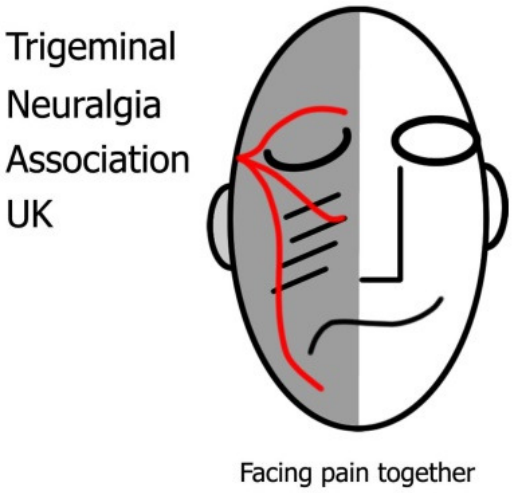
Patient Participation Group

Newsletter

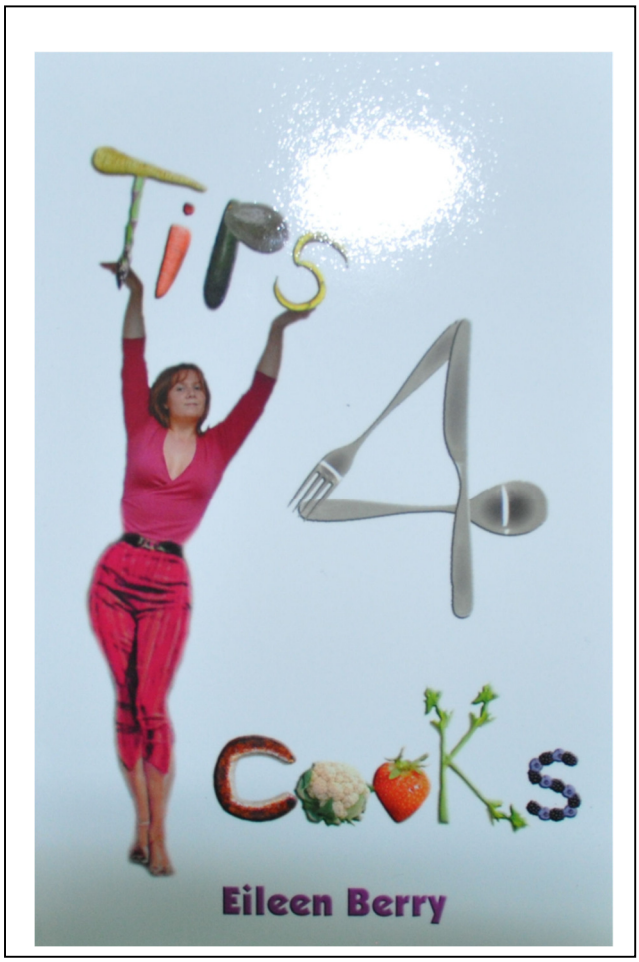


Incorporating the

Friends of the Badgerswood and Forest Surgeries

October 2016 Issue 23

Fundraising – Tips 4 Cooks



Brian Donnachie is a patient of Badgerswood. He has very kindly given the PPG copies of this book “Tips 4 Cooks” to sell to raise money for our latest projects. It was written by his wife Eileen who sadly passed away recently

We would recommend a minimum donation of £2. Copies are available in the receptions of Badgerswood and Forest surgeries. Please support us and give a thank you to Brian by buying a copy of “Tips 4 Cooks”.

Chairman and Vice-chairman Report

We are very fortunate to have an Educational Article this time on Trigeminal Neuralgia written by Marcia Hammond of the Trustee and Publications Office of the Trigeminal Neuralgia Association. Trigeminal neuralgia causes severe facial pain but the problem is frequently not recognised and is difficult to treat. Anyone who suffers from recurrent facial pain and may have this problem should read this article.

A new telephone system has now been installed into Badgerswood Surgery and we hope that patients who are phoning in to make an appointment or obtain results etc, now find the system much easier to use. The system is similar to that already in use in Forest Surgery.

The Bordon New Town Development is progressing slowly and we and representatives of the public are now becoming more involved. We are involved in the Health and Care Stakeholder Group and 2 design groups, the Health Campus Model and the Healthy Life style Model. We have written a short article on this later in the newsletter.

We again thank Sarah Coombes for the next Great British Doctor article this time about William Harvey. Although we now all accept that blood is pumped round the body by the heart, William Harvey's studies to prove this were not easily accepted by the medical fraternity. His life and his research at the time of King Charles 1 4 centuries ago is clearly documented and is fascinating.

We have decided to re-introduce our 'Notice-board' which appeared in previous newsletters. Dr Leung has provided articles for this for us.

The development of Healthspring is progressing steadily. We are now expanding our Faculty of educators and are in regular contact with the team in India. An article on Healthspring appears later in the newsletter. We hope to present this at our members' meeting in October.

We hope to set up a First Aid Training Team soon and plan to co-ordinate this initially with the Practice and Headley Parish Council who are soon to have a defibrillator installed in the telephone box in the High Street next to the Holly Bush pub.

Following this Issue, we hope to have a regular feature on Southern Health. I am sure you are aware that our Trust has made headline news recently. As Chairman of the PPG I have just been appointed as a Governor to Southern Health and will record developments and highlights of meetings in the

newsletter. Any comments and advice can be made through the PPG and would be most welcome.

We keep in touch with Mission ABC, the respiratory team run by Prof Chauhan, and will keep you informed of how the research and work of his team is progressing.

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Issues raised through the PPG

This past 3 months we have had 4 complaints from patients about the time they have spent waiting in the waiting rooms for appointments. Three of these came through the 'Friends and Family Test' forms which is unfortunate because these provide no details for us about the times, the patients, the clinics and especially whether the problem arose all from 1 clinic. The other was not really a complaint, but more a comment from one of our members who wrote to us to say that he wished to mention that he had waited 50 minutes in the waiting room at Badgerswood Surgery 1 day for his appointment.

