

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Cardiology

Type of activity Audit

Title Hypertension

started 01/09/2002

completed 01/09/2002

hours 12

Background to activity

Review of hypertension management

1. A continuation from last years PDP, plus a part of new contract, practice purchased 24 hour ambulatory BP machine
Own personal interest in becoming a GPSIE in cardiology

What did you do

Audit of hypertension in practice

Arranged meeting with Hypertension specialist from Addenbrookes
Partners and nurses to attend

What did you learn?

Surprise surprise we are not as good as we think we are!
Significant proportion of patients have inadequate bp control
Arrange meeting with local hypertension specialist

See attached learning sheet detailing this learning activity and summary of audit

Devised protocol of use of ABPM machine in practice + practice protocol for hypertension on discussion with nurses and partners.

- " To be used to diagnose all new hypertensives
- " Monitor unresponsive hypertensives
- " Review all diabetics
- " Nursing team empowered to run this protocol themselves before returning patient to Doctor

Attached Files:**hypertension.doc**

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Cardiology

Type of activity Audit

Title Review of all patients on statins and all patients with IHD

started 01/03/2003

completed 31/03/2003

hours 10

Background to activity

continuation of audit from last year
local and national priority

What did you do

Audit see enclosed sheet

What did you learn?

Firstly, systematic review of all patients under secondary prevention has been instigated within the surgery. Patients with cholesterol not fulfilling all its standards have had their dose of statin altered accordingly. Patients "usual doctor" was checked and altered where appropriate to ensue ownership. Those without appropriate blood tests or review of blood pressure or hypertension are being recalled. The IHD templates have been updated on the computer and our Health care assistants/nurses are reviewing each patient systematically. Recalling for blood tests or review were appropriate

Following a review of all the secondary treatments the Practice will then look further at primary hyperlipidaemia. It was decided to concentrate predominantly on secondary prevention in view of the much stronger evidence base and lower numbers needed to treat to prevent death or morbidity

Attached Files:

IHD.xls

Type of activity Lecture

Title Primary care of arrhythmias presented by Dr Grace consultant cardiologist.

started 31/03/2004

completed 31/03/2004

hours 2

Background to activity

Arrhythmias are common in practise and I needed to update myself on the present cardiac electrophysiological techniques that are being performed at Papworth which my patients may be offered.

What did you do

Small informal presentation by Dr A Grace cardiologist at Papworth hospital with local GPs.

What did you learn?

see attached file

Attached Files:

adifrequency ablation.do

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Cardiology

Type of activity Research

Title Excercise induced hypertension

started 06/11/2003

completed 06/11/2003

hours 1

Background to activity

Patient reported from BUPA check as having excersize induced hypertension (BP raised to 230/100)
 Pateint fir marathon runner, recently lost 2 stone in weight secondary to training
 Clinic suggest I arrange echo and 24 hr ambulatory BP

What did you do

Search on internet
 Discussed with Consultant clinical pharmacologist

What did you learn?

These patents have an increased risk of LVH and ischaemic heart disease
 This is probally a factor of being hypertensive as opposed to any particlarly advers effect of excersize induced hypertension,
 this condition is probably just an early marker for hypertension

In a young person treating the Blood pressure will reverse any LVH
 Echo to look for LVH not needed as is reversible, is more useful as guide to treatment by looking for end organ damage,
 however 24 hour ABPM will demonstrate need for treatment, so again echo not needed

In an athelete B Blockers should be avoided as will reduce excersize toleranc
 Better for ACE, CCB, diuretic sequence
 If this not sufficient add in alpha blocker
 Nebivol is not supposed to have such an adverse affect on cardiac output so may be an option

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Cardiology

Type of activity Significant Event Analysis**Title** sudden death in surgery**started** 17/05/2004**completed** 17/05/2004**hours** 1**Background to activity**

An 84 yr old man had made a routine appointment for afternoon surgery and was waiting in the waiting area to be called by the doctor. He suddenly stood up and collapsed. The receptionists immediately alerted the doctors to the situation. Three doctors and the practice nurse were present. The waiting area was cleared of patients, a screen erected and CPR established. An ambulance was called to the scene, but at their arrival the patient was pronounced dead after 30 minutes of active CPR. A subsequent postmortem showed he had died of a ruptured thoracic aneurysm.

