5 minutes more

...is safe practice sustainable?

Dr Dan Rutherford

Biography

1979-84	General medicine, gastroenterology
1984-2000	NHS GP, St Andrews
2000-2001	www.netdoctor.co.uk
2001-2007	NHS locum
2003-2015	OOH GP
2003-current	Private GP, St Andrews
2010-current	Clinical tutor, St Andrews University Medical School

GP experience = 34 years

1998-current Medico-legal reporting, clinical negligence

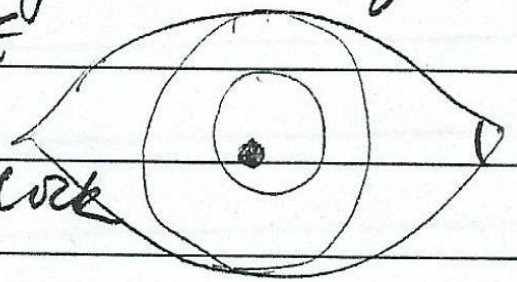
Dr Dan Rutherford

GP clinical negligence claims

2 claims per career (doubled since 2008)

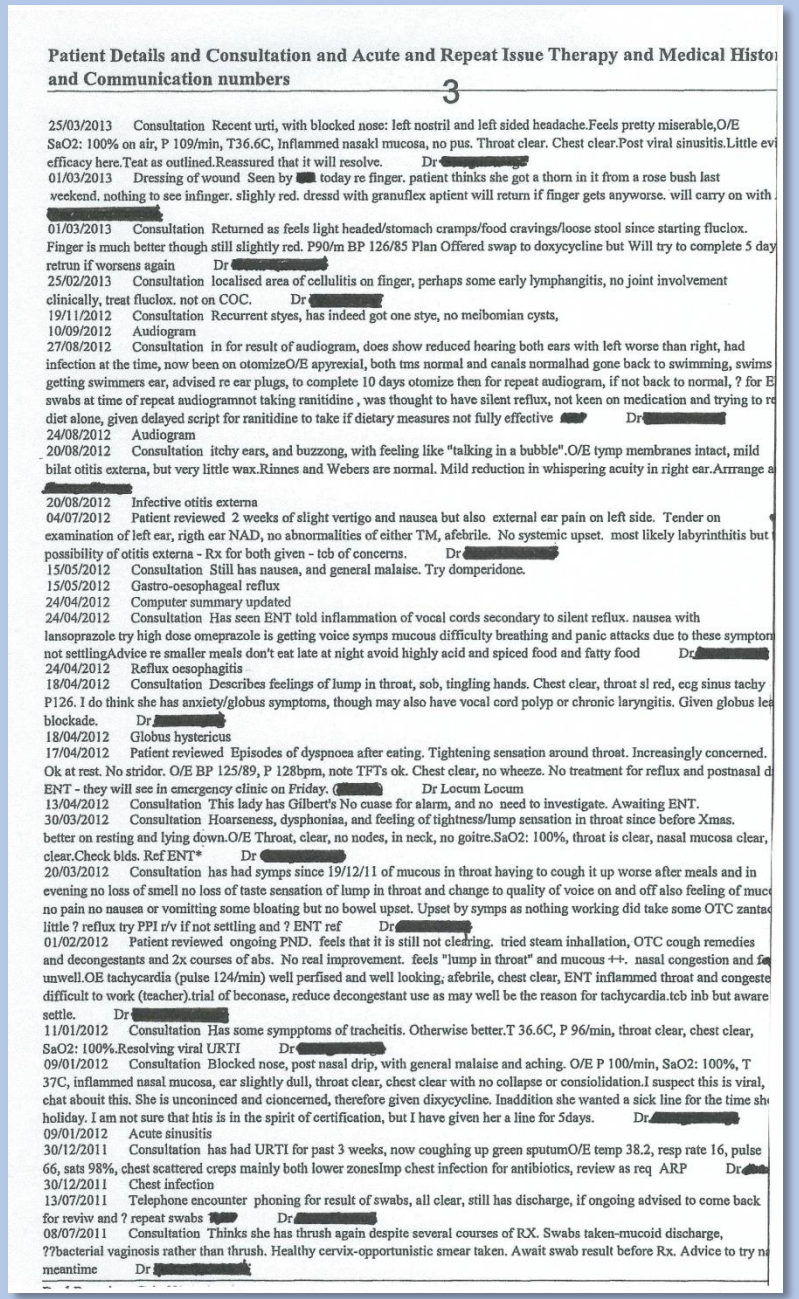
- 88% fear being sued
- 72% --> stress & anxiety
- 64% reconsidering future in profession

(MPS survey)

12/7/05	A	Acutely painful (R) eye overnight. Contact lens wearer. 7c corneal abrasion 7o'clock (R). 	Rx: Benoxinate edrops. Chloramph. eye oint. 1/2

Medical record details

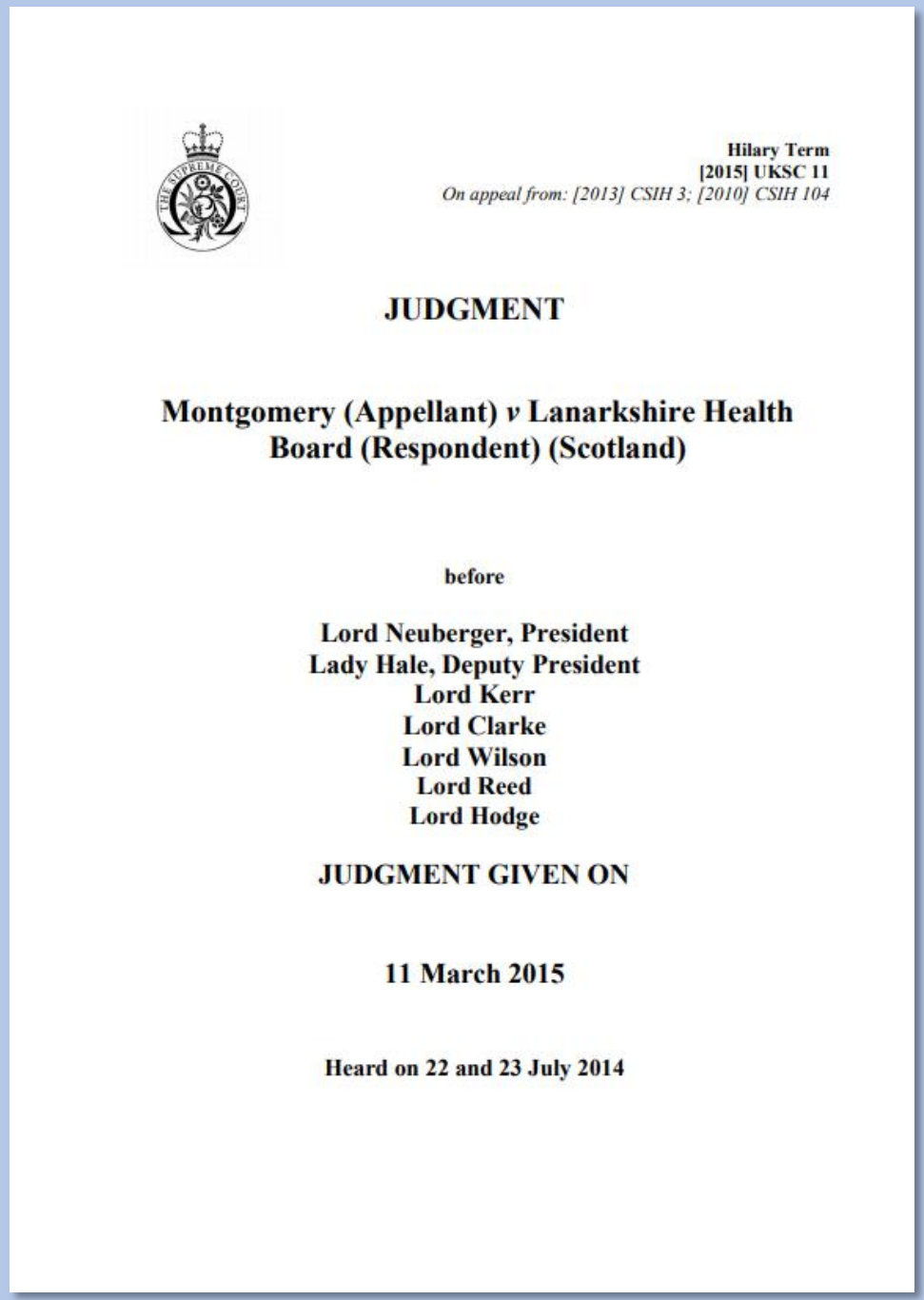
- 1 page
- 2 years
- 29 consultations



Patient Details and Consultation and Acute and Repeat Issue Therapy and Medical Histo
and Communication numbers