We have intermittently had complaints from both surgeries from patients who have had to wait beyond their clinic time. Our surgery is of course not alone in this respect and hospital out-patient clinics are notable for the length of time that they tend to over-run.

We have mentioned before about the surveys the PPG have carried out on our surgery waiting times. I can provide the figures again for you:

1. All the doctors arrive on time and start their clinics on time. They all wait well beyond the times the clinics are due to end if necessary to see all patients.
2. Patients are given clinic times which are thought to be appropriate for a GP appointment. However, patients arrive with unknown problems and it is impossible to know how long individual appointments will take.
3. Our GPs do not run their clinics according to the time allocated to the patient, but give each patient sufficient time for the consultation to sort each patient's problem. If the time allocated is 10 minutes and it takes 20 minutes to sort a problem, the patient will be given 20 minutes and the next patients will have to wait.
4. Patients who have to wait to be seen should be reassured that the GP is spending sufficient time with each patient to sort every problem and the same will happen to them when their turn comes.
5. On average, patients normally are unconcerned if they are seen within 20 minutes of their allocated time.
6. On average, patients become unhappy if they have to wait beyond 30 minutes.

We collect the Friend and Family Test forms in batches. Had we designed these forms, we would have obtained information to help us identify specifically where the above problems had arisen. We do not even know which surgery had the problem or if we are looking at both surgeries. It may even have been only 1 clinic which had 1 patient who took an excessive length of time and held everyone else up.
From the Practice, we apologise to all the patients. We have had no comments about hold ups since that time.

How can we improve things?
We could reduce the chance of patients waiting to be seen if we lengthened clinic appointment times, but this would reduce the number of patients being see in each clinic. This would therefore mean that the time for an appointment would become longer and on occasion, our elective appointment time has run to 3 weeks.

If we identify a patient who has a complex problem, we could give that patient a double appointment time. Also if a patient knows they are likely to need a long time to sort their problem, it may be appropriate for that patient to mention this when booking the appointment and make a double appointment time. We are anxious this may be over-used.

Triaging with nurses and pharmacists seeing selected cases has been discussed in previous newsletters and certainly helps. This means discussing with the receptionist what your problem is so that you can be allocated an appropriate appointment, seeing a nurse or a pharmacist with a specific problem more quickly. Not everyone is happy to do this, feeling that the receptionist is being intrusive which they are not, simply trying to triage the problem.

Emergency appointments are all seen on the day so slots are kept for these. Urgent appointments are given appropriate appointments. Remember that what may seem to you to be an emergency or urgent problem may not actually appear to be a medical emergency by the practice and therefore simply given an elective appointment as appropriate. Also you may be told first thing in the morning that no slots are available but by lunch time it is obvious that all the emergency slots are not needed and also that some patients have phoned to cancel their appointment that day, so some slots may now be immediately available.

A call later in the day may therefore mean an immediate appointment might now be free.

Do you have any ideas about how the clinics could run without delay in waiting time without affecting numbers of patients seen in a clinic and without shortening the time a patient needs for their consultation who has an unforeseen complex problem? Most of our patients are very understanding.

Last week my wife waited just over 2 hours beyond her appointment time to be seen in a clinic at the Royal Surrey.

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Headley Bowling Club Donation

Barbara Symonds, our fund-raiser, accepts a cheque for £400 from the Headley Bowling Club. This kind donation will be used towards the purchase of a new examination couch for Badgerswood Surgery and for a digital projector for use by the PPG and our new First Aid training team. We thank the Bowling Club very much for their kind donation.

Whitehill and Bordon – a green and healthy town

An interim governance structure for the development of Whitehill and Bordon Healthy New Town was proposed in 5th July 2016. This article briefly summarises the objectives, the structure, the steering group, workstreams, and the role of the PPG in these workstreams.

Objectives

The primary objective is to develop Whitehill and Bordon as a green and healthy town working on this through 4 workstreams:

a) ***Development of the Place***

i) Urban development
- accessible to all areas
- dementia friendly
- encourage active travel in the town
- healthy food environment

