SPRING 2014 NEWSLETTER

After a long and wet winter we are all ready to welcome a warmer and dryer spring.

This is one of the most beautiful times of year in our area as trees start to produce leaves, flowers bloom and local gardens are filled with wonderful colours and fragrances. For the practice it is a busy time of year with many deadlines and also new and exciting changes which we are keen to share with you.

Please note that we will be closed on the bank holiday dates listed to your right.

Easter and Bank Holiday Closing
on the dates listed

Friday 18th April

Monday 21st April

Monday 5th May

Monday 26th May

An out of hours GP service will be available for urgent care by calling 111

"Doctor, I feel I am being watched?!" *by Dr Daphne Coutroubis*

Over the last few months you may have experienced a consultation where you were either videoed with your consent or your consultation was observed by a second doctor. You may have wondered why this happened and I hope to be able to answer that for you!

A doctor training in general practice has to undergo continuous assessments with their supervisor and these usually take the form of Video consultations and observed consultations. Videoing consultations and being observed whilst consulting are both excellent methods of analysing and improving consultation and communication skills. It has become an important part of medical training in the UK. It is a valuable tool and generates really useful discussions and feedback for the GP Registrar
These are some of the areas that are being assessed in the consultation:

- **Practising holistically**: the ability of the doctor to operate in physical, psychological, socioeconomic and cultural dimensions, taking into account feelings as well as thoughts.
- **Data gathering and interpretation**: the gathering and use of data for clinical judgement, the choice of physical examination and investigations, and their interpretation.
- **Making a diagnosis and making decisions**; demonstrating a structured approach to decision making.
- **Clinical management:** the recognition and management of common medical conditions in primary care.
- **Managing medical complexity and promoting health**: aspects of care beyond managing straightforward problems, including the management of comorbidity, uncertainty, risk and the approach to health rather than just illness.

Everything that is discussed during the consultation is completely confidential. A consent form should be signed by the patient prior to starting consultation. The consultation is ONLY of the doctor and patient talking together. Clinical examinations are not recorded and the camera can be switched off at any point during the consultation. Only people directly involved in the assessment will see the video and it will only be used to assess the doctor consulting.

So, don't be alarmed if you are asked to participate and know that you are within your rights to say no, however your support is very much appreciated and we value your help in facilitating the education of trainee doctors within the practice.

Staff News

Goodbye to Dr Simon Vavasour: Goodbye to Dr Simon Vavasour who has been working with us for the last year as a Partner and has now been offered an opportunity to extend his hospital work in Urology. We do wish him well for the future.
Retirement of Dr Nick Barrie: Dr Barrie now works 1 session a week on a Wednesday morning only. If you would like to see Dr Barrie then you will need to consider booking ahead or alternatively consider moving over to one of our other doctors.

A warm welcome to the New Members of our Team
Dr Susan Ferrier: Dr Ferrier joined the Practice from February on a part time basis but will increase to full time as from May.
Biz Rutter: Biz is our new Health Care Assistant and has joined the nursing team. In addition to all her other nursing duties, Biz will also be carrying out our Health Checks.
Samantha Shearman: Sam is our new Reception Supervisor and will be supporting the team as well as updating our website and other IT related projects within the practice.

Bowel Cancer Screening *by Dr Tina George*

Bowel cancer is the one of the commonest cancers in the UK and it is a leading cause of cancer deaths. Recently, it has come to our attention that many patients have not taken the opportunity to be screened for bowel cancer. However, the NHS Bowel Cancer Screening Programme offers free screening every 2 years to men & women aged between 60 and 74.

What is screening?
Screening means looking for early signs of a disease in healthy people who do not have symptoms. The aim of bowel cancer screening is to detect cancer at an early stage when treatment is more likely to be effective.

Why is bowel cancer screening important?
Regular screening has been shown to reduce the risk of dying from bowel cancer by 16%. Bowel cancer screening can also detect 'polyps' which are not cancers but may develop into cancers over time. These can easily be removed, reducing the risk of bowel cancer developing.

How does the screening test work?
The test is called a 'Faecal Occult Blood (FOB) Test'. It detects small amounts of blood, which usually cannot be seen, within your bowel motions. Polyps and bowel cancers sometimes bleed which is why we screen for blood in the motions. An abnormal results means that blood has been found in your FOB test sample – *it does not give a diagnosis of cancer* but it does mean that you will be offered a further test, known as a colonoscopy. The advantage of the FOB test is that it can be carried out in the privacy of your home. The screening kits will be sent to you and there are accompanying instructions which are easy to follow. The test is effective and only takes a few minutes. Like all screening tests, it is not 100% reliable *but taking part in bowel cancer screening is known to reduce your risk of dying from the condition.*

What should I do next?
Please consider carefully the above information when making a decision about whether to participate in bowel cancer screening. If you are aged between 60 and74 and you have declined a previous invitation or you have not had bowel cancer screening in the last 2 years but would like to, please contact your programme hub on **Freephone 0800 707 60 60**. For more information on screening for cancer, please visit www.cancerscreening.nhs.uk.

Difficult conversations with patients - by Dr Angie Gurner

When patients are unwell and their health is deteriorating they do not always want to think about difficult aspects of care regarding end of life and families are often very reluctant to discuss this. As doctors we sometimes need to bring up these sensitive topics so that we can be aware of patients' and families' views on future health care. This enables us to plan their care more carefully and to look after patients according to their wishes. Sometimes this includes conversations about where a patient would choose to die and these conversations can be hard for doctors and nurses as well. Often it is easier to approach these topics when a patient has a cancer diagnosis as they have support from specialist nurses or hospice care and progression of their illness is more expected. However in elderly patients with chronic ill health who are needing more care it is just as important that we establish patients' wishes.

It is important that patients and families understand what we mean by "resuscitation" and we need to know if a patient wants to be resuscitated in the event of a collapse, the heart stopping and the patient being unconscious. In this situation either at home or in a nursing home, unless there is a 'do not resuscitate' order in place signed by a doctor and available to the paramedic team attending then they have an obligation to undertake active resuscitation in the form of chest compressions and artificial ventilation and transfer a patient to Accident and Emergency for ongoing treatment. When patients are very frail a positive outcome is extremely unlikely and even if the patient survives a short time their quality of life is often significantly worse and they may remain in hospital in an intensive care situation. If patients and their families would feel that however advanced the disease or frail the patient they would want all medical interventions in any circumstances and we would always respect these views. However if that is not the case it is important that a discussion occurs with the medical team so that an appropriate order can be put in place.

It is most important to recognise that a resuscitation order applies purely to the emergency events described above in terms of a collapse. This means we will still administer good supportive nursing care and treatment of other medical problems such as chest infections and urinary infections which can often be easily treated in the community with great benefit to the patients. All this treatment continues regardless of any resuscitation order unless a patient has expressly refused treatments such as antibiotics in a living will.

If we do bring up a difficult conversation in these circumstances it is because this will make planning of future care for you much easier and we can be sure it is what you want.