3

25/03/2013 Consultation Recent urti, with blocked nose: left nostril and left sided headache.Feels pretty miserable,O/E SaO2: 100% on air, P 109/min, T36.6C, Inflammed nasakl mucosa, no pus. Throat clear. Chest clear.Post viral sinusitis.Little evi efficacy here.Teat as outlined.Reassured that it will resolve. Dr [redacted]
01/03/2013 Dressing of wound Seen by [redacted] today re finger. patient thinks she got a thorn in it from a rose bush last weekend. nothing to see infinger. slighly red. dressd with granuflex aptient will return if finger gets anyworse. will carry on with [redacted]
01/03/2013 Consultation Returned as feels light headed/stomach cramps/food cravings/loose stool since starting fluclox. Finger is much better though still slightly red. P90/m BP 126/85 Plan Offered swap to doxycycline but Will try to complete 5 day retrun if worsens again Dr [redacted]
25/02/2013 Consultation localised area of cellulitis on finger, perhaps some early lymphangitis, no joint involvement clinically, treat fluclox. not on COC. Dr [redacted]
19/11/2012 Consultation Recurrent styes, has indeed got one stye, no meibomian cysts,
10/09/2012 Audiogram
27/08/2012 Consultation in for result of audiogram, does show reduced hearing both ears with left worse than right, had infection at the time, now been on otomizeO/E apyrexial, both tms normal and canals normalhad gone back to swimming, swims getting swimmers ear, advised re ear plugs, to complete 10 days otomize then for repeat audiogram, if not back to normal, ? for E swabs at time of repeat audiogramnot taking ranitidine , was thought to have silent reflux, not keen on medication and trying to re diet alone, given delayed script for ranitidine to take if dietary measures not fully effective [redacted] Dr [redacted]
24/08/2012 Audiogram
20/08/2012 Consultation itchy ears, and buzzong, with feeling like "talking in a bubble".O/E tymp membranes intact, mild bilat otitis externa, but very little wax.Rinnes and Webers are normal. Mild reduction in whispering acuity in right ear.Arrrange a [redacted]
20/08/2012 Infective otitis externa
04/07/2012 Patient reviewed 2 weeks of slight vertigo and nausea but also external ear pain on left side. Tender on examination of left ear, rigth ear NAD, no abnormalities of either TM, afebrile. No systemic upset. most likely labyrinthitis but possibility of otitis externa - Rx for both given - tcb of concerns. Dr [redacted]
15/05/2012 Consultation Still has nausea, and general malaise. Try domperidone.
15/05/2012 Gastro-oesophageal reflux
24/04/2012 Computer summary updated
24/04/2012 Consultation Has seen ENT told inflammation of vocal cords secondary to silent reflux. nausea with lansoprazole try high dose omeprazole is getting voice symps mucous difficulty breathing and panic attacks due to these symptom not settlingAdvice re smaller meals don't eat late at night avoid highly acid and spiced food and fatty food Dr [redacted]
24/04/2012 Reflux oesophagitis
18/04/2012 Consultation Describes feelings of lump in throat, sob, tingling hands. Chest clear, throat sl red, ecg sinus tachy P126. I do think she has anxiety/globus symptoms, though may also have vocal cord polyp or chronic laryngitis. Given globus lea blockade. Dr [redacted]
18/04/2012 Globus hystericus
17/04/2012 Patient reviewed Episodes of dyspnoea after eating. Tightening sensation around throat. Increasingly concerned. Ok at rest. No stridor. O/E BP 125/89, P 128bpm, note TFTs ok. Chest clear, no wheeze. No treatment for reflux and postnasal d ENT - they will see in emergency clinic on Friday. ([redacted] Dr Locum Locum
13/04/2012 Consultation This lady has Gilbert's No cuase for alarm, and no need to investigate. Awaiting ENT.
30/03/2012 Consultation Hoarseness, dysphoniaa, and feeling of tightness/lump sensation in throat since before Xmas. better on resting and lying down.O/E Throat, clear, no nodes, in neck, no goitre.SaO2: 100%, throat is clear, nasal mucosa clear, clear.Check blds. Ref ENT* Dr [redacted]
20/03/2012 Consultation has had symps since 19/12/11 of mucous in throat having to cough it up worse after meals and in evening no loss of smell no loss of taste sensation of lump in throat and change to quality of voice on and off also feeling of muc no pain no nausea or vomitting some bloating but no bowel upset. Upset by symps as nothing working did take some OTC zantac little ? reflux try PPI n/v if not settling and ? ENT ref Dr [redacted]
01/02/2012 Patient reviewed ongoing PND. feels that it is still not clearing. tried steam inhallation, OTC cough remedies and decongestants and 2x courses of abs. No real improvement. feels "lump in throat" and mucous ++. nasal congestion and fa unwell.OE tachycardia (pulse 124/min) well perfised and well looking, afebrile, chest clear, ENT inflammed throat and congeste difficult to work (teacher).trial of beconase, reduce decongestant use as may well be the reason for tachycardia.tcb inb but aware settle. Dr [redacted]
11/01/2012 Consultation Has some sympptoms of tracheitis. Otherwise better.T 36.6C, P 96/min, throat clear, chest clear, SaO2: 100%.Resolving viral URTI Dr [redacted]
09/01/2012 Consultation Blocked nose, post nasal drip, with general malaise and aching. O/E P 100/min, SaO2: 100%, T 37C, inflammed nasal mucosa, ear slightly dull, throat clear, chest clear with no collapse or consiolidation.I suspect this is viral, chat abouit this. She is unconinced and cioncerned, therefore given dixycycline. Inaddition she wanted a sick line for the time sh holiday. I am not sure that htis is in the spirit of certification, but I have given her a line for 5days. Dr [redacted]
09/01/2012 Acute sinusitis
30/12/2011 Consultation has had URTI for past 3 weeks, now coughing up green sputumO/E temp 38.2, resp rate 16, pulse 66, sats 98%, chest scattered creps mainly both lower zonesImp chest infection for antibiotics, review as req ARP Dr [redacted]
30/12/2011 Chest infection
13/07/2011 Telephone encounter phoning for result of swabs, all clear, still has discharge, if ongoing advised to come back for reviw and ? repeat swabs [redacted] Dr [redacted]
08/07/2011 Consultation Thinks she has thrush again despite several courses of RX. Swabs taken-mucoid discharge, ??bacterial vaginosis rather than thrush. Healthy cervix-opportunistic smear taken. Await swab result before Rx. Advice to try na meantime Dr [redacted]



Hilary Term
[2015] UKSC 11
On appeal from: [2013] CSIH 3; [2010] CSIH 104

JUDGMENT

Montgomery (Appellant) *v* Lanarkshire Health Board (Respondent) (Scotland)

before

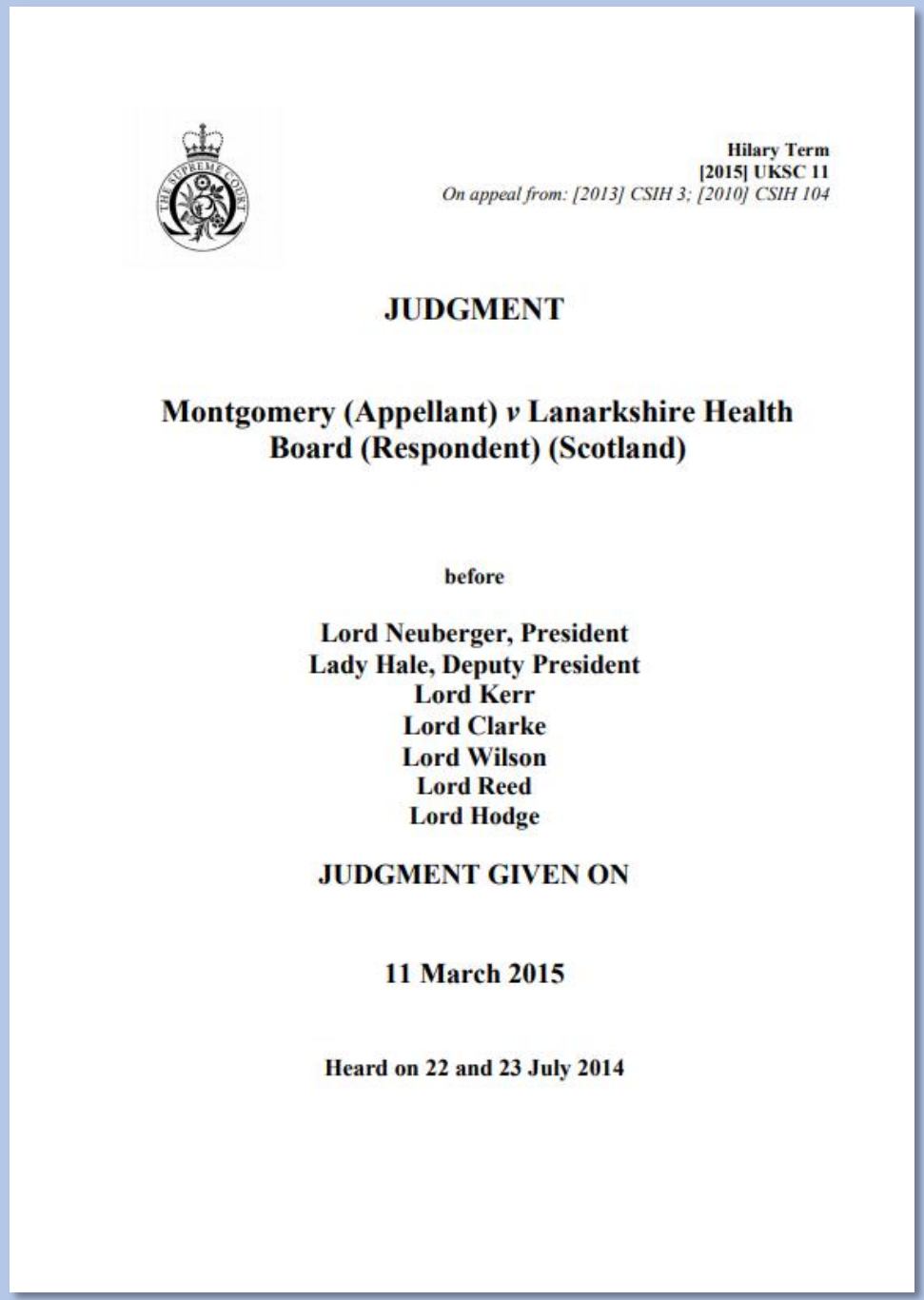
Lord Neuberger, President
Lady Hale, Deputy President
Lord Kerr
Lord Clarke
Lord Wilson
Lord Reed
Lord Hodge

JUDGMENT GIVEN ON

11 March 2015

Heard on 22 and 23 July 2014

- Mother short stature & diabetic
- Baby‘s shoulders impacted at delivery
- Forceps extraction, brachial plexus injury, cord compression, cerebral palsy



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Lord Kerr
Lord Clarke
Lord Wilson
Lord Reed
Lord Hodge

JUDGMENT GIVEN ON

11 March 2015

Heard on 22 and 23 July 2014

- Risk scenario evident in advance
- Risks of shoulder dystocia in diabetic mothers definable
- Risks of alternative treatment (Caesarean section) definable
- Time to ponder

General Practice & Montgomery

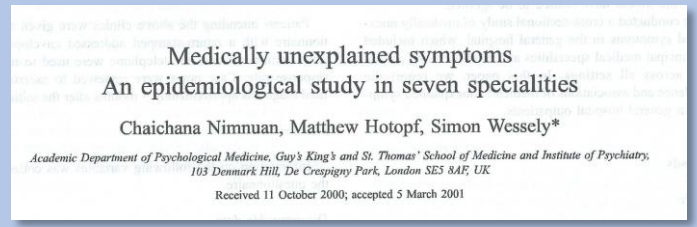
- GPs don’t “do” the same stuff

General Practice & Montgomery

- GPs don’t “do” the same stuff
- Diagnostic uncertainty is common

Prevalence of Medically Unexplained Symptoms

Specialty	% Unexplained at 3 months
Dental	37
Chest	41
Rheumatology	45
Cardiology	53
Gastroenterology	58
Neurology	62
Gynaecology	66
Total	**52**



Medically unexplained symptoms
An epidemiological study in seven specialities

Chaichana Nimnuan, Matthew Hotopf, Simon Wessely*

Academic Department of Psychological Medicine, Guy's King's and St. Thomas' School of Medicine and Institute of Psychiatry, 103 Denmark Hill, De Crespigny Park, London SE5 8AF, UK

Received 11 October 2000; accepted 5 March 2001

General Practice & Montgomery

- GPs don’t “do” the same stuff
- Diagnostic uncertainty is common
- Prescribing is the highest GP risk area

General Practice & Montgomery

- GPs don't "do" the same stuff
- Diagnostic uncertainty is common
- Prescribing is the highest GP risk area
  - Adverse drug events → 6.5% hospital admissions
  - 50% preventable

combination with antibacterials for the eradication of *Helicobacter pylori* (see specific regimens). Following endoscopic treatment of severe peptic ulcer bleeding, an intravenous, high-dose proton pump inhibitor reduces the risk of rebleeding and the need for surgery. Proton pump inhibitors can be used for the treatment of *dyspepsia* and *gastro-oesophageal reflux disease*.

Proton pump inhibitors are also used for the prevention and treatment of NSAID-associated ulcers. In patients who need to continue NSAID treatment after an ulcer has healed, the dose of proton pump inhibitor should normally not be reduced because asymptomatic ulcer deterioration may occur.

A proton pump inhibitor can be used to reduce the degradation of pancreatic enzyme supplements in patients with cystic fibrosis. They can also be used to control excessive secretion of gastric acid in *Zollinger–Ellison syndrome*; high doses are often required.