ii) Homes
- smart, flexible, healthy
- promote independence

b) ***Developing how the People will interact***

All people encouraged to have healthy, active lifestyles

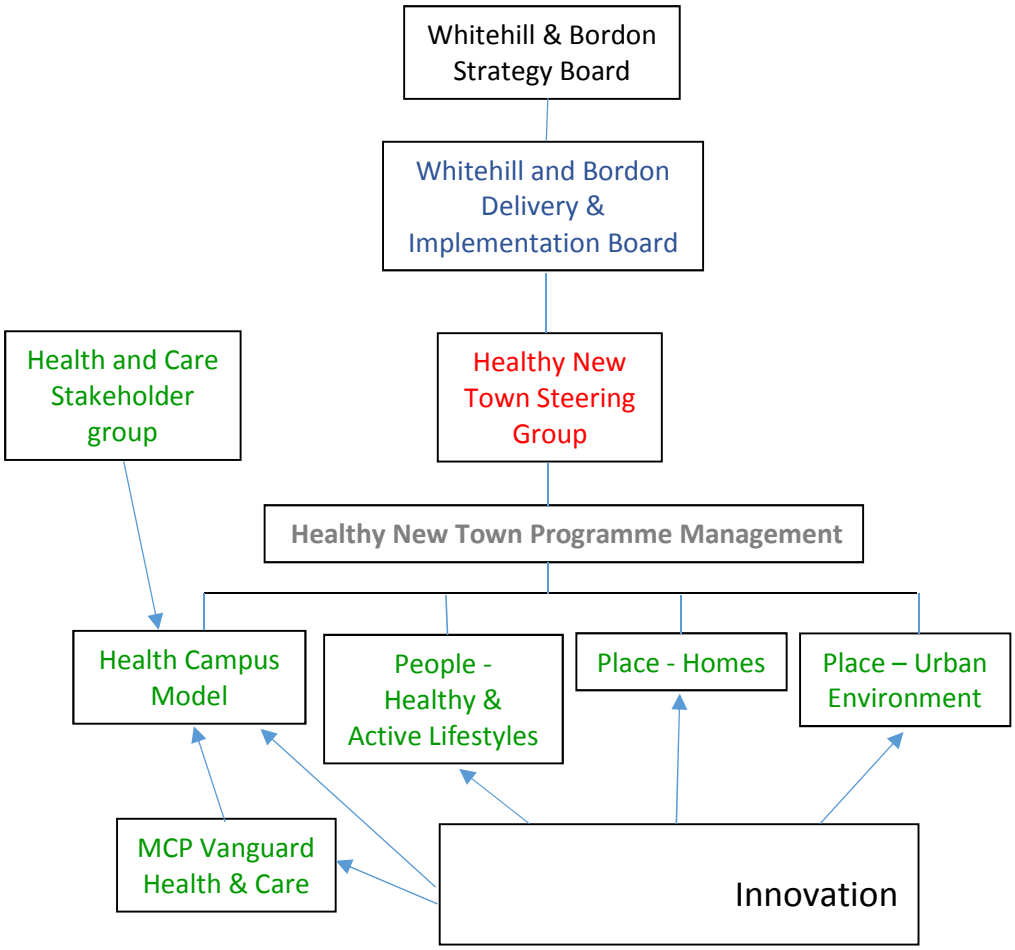
c) ***Provision of Health Care***

Development of MCP clinical model for extended primary care
- integrated care
- access to primary care
- extending care
- specialist support
- self-management

d) ***Innovation***
- care
- economic development
- smart cities

Interim Governance Structure

The Governance Structure is as outlined in the diagram below:



The Healthy New Town Programme is responsible for the day to day management and work programme of the Whitehill and Bordon development. Feeding into this are 4 workstreams as have been outlined above.

The Health Campus Model is responsible for the design of the clinical service model and the buildings to go with this. There is input into this workstream from the Health and Care Stakeholder Group which devolved from the Chase Hospital Stakeholder Group and is integral in the discussions about the Chase Hospital as well as any new Health Centre developments. Also the Multi-specialty Clinical Provider (MCP) section of the Vanguard project feeds into this. The PPG sits on all parts of this model, the Health Campus Model, the Stakeholder Group, and the MCP health and care group.

The People – Healthy and Active Lifestyles workstream is involved in looking at how people can be encouraged to use the facilties being provided to become and remain healthy. Withdrawal of Fast Food outlets from the centre of town with encouragement to improve diet. Encouragement to exercise more with cycle tracks, sports pitches and other facilities. A healthy town, a safe town, a dementia friendly town etc. More encouragement into self-management of care. Again the PPG are actively involved in this group. Not just active encouragement but monitoring of progress or lack of.

Places – Home and Places – Urban have their own workstreams to develop the structure of the town to make it a healthy town for the future. Each of these has its own workstream. The PPG is not involved in either of these.

All of these interact and are fed with Innovative ideas from different sources, each having input from NHS England following on from our successful bid to become a 'Healthy' new town as labelled by NHS England.

The Healthy New Town Programme feeds up to the Steering Group. This addresses any barriers to progress, seizes opportunities to development, and reports quarterly to the Delivery and Implementation Board. Chaired by a Director from East Hampshire District Council, this Group is made up of various local representatives including GP Practices, HCC, EHDC, the Clinical Commissioning Group etc.

The role of the Delivery and Implementation Board is to report annually to the Strategy Board regarding the successful regeneration of Whitehill and Bordon.

There is a deadline. Although the 3,500 houses will not be complete until well into the 2020s, the development programme is planned for completion by 2019.

PPG Calendar

The Patient Participation Group (PPG) of Badgerswood and Forest Surgeries has decided to produce a calendar each year of our local area. A competition will be held with entries of photographs taken each month in our surrounding area. Every month a panel consisting of the PPG committee will select from all the submissions which photograph will be used for the calendar. These photographs will appear on the Practice website and will be published in our newsletter throughout the year.

Each year the calendar will have a theme which will be used as the title of the calendar and entries are invited from anyone who wishes to submit photographs relevant to that theme. Entries will start in October and by the end of the following September it is hoped that there will be 12 representative photographs in each category of our region taken at different times of the year, suitable to collate into the local PPG calendar for the following year.

How to enter the competition

Once you have your picture or pictures for the month, submit this with your name and address and a contact detail (telephone number, mobile number, email, etc) with **a note of where it was taken** and the date and time of when it was taken. If under the age of 20, please state your age as this may affect the decision of the judges when choosing the picture for the month.

Send or bring your entries in a sealed envelope addressed **"The PPG Calendar competition"** to either Badgerswood or Forest Surgery or by email to ppg@bordondoctors.com

The competition for each month's photographs closes at midnight on the last day of each month. Photographs can be handed in or sent by midnight of the last day of each month. Photos received after this date will not normally be considered.

Please ensure you read the full terms and conditions before entering.

Terms and conditions

1. Photographs must be taken within the Headley, Lindford, Whitehill, Bordon or the immediate surrounding areas only. Preference will be given to photographs which are taken of easily identifiable sites. All photographs must indicate where the photo was taken.
2. The theme is open to the interpretation of the photographer and can feature any aspect which is thought to represent the Title of the competition.
3. One photograph will be chosen each month and after 12 months the photographs will be available to purchase as the "PPG Calendar".
4. Each monthly photograph chosen for the calendar will appear on the Practice website and in the quarterly newsletters
5. At the end of the year, the competition will have one overall winner for the year voted by the judges and this picture will take pride of place on the cover of the calendar.
6. The decision of the judges is final.
7. Entries can be submitted as hard printed copies or in electronic form. Unfortunately printed entries cannot be returned.
8. Any profits from the sale of the calendar will be used for the benefit of the people of Headley, Lindford, Whitehill, Bordon and surrounding areas and details of this will appear on our Practice web-site and in our newsletters.
9. Photographs of any people or private property will require permission for the publication of these photographs. Successful photographers may therefore be asked to provide this permission and in this case, consent forms will be provided if required

The competition is not open to professionals and entries must not have been successful at other national competitions. The photographs chosen for the calendar will remain the copyright of the PPG and entrants agree to this prior to sending their photographs to this competition.