What did you do

SEA with partners

What did you learn?

1. It is essential that all staff are aware of the location of the resuscitation tray and defibrillator - this should be documented in the practice handbook and highlighted at resuscitation training.
Action: JM
2. All clinical staff are up to date with advanced CPR training and the reception staff undergo basic CPR training once a year as a minimum. The ideal time for this is at an in-house practice shutdown.
Action: RH to arrange shutdown
3. Written procedure on how to manage a collapse, documenting how to manage the patient if no doctor is present e.g. give oxygen, call an ambulance, and how to manage other patients in the surgery. A copy should be kept in the reception area and in the practice handbook.
Action: EP/MR to write procedure
4. A debriefing session is essential after the event for all the staff.
5. Medical confidentiality needs to be respected at all times with regard to such an event.
6. Location of equipment needs to be documented so that items can be found promptly by all members of staff - this could be kept on the treatment room doors.

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Cardiology

Type of activity Small group work**Title** Heart Failure**started** 11/12/2002**completed** 11/12/2002**hours** 2**Background to activity**

Publishing of NSF in heart failure

audit by partner showed wide discrepancy in diagnosis and management within the surgery

What did you do

small group discussion with other gps

What did you learn?

Best way to treat heart failure is to aggressively tackle RF before sx develop

Although an echo can establish diagnosis it would overload dept if all were now sent up

The rapid access chest pain clinic also has rapid access to angioplasty etc

Careful how we label heart failure as diagnosis. NSF may be unworkable and not fully costed

Began to plan to undertake diploma in cardiology this year, with a view to setting up community heart failure clinic

Attached Files:**heart failure.doc****Type of activity** Small group work +/- lectures**Title** Update on Hypertension**started** 18/03/2004**completed** 18/03/2004**hours** 2**Background to activity**

Personal Interest in Hypertension

Conflict between latest bhs and NICE guidelines

What did you do

Arranged local consultant to lead interactive group session

What did you learn?

We have been using 24 hour abpm incorrectly, we should count daytime readings only

Ignore NICE guidelines!

Avoid b blockers

Attached Files:**ambridge bp guidelines.do**

From to

Rob Howlett

6

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Child Protection

Type of activity Small group work

Title Child protection

Background to activity

started 06/02/2003

completed 06/02/2003

hours 2

Child protection
Publication of Climbie report
All GPs must undergo regular training in child protection issues

What did you do

Arranged for rolling program of multidisciplinary meetings by senior nurse in child protection

What did you learn?

Became aware of policies in North Essex
I now have a list of all relevant contacts
Lent to record if I actively decide not to refer a child for child protection issues
Disseminate primary health care team protocol within practice

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Chronic disease

Type of activity Audit

Title Chronic disease management and Ngms contract

started 01 04 2004

completed 16 08 2004

hours 20

Background to activity

new gms contract has introduced quality points for chronic disease management
this has finally given me leverage with my partners to implement good practice via audits

What did you do

over the 4 month period i carried out repeated small audits around diabetes, IHD, hypertension, epilepsy, strokes, COPD, asthma and mental Health

Much of this was via small PDSA cycles

I presented audits in excel format to members of the primary health care team

maintained and created appropriate disease registers

developed mail shots to recall patients

partook in qualitative assesment of patient's attitudes to their diagnosis of asthma

altered medications

recalled patients for blood tests

What did you learn?

the enclosed word document shows the progression in disease quality points

the maximun clinical points available are 587

at the beginning of this period the practice was on 324 points

at the end of the period the practice was on 509

disease registers are now more accurate

2 audits are still in progress

1. I have audited patient's within the practice on bendrofluazide, but not labelled as being hypertensive (I have identified 13 patients smokers/ex-smokersn=18)

this list is now being passed around the partners for their comments, those patients hypertensive will now be coded as such

2. I have identified 13 pateinets smoker/ex-smokers, labelled as asthmatic

they have all been invited in for spirometry to try to identify those actuall with copd, not asthma

Attached Files:

quality points 7 2004.doc

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Communication skills

Type of activity Patient feedback/complaints**Title** Review of interpersonal skills via IPQ**started** 01/07/2003**completed** 06/11/2003**hours** 2**Background to activity**

Part of appraisal process

What did you do

carried out Improving practice questionnaire in the surgery.
questionnaires handed out to 40 patients

What did you learn?