Proton pump inhibitors

- DRUG ACTION Proton pump inhibitors inhibit gastric acid secretion by blocking the hydrogen-potassium adenosine triphosphatase enzyme system (the 'proton pump') of the gastric parietal cell.

IMPORTANT SAFETY INFORMATION

MHRA ADVICE: PROTON PUMP INHIBITORS (PPIS): VERY LOW RISK OF SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS (SEPTEMBER 2015)

Very infrequent cases of subacute cutaneous lupus erythematosus (SCLE) have been reported in patients taking PPIs. Drug-induced SCLE can occur weeks, months or even years after exposure to the drug.

If a patient treated with a PPI develops lesions—especially in sun-exposed areas of the skin—and it is accompanied by arthralgia:

- advise them to avoid exposing the skin to sunlight;
- consider SCLE as a possible diagnosis;
- consider discontinuing PPI treatment unless it is imperative for a serious acid-related condition; a patient who develops SCLE with a particular PPI may be at risk of the same reaction with another;
- in most cases, symptoms resolve on PPI withdrawal; topical or systemic steroids might be necessary for treatment of SCLE only if there are no signs of remission after a few weeks or months.

- CAUTIONS Can increase the risk of fractures (particularly when used at high doses for over a year in the elderly) · may increase the risk of gastro-intestinal infections (including *Clostridium difficile* infection) · may mask the symptoms of gastric cancer (in adults) · patients at risk of osteoporosis

CAUTIONS, FURTHER INFORMATION

- Risk of osteoporosis Patients at risk of osteoporosis should maintain an adequate intake of calcium and vitamin D, and if necessary, receive other preventative therapy.
- Gastric cancer Particular care is required in those presenting with 'alarm features', in such cases gastric malignancy should be ruled out before treatment.

- SIDE-EFFECTS
- **Common or very common** Abdominal pain · constipation · diarrhoea · flatulence · gastro-intestinal disturbances · headache · nausea · vomiting
- **Uncommon** Arthralgia · dizziness · dry mouth · fatigue · myalgia · paraesthesia · peripheral oedema · pruritus · rash · sleep disturbances
- **Rare** Alopecia · anaphylaxis · blood disorders · bronchospasm · confusion · depression · fever · gynaecomastia · hallucinations · hepatitis · hypersensitivity reactions · hypomagnesaemia (usually after 1 year of treatment, but sometimes after 3 months of treatment) · hyponatraemia · interstitial nephritis · jaundice · leucocytosis · leucopenia · pancytopenia · photosensitivity · Stevens-Johnson syndrome · stomatitis · sweating · taste disturbance · thrombocytopenia · toxic epidermal necrolysis · visual disturbances

SIDE-EFFECTS, FURTHER INFORMATION

Rebound acid hypersecretion and protracted dyspepsia may occur after stopping prolonged treatment with a proton pump inhibitor.

- MONITORING REQUIREMENTS Measurement of serum-magnesium concentrations should be considered before and during prolonged treatment with a proton pump inhibitor, especially when used with other drugs that cause hypomagnesaemia or with digoxin.
- PRESCRIBING AND DISPENSING INFORMATION A proton pump inhibitor should be prescribed for appropriate indications at the lowest effective dose for the shortest period; the need for long-term treatment should be reviewed periodically.

above

Esomeprazole

- INDICATIONS AND DOSE

NSAID-associated gastric ulcer

- BY MOUTH
- Adult: 20 mg once daily for 4–8 weeks
- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
- Adult: 20 mg daily continue until oral administration possible, injection to be given over at least 3 minutes

Prophylaxis of NSAID-associated gastric ulcer in patients with an increased risk of gastroduodenal complications who require continued NSAID treatment

- BY MOUTH
- Adult: 20 mg daily

Prophylaxis of NSAID-associated gastric or duodenal ulcer

- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
- Adult: 20 mg daily continue until oral administration possible, injection to be given over at least 3 minutes

Gastro-oesophageal reflux disease (in the presence of erosive reflux oesophagitis)

- BY MOUTH
- Child 1–11 years (body-weight 10–19 kg): 10 mg once daily for 8 weeks
- Child 1–11 years (body-weight 20 kg and above): 10–20 mg once daily for 8 weeks
- Child 12–17 years: Initially 40 mg once daily for 4 weeks, continued for further 4 weeks if not fully healed or symptoms persist; maintenance 20 mg daily
- Adult: Initially 40 mg once daily for 4 weeks, continued for further 4 weeks if not fully healed or symptoms persist; maintenance 20 mg daily
- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
- Adult: 40 mg daily continue until oral administration possible, injection to be given over at least 3 minutes

Symptomatic treatment of gastro-oesophageal reflux disease (in the absence of oesophagitis)

- BY MOUTH
- Child 1–11 years (body-weight 10 kg and above): 10 mg once daily for up to 8 weeks
- Child 12–17 years: 20 mg once daily for up to 4 weeks
- Adult: 20 mg once daily for up to 4 weeks, then 20 mg daily if required
- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
- Adult: 20 mg once daily continue until oral administration is possible, injection to be given over at least 3 minutes

Zollinger–Ellison syndrome

- BY MOUTH
- Adult: Initially 40 mg twice daily, adjusted according to response; usual dose 80–160 mg daily, daily doses above 80 mg should be given in 2 divided doses

Severe peptic ulcer bleeding (following endoscopic treatment)

- INITIALLY BY INTRAVENOUS INFUSION
- Adult: Initially 80 mg, to be given over 30 minutes, then (by continuous intravenous infusion) 8 mg/hour for 72 hours, then (by mouth) 40 mg once daily for 4 weeks

***Helicobacter pylori* eradication in combination with clarithromycin and amoxicillin or metronidazole**

- BY MOUTH
- Adult: 20 mg twice daily

- UNLICENSED USE Tablets and capsules not licensed for use in children 1–11 years.
- INTERACTIONS → Appendix 1: proton pump inhibitors
- PREGNANCY Manufacturer advises caution—no information available.
- BREAST FEEDING Manufacturer advises avoid—no information available.
- HEPATIC IMPAIRMENT
- In adults In severe hepatic impairment max. 20 mg daily. Severe peptic ulcer bleeding in severe hepatic impairment, initial intravenous infusion of 80 mg, then by continuous intravenous infusion, 4 mg/hour for 72 hours.
- In children 1–11 years max. 10 mg daily in severe impairment. 12–17 years max. 20 mg daily in severe impairment.
- RENAL IMPAIRMENT Manufacturer advises caution in severe renal insufficiency.
- DIRECTIONS FOR ADMINISTRATION
- With intravenous use in adults For *intravenous infusion* (*Nexium*®), give continuously *or* intermittently in Sodium Chloride 0.9%; reconstitute 40–80 mg with up to 100 ml infusion fluid; for intermittent infusion, give requisite dose over 10–30 minutes; stable for 12 hours in Sodium Chloride 0.9%.
- With oral use Do not chew or crush capsules; swallow whole or mix capsule contents in water and drink within 30 minutes. Do not crush or chew tablets; swallow whole or disperse in water and drink within 30 minutes. Disperse the contents of each sachet of gastro-resistant granules in approx. 15 mL water. Stir and leave to thicken for a few minutes; stir again before administration and use within 30 minutes; rinse container with 15 mL water to obtain full dose. For administration through a gastric tube, consult product literature.
- PATIENT AND CARER ADVICE
- With oral use Counselling on administration of gastro-resistant capsules, tablets, and granules advised.

- MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

Gastro-resistant capsule

- Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole magnesium dihydrate) 20 mg Esomeprazole 20mg gastro-resistant capsules | 28 capsule PoM £12.95 DT price = £2.64

Esomeprazole (as Esomeprazole magnesium dihydrate) 40 mg Esomeprazole 40mg gastro-resistant capsules | 28 capsule PoM £17.63 DT price = £3.30

- Emozul (Consilient Health Ltd)

Esomeprazole (as Esomeprazole magnesium dihydrate) 20 mg Emozul 20mg gastro-resistant capsules | 28 capsule PoM £2.64 DT price = £2.64

Esomeprazole (as Esomeprazole magnesium dihydrate) 40 mg Emozul 40mg gastro-resistant capsules | 28 capsule PoM £3.30 DT price = £3.30

- Ventra (Ethypharm UK Ltd)

Esomeprazole (as Esomeprazole magnesium dihydrate) 20 mg Ventra 20mg gastro-resistant capsules | 28 capsule PoM £2.55 DT price = £2.64

Esomeprazole (as Esomeprazole magnesium dihydrate) 40 mg Ventra 40mg gastro-resistant capsules | 28 capsule PoM £2.97 DT price = £3.30

Gastro-resistant tablet

- Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole magnesium trihydrate) 20 mg Esomeprazole 20mg gastro-resistant tablets | 28 tablet PoM £18.50 DT price = £2.65

Esomeprazole (as Esomeprazole magnesium trihydrate) 40 mg Esomeprazole 40mg gastro-resistant tablets | 28 tablet PoM £25.19 DT price = £3.31

- Nexium (AstraZeneca UK Ltd, Pfizer Consumer Healthcare Ltd)

Esomeprazole (as Esomeprazole magnesium trihydrate) 20 mg Nexium 20mg gastro-resistant tablets | 28 tablet PoM £18.50 DT price = £2.65

Esomeprazole (as Esomeprazole magnesium trihydrate) 40 mg Nexium 40mg gastro-resistant tablets | 28 tablet PoM £25.19 DT price = £3.31

Powder for solution for injection

- Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole sodium) 40 mg Esomeprazole 40mg powder for solution for injection vials | 1 vial PoM £3.07–£3.13 (Hospital only)

- Nexium (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole sodium) 40 mg Nexium I.V 40mg powder for solution for injection vials | 1 vial PoM £4.25 (Hospital only)

Gastro-resistant granules

CAUTIONARY AND ADVISORY LABELS 25

- Nexium (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole magnesium trihydrate) 10 mg Nexium 10mg gastro-resistant granules sachets | 28 sachet PoM £25.19 DT price = £25.19

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Lansoprazole

07-Jun-2017

- INDICATIONS AND DOSE

***Helicobacter pylori* eradication in combination with amoxicillin and clarithromycin; or in combination with amoxicillin and metronidazole; or in combination with clarithromycin and metronidazole**

- BY MOUTH
- Adult: 30 mg twice daily

Benign gastric ulcer

- BY MOUTH
- Adult: 30 mg once daily for 8 weeks, dose to be taken in the morning

Duodenal ulcer

- BY MOUTH
- Adult: 30 mg once daily for 4 weeks, dose to be taken in the morning; maintenance 15 mg once daily

NSAID-associated duodenal ulcer | NSAID-associated gastric ulcer

- BY MOUTH
- Adult: 30 mg once daily for 4 weeks, continued for further 4 weeks if not fully healed

Prophylaxis of NSAID-associated duodenal ulcer | Prophylaxis of NSAID-associated gastric ulcer

- BY MOUTH
- Adult: 15–30 mg once daily

Zollinger–Ellison syndrome (and other hypersecretory conditions)

- BY MOUTH
- Adult: Initially 60 mg once daily, adjusted according to response, daily doses of 120 mg or more given in two divided doses

continued →

combination with antibacterials for the eradication of *Helicobacter pylori* (see specific regimens). Following endoscopic treatment of severe peptic ulcer bleeding, an intravenous, high-dose proton pump inhibitor reduces the risk of rebleeding and the need for surgery. Proton pump inhibitors can be used for the treatment of *dyspepsia* and *gastro-oesophageal reflux disease*.