Theme for 2016 / 2017 - The changing seasons

The Care Quality Commission, PPGs and Practice Assessments

In the past 3 months, our PPG has been approached by 2 neighbouring Practices to help with the formation of Patient Participation Groups. In 1 case, the neighbouring Practice has been given a "Requires Improvement" rating, one of the main reasons for this being the fact that the Practice did not have a PPG. This puts this Practice into the lowest 15% of GP Practices in the country according to the CQC rating.

We are aware that this Practice about 3 to 4 years ago tried to form a PPG but unsuccessfully and since the CQC visited, a further attempt has been made again to form a PPG. We have now been approached to help which we are very happy to do.

We have also been approached by another Practice who are also having problems forming a PPG before the CQC visits.

We have run an article on this before. Despite what the National Association of Patient Participation groups (NAPP) feels and whatever the British Medical Association and NHS England have stated, the CQC must realise that PPGs are formed by patient volunteers. Despite the fact that having a PPG in every GP Practice has become part of the GP contract, one cannot dictate that a Practice must form a group of volunteers. The CQC can look at a Practice to see that they have tried to form a PPG, but if they try and fail, the CQC cannot criticise them for this and must not penalise the practice by giving an unacceptable rating. This is particularly the case if the CQC continues to rate the Practice down on a repeat visit if they still have been unable to form a PPG by being unable to find a group of patients willing to volunteer their time freely to help.

We will continue to help our neighbours as much as we can.

Flu Clinics

If you are aged 65+ or in an at risk group
you can book in to our flu clinics now.
Please call reception at your surgery now.
If you are unsure of your eligibilit0y
check with your surgery now

Trigeminal Neuralgia

'The worst pain known to man'

by Marcia Hammond, Trustee and Publications Office, TNA UK

Imagine a sudden, electric shock-like pain in your face, so severe that it brings you to your knees. That is what Trigeminal Neuralgia (TN) can feel like and why it's been called 'the worst pain known to man'.

What is TN?

The condition is a disorder of the trigeminal nerve which provides sensation in the face. It tends to affect both men and women over the age of 50 years, although unfortunately children and younger people can develop the condition. Because TN is difficult to diagnose, the exact incidence is not known. But there are currently thought to be around 8 to 12.6 new cases diagnosed per 100,000 population in the UK and 60,000 to 95,000 people in the UK living with the condition.

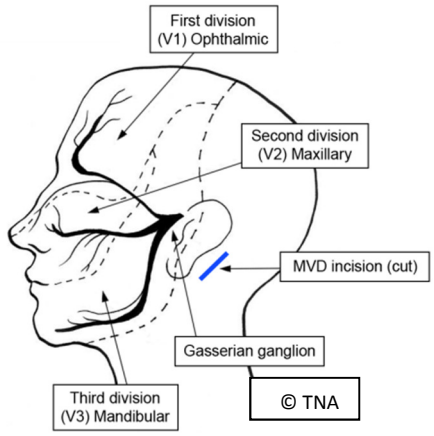
What causes TN?

The exact cause is unknown and it is possible that there may be a number of factors involved. In some cases there is compression of the nerve where it emerges from the brain stem at the base of the skull, by a blood vessel. The damage to the myelin sheath around the nerve causes it to malfunction and send messages of intense pain to the brain in response to just a light touch on a 'trigger' area of the face.

TN pain

The pain can last from a few seconds to a few minutes and multiple bursts in quick succession can occur up to 200 times a day. There can be periods of complete pain remission lasting weeks, months or sometimes years. But these gradually become shorter and shorter, and sufferers therefore live in constant fear of another severe attack of debilitating pain. Any light touch to the face or facial movement such as eating, talking, smiling or kissing, washing the face or brushing the teeth can provoke an attack and this can completely destroy quality of life. Unable to live normally, sufferers become isolated and depressed. Even now, every year people commit suicide because they cannot cope with the pain.

The Trigeminal nerve



This diagram shows the three branches of the nerve and the areas of the face for which each provides sensation. The maxillary and mandibular branches (V2 and V3) are most commonly affected by classic TN. (The trigeminal nerve is the fifth of 12 cranial nerves – which emerge from the brain – and so its branches are denoted by the Roman numeral 'V').

Diagnosis is tricky

There is no definitive test to diagnose TN. Because the pain most commonly affects the area in or around the mouth and cheeks, sufferers often turn first to a dentist for a diagnosis and treatment. Unfortunately, many patients suffer for months or years without correct treatment and even undergo extensive, unnecessary dental work before the condition is correctly diagnosed.

Treatment of TN

Normal painkillers bring no relief and initially anti-convulsants (epilepsy drugs) are prescribed. However, these often have unpleasant side effects and lose their efficacy with time, leading to escalating dosages. When medication is no longer effective, or if the side effects cannot be tolerated, various surgical procedures can be considered, although these carry a risk of complications and the pain-relief is not always long-lasting. Generally, these procedures involve deliberately damaging the nerve where its branches meet, at the Gasserian Ganglion, to interrupt the transmission of pain. But they often result in numbness in part of the face, which can be permanent, or occasionally even a painful numbness (Anaesthesia Dolorosa), which is virtually untreatable.

Cranial surgery

The most effective treatment is a surgical procedure, Microvascular Decompression (MVD). This is cranial surgery in which blood vessel(s) compressing the nerve are moved away and separated from it by a piece of synthetic material. Unfortunately, TN has a habit of recurring and even this operation does not always give permanent relief, although it is currently the longest lasting treatment. But not all cases of TN are found to be caused by a blood vessel, in which case MVD is not an option. Interestingly, compression of the nerve is sometimes seen on MRI scans of people who do not have TN.

