13 Management: Community orientation

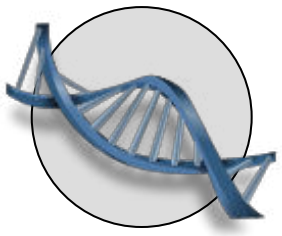
This competency area is about the management of the health and social care of the practice population and local community.

This section of the competence framework demonstrates better than almost any other, how the mindset and concerns of GPs are different to those of other specialists. For the trainee, this section presents a particular challenge because, other than in the section on resource management, it does not build on much of our previous training. Having said that, the context is not unfamiliar as undergraduate and pre-specialist training increasingly provide exposure to aspects of community medicine.

This area takes us beyond the focus on the patient and gets us to think about the wider community. There are three separate but related themes which build progressively on each other as this chapter shows:

- Understanding the features of the local community
- Understanding the nature and availability of local healthcare resources
- Managing resources, in particular the tension between the needs of individual patients and the wider patient community

Which aspects of our DNA, our deeper features, are prominent in community orientation? If we look back at the competencies for the 'Management' section (see page 117), we see that **problem-solving skills** are particularly important.



Joined up?
See p14

Needs Further Development	Competent for licensing	Excellent	
Identifies important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features.	Applies an understanding of these features to improve the management of the practice's patient population.	Uses an understanding of these features to contribute to the development of local healthcare delivery e.g. service design.	**1**

Discussion point: the inverse care law

The inverse care law was first described by Dr Julian Tudor Hart in 1971. It states that 'the availability of good medical care tends to vary inversely with the need for it in the population served.' This law is often quoted because availability, access to and use of services are thought to vary in accordance with this law.

Those who need healthcare least are said to use services such as the treatment of disease and health promotion more frequently and more effectively than those with the greatest objective need.

Sometimes people in need are 'excluded' by the system. Try looking at those who are 'exception reported' from QOF and check the reasons for this.

The first progression is about the importance of understanding the local community and how doctors tailor their services to meet the community's needs. We move from:

Having an understanding of those features of the local community that make it different from other populations.

↓

On the basis of this understanding, being able to improve the way current services are provided.

↓

Developing existing services and designing new ones to improve local healthcare

Looking at each of the competencies in turn:

Identifies important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features.

GPs don't just treat *patients*, but provide healthcare to a local *population*. Getting to know the features of the local community is therefore more than just getting to know the patients and we can improve our insight by considering the community from different, but interrelated, perspectives.

Our aim as GPs is to maximise the health of our local population and to do this, we need to understand the factors that influence health, the degree of influence that we have over these factors and how we can best improve community health within the available resources. Of course, this is not just *our* responsibility. Social services and education have a large part to play and in future, particularly through greater involvement in the commissioning of health services, GPs will be more actively involved in community health.

The word picture identifies some key features of the population, which we will now discuss.

1. Socioeconomic

Let's start by considering the relationship between socioeconomic factors and health. Of the 'characteristics of the local community' mentioned above, this relationship is particularly important and addressing it is part of what many practitioners most value about working in the NHS. Let's consider this in more detail.

The NHS was established in 1948 to address the inequality in health care services. It was set up as a service that was free at the point of use, was responsive to local needs and had a fairly even geographical spread across the country. The idea was that all citizens should receive the same high standard of care. As a result of the state-funded system, doctors no longer clustered in the most prosperous areas, because their livelihood was no longer dependent upon the patient's ability to pay. Also, patients of all socioeconomic classes were able to get the care of a practitioner when they (the patients) felt it was required. The power of these principles cannot be underestimated. Ask yourself: how would you feel and what would you do if you had to turn away patients could not pay your bills? This happened frequently before the NHS.

Why is access to healthcare important? There are some significant factors that we should be aware of. The first is that there is a clear correlation between position on the socioeconomic scale and the health that might be expected. This can be difficult for people who are more privileged in life (including doctors) to appreciate.

The evidence shows us that:

Together with inequalities in mortality, inequalities in *morbidity* contribute to large differences in the number of years of healthy living that might be expected.