Reassuring to see that I score above average in all categories
My overall score is 82% compared to 62% average for all doctors in study
My lowest scores were for reassurance (77% cf 69% average) and time for visit (77% cf 61% average)

I would like level of reassurance felt to be higher
I must work more on this aspect of my consultation skills

Attached Files:**review ippqs.xls**

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

General medicine

Type of activity Lecture

Title thyroid disease

started 03/03/2004

completed 03/03/2004

hours 1

Background to activity

opportunistic learning.
Chance to meet new consultant

What did you do

interactive lecture

What did you learn?

notes attached

Attached Files:



thyroid lecture.doc



thyroid bmj.pdf

Type of activity Reflective practice

Title Patient death from sepsis

started 04/08/2003

completed 04/08/2003

hours 3

Background to activity

Patient presented at surgery with bad sore throat, initially requesting visit.

Given 250mg penicillin qds

Subsequently developed septicaemia of unknown cause, patient in early 30s with young family, subsequently died

What did you do

Significant event meeting, partners, practice manager and practice nurses

What did you learn?

Discussed management of urgent requests for visits
Inappropriate for all requests to go to one doctor

If we use penicillin in adults we should give 500mg qds

Attached Files:



temp.rtf



learning activities.mdi

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Malignant disease

Type of activity Significant Event Analysis

Title new cancer diagnosis

started 17/05/2004

completed 17/05/2004

hours 1

Background to activity

case 1

An 84 yr old lady, BT, presented with a skin lesion on her face which was clinically described as a horny solar keratosis. The lesion was excised and histology was reported as "seborrhoeic keratosis showing Bowenoid changes, incompletely excised."

case 2

Carcinoma of colon in patient with long history of irritable bowel syndrome and diverticulitis.

Date: June 2003

CF, a 64 yr old woman, presented in June 2003 with rectal bleeding. She had a long history of IBS and diverticulitis but her symptoms were worsening and therefore MT referred her to Mr Millar, consultant colorectal surgeon. In July 2003 she presented to EP with symptoms suggestive of diverticulitis and was referred as an emergency after the second consultation. CT scan was normal but a barium enema showed a tumour in the sigmoid colon. Subsequently CF has developed abnormal liver function tests and is currently having chemotherapy.

What did you do

SEA with partners

What did you learn?

case 1

1. A skin lesion should always be excised rather than curetted if there is any doubt about the diagnosis.
2. All minor surgery procedures need to be entered via the minor surgery template.
3. MR raised the point that probably dual pathology is present in this case and it might be worth writing to the pathologist for clarification of this point.

case 2

1. Difficulty of assessing patients with rectal bleeding with other GI pathology. Plan to invite Mr Millar to post-graduate meeting to discuss this issue and how to manage people with symptoms suggestive of cancer that do not fulfil the criteria for the two week wait.
2. Identify which investigations are available for open access i.e that can be requested by GPs. This was particularly with reference to which X Rays are available from Addenbrookes. It was proposed that the secretaries keep an updated list, although it may be easier to refer to Addenbrookes website. When a GP finds that a particular investigation is available this could be highlighted at a practice meeting - possibly have a clinical slot added to the regular agenda of a practice meeting to discuss any interesting patients or care pathways.

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Mental health

Type of activity Reflective practice

Title FOLIC ACID AND DEPRESSION

started 10/10/2002

completed 10/10/2002

hours 3

Background to activity

Noticed interesting paper in BMJ on link between folic acid and confusion in the elderly

What did you do

Critical appraisal paper
search for similar papers+ literature review
Meeting with partners and district nurses

What did you learn?

Educational Activity.