A link with Multiple Sclerosis (MS)

TN is more common in people with MS than in healthy people. The common link may be that in both, the insulating sheath around nerves is damaged. It is thought that the number of MS sufferers who also have TN could be anywhere from 4% to as many as 15%.

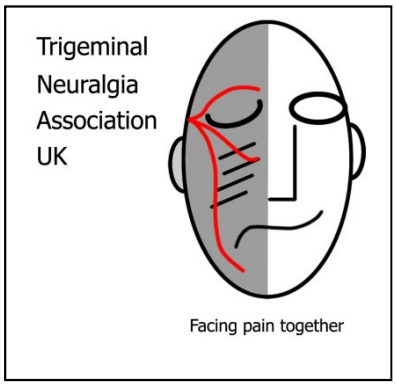
What can TN sufferers do to help themselves?

Regrettably, because there is no permanent cure, many sufferers have to learn to live with the condition. This means that self-help is essential to enable them to cope and there is a lot that sufferers can do.

Most self-help aims to avoid things that trigger pain attacks or worsens the pain during an attack. This can be anything from modifying the diet to avoid certain foods, protecting the head and face from cold draughts or wind with a hat, scarf or balaclava, and avoiding chewy foods (eating is a very common trigger). When someone is actually having pain attacks they might liquidise their food or use a straw (which reduces contact of liquids with the inside of the mouth). They may also avoid triggers like shaving, washing the face, etc. It is helpful if they can find a distracting hobby like puzzles or gardening to take their mind off the pain although this can often be difficult to do. Sufferers can also learn psychological techniques, such as Cognitive Behavioural Therapy, which can help people cope with long-term pain, and manage the distress it causes.

Because one person’s experience of TN can be quite different to another’s there are a lot of self-help tips and the Trigeminal Neuralgia Association (TNA) have collected these into three booklets which members can buy from the Association or download from the website.

The Trigeminal Neuralgia Association UK



Professor Joanna Zakrzewska (an expert in facial pain), together with an energetic patient, recognised the need of TN sufferers for information and support. They formed a group which later became the Trigeminal Neuralgia Association UK (TNA UK) (www.tna.org.uk), achieving charitable status in 2002. As well as providing information and support to members, the Association aims to raise awareness of TN among medical professionals *and* the general public. TNA UK receives no government or corporate funding and is entirely dependent on membership fees and donations. All the officers of the Association give their time voluntarily and TNA UK has been contacted by thousands of sufferers, with around 10 new members joining each week.

There are many gaps in medical knowledge and understanding of TN and also misconceptions as to the progression and prognosis of the condition. TNA UK is involved with drug companies to develop new treatments and in research to try and find out more about this devastating condition.

Healthspring

We have reported in previous newsletters on Healthspring, the development of a Primary Care health system in India. The aim to produce a care system throughout India is slowly spreading. We started in Mumbai (Bombay), moved into Pune, a new build city adjacent to Mumbai, opened surgeries about 3 months ago in Delhi, are now about to open surgeries in Hyderabad, have identified sites in Bangalore and Calcutta and are now looking towards Chennai (Madras).

Here at Badgerswood we are involved in helping to develop standards of training and to produce a formal training and assessment system for the doctors in India. Dr Sherrell and Dr Mallick have been involved since I was first approached. The teaching faculty is expanding progressively as more colleagues here in the UK express an eagerness to help.

Many of the Indian doctors have gaps in knowledge and are working In groups covering for each others' deficiencies. We are developing a distance learning programme which will be fully comprehensive of the curriculum of knowledge for a trainee GP suitable for India and when completed should be of a standard equal to any in the world. Training is needed into techniques of how to communicate to patients and how to examine properly. This can be taught partly by video instruction but will undoubtedly need a regular group visiting India to instruct.

We can teach the doctors to a high standard with all the materials necessary, but to ensure that the doctors study and learn, we also need to test them, so we are also setting up an examination system based on continual multiple choice questions linked to the distance learning programme, and by direct testing when we will be visiting.

In a previous newsletter, Dr Mallick gave an account of training of GPs in the UK. There is a desire in India in the future to develop a formal training system in Primary Care similar to that in the UK. We plan to establish basic training of specialty subjects in relevant hospital units followed by a formal training programme in Primary Care which we hope to introduce in Healthspring. In this regard, we have been in touch with the Chancellor of the University and Hospital of West Bengal with a view to developing this formal training programme there initially and we are now looking to assist India in developing an Indian College of General Practitioners.

In October, our members' meeting will be on 'Healthspring' where we will be discussing our developments in India in detail.

Noticeboard
by Dr Leung

A pill for asthma?

This story came up in late July 2016.

What is asthma - Asthma is a condition where the airways 'narrow down' and cause breathing problems. We control asthma with inhalers. Where was this reported – in the Lancet, a trustworthy source.

What did it say – that this new drug, Fevipiprant, reduced the sputum eosinophil count – eosinophils are a kind of white cell and can be thought of as a measure of inflammation. Patients with more severe asthma have a higher count.

Believability – yes, it sounds promising, but the eosinophil count is a 'surrogate' marker. It's reducing exacerbations that really counts and they only looked at 61 patients. In trial terms, that's a very small number. So we are still years away from a pill being available to everyone.

Nurseries and conjunctivitis

Conjunctivitis is usually a mild and self-limiting condition and it's not clear that antibiotics do much good. In fact, Public Health England clearly state that no school or nursery exclusion is necessary.

The research looked at 164 policies from childcare providers and found that only 13% complied with Public Health England guidance. The others demanded exclusion of the child! So what do parents and doctors do? Gentle cleansing is usually all that is required. Parents can buy chloramphenicol from any pharmacy without a prescription if they really want to.

As for doctors, they found that 43% felt pressurised into prescribing, especially younger doctors aged 30 to 49, whereas oldies over 50 were more likely to stand fast and refuse.

Conjunctivitis is a very common condition. One in five children will have conjunctivitis each year. They estimated that 240,000 consultations were wasted each year and 360,000 days work lost.

Conference Report - The European Association for the Study of Diabetes

The treatment of diabetes has been revolutionised in the last 10 to 20 years. Patients are living longer, have fewer complications and now have so many more options. It's a fast moving area and last week, some 15,000 doctors and researchers converged on Munich to share the latest research. Here are some gems:-

Interval training – we all know that exercise is good for us, but this study from Finland showed that high intensity interval training actually changes brain metabolism, at least for people with 'impaired glucose tolerance' (not quite diabetes yet). This is a specific group they looked at but it's amazing that exercise can change your brain chemistry.

More interval training - this one's from Germany. They looked at 'mitochondrial biogenesis', or how the motors in cells of Type 2 diabetics worked. They found that this improved after 12 weeks of high intensity interval training but these benefits were lost after stopping for 4 weeks.

Fat in the liver – from Denmark. They asked volunteers to alternate between completely fasting, and eating twice as much on the non-fasting days. Not surprisingly, their weights stayed the same, but the fat in the liver went down. They postulated that the oscillation made better use of the glycogen stores (of energy) in the liver.

Lean and obese subjects have different brains! – and the drug exenatide, an injection used by some type 2 diabetics, changes the way obese subjects respond to just looking at food.

Again, many papers reaffirmed the need for good early control. It will pay dividends for years to come.

Dr Leung

Self-care and self-management

Since the introduction of the self-measuring Blood Pressure machines in the reception areas of both our surgeries, it is remarkable how many people have diagnosed their own problem of high blood pressure, arranged to be seen by the doctors to have this treated, then monitored the effect of the treatment themselves by regular measurements on the machines and only returned for further consultations when their blood pressure has gone out of control again. This is an ideal example of patient self-care and management.

There is however a great contrast between how patients deal with other problems. A lack of medical knowledge can lead to an uncertainty about when to ask for medical advice. When is a problem a trivial problem or a symptom of something which is very important and if left too long may be too late to sort? How do you know when you should not leave something risking the doctor saying at some future time 'I wish you had come to me sooner with this'. Never fear the doctor being critical of your concern about coming with something minor. He /she will always be happy to see you and reassure you that there is nothing serious rather than miss something vital which should be seen early.

There is no doubt however that some knowledge may help you to decide when you should be seeing your doctor, nurse or pharmacist about a problem and over the past 5 years we have published in our newsletters a series of articles trying to help you identify how to manage certain ailments. These have been written so that you can identify conditions which you may have which you are not aware of eg "I wonder if I am diabetic" or how to try to help you look after a condition yourself which you have or to indicate to you when you should be aware that there is a problem with a condition which should mean that you really should be making a consultation. We now have a large series of articles and these are all available for you to download from us.

We originally printed a booklet of the first 10 educational articles but this is too expensive for us to repeat. If you would like a copy of these articles, we will be happy to reproduce these electronically for you. These will be free to our members. For anyone else who wishes a copy of any of these articles a donation to the PPG would be most welcome. Please contact us at PPG@headleydoctors.com or PPG@bordondoctors.com or leave your contact details at one of the surgery receptions. We will send you a list of all our articles and you can ask for a copy of any article or articles you may want.

Great British Doctors No 10
William Harvey (1578 – 1657)

The name of William Harvey is famous to doctors throughout the world. Born in Folkestone, Kent, the eldest of 9 children of Thomas Harvey, the mayor of Folkestone, William Harvey's statue stands on the foreshore at Folkestone.

It is remarkable that over 350 years after his death, the medical profession still celebrate his life and achievements. In 1782, a Harveian Society of doctors was founded in Edinburgh which meets regularly for a dinner to toast William Harvey and discuss what he achieved. The Harveian Society of London was founded in 1831 and meets monthly. Each year in June the President of the London Society and its members travel to Folkestone to lay flowers at his statue. Each year, the Royal College of Physicians of London hosts a prestigious lecture, the Harveyan Lecture, in his honour. In 1973, the William Harvey Hospital was constructed in Ashford several miles from his birthplace.

Harvey was a graduate of Caius College, Cambridge qualifying in 1597 with a BA. Following this he spent 2 years travelling through Europe before entering Medical School in Padua in northern Italy. At that time, Padua was the centre of medical learning in Europe. Medicine as a subject was originally taught in Edinburgh from the start of the 16th Century and modelled its teaching on that of Padua. In fact the anatomy lecture theatre in Edinburgh which is still in existence today, was a copy of the anatomy lecture theatre in Padua. Harvey qualified in medicine from Padua in 25th April 1602. While in Padua, Harvey became interested in some modern theories about the circulation of blood which challenged the established theories of the time.

Established theory of circulation

The established theory of the time came from the teachings of Galen, the Greek physician of the 2nd century A.D., whose theories held till the 16th century. Everyone accepted these as accurate and no-one had ever questioned these. According to Galen, venous blood was 'concocted' in the liver using broken down food and was conveyed through the veins supplying nourishment to all parts of the body. This nourishment was soaked up by the different parts of the body, and there was a continuous ebb and flow of blood in the veins, with fresh supplies from the liver replacing what had been consumed.

Some of the blood concocted in the liver was conveyed from the liver into the right ventricle of the heart. Galen believed that the interventricular septum (the central wall of the heart) was porous, and so blood flowed from the right ventricle into the left where a further 'concoction' took place. Here the blood, and inspired air that had passed through the lungs and travelled through the pulmonary vein and into the left ventricle, became arterial blood endowed with 'vital spirit', which was then conveyed through the arteries to all parts of the body. Waste vapours given off by the concoction were at the same time expelled through the pulmonary vein into the lungs and so breathed out of the body. The circulatory system according to Galen's teachings was an open-ended system in which blood and air simply dissipated at the ends of veins and arteries into the local tissues. Blood was not seen to circulate but rather to slowly ebb and flow.

The timing of these movements was held to coincide with the movement of the heart. When the heart was in diastole or relaxed, it was thought to suck venous blood into the right ventricle and air into the left as an *active* movement, and the heart was believed to be in diastole when it struck the chest wall and the apex beat occurred (when the very tip of the left ventricle pushes against the chest wall). When in systole (contracted), the heart was believed to expel the venous blood through the pulmonary artery, arterial blood through the aorta and waste vapours through the pulmonary vein.

Doubters

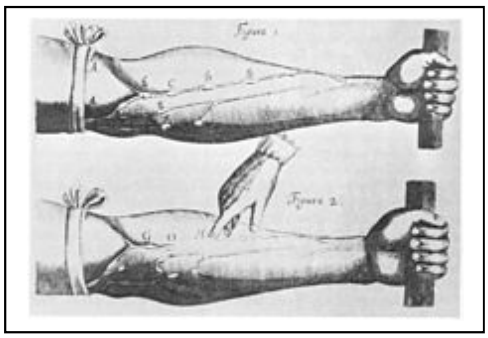
In Padua, doubts were beginning to arise regarding Galen's theory.
Andreas Vesalius was the first to declare that there were no porosities through the interventricular septum of the heart.
Renaldus Columbus pointed out that the current opinion on the timing of the heart was wrong and that the active movement of the heart was in

systole. He agreed with Vesalius about the lack of existence of pores in the septum, He also maintained that blood left the right ventricle of the heart through the pulmonary artery, passed through the lungs, entered the pulmonary vein and into the left ventricle.
Hieronymus Fabricius, who became lecturer in surgery and anatomy at Padua in 1565 and was still teaching when Harvey arrived, challenged Colombus's findings. He did however demonstrate the existence of valves in the veins.

Return to England

Immediately after qualifying from Padua, Harvey returned to England. He became MD Cambridge, joined the College of Physicians and married. He had no family.

In 1607 he was appointed to St Bartholomew's Hospital. In 1616 he was awarded the post of Lumleian lecturer in anatomy, a national post, and on 3rd February 1618, he was appointed Physician Extraordinaire to King James 1.



Harvey's appointment to the King gave him great access to material for his studies. He spent 3 years travelling abroad accompanying James' army, and on his return, requested from the King access to all animals killed on the King's estates by hunting for his studies. As an anatomist, he carried out numerous dissections on bodies, and numerous studies of comparative anatomy eventually leading to his great publication in 1628 "De Motu Cordis" - "On the motion of the heart and blood" in which he demonstrated that the blood did not 'ebb and flow' as everyone believed and had been thought by Galen, but flowed in a circuitous route around the body pumped, not by the liver, but by the heart.

So badly was his work received by his fellow colleagues at the time who failed to believe his work and his theories, that his clinical practice fell dramatically immediately. But in time, of course, we know Harvey was right. We now accept what he took almost a life-time to prove. Of course blood circulates round the body pumped by the heart. Is there anyone now thinks otherwise?

Changes in the Practice

We have a new telephone system in Badgerswood Surgery following the discussions we had with the Practice. This is the same system we have at Forest Surgery. I hope you all now find it easier to make calls into the Surgery, particularly early in the mornings when trying to make clinic appointments. We had many communications about problems phoning in previously so a reduction in these comments will mean this system is working well.

We hope soon to have set up a First Aid training team. Headley Parish Council is installing a defibrillator in the old telephone box in the High Street and we plan to work with them in first aid training of villagers who work and live near the box. We also plan to expand out from there, hoping to train through Headley village and into Whitehill and Bordon. We will keep you informed about progress here.

In the past few months Woolmer Surgery has had to reduce the number of clinics which it has been running in Bordon and patients have slowly been re-registering with our Practice. Woolmer Surgery has now decided to close completely. This surgery is linked to a surgery in Liss and many Bordon patients are planning to remain registered there. However it is likely that many of their patients will wish to re-register locally.

When the beds at Chase Hospital closed, the nursing home, Wenham Holt in Rake, agreed to allocate 4 beds for End-of-Life care for our region. SE Hampshire CCG agreed that since there would be a transport problem for relatives to see patients, they would provide this free to the nursing home. Recently Wenham Holt has unilaterally decided not to accept any more NHS patients as had been agreed. SE Hampshire CCG has had to make urgent alternative arrangements and meantime patients will be transferred to Petersfield Hospital. The same transport arrangements will still apply.

Practice Details

	Badgerswood Surgery	Forest Surgery
Address	Mill Lane Headley Bordon GU35 8LH	60 Forest Road Bordon Hampshire GU35 0BP
Telephone Number	01428 713511	01420 477111
Fax	01428 713812	01420 477749
Web site	www.bordondoctors.com	
G.P.s	Dr Anthony Leung Dr I Gregson Dr H Sherrell Dr Laura Hems	Dr Charles Walters Dr F Mallick Dr L Clark
Practice Team	**Practice Manager** Sue Hazeldine **Deputy Practice Manager** Tina Hack **1 nurse practitioner** **3 practice nurses** **2 health care assistants (HCAs)**	
Opening hours	Mon 8.30 – 7.30 Tues/Wed/Thurs 8.30 – 6.30 Fri 7.30 – 6.30	
Out-of-hours cover	**Call 111**	

Committee of the of the PPG

Chairman	David Lee
Vice-chairman	Sue Hazeldine
Secretary	Yvonne Parker-Smith
Treasurer	Ian Harper
Committee	Nigel Walker
	Heather Barrett
	Barbara Symonds
	Gerald Hudson
	Sarah Coombes

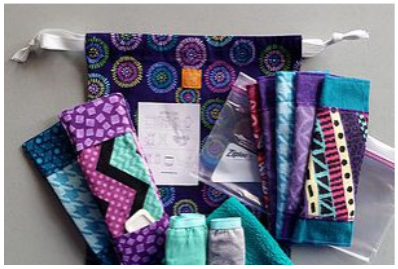
Contact Details of the PPG ppg@headleydoctors.com
ppg@bordondoctors.com

Also via forms available at the surgery reception desk

DAYS FOR GIRLS

Every Girl. Everywhere. Period.

What if not having sanitary supplies meant DAYS without school and DAYS of isolation? Girls use leaves, mattress stuffing, newspaper, corn husks, rocks, anything they can find...but still miss up to two months of education and opportunity every year. It turns out this issue is a surprising but instrumental key to social change for women all over the world and the cycle of poverty is changed when girls stay in school.

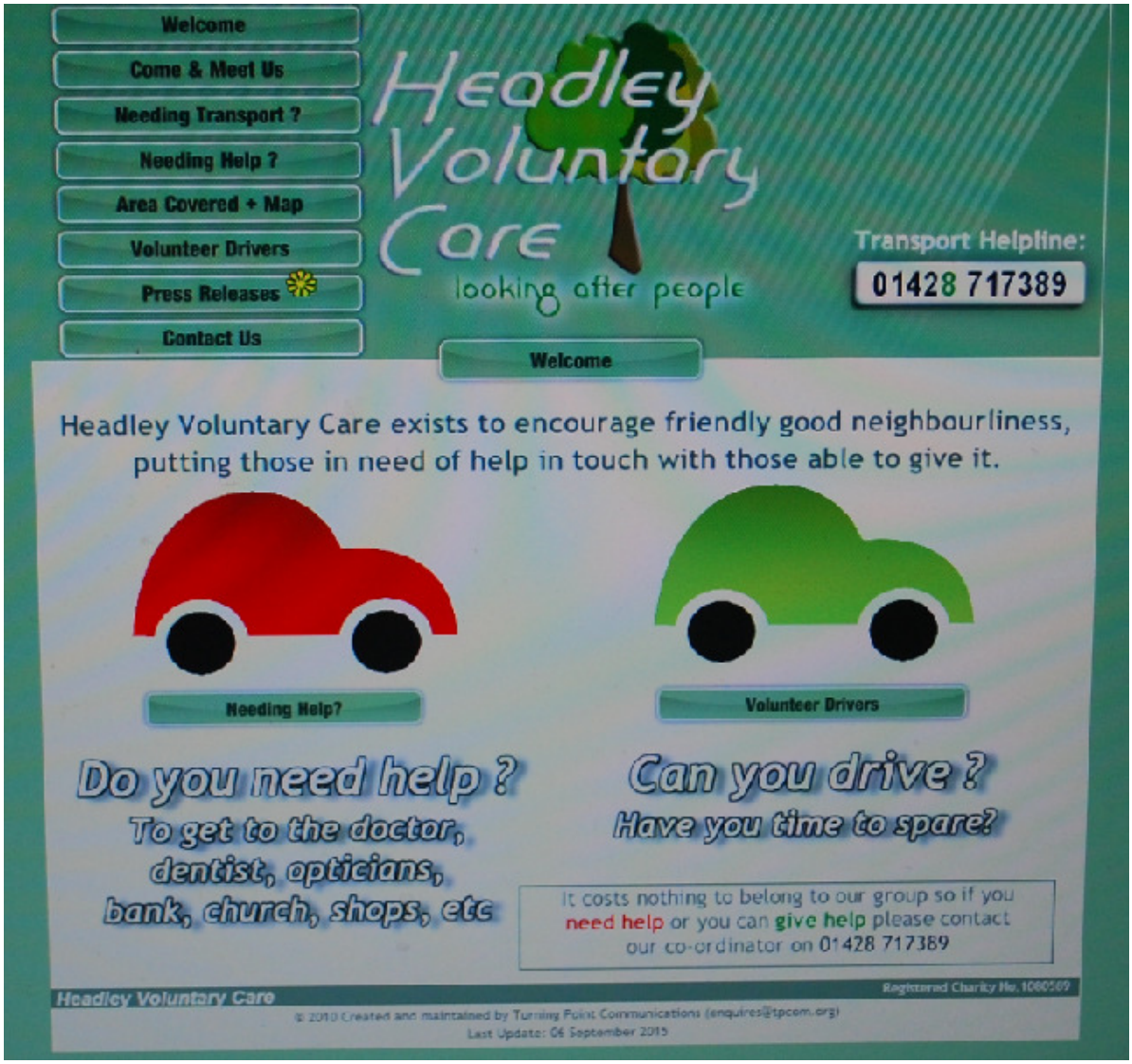


Days for Girls International (http://www.daysforgirls.org/) supplies hygiene kits to girls and women containing soap, washcloths, knickers and washable, re-usable pads and liners sewn by volunteers around the world, including the UK.

After distribution of kits, absenteeism dropped from 36% to 8% in Uganda and from 25% to 3% in Kenya.

There are many ways to aid this effort: donate money via the website above or donate kit materials: 100% cotton fabric, flannel, cotton thread or volunteer to sew kits.

For further information contact Marcia Hammond, 07885 427786 or e-mail Marcia@resmedica.co.uk



NEIGHBOURCARE
HAMPSHIRE VOLUNTARY CARE GROUPS

Bordon and Whitehill Voluntary Car Service

We take people in the Bordon and Whitehill community who do not have their own transport to Hospitals, local Surgeries, Dentists, etc. If you need help please call us.

Also, we are desperately in need of co-ordinators to help us take telephone calls from patients and arrange drivers. They do this at their own home. Can you help us?

Our telephone number is

01420 473636

Headley Pharmacy

Opening hours
Mon – Fri 0900 - 1800
Sat 0900 - noon

Tel: 01428 717593

Visit the new expanded pharmacy in Badgerswood Surgery

Chase Pharmacy

Opening hours
Mon – Fri 0900 – 1800

Tel: 01420 477714

The pharmacy at Forest Surgery, adjacent to Chase Hospital

Both pharmacies are open to all customers

for

Prescription Dispensary
Over-the-counter medicines
Chemist shop
Resident pharmacist
Lipotrim weight-management Service

You don't need to be a patient of
Badgerswood or Forest Surgery to use either pharmacy