Typically, persons with high socioeconomic positions live more than 10 years longer in good health than those in the lowest positions.

The *relative* as well as the absolute gap is important. Life expectancy data in England indicated in the early 21st century that since 1997 the relative gap in life expectancy had increased between England as whole and the 20% of local authorities with the lowest life expectancy. There were also differences between genders; in men the relative gap increased by nearly 2%, in women by 5%.

Health inequalities are mainly caused by greater exposure in lower socioeconomic groups to material, psychosocial and behavioural (smoking, alcohol consumption, nutrition) risk factors.

Studies looking at deprivation and the quality of primary care services show that the quality of care (e.g. glycaemic control in diabetes and influenza immunisation uptake) falls with increasing deprivation.

There is a social gradient in health according to income, occupation, education and parents' social class.

Tip: thinking about health and socioeconomic factors

You may be asked about this relationship in knowledge tests, but you should also think about the practical application of this knowledge.

Of the social factors listed, which do you feel you have an influence over? How would you apply this influence in dealing with a patient's problem? We have a clear role in managing addiction and stress…but what else?

Now think about your own practice. Which factors are particularly important in your own community? How would you find out?

What if anything have you done in your practice to address these issues? What do you think is a good use of your time and what is not?

Whose responsibility is it to join up health and social services? Can you think of any practical small scale project that is a good example of this in your community?

So what are the main social factors that impact upon health?

- Stress (modifying factors being control ,predictability, degree of support, threat to status, presence of outlets)
- Inadequate housing
- Early life (the effects of early development last a lifetime: a good start in life means supporting mothers and young children)
- Social exclusion
- Work control
- Organisational justice
- Job insecurity
- Social support
- Unemployment
- Addiction (Individuals turn to alcohol, drugs and tobacco and suffer from their use)
- Food
- Transport

The single assessment process (SAP): an example of integrating health with social factors

This is an example of how policy developments have recognized and reflected the importance of taking both medical and social factors into account when thinking about health. The SAP in this example relates to the health of older people. The table overleaf shows questions developed by the East Birmingham Primary Care Trust.

It's worth looking through the questions. Do any surprise you? Some look at social factors that are not frequently asked about (e.g. do you feel safe?) and others challenge our assumptions about the elderly (do you have any sexual concerns?).

Housing is a major social factor, but interestingly this questionnaire takes a more sophisticated look by asking not about housing itself, but about the effects of inadequate or inappropriate housing. Which do you think these questions might be?

SAP Questionnaire	
MAINTAINING A SAFE ENVIRONMENT	**COMMUNICATION**
o Have you any history of falls? o Are there any hazards in the home? o Are you able to summon help? o Are you able to self medicate? o Do you have any memory problems?	o Have you have any problems with your eyesight, hearing or speech?
BREATHING	**EATING AND DRINKING**
o Do you have a persistent cough? o Do you have any difficulties or discomfort breathing?	o Do you have any difficulties with eating, chewing or swallowing? o Have you had any weight loss? o Do you have any problems preparing meals or shopping or feeding yourself? o Do you have adequate cooking facilities?
ELIMINATION	**PERSONAL CLEANSING AND DRESSING**
o Do you have any problems passing urine? o Do you have any problems with your bowels? o Do you have adequate toilet facilities? o Do you have a catheter or stoma? o Do you use any laxatives? o Are you able to get to the toilet/ commode?	o Do you have any skin problems including eczema, pressure sores and leg ulcers? o Can you wash dress and undress without assistance? o Do you have any carers/ statutory or voluntary?
MOBILISING	**CONTROLLING BODY TEMPERATURE**
o Do you have any problems mobilising e.g. walking unaided, climbing the stairs, walking outside? o Do you have any pain or joint stiffness?	o Is there heating in the house – upstairs / downstairs? o Do you have adequate bedclothes?
SOCIAL/LEISURE	**PSYCHOLOGICAL**
o Do you have any financial problems? o Do you have regular social contact? o Do you have difficulty getting to public services? o Do you have any support services?	o Are you in any pain? o Do you feel down / low? o Have you any concerns over your condition? o Do you feel safe inside / outside your home? o Do you have any sexual concerns?
SLEEPING	**HEALTH PROMOTION**
o Do you have trouble sleeping or take night sedation? o Do you go to bed at night?	o Do you smoke? o Do you exercise regularly? o Do you drink alcohol? o Have you had a flu jab? o Have you had any screening? e.g. breast, cervix, prostate, cholesterol, BM, BP. o Are you concerned about your weight?
CARERS NEEDS	
o Do you have any problems getting out? o Do you have any support? o Do you feel able to carry out the care?	