What did you do? Reflect... Have you changed practice or learnt anything new. Any beneficial outcomes for patients

Low folate even in normal range can cause depression, cognitive impairment and dementia
Study showed adding 500mg folate to younger women on Prozac improved depression scores
Another study showed 50 mg methyl folate as effective as trazodone
Impact of folate treatment is slow and cumulative

1. District nurses to check folate level whenever they take a blood test in patient
2. Partners to consider adding in folate supplements to any depressed elderly patient

Attached Files:**folic acid.doc**

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Mental health

Type of activity Significant Event Analysis

Title SEctioning

started 17/05/2004

completed 17/05/2004

hours 1

Background to activity

Significant event analysis with partners and local CMHT

What did you do

SD was sectioned under Section 2 of the Mental Health Act on 6th January 2004. This was the culmination of a chain of events which began on 18th December 2003. SD registered with the practice in 2003 and had mainly seen RH up to that point.

On 18th December, SD requested an appointment urgently with RH for that morning and was told to come as a morning extra. However, she turned up in the middle of morning surgery and her behaviour was threatening towards the staff. MT therefore saw SD and prescribed treatment for cellulites which SD refused to take. Subsequent requests for appointments were related to a complaint of polymyalgia rheumatica. SD requested a home visit for a blood test.

On 24th December 2003 there were discussions with the Community Mental Health Team as there were concerns about SD's behaviour. MT met with the social worker and forms for a section 2 were completed (although the section 5(2) form was used in error) but the section was not served as SD was not at home.

SD continued to call the surgery, sometimes using a false name. On 2nd January 2004 it was felt that there had been a breakdown in trust and a letter was written to SD suggesting she might consider changing practice. SD received the letter on 5th January and spoke to MT, asking for clarification of what was said in the letter and at this point SD contacted the press.

On 6th January 2004 the situation had come to a head. JH arranged to see SD with an approved social worker and duty psychiatrist with view to completing a section 2. The first meeting failed as SD would not let anyone into the house. Having obtained a search warrant JH, the ASW and the psychiatrist were able to gain entry and serve the section.

SD was admitted to Fulbourn. Subsequently a section 3 was completed but later was withdrawn.

What did you learn?

1. The difficulty of assessing patients who have multiple presentations - Dr Hunt stressed the need to look at the whole picture/ form of the illness, rather than concentrating on isolated episodes.
2. How to manage a patient whose behaviour is disruptive to the other patients in the practice - need to strike the balance between one patient's particular needs and what effect that has on the care given to all the other patients in the practice. It was acknowledged that this is a very difficult problem and it was probably not possible to have handled the situation any differently.
3. The difficulty that arises if a patient refuses to see a particular doctor in the practice. It was decided that if this situation arises again the practice would make the patient aware that it is very difficult to treat a patient if they refuse to see a particular doctor.
One of the partners would write to the MPS/MDU to get clarification about whether practice can refuse to see a patient, and a practice's response to a patient who refuses to see a particular doctor.
Action: MT/JH
4. When sectioning a patient, rely on advice from the ASW and psychiatrist. It is the responsibility of the ASW to provide the correct forms.
5. Response to patients who report event to the Press. The practice needs to have a written standard response, which is kept in the Practice Handbook. e.g. "with respect to patient confidentiality the practice is not able to comment on the case".

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Mental health

Type of activity Significant Event Analysis**Title** suicide**started** 17/05/2004**completed** 17/05/2004**hours** 1**Background to activity**

IB, a 67 yr old man with known atrial fibrillation and history of pulmonary embolus, on warfarin. Presented to RH following a car accident. IB had contacted his insurance company after the accident and was told that he should report his medical problems to the DVLA. RH reassured him that he did not have any medical problems that had to be reported to the DVLA. The insurance company then said they would send a form for completion and RH reassured IB again.

A week later IB shot himself, leaving a note, citing his concern about loss of independence if he could not drive as the reason.