Proton pump inhibitors are also used for the prevention and treatment of NSAID-associated ulcers. In patients who need to continue NSAID treatment after an ulcer has healed, the dose of proton pump inhibitor should normally not be reduced because asymptomatic ulcer deterioration may occur.

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- advise them to avoid exposing the skin to sunlight;
- consider SCLE as a possible diagnosis;
- consider discontinuing PPI treatment unless it is imperative for a serious acid-related condition; a patient who develops SCLE with a particular PPI may be at risk of the same reaction with another;
- in most cases, symptoms resolve on PPI withdrawal; topical or systemic steroids might be necessary for treatment of SCLE only if there are no signs of remission after a few weeks or months.

- CAUTIONS Can increase the risk of fractures (particularly when used at high doses for over a year in the elderly) · may increase the risk of gastro-intestinal infections (including *Clostridium difficile* infection) · may mask the symptoms of gastric cancer (in adults) · patients at risk of osteoporosis

CAUTIONS, FURTHER INFORMATION

- Risk of osteoporosis Patients at risk of osteoporosis should maintain an adequate intake of calcium and vitamin D, and if necessary, receive other preventative therapy.
- Gastric cancer Particular care is required in those presenting with 'alarm features', in such cases gastric malignancy should be ruled out before treatment.

- SIDE-EFFECTS
- **Common or very common** Abdominal pain · constipation · diarrhoea · flatulence · gastro-intestinal disturbances · headache · nausea · vomiting
- **Uncommon** Arthralgia · dizziness · dry mouth · fatigue · myalgia · paraesthesia · peripheral oedema · pruritus · rash · sleep disturbances
- **Rare** Alopecia · anaphylaxis · blood disorders · bronchospasm · confusion · depression · fever · gynaecomastia · hallucinations · hepatitis · hypersensitivity reactions · hypomagnesaemia (usually after 1 year of treatment, but sometimes after 3 months of treatment) · hyponatraemia · interstitial nephritis · jaundice · leucocytosis · leucopenia · pancytopenia · photosensitivity · Stevens-Johnson syndrome · stomatitis · sweating · taste disturbance · thrombocytopenia · toxic epidermal necrolysis · visual disturbances

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above

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- INDICATIONS AND DOSE

NSAID-associated gastric ulcer

- BY MOUTH
- Adult: 20 mg once daily for 4–8 weeks
- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
- Adult: 20 mg daily continue until oral administration possible, injection to be given over at least 3 minutes

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Prophylaxis of NSAID-associated gastric or duodenal ulcer

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Gastro-oesophageal reflux disease (in the presence of erosive reflux oesophagitis)

- BY MOUTH
- Child 1–11 years (body-weight 10–19 kg): 10 mg once daily for 8 weeks
- Child 1–11 years (body-weight 20 kg and above): 10–20 mg once daily for 8 weeks
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- Adult: Initially 40 mg once daily for 4 weeks, continued for further 4 weeks if not fully healed or symptoms persist; maintenance 20 mg daily
- BY INTRAVENOUS INJECTION, OR BY INTRAVENOUS INFUSION
- Adult: 40 mg daily continue until oral administration possible, injection to be given over at least 3 minutes

Symptomatic treatment of gastro-oesophageal reflux disease (in the absence of oesophagitis)

- BY MOUTH
- Child 1–11 years (body-weight 10 kg and above): 10 mg once daily for up to 8 weeks
- Child 12–17 years: 20 mg once daily for up to 4 weeks
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Zollinger–Ellison syndrome

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Severe peptic ulcer bleeding (following endoscopic treatment)

- INITIALLY BY INTRAVENOUS INFUSION
- Adult: Initially 80 mg, to be given over 30 minutes, then (by continuous intravenous infusion) 8 mg/hour for 72 hours, then (by mouth) 40 mg once daily for 4 weeks

***Helicobacter pylori* eradication in combination with clarithromycin and amoxicillin or metronidazole**

- BY MOUTH
- Adult: 20 mg twice daily

- UNLICENSED USE Tablets and capsules not licensed for use in children 1–11 years.
- INTERACTIONS → Appendix 1: proton pump inhibitors
- PREGNANCY Manufacturer advises caution—no information available.
- BREAST FEEDING Manufacturer advises avoid—no information available.
- HEPATIC IMPAIRMENT
- In adults In severe hepatic impairment max. 20 mg daily. Severe peptic ulcer bleeding in severe hepatic impairment, initial intravenous infusion of 80 mg, then by continuous intravenous infusion, 4 mg/hour for 72 hours.
- In children 1–11 years max. 10 mg daily in severe impairment. 12–17 years max. 20 mg daily in severe impairment.
- RENAL IMPAIRMENT Manufacturer advises caution in severe renal insufficiency.
- DIRECTIONS FOR ADMINISTRATION
- With intravenous use in adults For *intravenous infusion* (*Nexium*®), give continuously *or* intermittently in Sodium Chloride 0.9%; reconstitute 40–80 mg with up to 100 ml infusion fluid; for intermittent infusion, give requisite dose over 10–30 minutes; stable for 12 hours in Sodium Chloride 0.9%.
- With oral use Do not chew or crush capsules; swallow whole or mix capsule contents in water and drink within 30 minutes. Do not crush or chew tablets; swallow whole or disperse in water and drink within 30 minutes. Disperse the contents of each sachet of gastro-resistant granules in approx. 15 mL water. Stir and leave to thicken for a few minutes; stir again before administration and use within 30 minutes; rinse container with 15 mL water to obtain full dose. For administration through a gastric tube, consult product literature.
- PATIENT AND CARER ADVICE
- With oral use Counselling on administration of gastro-resistant capsules, tablets, and granules advised.

- MEDICINAL FORMS

There can be variation in the licensing of different medicines containing the same drug. Forms available from special-order manufacturers include: oral suspension

Gastro-resistant capsule

- Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole magnesium dihydrate) 20 mg Esomeprazole 20mg gastro-resistant capsules | 28 capsule PoM £12.95 DT price = £2.64

Esomeprazole (as Esomeprazole magnesium dihydrate) 40 mg Esomeprazole 40mg gastro-resistant capsules | 28 capsule PoM £17.63 DT price = £3.30

- Emozul (Consilient Health Ltd)

Esomeprazole (as Esomeprazole magnesium dihydrate) 20 mg Emozul 20mg gastro-resistant capsules | 28 capsule PoM £2.64 DT price = £2.64

Esomeprazole (as Esomeprazole magnesium dihydrate) 40 mg Emozul 40mg gastro-resistant capsules | 28 capsule PoM £3.30 DT price = £3.30

- Ventra (Ethypharm UK Ltd)

Esomeprazole (as Esomeprazole magnesium dihydrate) 20 mg Ventra 20mg gastro-resistant capsules | 28 capsule PoM £2.55 DT price = £2.64

Esomeprazole (as Esomeprazole magnesium dihydrate) 40 mg Ventra 40mg gastro-resistant capsules | 28 capsule PoM £2.97 DT price = £3.30

Gastro-resistant tablet

- Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole magnesium trihydrate) 20 mg Esomeprazole 20mg gastro-resistant tablets | 28 tablet PoM £18.50 DT price = £2.65

Esomeprazole (as Esomeprazole magnesium trihydrate) 40 mg Esomeprazole 40mg gastro-resistant tablets | 28 tablet PoM £25.19 DT price = £3.31

- Nexium (AstraZeneca UK Ltd, Pfizer Consumer Healthcare Ltd)

Esomeprazole (as Esomeprazole magnesium trihydrate) 20 mg Nexium 20mg gastro-resistant tablets | 28 tablet PoM £18.50 DT price = £2.65

Esomeprazole (as Esomeprazole magnesium trihydrate) 40 mg Nexium 40mg gastro-resistant tablets | 28 tablet PoM £25.19 DT price = £3.31

Powder for solution for injection

- Esomeprazole (Non-proprietary)

Esomeprazole (as Esomeprazole sodium) 40 mg Esomeprazole 40mg powder for solution for injection vials | 1 vial PoM £3.07–£3.13 (Hospital only)

- Nexium (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole sodium) 40 mg Nexium I.V 40mg powder for solution for injection vials | 1 vial PoM £4.25 (Hospital only)

Gastro-resistant granules

CAUTIONARY AND ADVISORY LABELS 25

- Nexium (AstraZeneca UK Ltd)

Esomeprazole (as Esomeprazole magnesium trihydrate) 10 mg Nexium 10mg gastro-resistant granules sachets | 28 sachet PoM £25.19 DT price = £25.19

76

Lansoprazole

07-Jun-2017

- INDICATIONS AND DOSE

***Helicobacter pylori* eradication in combination with amoxicillin and clarithromycin; or in combination with amoxicillin and metronidazole; or in combination with clarithromycin and metronidazole**

- BY MOUTH
- Adult: 30 mg twice daily

Benign gastric ulcer

- BY MOUTH
- Adult: 30 mg once daily for 8 weeks, dose to be taken in the morning

Duodenal ulcer

- BY MOUTH
- Adult: 30 mg once daily for 4 weeks, dose to be taken in the morning; maintenance 15 mg once daily

NSAID-associated duodenal ulcer | NSAID-associated gastric ulcer

- BY MOUTH
- Adult: 30 mg once daily for 4 weeks, continued for further 4 weeks if not fully healed

Prophylaxis of NSAID-associated duodenal ulcer | Prophylaxis of NSAID-associated gastric ulcer

- BY MOUTH
- Adult: 15–30 mg once daily

Zollinger–Ellison syndrome (and other hypersecretory conditions)

- BY MOUTH
- Adult: Initially 60 mg once daily, adjusted according to response, daily doses of 120 mg or more given in two divided doses

continued →

presenting with 'alarm features', in such cases gastric malignancy should be ruled out before treatment.

- SIDE-EFFECTS
- **Common or very common** Abdominal pain · constipation · diarrhoea · flatulence · gastro-intestinal disturbances · headache · nausea · vomiting
- **Uncommon** Arthralgia · dizziness · dry mouth · fatigue · myalgia · paraesthesia · peripheral oedema · pruritus · rash · sleep disturbances
- **Rare** Alopecia · anaphylaxis · blood disorders · bronchospasm · confusion · depression · fever · gynaecomastia · hallucinations · hepatitis · hypersensitivity

PPI side effects

reactions · hypomagnesaemia (usually after 1 year of treatment, but sometimes after 3 months of treatment) · hyponatraemia · interstitial nephritis · jaundice · leucocytosis · leucopenia · pancytopenia · photosensitivity · Stevens-Johnson syndrome · stomatitis · sweating · taste disturbance · thrombocytopenia · toxic epidermal necrolysis · visual disturbances

SIDE-EFFECTS, FURTHER INFORMATION

Rebound acid hypersecretion and protracted dyspepsia may occur after stopping prolonged treatment with a proton pump inhibitor.

- MONITORING REQUIREMENTS Measurement of serum-magnesium concentrations should be considered before and during prolonged treatment with a proton pump inhibitor, especially when used with other drugs that cause hypomagnesaemia or with digoxin.
- PRESCRIBING AND DISPENSING INFORMATION A proton pump inhibitor should be prescribed for appropriate indications at the lowest effective dose for the shortest period; the need for long-term treatment should be reviewed periodically.

