e-learning visit* www.e-GP.org.uk. *For more information about the Health e-Working e-learning, visit* www.e-lfh.org.uk/healtheworking

Rheumatoid arthritis: the importance of early diagnosis

Dr Graham Davenport
RCGP Clinical Champion for Osteoporosis

Rheumatoid arthritis is the commonest inflammatory polyarthropathy in the United Kingdom with the average general practitioner having 20 rheumatoid patients in a population of 2,000 and seeing approximately one new case a year.

It has always been accepted that rheumatoid arthritis is a chronic progressive disorder, predominantly affecting the synovium which invariably leads to progressive permanent joint damage and consequent deformities. The disease has a significant impact on the economy with a third of sufferers choosing to stop work within two years of diagnosis due to pain and disability. The estimated cost to the economy from work-related disability and sick leave due to rheumatoid arthritis is £8billion per year(1).

However, it is now accepted that early diagnosis and treatment can prevent joint destruction before irreversible changes have occurred. In patients with as little as six months of disease activity, 40 per cent have radiographic evidence of peri-articular erosion and radiological deterioration is closely correlated with progressive functional impairment.

Prior to joint erosions, there is a period of extensive sub clinical inflammation which is directly related to the functional outcome and this gives doctors an opportunity to intervene therapeutically.

NICE guidance on the management of rheumatoid arthritis (published January 2009) recommends that patients with rheumatoid arthritis be treated with methotrexate and at least one other disease-modifying ant-rheumatic drug (DMARD), plus short-term glucocorticoids, within three months of diagnosis(2).

A key priority is the urgent referral of any patient with suspected persistent synovitis, especially if more than one joint is affected and the small joints of the hands and feet are involved. It also advises that these patients should be reviewed annually to monitor disease progression, associated co-morbidities and drug side-effects.

The King's Fund Report commissioned by the Rheumatology Futures Group, published in January 2009, outlined key priorities for action to improve the care of rheumatoid patients(3). It found that GPs were poor at early identification of rheumatoid arthritis and were unclear about the benefits of early aggressive treatment. GPs were also unsure of the availability of local services and how to manage acute flares.

The National Audit Office report on services for people with rheumatoid arthritis was published in July 2009 and echoed the above findings(4). Most patients themselves delay seeking help from their GP for three months or more following symptom onset. Additionally, there is a delay because most patients visit their GP four-times before referral to the specialist. Over recent years, the average length of time from symptom onset to treatment has remained at nine months compared to the recommended three-month interval.

A Parliamentary Public Accounts Committee published several recommendations in February this year(5). It pointed out the GPs receive on average only two hours of teaching about musculoskeletal conditions, including rheumatoid arthritis, during their training and made a recommendation that further training should be encouraged.

As a result of these reports, representatives of the RCGP, the Rheumatology Futures Group, the Primary Care Rheumatology Society and Arthritis Research formed a working party to look at how we could develop guidelines for both patients and GPs to ensure early referral and treatment.

KEY POINTS

- There is NO specific diagnostic test for rheumatoid arthritis.
- Go from the clinical symptoms and signs.
- Look for the S-factor
- Refer promptly for early initiation of aggressive immunosupressive therapy.
- Be alert to the possibility of ankylosing spondylitis in a young adult with persistent low back pain.

This has resulted in the *S-factor* poster campaign which targets patients with early inflammatory arthritis. It was launched at the BSR Conference in April, supported by an educational video podcast(6). The key points are to remind both patients and GPs that the clinical signs of early inflammatory arthritis are:

1. **Swelling** – persistent swelling in one or more joints, especially hand joints
2. **Stiffness** – early morning stiffness, usually lasting over 30 minutes
3. **Squeeze test** – positive in one or more joints. Characteristically, squeezing the joints in inflammatory arthritis is painful.

If patients have the 'S-factor' then early referral to the specialist is essential so that early aggressive treatment with DMARDs can be started urgently. GPs often initiate investigations but can be falsely reassured by normal or marginally raised inflammatory markers, such as ESR and CRP, and a negative test for rheumatoid factor. These are often negative in early rheumatoid arthritis and GPs should not delay referring patients on the basis of normal investigations.

Anti-cyclic citrullinated peptide (anti-CCP) antibodies show great specificity for rheumatoid arthritis and help to indicate which patients are likely to have more aggressive joint disease but again their presence or not should not influence the referral decision(7).

A supporting poster reminds patients and doctors about ankylosing spondylitis There is often a considerable delay in the diagnosis of ankylosing spondylitis with the patient's back symptoms often attributed to a musculoskeletal cause. The key features of ankylosing spondylitis are spinal pain and stiffness lasting for more than three months. There is usually of gradual onset in a young adult with a worsening of symptoms on rest and pain during the night associated with improvement on getting up and exercising.

By following the key points above, GPs can support their patients to remain in work and help reduce the enormous burden of disability due to rheumatoid arthritis.

- *For further information about RCGP Clinical Priorities and the work of the Clinical Champions, please visit* www.rcgp.org.uk/clinical_and_research/circ/clinical_priorities_and_ccs.aspx, *email* circ@rcgp.org.uk or *call 0203 170 8245.*
- *We are looking to recruit GPs with an expertise in all clinical, educational and research areas to act as an Expert Resource within the College. To register, please visit* www.rcgp.org.uk/clinical_and_research/circ/expert_resource.aspx *or email* rwebb@rcgp.org.uk *for information.*

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How is your flying?

Dr Jonathan Botting
RCGP Clinical Champion for Minor Surgery

Please imagine the following scene. You are waiting at the airport for your plane to fly you and your family on holiday. An announcement comes over the public address system: "Ladies and gentlemen we have a problem. There are too many of you to all fit on the aircraft, but here at Dodgy-Air we have laid on a second plane. Our new plane has a very enthusiastic chap who, though not a certified pilot, flew a little plane once and is looking forward to piloting you all today..." I assume you would all decline the services of Dodgy-Air? And yet, across the UK doctors are providing surgical activity in exactly the same way as our enthusiastic amateur.

'See one, do one, teach one,' was part of many doctors' training in the past but the world has moved on to DOPs and COTs and CEX and CBDs. Today's doctors are asked to produce evidence of their existing skills and of their continuing professional development. Those GPs wishing to provide surgical activity as part of a specialist interest are required to meet accreditation requirements which include a number of observed procedures, case-based discussions and reflective practice(1,2).

Patients being referred to such services not only benefit from care closer to home(3) but also from a training scheme that ensures the practitioner has evidence of their skills and knowledge. However, much of the surgical activity that has traditionally taken place in primary care has not been delivered by clinicians who have benefitted from such a training process. Without peer review, observed procedures, CPD or the requirement to regularly audit surgical activity and histological results, much of primary care surgery is an unknown quantity. Unfortunately, when it does become the subject of critical review, the results can be alarming(4).

With constraints to public funding increasing it is essential that all providers of healthcare ensure they offer value for money. Primary care has been highlighted as the universal panacea for affordable healthcare, without the overheads of acute trusts and with an adaptive workforce.

The response from secondary care has been variable but no senior clinician is likely to support diversion of activity if it threatens his or her own unit's viability. Published papers have mainly been highly critical of the ability of GPs to adequately diagnose or treat skin cancers(5). If we are poor at treating potentially life-threatening skin conditions, are we any better at treating more minor, benign conditions? And if we are not, how can we be offering value for money to the NHS?

These published critical assessments of primary care surgery have not gone unnoticed by PCTs and a number throughout the UK have withdrawn their surgical contracts for benign skin lesions. As GPs, we have done little if anything coordinated to protect and promote this activity, which has either been diverted to secondary care or has ceased to be commissioned at all by some PCTs. So are GPs providing an unsafe, unwarranted and unregulated service to their patients? The only way to answer this is by auditing what we do and how we do it.

This can be achieved in a number of ways:

- **Auditing of knowledge:** Evidence, not just of CPD but also of diagnostic skills
- **Auditing of skills:** Evidence of observed activity (DOPS) and of surgical logbooks
- **Auditing of outcomes:** Evidence of diagnostic skills, histological analysis, surgical competency and patient acceptability

The publication of such results would do much to support activity in primary care if they showed that we are skilled diagnosticians and surgeons. In order for the majority of GPs who provide limited surgical activity under a directly enhanced service to meet these audit requirements there needs to be adequate training and assessment.

The ASPC (Association of Surgeons in Primary Care) promotes the vision that all GP members providing surgical activity will partake in collaborative audit in order to benchmark their own performance against their peers. This already happens for members of BANSV (British Association of Non-Scalpel Vasectomists) who have now affiliated with ASPC.

Work being planned through the RCGP and, using expertise from HQIP, aims to pilot peer reviewed audits to a number of specialties including minor surgery. If the pilots are successful and fully implemented, taking this to the next level it would allow individual practitioners to compare their audit results nationally, enabling them to benchmark their own performance.

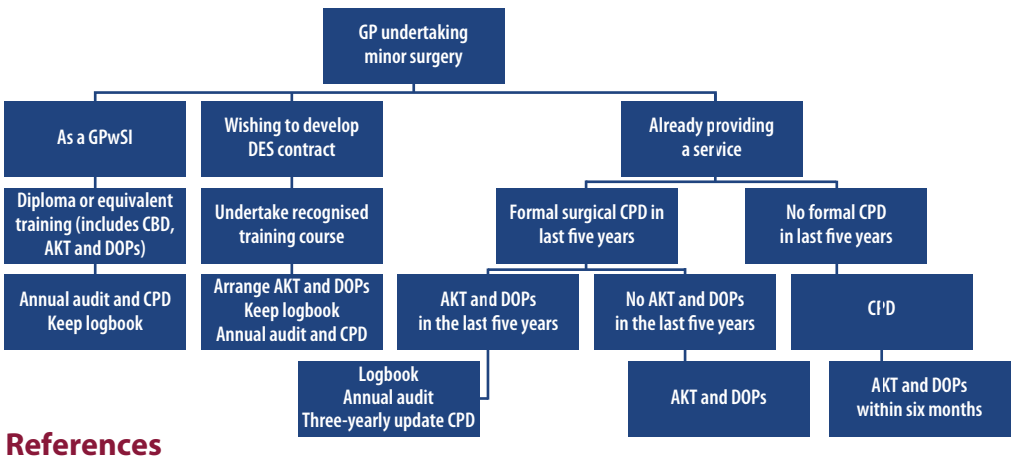
But how to audit knowledge and skills? Here current educational practice provides suitable models. Observed procedures (either as DOPs or CEXs) enable a suitable framework for recording surgical skills. Already a part of the dermatology GPwSI framework, this should be a mandatory part of a DES contract. The old 'minor surgery list' is no longer fit for purpose.

AKTs provide a suitable method for assessing knowledge. Experience of delivering AKTs and DOPs for assessing PCT-wide surgical services has already been developed(6).

There is a natural and understandable reluctance to undergo any form of test or evaluation, especially for an activity that may have been provided for years. However, evaluation may be formative or summative and when undertaken with an educational and formative aim it facilitates the goal of lifelong learning. In addition, revalidation(7) will ensure that it is in our interests to show evidence of this approach, especially if we are providing any activity beyond that expected within the MRCGP curriculum. In undertaking assessment of skills and knowledge, GPs not only provide evidence of their qualifications, they can also show evidence of CPD.

Auditing skills and knowledge can be viewed as an unwanted hurdle, or it can be viewed as a facilitating and enabling process. When applied to our airline pilot, it is exactly what we want for the safety of ourselves and our families. So returning to Dodgy-Air's offer: are you going to ask for a pilot with the knowledge and the skills? And the evidence to show it?

Proposed method of developing primary care surgery CPD



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Headache in children and the elderly

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

FACT FILE 5a: HEADACHE IN CHILDREN

BACKGROUND

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

DIAGNOSIS

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

MANAGEMENT

- Trigger factors can be subtle and children have a lower threshold to stress, missing meals, irregular sleep patterns, dietary irregularities, especially missed meals and lack of hydration. A high fibre regular cereal snack, a regular intake of fluid and avoidance of caffeinated drinks is helpful.
- For the acute attack, effective pain relief analgesics should be given early in their optimum doses, paracetamol 10-20mg/kg every 6-8 hours (maximum 60mg/kg/day) and ibuprofen 10-15mg/kg every 6-8 hours. In some children, nausea and vomiting are troublesome symptoms and early treatment with antiemetics such as metoclopramide or domperidone may help and improve the response to painkillers.
- Oral triptans are safe but due to the high placebo response in childhood trials, efficacy and therefore licence has not been obtained. Nasal sumatriptan in a dose of 10mg is licensed in those above12 years.
- Pizotifen is the drug of choice for prevention although weight gain can be a problem. Propranolol can be useful and other drugs include amitriptyline, topiramate and valproate, although the antiepileptics are best left to specialist practice. See table on the right.

INVESTIGATING THE CHILD WITH HEADACHE

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

Other syndromes are associated with migraine

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

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

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

MIGRAINE IN ADULTS	MIGRAINE IN CHILDREN	TENSION-TYPE HEADACHE IN CHILDREN
Usually unilateral	Usually bilateral	Usually bilateral
Moderate-to-severe headache	Mild-to-severe headache. May be inferred from behaviour in younger children.	Mild-to-moderate headache
Throbbing/stabbing nature of pain	Can take any form	Pressure or band-like pain
Four to 72 hours	Usually less than four hours	Variable
Associated symptoms include nausea, vomiting, photophobia or phonophobia	Not always present	No associated symptoms
Can be associated with a aura in 30 per cent	Aura less common	No aura
Frequently prevents normal activity	Frequently prevents normal activity	Sufferer usually able to continue with normal activities

DRUGS USED IN THE PREVENTION OF MIGRAINE

DRUG	DOSE UNDER 12 YEARS	DOSE 12-18 YEARS
Pizotifen	0.5-1.0mg/day Single dose – night	1.5-3.0mg/day Single dose – night
Propranolol	0.2-0.5mg/kg TDS Max 4.0mg/kg/day	20-40mg tds Max 160mg/day
Amitriptyline		Up to 50mg/night
Topiramate		2-3mg/kg/day Gradual increase to target dose

FACT FILE 5b: HEADACHE IN THE ELDERLY

BACKGROUND

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

Headaches with higher prevalence in the elderly:

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

DIARY DATES

JULY

1 **Increase your effectiveness**
09:00 – 17:00
Windermere Hydro Hotel
Bowness on Windermere
Members: £80
Non-members: £100

2 **Third RCGP conference on drug treatment in prisons**
09:30 – 16:00
The Royal York Hotel, York
Members: £90
Non-members: £120

5/6 **Foot and ankle: what can I do in 10 minutes?**
17:30 – 21:00
University of Birmingham
Price: £42.50

7/8 **Intensive communication skills**
09:00 – 16:30
Cedar Court Hotel, Leeds
Members: £420
Non-members: £450

13 **Back pain: what can I do in 10 minutes?**
17:30 – 21:00
Shrewsbury Postgraduate Centre
Price: £42.50

16 **Back and knee pain: what can I do in 10 minutes?**
09:30 – 17:00
University of Birmingham
Price: £77

21 **Back and knee pain: what can I do in 10 minutes?**
17:30 – 21:00
Warwick Postgraduate Centre
Price: £77

27 **'Preparing for appraisal' support group**
19:00 – 21:00
University of Nottingham
FREE

AUGUST

26 **Let's innovAiT**
09:30 – 18:00
The Audrey Emerton Centre, Brighton
FREE

SEPTEMBER

23 **Dealing with difficult people**
(aimed at practice staff)
09:30 – 12:30
RCGP, Edinburgh
Price: £45

OCTOBER

13 **Perspectives on mental health in primary care**
19:00 – 21:00
Chancellors Hotel
Manchester
Members: £20
Non-members: £45

14 **MRCGP for trainers: helping your registrar through the exams**
9:00 – 21:00
RCGP Assessment Centre, Croydon
Members: £150
Non-members: £175

14 **Anaphylaxis: the essential update**
19:00 – 21:00
Royal College of Physicians, Edinburgh
Members: £20
Non-members: £45

Royal College of General Practitioners

Sustainable Primary Care

growing healthy partnerships

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7-9 October 2010
Harrogate International Centre

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