What did you do

SEA with partners

What did you learn?**Suicide**

1. If a patient cannot be reassured this may be a pointer to depression, although in this case the patient had appeared to be reassured at the consultation.
2. Fitness to drive advice available on Mentor and DVLA website
3. Important to provide support to staff after a traumatic event.
4. It is impossible to predict all suicides. Known statistics about suicide: two-thirds of cases see a doctor within a month and one third see a doctor within a week of suicide

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Mental health

Type of activity Small group work**Title** Substance abuse both in surgery and police cells**started** 11/11/2002**completed** 11/11/2002**hours** 6**Background to activity**

Practice continues to provide methadone substitution for heroin addicts. No common policy

I am a police surgeon and find it difficult establishing drug protocol in cells and protocol for establishing fitness for interview

What did you do

1. Attended full day course on substance abuse organised by equip
2. Made notes of course
3. Developed practice protocol for methadone substitution
4. organised meeting at practice to be attended by custody sergeants, doctors and consultant in charge of substance abuse

What did you learn?

Practice protocol developed for management of substance abuse

All patients to be referred to cdat before starting treatment

Realised that doses of methadone may need to be higher than I thought

Maintenance treatment is fine

Urine checks are supportive not policing

Attached Files:**substance abuse.doc**

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Mental health

Type of activity Small group work +/- lectures

Title Substance abuse workshop

started 22/06/2004

completed 22/06/2004

hours

Background to activity

I see patients on methadone as part of enhanced service
This workshop is part of the formal on going training

What did you do

lectures and small group work

What did you learn?

See attached word document

Sleep disturbance is very common and may persist for up to 8 months

Hypnotics have no effect

DO NOT prescribe hypnotics or diazepam to substance abusers

If a user takes street heroin there are many metabolites that will then appear on urine testing (Opiates,6MAM, morphine and codeine) this does not therefore imply multiple drug usage.

95% of users on stable maintenance will be honest with you about what might be in urine, so why test?

It is to protect you! Vital to do this quarterly

There is NO indication for medical certification by patients on stable methadone substitution.

Sudden withdrawal of large doses of BDZ can be fatal. If you have no choice but to give initial blind prescription, then give chlordiazepoxide at 2/3 of their BDZ dosage, divided over a 24 hour period

Attached Files:

substance abuse 7 2004.do

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Neurology

Type of activity Lecture

Title benign intracranial HT

started 07/07/2004

completed 07/07/2004

hours 2

Background to activity

saffron wsalden meeting

What did you do

talk by new Addenbrookes consultant

What did you learn?

Addenbrookes developing new ways of lx chronic headaches with cerebral angiography

Attached Files:



BI hypertension lecture.rtf

Type of activity Small group work +/- lectures

Title epilepsy

started 05/03/2003

completed 05/03/2003

hours 2

Background to activity

target area in new contract

unclear with new medication

I have a patient with difficult to control epilepsy who has commenced drugs about which I know little!

What did you do

arranged for local constnant to give small interactice talk at local hospital

watched videos of faints, fits and seizures

group work to try and identify diagnosis

What did you learn?

faints can cause marked twitching, very like a classical seizure

frequent fainters get enhanced pulse rate then rebound up to 30 minutes later

use b blockers or ssri

behavioural tle

however bizarre always think of this diagnosis if stereotypic

petit mal can always be trigerred by hyperventillaion

adult psychogenic

*tend to be adult onset**vvery frequent attacks**trigerred by emotions**carpet burns**purely daytime*

there is a 10% lifetime risk of an epileptic dying from a seizure

see book "practical guide to epilepsy" Mark Manford

Attached Files:



epilepsy.ppt



test.txt

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Obs/gynae

Type of activity Distance based learning**Title** just in time menopause module**started** 08/10/2004**completed** 08/10/2004**hours** 1**Background to activity**

Wife is GPWSI in PMB

I wished to review my current knowledge

What did you do

completed bmj module

What did you learn?

nothing new

scored 100% in questions

my knowledge is up to date

Attached Files:

menopause bmj.pdf

Type of activity Distance based learning**Title** menorrhagia**started** 08/10/2004**completed** 08/10/2004**hours** 1**Background to activity**

Wife is currently on sabbatical, discussing her program with her I noted that my knowledge of menorrhagia is somewhat lacking

What did you do

Performed menorrhagia module on BMJ Learning

read module

answered multiple choice questions

discussed module with my wife (GPWSI in gynaecology)

What did you learn?