Tip: ethnic and cultural factors

Look at the patient profile for the practice. Ethnicity data may be held by the practice or by the primary care organisation. Find out which are the significant ethnic minorities. Do they have any special needs by virtue of ethnicity or culture?

Talk to the clinicians in the practice and find out if they experience any particular difficulties in dealing with this population. How do they modify their approach? This might include their consulting style. Does it also include any clinical tailoring?

Do some research to find out whether the ethnic minority population is at risk of any particular conditions. Are the GPs aware of these? Are any steps taken to screen for these? If you feel such steps are appropriate, try suggesting how the practice could go about this. This will provide excellent evidence of competence in this first progression.

Remember, it's *applying* your understanding that matters. It may not be possible to demonstrate that an actual improvement has occurred as a result of your actions, but showing some initiative and taking action that might later lead to improvement is what is needed.

2. Epidemiological and ethnic/cultural factors

Having considered the socioeconomic factors, let's think about the epidemiological ones that might have an influence on community health. The curriculum suggests a number of examples and it is worth remembering that some of the community are affected by more than one of these factors.

- Environmental and genetic factors affect the prevalence of metabolic problems e.g. Diabetes is more prevalent in the UK in patients of Asian and Afro-Caribbean origin.
- Hypertension is more common in patients of Afro-Caribbean origin and their responsiveness to standard hypertensive treatment is different than in Caucasian patients.
- Hyperuricaemia is more common in prosperous areas and is associated with obesity, diabetes, hypertension and dyslipidaemia
- Environmental and geographical factors influence the prevalence and treatment of cancers. For example, mining communities are at particular risk of respiratory pathology.
- Cultural and ethnic factors will influence treatment, for example Jehovah's Witnesses will not take certain forms of medication. These factors may challenge our approach to ethical issues, for example ritual circumcision in certain communities.

In clinical management, we need to exercise caution because the majority of evidence-based guidelines do not include ethnicity or socio-economic status as risk factors. For example, we know that algorithms to assess the risk factors for cardiovascular disease underestimate the risk in south Asian populations. Additionally, many studies are conducted in secondary care and are not always generalisable to primary care populations.

Applies an understanding of these features to improve the management of the practice's patient population.

Why is it important to go one step further and make use of this understanding? The reason is powerfully summed up in the following statement:

What good does it do to treat people's illnesses and then send them back to the conditions that made them sick?

Changing the conditions is therefore vital. If this is not done, we achieve little more than fire-fighting rather than preventing future combustions from occurring.

Changes may be instigated *externally*. GPs are often involved in implementing health policy and in the coming years, there will be increasing emphasis on addressing obesity, smoking cessation and alcohol at population level. Efforts with smoking cessation therapy have proved successful initially, although there are concerns that without continued vigilance, population improvements may relapse.

GP practices have already been highly effective at reducing health inequalities, in particular through improving access to specific services. For example, differences in cervical cytology uptake rates narrowed markedly in the 1990s and GP practices are now routinely achieving the target of > 80% uptake. Here are a number of other examples of situations in which practices have been instrumental in improving health by applying their understanding of the features of the local population:

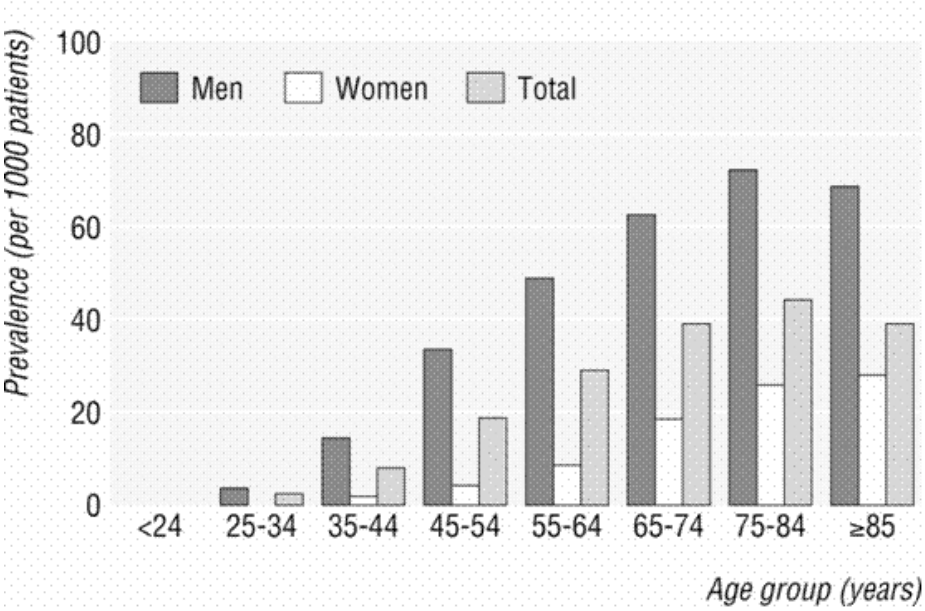
With stroke, enough is known about the risks of the disease to be confident that a systematic assessment of risk of all people aged 40–74 would be clinically and cost effective.

Male life expectancy in Birmingham has been improved through primary care by:

- targeted check-up offers to high-risk patients in 12 priority wards
- offering screening in community venues and
- offering heart checks in community pharmacies in target areas.

Better access to health promotion services has been developed for people with a learning disability, who are often unaware of the service and have difficulty with making the arrangements to come.

Alternatively, the initiative for changes may arise *internally*. For example, advances in medical science may lead to GPs looking at their current practice with new eyes. Because resources are limited, we usually target treatment to achieve maximum efficacy and our knowledge of population factors can be vital. If we don't have this knowledge, auditing the patient population can allow a profile of an 'at risk' group to be identified. To illustrate this, there are new drugs to manage chronic gout and this may prompt us to look at the epidemiology of the condition.



The histogram shows how the prevalence is very much higher in men, particularly from middle age onwards. On the basis of this, the practice may decide to review the treatment of middle aged men either opportunistically as they come into surgery or by inviting them.

Uses an understanding of these features to contribute to the development of local healthcare delivery e.g. service design.

Just to remind you that this competency is *above* the level required for licensing. It's importance is likely to increase as GPs take more active role in modifying and developing services and we can see how this competency builds upon the previous two.

A great deal is already going on with the development of integrated care pathways and the provision of near-patient services that were previously only available in secondary care. Here are some more examples of how GPs are delivering primary care in new ways:

In some communities, new premises are being built that provide primary care GP services alongside specialist clinics, for example for people with long-term medical conditions.

An alternative is to build centres that have well-being and social care services bolted on to clinical services such as diagnostics. Centres may have community beds and in this IT age, even a hub for 'tele- monitoring' of patients who are cared for at home.

Building community hospitals is an old idea that is coming around again, using them as hubs that link with home-care monitoring and support.

Needs Further Development	Competent for licensing	Excellent	
Identifies important elements of local health care provision in hospital and in the community and how these can be appropriately accessed by doctors and patients.	Uses this understanding to inform referral practices and to encourage patients to access available resources.	Uses an understanding of the resources and the financial and regulatory frameworks within which primary care operates, to improve local healthcare.	**2**

Whereas the first progression is about understanding the people that make up the local community, the second is to do with the resources that are available to them. We move from:

Knowing what resources are available both in the community and in hospital and how these can be accessed

Using this understanding to make targeted referrals to the appropriate agency and where relevant, educating patients as to what is available and how to access healthcare resources.