General Practice & Montgomery

- GPs don't "do" the same stuff
- Diagnostic uncertainty is common
- Prescribing is the highest GP risk area, but…drug risks are often ill-defined or idiosyncratic

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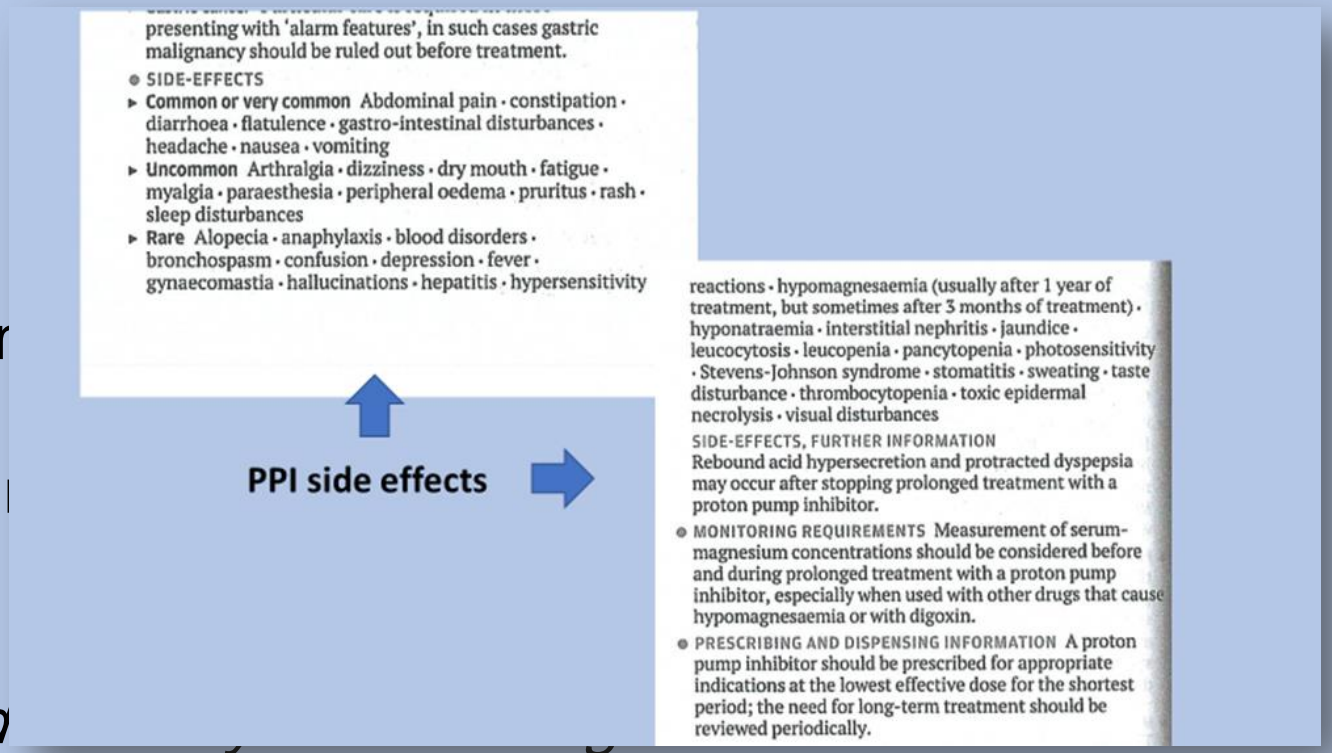

General Practice & Montgomery

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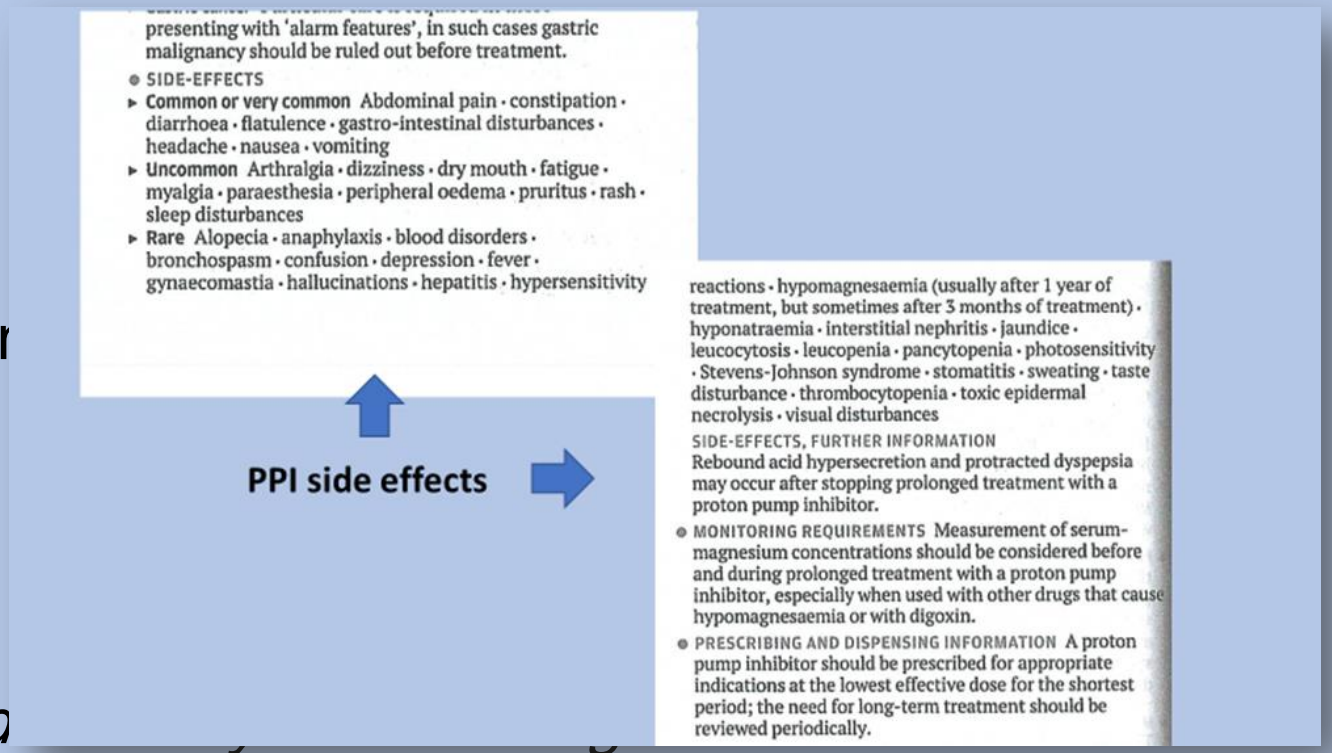
- Diagnostic uncertainty is comm
- Prescribing is the highest GP defined or idiosyncratic
- *"…reasonable person…would risk…"*
- **Time**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Hilary Term
[2015] UKSC 11
On appeal from: [2013] CSIH 3; [2010] CSIH 104

JUDGMENT

Montgomery (Appellant) *v* Lanarkshire Health Board (Respondent) (Scotland)

before

Lord Neuberger, President
Lady Hale, Deputy President
Lord Kerr
Lord Clarke
Lord Wilson
Lord Reed
Lord Hodge

JUDGMENT GIVEN ON

11 March 2015

Heard on 22 and 23 July 2014

92. There are, of course, arguments which can be advanced against this approach: for example, that some patients would rather trust their doctors than be informed of all the ways in which their treatment might go wrong; that it is impossible to discuss the risks associated with a medical procedure within the time typically available for a healthcare consultation; that the requirements imposed are liable to result in defensive practices and an increase in litigation; and that the outcome of such litigation may be less predictable.

93. The first of these points has been addressed in para 85 above. In relation to the second, the guidance issued by the General Medical Council has long required a broadly similar approach. It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires. This may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562 was no doubt received in a similar way by the manufacturers of bottled drinks. The approach which we have described has long been operated in other jurisdictions, where healthcare practice presumably adjusted to its requirements. In relation to the third point, in so far as the law contributes to the incidence of litigation, an approach which results in patients being aware that the outcome of treatment is uncertain and potentially dangerous, and in their taking responsibility for the ultimate

Time

- Time lack = key constraint to delivering expert generalist care
- Shorter consultations ⇔ patient dissatisfaction
- Shorter consultations ⇔ doctor burnout
- More time essential to manage multimorbid patients in primary care

Time

Under time pressure, GPs:

- Ask fewer questions about presenting symptoms
- Conduct less thorough clinical examination
- Give less lifestyle advice
- Prescribe more

We politely ask patients to only discuss one problem per appointment.

This helps ensure clinics run to schedule and other patients aren't inconvenienced. If you need an additional appointment to discuss further problems, our receptionist will only be too happy to help.

Longer appointments, based on clinical need are available on request, these will be triaged before we can book them.

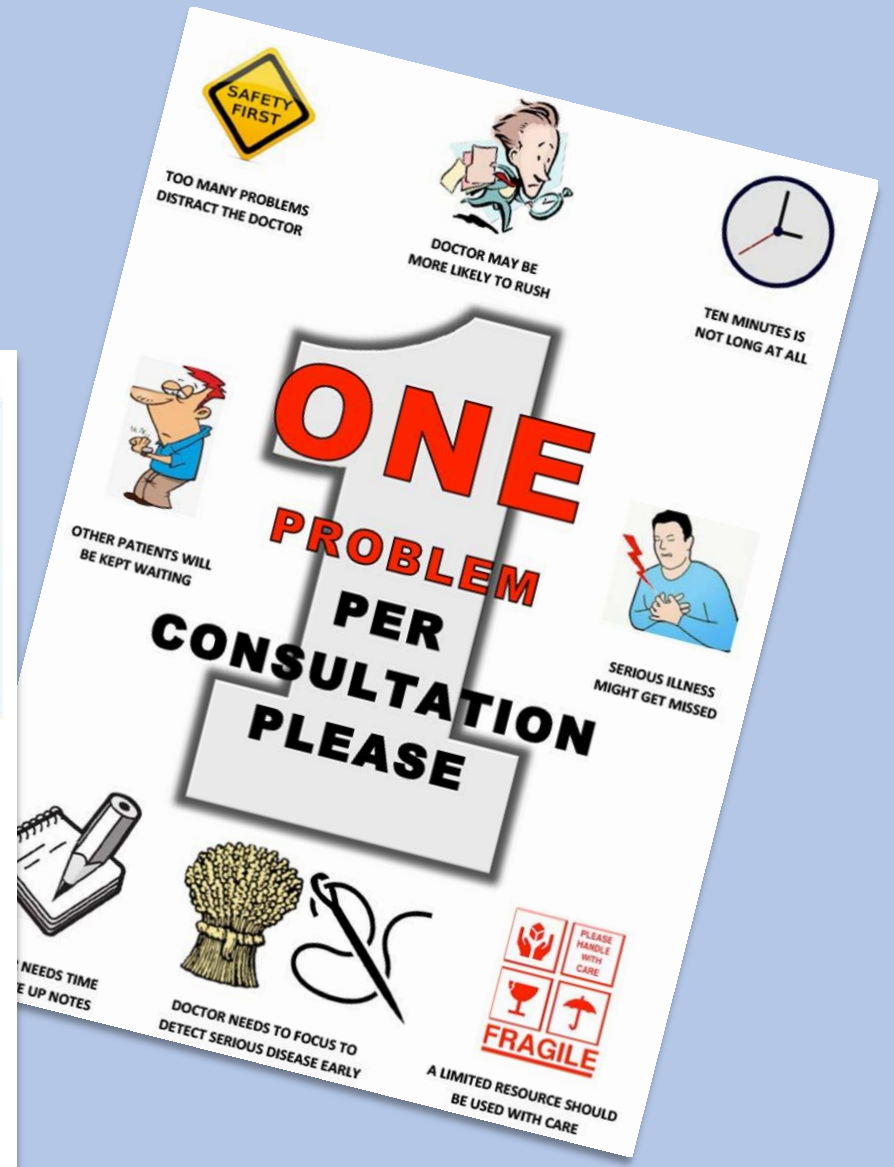
10 MINUTE GP APPOINTMENT

- One Appointment
- One Problem
- One Patient

It's tempting to bring a list of unrelated problems, but consider what's achievable in 10 minutes!

Top Tips

- **Before you see the GP**, work out what you're worried about, and highlight any particular concerns. Consider preparing short notes, including how you would describe your symptoms.
- **Get to the point:** don't beat about the bush and don't keep important issues until the end.
- **Wear accessible clothing** if you're likely to need to undress for examination.
- **Make sure you understand what happens next, if you are not sure** ask to go through the plan again.
- **Have your say and get your views heard; join our** Patient Participation Group (ask at reception).

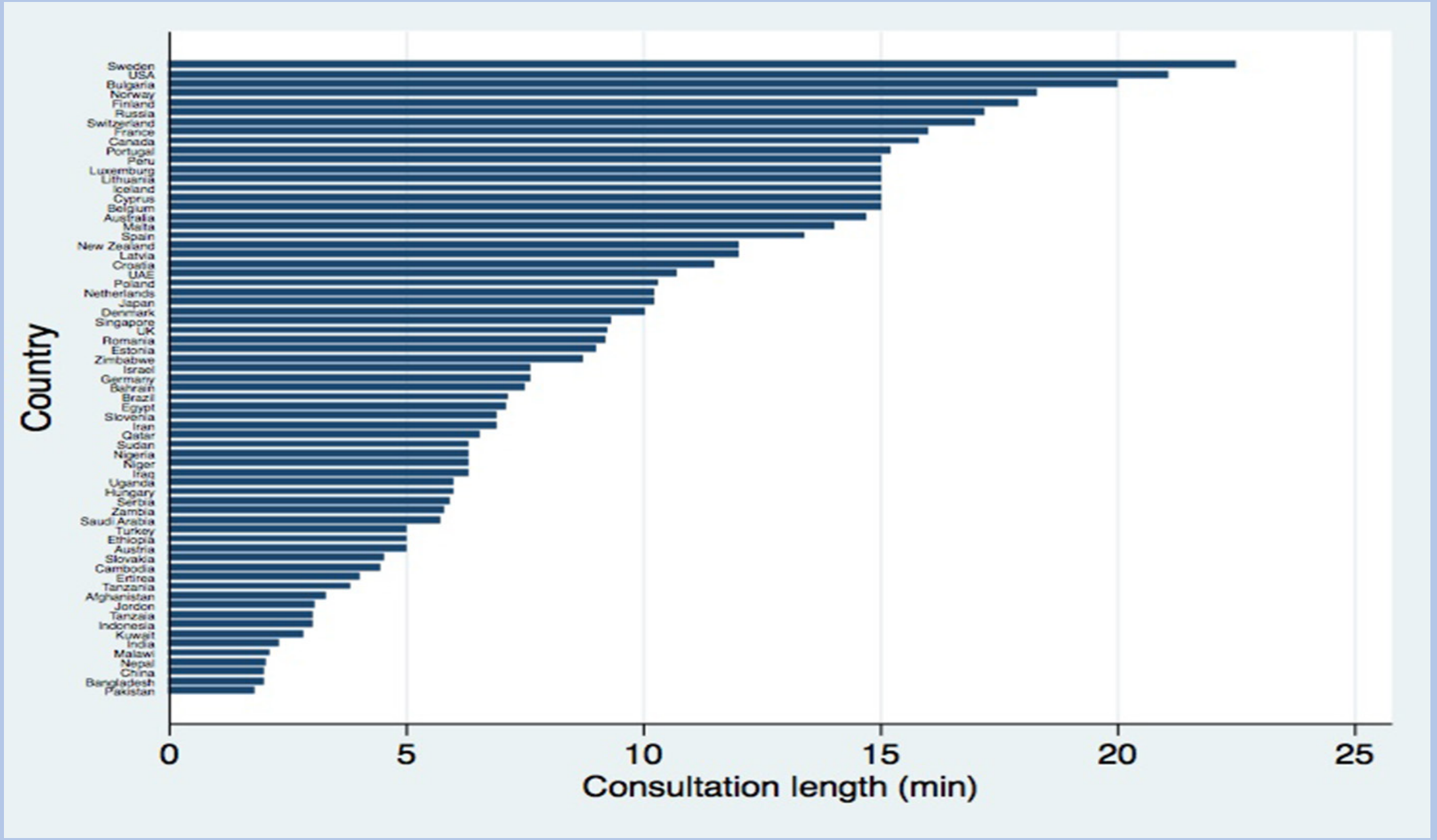


Apologies if I keep you waiting:

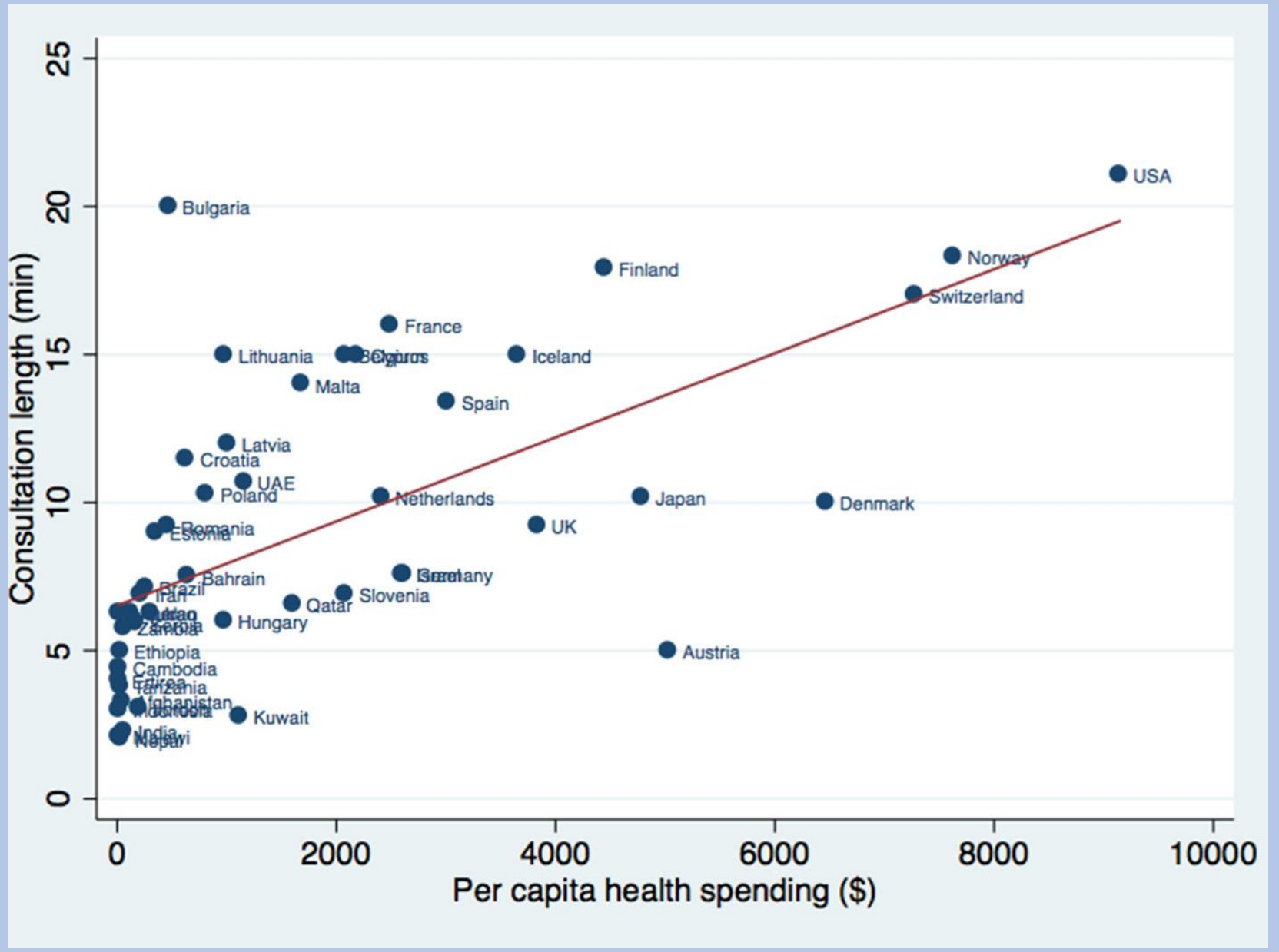
I'm trying to do my best for those ahead of you. Sometimes I'll be waiting for someone to stop crying before I turf them out, or I may be breaking bad news as sensitively as I can.

You will never know. And when it's eventually your turn, I will do the same for you.

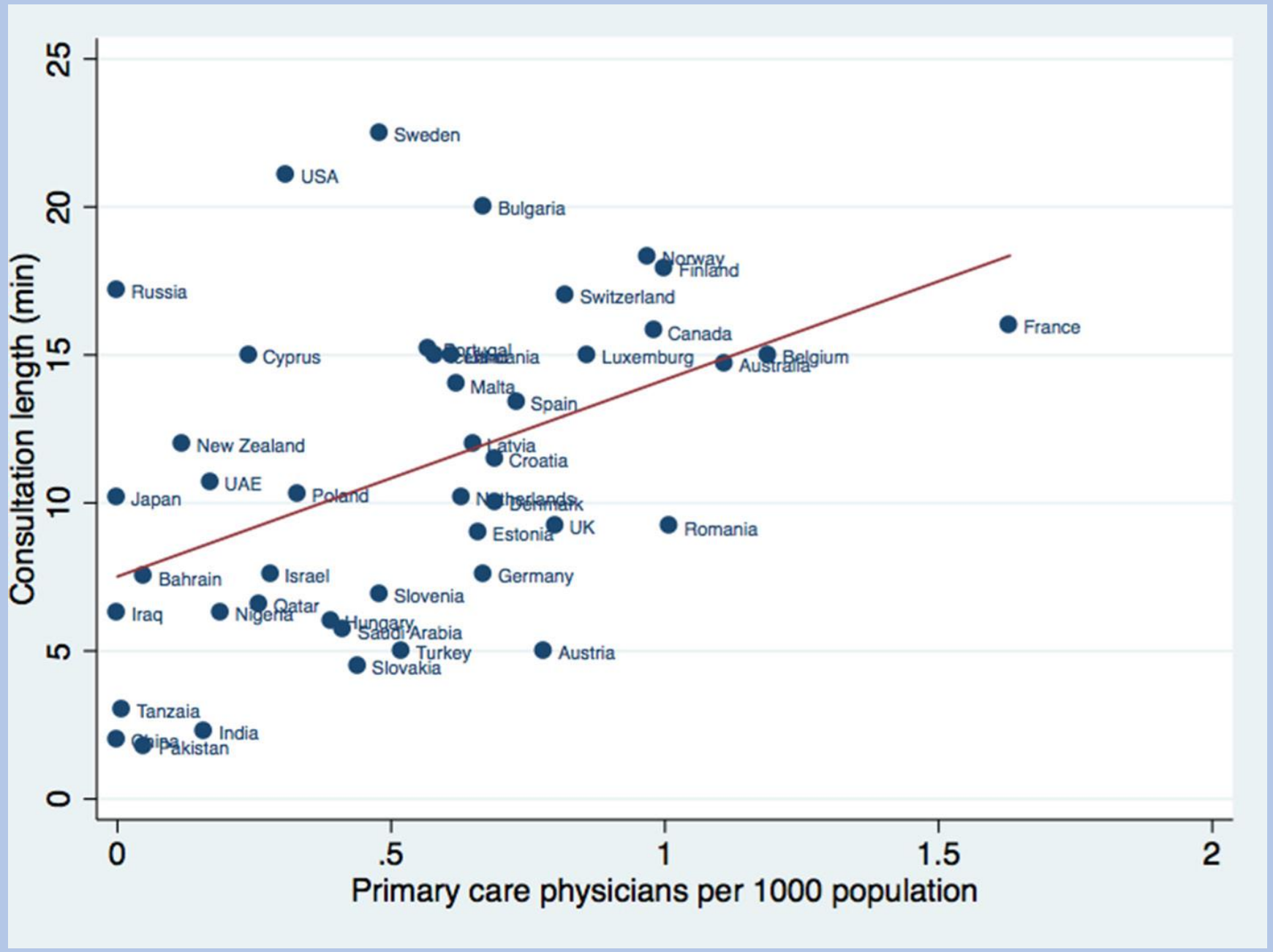
Consultation times - international



Consultation time vs health spending



Consultation time vs GP numbers



GP shortages

Shortage of general practitioners in the NHS

GPs are a scarce resource that must be deployed more wisely

Azeem Majeed *professor of primary care*

Department of Primary Care and Public Health, Imperial College London, UK

'No immediate solution' to GP shortage behind Scottish out-of-hours shutdown

By Jenny Cook on the 23 April 2018

NHS officials have said there is 'no immediate solution' to Scotland's primary care staff shortages following the three-month closure of out-of-hours GP services in Fife.

EXCLUSIVE 22nd May 2017

Record number of GP practices taken over by health boards amid doctor shortage

Exclusive by Helen McArdle @HMcardleHT
Health Correspondent

Scottish Government drive recruits just 18 new GPs

Hundreds of Scots GPs retire early as workload pressures cause 'burn-out'

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Scotland Business | Edinburgh, Fife & East | Glasgow & West

s' leader warns health rating'

Share

GPs retire early as cause 'burn-out'

WTE GPs -4% since 2013

GP Vacancies

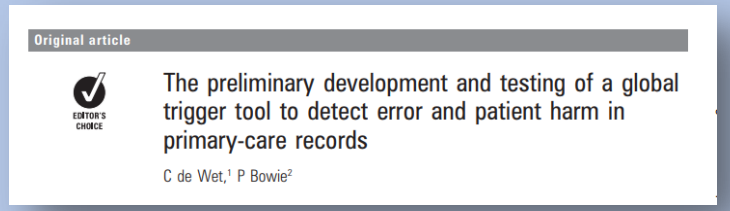
2013 9%

2015 22%

2018 24%

Adverse event rate in general practice

- Not well researched
- ?? 2%
- Most in patients > 60
- 59% medication related


Original article

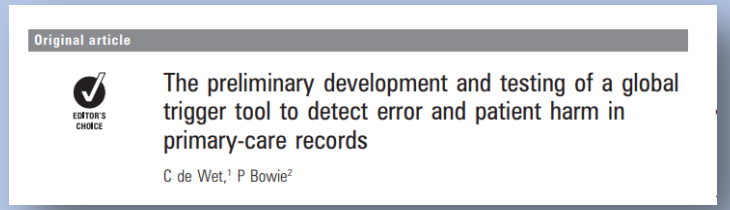
EDITOR'S CHOICE

The preliminary development and testing of a global trigger tool to detect error and patient harm in primary-care records

C de Wet,[1] P Bowie[2]

Adverse event rate in general practice

- 1 million GP consultations daily in UK
- 2% = 20,000 / day
- Drivers for complaints are not well understood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EDITOR'S CHOICE

The preliminary development and testing of a global trigger tool to detect error and patient harm in primary-care records

C de Wet,[1] P Bowie[2]

How much time is enough?

- Personal experience in private practice = 19 minutes
- 15 minutes NHS target ?
- DNA issues etc
    - patient co-operation

15 minute experience (GPs)

- Reduced stress for all staff
- No “one problem per appointment”
- Open appointments even better
  (unbooked, no time limit)

What about the patients?

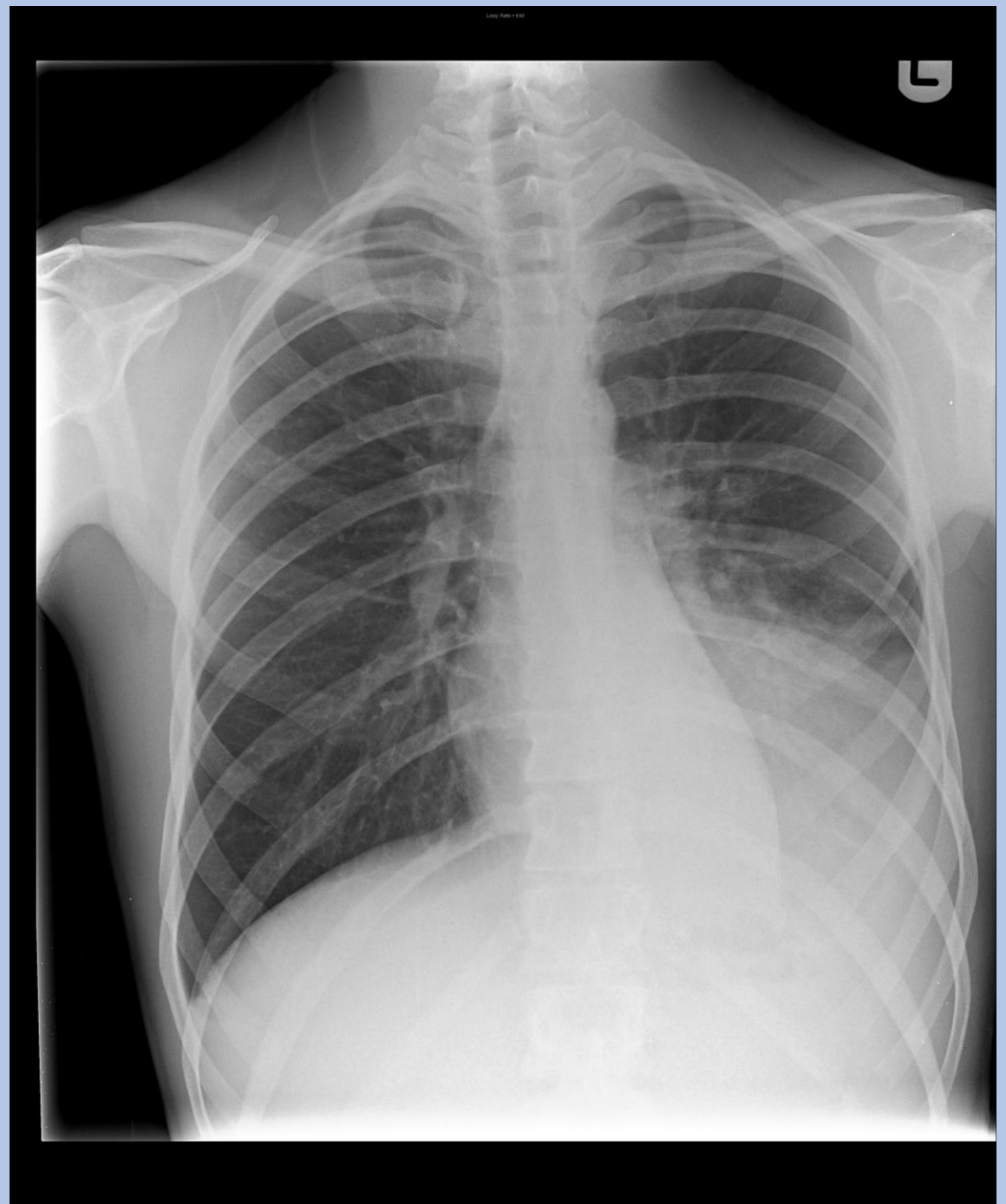
- Don’t like waiting (especially unbooked appts)
- Want more appointments
- Including out-of-hours

What about the patients?

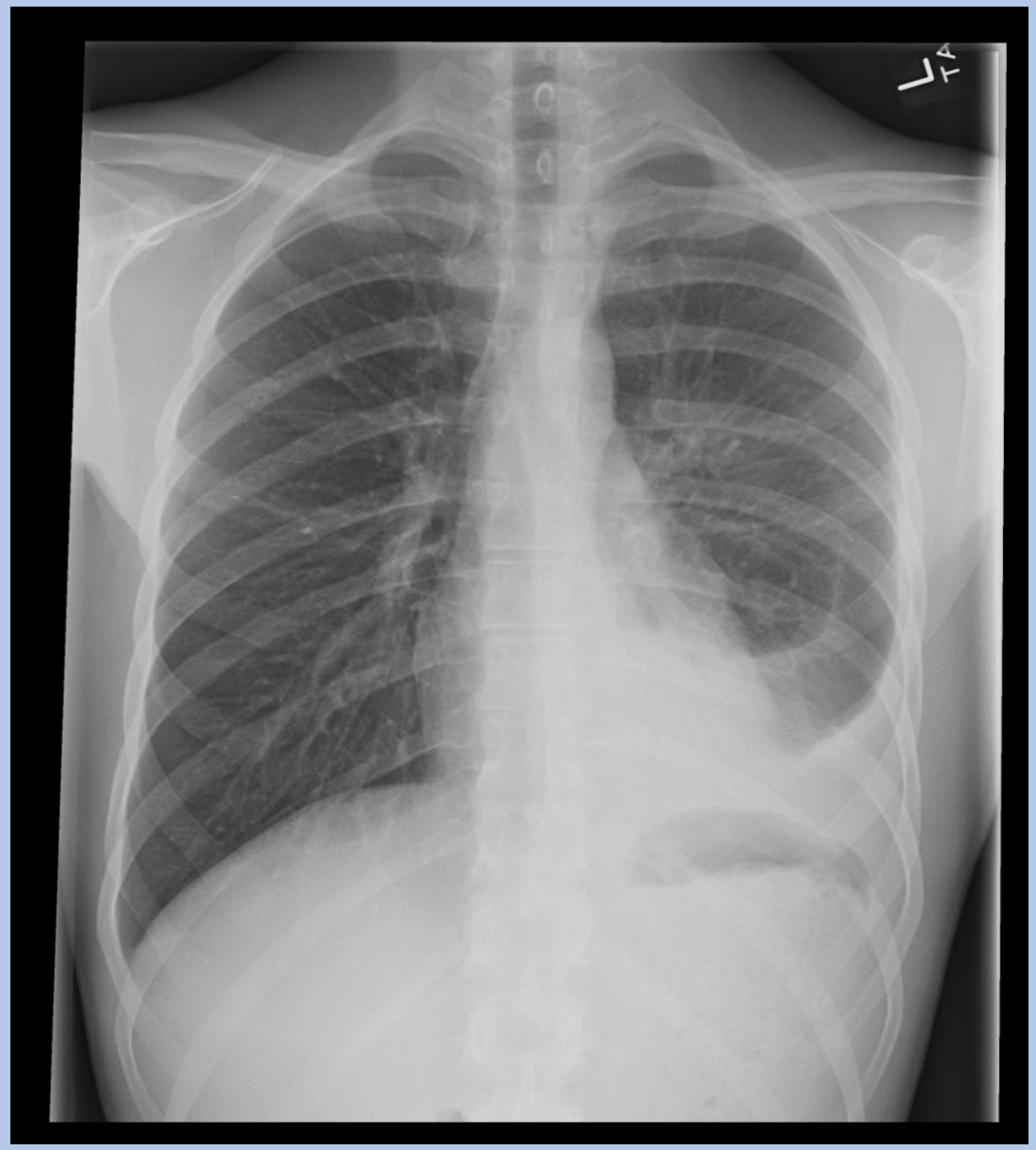
- Don’t like waiting (especially unbooked appts)
- Want more appointments
- Including out-of-hours
- No-win?

Patient A

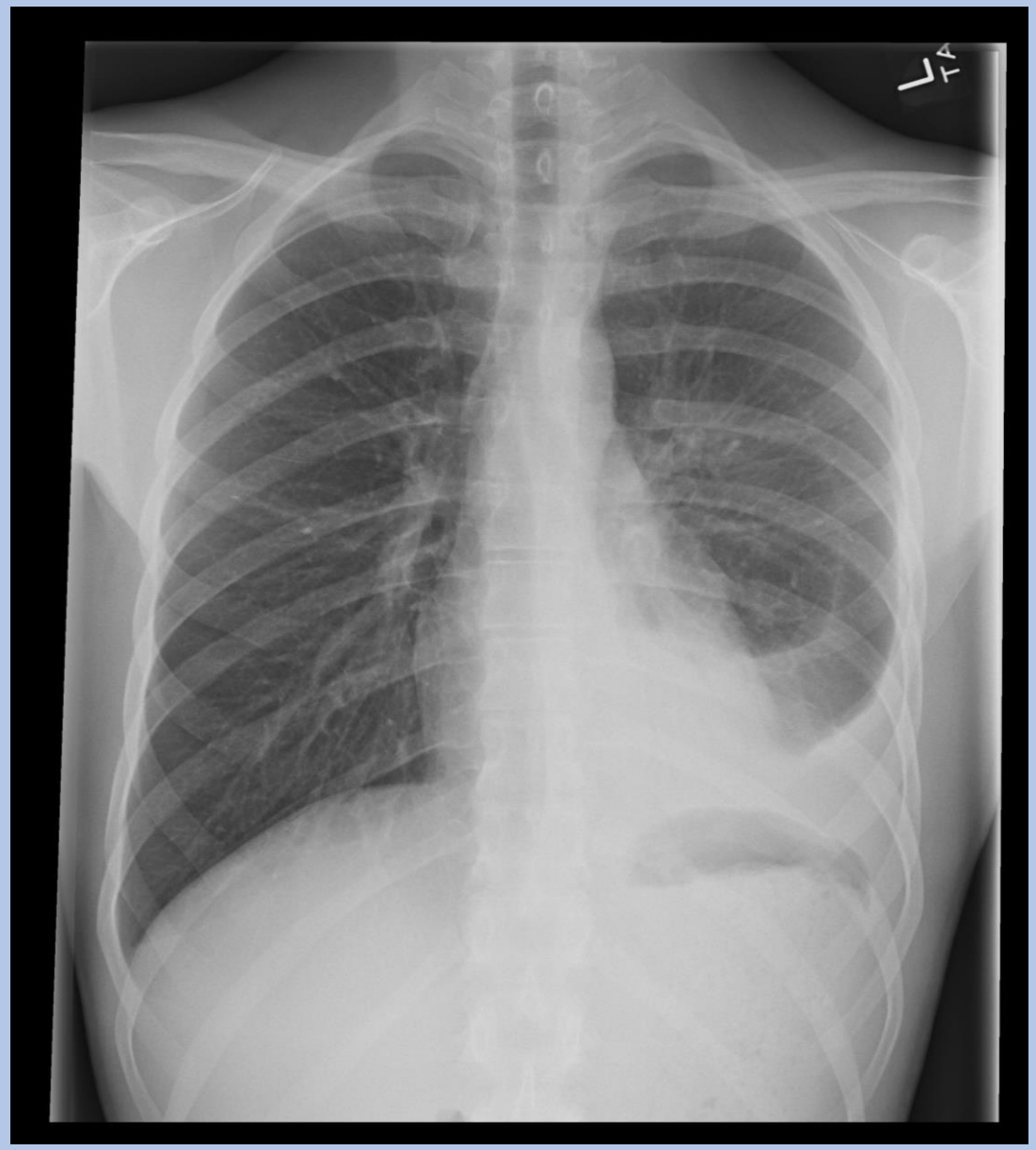
- Age 20, US student
- 12/3/18 chest pain, fever, vomiting
- Seen by OOH & GP, 13/3/18, 14/3/18, 15/3/18
- Mother came from US 16/3/18 -> hospital



- Discharged 19/3/18 (3 days)
- Incomplete antibiotic supply
- Follow up “6 weeks”
- Weak, chest pain, still feverish at times
- 20/3/18 high white cell count & inflammatory markers



- Chest X-ray 29/3/18
- Ongoing pneumonia left lung
- Needed re-admission
- Returned to Texas overnight



- Chest X-ray 29/3/18
- Ongoing pneumonia left lung
- Needed re-admission
- Returned to Texas overnight
- Was not fit for discharge on 16/3/18

Patient B

- Age 54
- Hodgkin's disease 1982 ->radiotherapy -> spinal cord damage -> long term suprapubic catheter
- August 2017 - blood in urine, catheter issues
- Late '17 – early '18 : cancelled appointments, snow
- Cystoscopy Feb 2018 : ? something seen – no action
- Changed hospitals March/April 2018
- CT 16/4/18 = advanced bladder cancer

Hunter v Hanley

'To establish liability by a doctor where departure from normal practice is alleged, three facts require to be established.

First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that *the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care*'

Hunter v Hanley

- *HvH* is insensitive to the increasingly difficult *context* of care delivery
- *"ordinary care"* is increasingly under threat from resource issues
- Going to get worse in the next 5-10 years
- Should the Courts acknowledge ?

Hunter v Hanley
V2 …

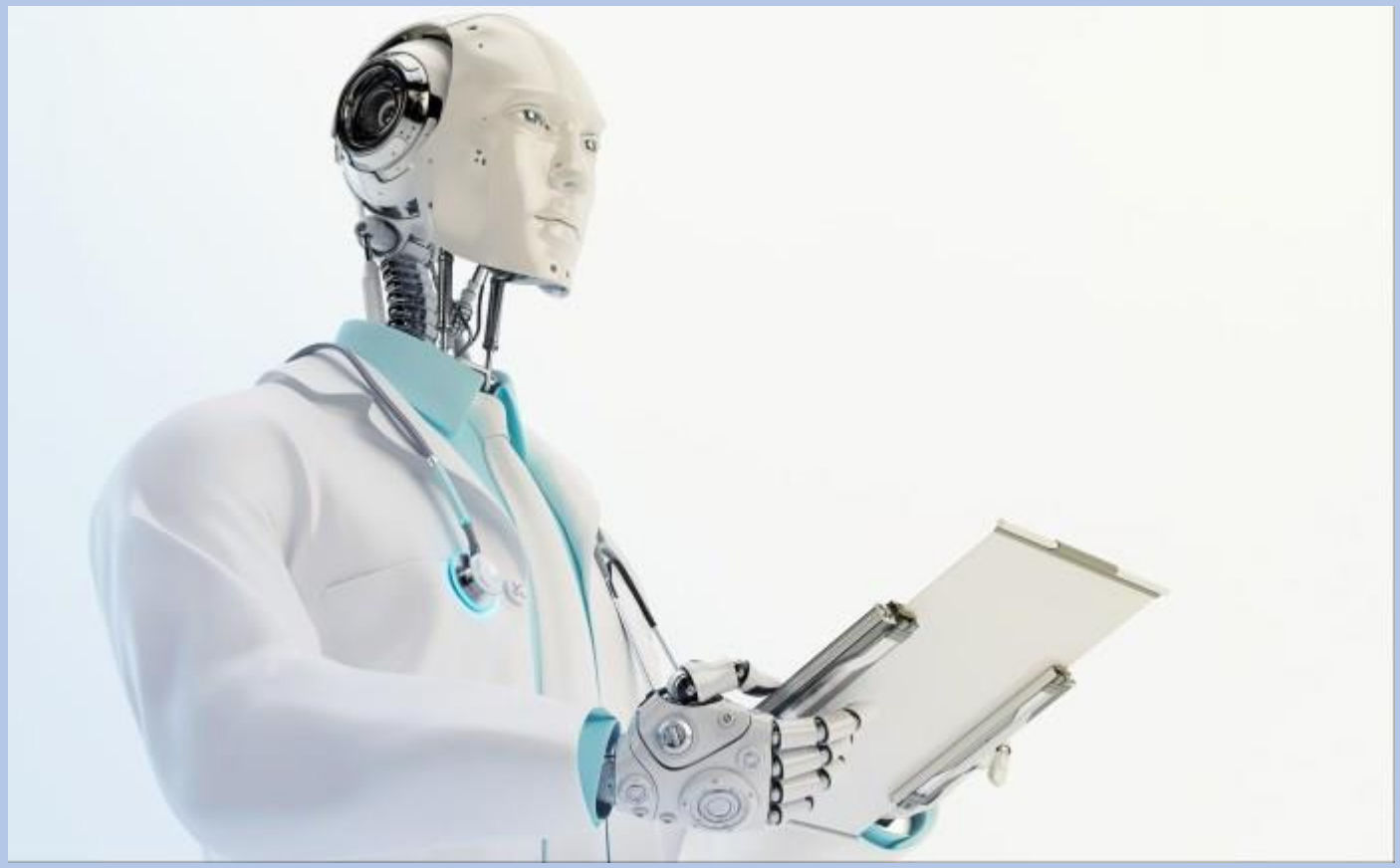
"…the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with a level of ordinary care that was deliverable within the context of current medical practice"

...is safe practice sustainable?

- General practice is under threat
- Resources too thinly spread
- Increasing personnel shortage
- Clinical negligence assessment should adapt…?


2001:
a space odyssey


2001:
a space odyssey



Hunter v Hanley
V3 ?

"…the course the computer adopted is one which no professional computer would have taken, using existing diagnostic and therapeutic algorithms with ordinary skill."

Hunter v Hanley
V3 ?

"…the course the computer adopted is one which no professional computer would have taken, using existing diagnostic and therapeutic algorithms with ordinary skill."

Thank you