I scored 100% on the multiple choice

It seems that my know ledge and management is up to date after all!

Attached Files:

menorrhagia.pdf

From to

Rob Howlett

18

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Obs/gynae

Type of activity Lecture

Title BREAST DISEASE

started 10/06/2004

completed 10/06/2004

hours 2

Background to activity

SAFFRON WALDEN MEETING, arranged locally

What did you do

attended meeting

read papers around subject

see attached summary created

What did you learn?

aromestase is clinically better in short term (marginally) but higher s/e, cost, and no long term studies

Attached Files:



breast lecture.doc

From to

Rob Howlett

19

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Orthopaedics

Type of activity Small group work +/- lectures

Title shoulder problems-talk by Mr Tythleigh-Strong

started 05/11/2003

completed 05/11/2003

hours 1

Background to activity

Saffron Walden group lecture by local consultant.

What did you do

Talk on treatment of common shoulder problems + open discussion regarding best practice + when to refer

What did you learn?

Subacromial inj okay.

instability-surgery for recurrent dislocators

RC tears-surgerry for pain

OA-surgery for pain

Frozzzen shoulder-surgery for loss of movement

Attached Files:



shoulders.doc

From to

Rob Howlett

20

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Prescribing

Type of activity Team work

Title Improve medication review in practice

started 01/10/2002

completed 30/03/2003

hours 10

Background to activity

Publication of NSF for the elderly

Critically reviewed paper in BMJ showing value of a pharmacist reviewing repeat prescribing over 65 yrs within a surgery

What did you do

Discussed with PCT and prescribing adviser

Developed IT links for local pharmacist to review patients notes from within his surgery

Checked caldecot guardianship

Presented to partners and staff

Trained local pharmacist in use of IT

Developed template for pharmacist to use

Developed way of pharmacist feeding back changes to doctors

What did you learn?

Policy is now finally starting after much priority work

Appropriate audit mechanism have been set in place to review performance, prescribing, compliance, quality and cost markers

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Primary care

Type of activity Reflective practice

Title Reflective Learning diary

started 04/11/2002

completed 08/11/2002

hours 6

Background to activity

Practice involved in advance access program. Need to review effective use of consultations

What did you do

Devised reflective learning diary. Shared this among team members
reviewed own consultations
See 2 attached examples

What did you learn?

Attached Files:



reflective learning diary 1.doc



reflective learning diary 2.doc

Type of activity Reflective practice

Title Burnout self test

started 01/08/2004

completed 01/08/2004

hours 2

Background to activity

I have been a GP for 16 years, How am I coping?
Am I at risk of burnout?

What did you do

Read 2 papers on stress from the Lancet
Performed a burnout self test to assess my risk of burnout

What did you learn?

I reviewed 2 Lancet papers on stress

Stress and burnout in doctors 14 December 2002 (paper enclosed)

"whereby perceived stress at work resulted in poor mental health. Job satisfaction protected consultants from burnout, in that it reduced the likelihood of emotional exhaustion developing, and was associated with higher personal accomplishment. Emotional exhaustion did lead to depersonalisation, but not low personal accomplishment. Burnout predicted psychiatric morbidity: emotional exhaustion increased the risk of psychiatric morbidity, whereas personal accomplishment reduced it.

The causal links between stress and burnout in a longitudinal study of UK doctors. I C McManus, 15 June 2002

Emotional exhaustion and stress showed reciprocal causation: high levels of emotional exhaustion caused stress ($\beta=0.189$), and high levels of stress caused emotional exhaustion ($\beta=0.175$). High levels of personal accomplishment increased stress levels ($\beta=0.080$), whereas depersonalisation lowered stress levels ($\beta=-0.105$).

The first paper suggested that personal achievement increases stress, the second that it reduces it

I performed a self test on my burnout risk, scoring 15/45 (full spreadsheet enclosed), placing me at low risk of burnout, despite perhaps me trying to over achieve

Attached Files:



lancet, doctors stress.pdf



burnout self test.xls

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Primary care

Type of activity Small group work**Title** Advanced access**Background to activity** started 05/02/2003 completed 30/03/2003 hours 15

Lack of appointments in surgery and funded time to attend advanced access program

What did you do

attended 5 hour workshop on advanced access

What did you learn?