Beyond accessing what is currently available, using our influence to improve the local provision of resources in line with what the population needs.

Looking at each of the competencies in turn:

Identifies important elements of local health care provision in hospital and in the community and how these can be appropriately accessed by doctors and patients.

This basic level is mainly about information gathering and there are two stages involved. **Firstly** we need to find out what hospital and community services are available. There may be specialist hospitals such as oncology and children's hospitals as well as district general or teaching hospitals. In the community, there will be a number of healthcare services provided by other members of the primary health care team such as health visitors, district nurses, midwives and community mental health workers.

Less commonly, there may be chiropodists and community physiotherapists. It is worth being aware of the roles and availability of paid carers, respite care and the services offered by local voluntary and statutory agencies.

In between community care and hospital care, there may be specialist outreach nurses such as diabetic and epilepsy liaison nurses, who can give specialist advice and support and can usually be contacted directly by sufferers.

You should already know the opening hours of your practice, including any extended hours that it offers. You will also need to find out how out-of-hours care is provided and how patients can access GPs and other providers of emergency care such as A&E, NHS direct and walk-in centres.

Secondly, you need to find out for whom these services are available and how they can be accessed by doctors and possibly directly by the patient.

As we saw in the first section in this chapter, social services are intertwined with health. It is therefore important to know how social services can be contacted by doctor and by patient.

Uses this understanding to inform referral practices and to encourage patients to access available resources.

As with many of the progressions, the basic level deals with understanding the issues whereas 'competence' is reached when we are able to apply what we have learned.

Tip: knowing what is available

In order to do your job effectively, you will probably need to keep a diary or address book in which the important contact details are logged.

You may also wish to add information on whether or not the patient can self-refer to these resources.

This list of contacts is good evidence of having achieved the first level.

Tip: evidence of competence from referral audit

To be competent, you should be able to show that your referral practises are 'informed'. Therefore, a quick audit of referrals, preferably including referrals to community resources as well as hospital clinics, should provide good evidence for your portfolio.

In the audit, look for the reason for referral and evidence of appropriateness (for example, that the referral was accepted and dealt with rather than redirected or sent back).

If you look further, you can use the same audit to provide evidence of other competencies such as clinical management and team working. It is entirely appropriate for one source of evidence to be used for multiple purposes in this way.

Assessors will look particularly closely at referral practises. Good referral practise partly means that the problem has been appropriately defined and that we have appropriately decided that it is beyond our sole management. However, it also means that the inquiry has been appropriately directed.

Because patients' problems can often be managed in a number of ways, 'encouraging patients to access available resources' may mean advising them about a range of people and resources that are available. For example, the curriculum teaches us that for visually impaired adults, we might recommend:

- RNIB talking books for the blind
- low vision aids
- financial support

Also, because GP care is holistic, we think of the patient in their own context which means that when we offer help, we think about the needs of the patient's family and carers as well as the patient. When it comes to resources, carers are frequently overlooked.

Many self-help groups for patients with significant/chronic conditions are good sources of support for carers and can often signpost other useful resources that you may not be aware of.

When you have offered such help, which might include advising about websites or giving a patient information leaflet, it is worth recording this in the medical record. This will help others involved in the patient's care to see that wider forms of help have been offered and will also provide evidence of your competence in this area.

Uses an understanding of the resources and the financial and regulatory frameworks within which primary care operates, to improve local healthcare.

This descriptor of excellence shows how we apply knowledge of the healthcare system rather than just our biomedical knowledge, to improve the health of a whole community of people rather than individual patients. To do this, we need to understand the system well enough to know *where* it needs to be changed and *how* change can be brought about.

This depends upon a number of things including knowing where the faults lie in the current service, the characteristics of the local population and what they need, what they expect (which may not be what they clinically need), what is feasible, allowable and what is cost-effective. As you can see, this is a complex calculation!

Making such improvements can occur at practice level, where it is mostly within the control of a few people and can happen quickly. Improving the services for the disabled through better access to the premises, or for deaf patients through better messaging systems such as a visual display, are two examples. The need for this might be prompted by knowledge of the legal frameworks within which primary care operates, which for the examples just given is the Disability Discrimination Act.

At locality level, making improvements is a much larger team-based exercise and to demonstrate this 'excellent' competency, we need to show that we are contributing to such exercises. For instance, there may be a need to allow GP access to imaging such as MRI scanning for orthopaedic problems, for example instability of the knee. This could be developed collaboratively between GPs, orthopaedic surgeons and radiology departments and an appropriate protocol produced. Recommendations could also be made by the group as to how the new service could be audited to check that it is meeting the needs that have been identified and is being used appropriately and cost-effectively.

Needs Further Development	Competent for licensing	Excellent	3
Identifies how the limitations of local healthcare resources might impact upon patient care.	Optimises the use of limited resources, e.g. through cost-effective prescribing.	Balances the needs of individual patients with the health needs of the local community, within the available resources.	

The third progression builds upon the previous two. Having understood the nature of the local population and the current availability of resources, we move from:

Understanding what the resource limitations are and how doctors have to work around these locally

Managing resources, being cost-aware, and where possible, cost-efficient.

More widely, being aware of the tension between serving the individual and serving the local community and trying to achieve a justifiable balance between the two.

Looking at each of the competencies in turn:

Identifies how the limitations of local healthcare resources might impact upon patient care.

This theme, although separate, is related to the previous two. Once we have found out about the local resources, we have to understand the local population to know how the limitations in resources might impact upon their care. At one level, the impact will apply nationally as for example with the limitations imposed by guidelines such as NICE. At another level, the local community might be affected by factors that are related to their specific needs. For instance, a lack of local translators might severely affect the healthcare of a non-English-speaking community.

Sometimes, national restrictions can have a differential affect on communities because of local factors. Restricted access to anti-obesity drugs may therefore

Tip: service redesign

Even if you are not yet able to demonstrate the 'excellent' competency, you can learn a great deal by joining in any service initiatives that your practice is part of.

Ask the GPs and practice manager about the practice development plan/business plan. Identify an area of service improvement and speak to the lead clinician or manager in the practice.

If you can, try to observe how the process is carried out, perhaps by sitting in at one of the relevant meetings.

Questions: If you were asked to make a suggestion, which area of service would like to improve? Why would this be your priority?

affect socio-economically deprived communities (where the incidence of obesity is higher) more than affluent communities.

Discussion: identifying local limitations in resources

Start close to home and find out from doctors and nurses in your practice where they think the limitations lie. A good place to start is to think about cutbacks in service and the impact that this had. For example, has the practice lost services that it used to provide, such as chiropody, physiotherapy, extended district nursing services? Have these been missed and if so by whom and why?

Beyond this, what services do local practitioners feel should be provided, but are not yet available? Again, what impact does this lack of service have on the local community? Do practitioners feel that this adverse impact is any worse locally than it would be nationally? If so, why? This question will help to gauge the relative importance of local factors.

Moving to locality level, try to find out what the priorities of the local commissioning body are. What limitations are they trying to rectify and why?

You can make a reflective note of your findings, which will be of interest to the practice and will be excellent evidence for your portfolio.

The implications of rationing: developing your insight

Try taking a topic that interests you and talking it through in a group, **addressing each of the following factors**:

- Why and how rationing occurs
- The intended and unintended consequences
- The way in which quality of healthcare is gauged (which is not just quantitative but also includes measures of quality of life)
- The political dimension and the ethical principles (particularly autonomy and justice) that are challenged by the rationing issue.

There are ongoing national debates about rationing. The curriculum suggests that you should be able to, for example:

- Describe the rationale for restricting certain investigations and treatments in the management of cardiovascular problems e.g. open access echocardiography, statin prescribing.
- Describe the rationale for restricting certain investigations and treatments in the management of skin problems e.g. prescribing of retenoids, access to phototherapy.
- Evaluate the effectiveness of the primary care service you provide from the male patient's point of view.
- Evaluate the arguments for and against a national screening programme for colorectal cancer.
- Discuss the rationale for restricting referrals for upper gastrointestinal endoscopy in the management of dyspepsia.

Optimises the use of limited resources, e.g. through cost-effective prescribing.

This competency is thought by assessors to be particularly important. You will notice that the word 'optimises' is used. This is because we are not simply talking about rationing, which often has negative connotations of cost-cutting, but about making the best use of resources and thereby ensuring that the greatest good is done for the greatest number of people (a utilitarian principle). Very often, making the best financial use of resources is not in conflict with producing the optimum management plan. For example, the curriculum teaches us to:

1. Recognise the place of simple therapy and expectant measures in cost-effective management, whilst ensuring that the patient's condition is adequately monitored.
2. Prioritise referrals accurately so that people with minor conditions don't delay/compromise the care of those with more serious conditions.

3. Avoid investigations or treatments that are unlikely to alter outcomes, so that the availability of these resources (e.g. imaging methods) is optimised.
4. Deal with situational crises and manipulative patients appropriately, without resorting to inappropriate investigation or referral.

Balances the needs of individual patients with the health needs of the local community, within the available resources.

The nub of this complex competency is understanding that we have responsibilities to individual patients *and* to wider communities. In a sense, one patient's gain is potentially another one's loss given that resources are finite and always will be.

To demonstrate this competency, we must be able to explain and justify the decisions that we make by showing that we recognise the tensions and have a rational way of approaching them. Probably the most important abilities that we need are to show sensitivity and awareness for the problems that rationing creates, particularly in the human dimension and to avoid prejudice and undue bias in trying to reach a compromise.

The word 'resources' should be widely interpreted. We are not just talking about finances, but about services, including our own time. Therefore, making optimal use of resources means thinking about *time* spent with patients as well as investigations, referrals and prescribing costs. The curriculum illustrates these points by teaching us that we need to:

- Give morally relevant reasons for decisions that balance individual patient needs with the needs of the wider community.
- Provide more time in the consultation in order to deal more effectively with some people, for example those with sensory impairment or learning disabilities.
- Consider the workload issues raised by patient problems, especially the demand for urgent consultation, and the mechanisms for dealing with this.

Note that the curriculum points out that 'balancing resources' means that we must also plan to give some people more resources than others. Such people are often, by virtue of their condition, less able to speak up for their needs and in these situations, part of our role as doctors is to act as their advocate.

Demonstrating the ability to balance resources

Important evidence of this ability will come from situations where you are aware of a conflict between opposing demands. It is helpful to think of these situations as being **' significant ethical events'** and in line with this, write a significant event analysis arising from personal reflection and discussion with peers. The essence of demonstrating this competency is being able to show that ethical principles have been used to inform the resource decision and that you have tried to recognise personal bias and where relevant, compensate for this.
Evidence might also arise from multisource feedback provided you have involved your colleagues in discussing your ethical dilemmas.

Let's consider another aspect of 'resources'. Quite often, when doctors talk about 'demanding patients', what they mean is *'inappropriately* demanding' patients! Managing such patients is difficult and emotionally draining. Part of the balance that we have to consider is the one between giving the patient what

Tip: demonstrating the optimum use of resources

You could readily demonstrate cost-effective prescribing by showing that you prescribe generically and by recording situations in which you chose a more cost-effective drug or avoided a more costly formulation, such as a modified release drug where this wasn't necessary.

Now look at the four numbered principles in the text. Try to produce evidence of these, particularly of the first three as the opportunity for these occurs frequently.

Examples from the range of areas discussed in this box will be ample evidence for the portfolio.

they want and confronting the patient, with the risk of a time-consuming complaint and damage to our emotional health. Time lost with complaints is an important loss of medical time that could be spent on patient care. On the other hand, not dealing with such an issue may simply store up problems for ourselves or colleagues in the future and is not fair to the majority of patients who don't shout for attention. In managing this we have to remember that *our* health is also an important resource that is finite and should be used with care.

In the next and final chapter on 'Management', we will consider how we manage ourselves well enough to maintain our performance.