Came away inspired, discusses with partners and practice staff at in house shutdown

Devised reflective learning diary to be shared by doctors and practice nurses to try and assess which patients could have been managed by different type of consultation (place or consultant)

Each Partner and nurse completed diary, results discussed as practice

Began to distribute Improving practice questionnaire amongst individual patients consulting at surgery to assess patients attitudes to our surgery and my consultation technique

Practice planned to start advanced access July 2003

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Primary care

Type of activity Team work

Title Review management of chronic diseases within practice.

started 01/03/2003

completed 01/03/2003

hours 10

Background to activity

Imminent arrival of new contract and quality markers

By annual statin audits have shown our management not to be up to scratch and this finally gave me opportunity to push things through the practice

What did you do

organised and arranged multidisciplinary afternoon meeting with receptionists, district nurses, health care assistants and doctors

Each partner given one of the main chronic diseases to present

Audited the above disease for each partner to help with their presentation

What did you learn?

Check and reassign correct doctor as usual doctor to ensure correct ownership of patient/chronic disease by doctor
Story board and then rewrite EMIS templates

Disease Czar for each disease category in practice but individual doctors to retain control of their individual patients within agreed structure/guidelines

Agree to replace retiring notes summariser with someone with active nursing qualifications and pay more, extend role and extend hours

Separate pile of highlighted notes for scanning when new diseases appear on hospital letters

Attached Files:

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

Respiratory

Type of activity Lecture

Title Asthma update

started 27/11/2002

completed 27/11/2002

hours 2

Background to activity

Increasing number of patients within surgery with asthma, I am asthmatic, both our practice nurses are now asthma trained and are taking over increased management of asthmatics

I have had two patients with hard to control asthma not responsive to steroids although hospital labelled them as asthmatic

What did you do

arranged local consultant to speak to doctors and nurses small group work and lecture

What did you learn?

Understanding that long term chronic asthma causes permanent damage hence apparent lack of response to steroids

There are no effective treatments for acute Bronchiolitis (steroids may give short term relief) and it does lead to an increased risk of asthma

Reduced infections in early life increase risk of asthma

Patients with poorly controlled asthma have bronchial hyper reactivity and may respond to many allergens but are not actually allergic to them

1. Try and cut down patients on high dose chronic steroid use (it probably is not helping them)
2. Consider different asthma phenotypes to select appropriate treatments
3. Arrange follow up practical vitalographs meeting
4. Get rid of our cheap spirometer and buy an expensive one that works

Attached Files:



fm7_ug.pdf

LEARNING ACTIVITY REPORT DETAIL

Total events 31

Total hours 125

rheumatology

Type of activity Lecture

Title rheumatology update

started 16/10/2003

completed 16/10/2003

hours 1

Background to activity

saffron walden hospital meeting.opportunity to meet local consultant .

What did you do

U/sound -hands show inflam. changes around joint surfaces in early RA
 -colour doppler shows halo in temporal arteritis pre steroids.
 -shoulders in PMR.
 -sacroileitis in sero-ve arthritis.
 -some OA has inflam component,showson u/s.

Treatments:

1. Oa-some rsond to 7.5 mg pred + fossamax cover.
 -hydroxyquinine will effect some OA.
- 2.Early RA-can give 7.5 mg pred + fossamax whilst waiting referral as still slows progression joint changes.
 -salazopirine
 -methotrexate+ folic acid 5mg/w to dec s/e + nausea.Is best DM drug but several deaths c pneumonitis.
 -hydroxyquinine-less s/e, not DM drug.
 -anti TNF £10,000/y.Available Addenb if failure 2 DM drugs.Given early in disease in USA shown to turn off RA progression.
3. PMR-120mg depo IM, then wait for Sx to return after 6w,80mg etc as some don't return. Has steroid sparing potential.

What did you learn?

Use of u/s-? have local resourses for diagnosis.

IM steroids for steroid sparing.

2w wait physio Addenb.!

Attached Files: