DOWNLOAD PDF FUTURE OPTIONS FOR GENERAL PRACTICE

Chapter 1 : Looking to the future: general practice through the eyes of GP trainees | The King's Fund

Future Options for General Practice - CRC Press Book With the advent of the new health authorities, multifunds and consortia, it is likely that the GP's professional leadership of primary care will rapidly become only one of a number of provider options.

Anna Charles There is undoubtedly a workforce crisis in primary care â€" practices are struggling to recruit and retain experienced GPs and insufficient numbers are entering training. But will these measures be enough? As part of our recent report Understanding pressures in general practice we conducted a survey of GP trainees, exploring their intended future working patterns along with their views on the pressures facing general practice. We received responses from trainees, and the key findings are: A minority of respondents intend to work full-time in general practice. A greater proportion intend to do part-time work, particularly at earlier career stages. Many respondents do not intend to take on partnerships. Medical education or other clinical NHS work are favoured options for additional work alongside general practice. Some of the findings â€" particularly the popularity of portfolio working â€" are perhaps no surprise, as a trend away from full-time clinical work is well established among senior GPs. This could be a positive development for the profession, as research has shown there may be benefits to portfolio working for professionals and their patients. It seems this is not necessarily about working less but working differently, and many trainees intend to combine clinical work in general practice with other work in the health service. Flexible careers and opportunities for portfolio working are principal factors attracting trainees into the specialty. It is important that the changing aspirations of the next generation of GPs are recognised, and there is some welcome acknowledgement of this in the General practice forward view. However, the overwhelming preference for portfolio or part-time careers has implications for capacity within the future GP workforce, and the adequacy of workforce planning to meet future demand in primary care. Our findings also challenge a commonly held assumption: It appears that this is only true to an extent. More female than male respondents opted for part-time work, while the opposite was true for full-time work and portfolio working. However, these differences diminish significantly over progressive career points; looking ahead to 10 years after qualification, a fifth of male respondents and a quarter of female respondents intend to work part-time, and just under half of both male and female respondents intend to have portfolio careers. It seems changing work patterns cannot simply be attributed to feminisation of the workforce; there are more complex factors at play. Reasons commonly given by respondents for not intending to pursue full-time clinical work include: Many of these drivers relate to unattractive aspects of the work in general practice, rather than the attractions of other work. Reduced clinical time was seen as a way to achieve a manageable yet fulfilling career. Many seemed to view this not as a choice but as a necessity for their work to be sustainable, while some expressed concern that even part-time or portfolio working would not sufficiently alleviate the pressures. These comments from survey respondents offer further insight: This is driving GPs away from full-time clinical work or partnerships, as they attempt to protect themselves and their careers from destruction. I worry about missing a diagnosis. Resilience is fashionable, but the greater question needs to be asked; is there unsustainable expectation of the current workforce? I was left with an impression of trainees who are worried for the sustainability of their careers and their chosen specialty. This resonates with the concerns I have heard from my peers and former colleagues, who I trained with as a junior doctor. To me, the findings from our survey â€" particularly the detailed comments â€" speak volumes about the current state of general practice, as seen through comparatively fresh eyes. GPs train on the job; they witness the pressures facing the service and the impact on their senior colleagues. Their views are inevitably shaped by these experiences. Enhanced training options, streamlined application processes and incentive payments are all welcome, but they are sticking plasters. The remedy must be prolonged investment and reform to general practice to make this a truly attractive and rewarding career. View the full results from our survey.

Chapter 2 : General Practice

Future Options for General Practice is written by enthusiastic entrepreneurs. It is an excellent source document for anyone who wants to learn at first hand the vision of those who have developed imaginative partnerships between general practitioners, managers, and health commissions.

Key role in decision making and diagnosis and immediate impact on health promotion and preservation Flexibility Variety of patients and cases to treat Patient contact and scope for developing long-term doctor-patient relationships over years, if not a lifetime Can provide holistic care to patients Challenges Very demanding and dependent patients The long-term doctor-patient relationships can seem daunting, especially in a small community Training The indicative length of specialty General Practitioner GP training is three years of run-through training. A few deaneries also offer some four year programmes where usually, but not always, the extra year is spent in a general practice or community setting. This involves a minimum of 12 months 18 in Scotland full-time employment, or equivalent, as a specialty trainee, under supervision of a GP trainer plus a minimum of 12 months full-time employment, or equivalent, in hospital training posts approved for GP training. Independence - professional and managerial. Ability to treat patients outside strict organisational strictures or protocols. Early advancement to peak career earnings. What are the hours like? How intensive is your work schedule? General Practice is hard work, with long hours - somewhat better recently with the loss of out of hours responsibility. Is there scope for flexibility, for example part-time work? General practice provides the best opportunities for flexible work patterns. What are the highlights and advantages of working in this specialty? Patient contact, continuity and community leadership. Professional isolation in small practices and keeping up to date. Also the personal responsibility for covering sickness. What are the routine aspects, if any, of your role? Seeing a mixture of very sick patients, chronic disease management and worried patients who are essentially well. Ability to develop other portfolios - for example police surgeon, occupational health, special interests within general practice and teaching. Please describe your duties in a typical day. Surgery consultations, home visits and administration. What are the necessary personality characteristics for this career? The ability to get on well with people, patience, the ability to live with uncertainty and to manage risk. What advice would you give to someone interested in pursuing a career in this branch of medicine? Do appropriate hospital jobs, look for the best possible traineeship, give per cent and receive per cent in return. How competitive is this specialty? Competition is currently very high to secure a partnership. Additional commentsâ€¦ A specialist is someone who knows more and more about less and less. General practice is the hardest specialty to do well. General practitioners are born, not made. Training can improve a GP, but not create the fundamental personal qualities to do the job. There are several aspects. First was the potential for continuity of care and follow up of patients as they go on their journeys through life. In an age when medical continuity of care becomes less and less possible, general practice seemed like the best option to keep this opportunity open. The diversity of illness in general practice was another factor. We currently are seeing an up and coming amount of general practitioners with special clinical interests and portfolio careers enabling doctors in general practice to both maintain a generalist approach to medicine whilst also allowing for a degree of specialisation in certain fields. The third aspect was the ability to shape my lifestyle so that I had a very good chance at striking a good work-life balance whilst following a career in general practice. How many hours do you work in a typical week? I am currently a full-time salaried GP and work 35 hours a week but 3. These are my contracted hours, but as in any job in medicine you do often work longer than this. Work is very intensive during this time but very manageable. My contract means I do no evenings, nights or weekends. This is certainly a challenging and difficult specialty with many stressful events but certainly not necessarily the most demanding on your time. There is a great amount of opportunity for part-time work and even flexible working hours in some cases if arranged under local agreement. What are the highlights and advantages of working in general practice? The working hours can be excellent. What are the challenges and disadvantages? Patients can be an unknown quantity and you never know what is coming into surgery next. The workload can be enormous and seem like it will never end which is stressful. Also when

unexpected illness or absence from work occurs the extra strain on your workload can be difficult. Patient care and provision of general medical services to my population. Two three-hour surgeries and administration regarding referrals, results checking etc. Two or three home visits each day on top of this. What are the necessary personality characteristics for a career in general practice? Good communication skills, flexibility, organisation and a sense of humour. What advice would you give to someone interested in pursuing a career in general practice? It offers an excellent base of knowledge and experience as well as an understanding to many aspects of medicine including working in the community. This will serve you well if you change your mind along the way and decide to pursue another career. If you do go for training become involved in your local scheme and take advantage of study leave in each job. Look around the training practices before you choose one and talk to all the staff, not just the trainer before making up your mind, including the trainee there at the time. This is very dependant on the area of the country and the practice you want. As in other careers, higher profile jobs are far more competitive.

Chapter 3 : BMA - General practice

Note: Citations are based on reference standards. However, formatting rules can vary widely between applications and fields of interest or study. The specific requirements or preferences of your reviewing publisher, classroom teacher, institution or organization should be applied.

Professor Sir Chris Ham General practice represents a paradox. On the one hand, it is widely and rightly viewed around the world as a model of primary care to be studied and emulated. On the other hand, it is based on small, independently minded units, unable to operate on the scale needed to meet changing population needs. GPs in some areas recognise that practices have to change to rise to the challenges of an ageing population and shifting disease burden. We have studied four of these areas in our new report, Commissioning and funding general practice: These innovations in care are valuable, but much more is needed to ensure general practice really is fit for the future. In our report, we make the case for the development of family care networks led by GPs and integrated with a range of other services such as those provided by community nurses, physiotherapists, mental health professionals, pharmacists, social care staff, and some services currently provided in hospitals. Family care networks would have responsibility for out-of-hours primary care and would be tasked with providing a rapid and joined-up response to patients at times of crisis. They would deliver care that is preventive and proactive with the aim of supporting people to remain independent for as long as possible. Practices would have to collaborate through federations and work at sufficient scale to be able to lead the development of family care networks. This is likely to mean serving populations in the range of 25, to , and possibly even larger over time. The opportunity this offers is to strengthen the role of GPs primarily as providers of care, co-ordinating the delivery of services on behalf of their patients and working in collaboration with others to provide joined-up services in the community. Hospital specialists such as geriatricians and paediatricians would work alongside GPs in these networks to make a reality of care closer to home. Our vision will not be realised unless there are fundamental changes to the commissioning and funding of general practice. We therefore propose that federations of practices should be able to take on a population-based, capitated contract that includes funding for the extended services to be provided in family care networks. The new contract would be optional, enabling GPs to retain their existing contracts where they wish. Funding in the new contract would include the costs of care delivered by practices and there would be flexibility for federations to use savings in other areas of care to increase spending in practices. One of the potential benefits would be to reverse the decline in the share of the NHS budget allocated to primary care highlighted by the Royal College of General Practitioners and others. Key features of the approach we propose include: The registered list of patients means that practices are uniquely well positioned to take the lead in developing innovative models of care under the proposed approach. But if they are unable or unwilling to do so, then NHS trusts providing community services and acute services should be offered the opportunity of taking the lead, preferably in partnership with practices. At a time when the need for innovation in the NHS has never been greater, encouraging a variety of approaches to be tested and evaluated has obvious attractions, not least in unfreezing ways of working that appear increasingly anachronistic. Much therefore hinges on GP leaders at a local level to show the way, building on the examples described in our report and going much further to develop the new models of care needed in the future. This blog is also featured on the British Medical Journal website.

Chapter 4 : General practice (GP) | Health Careers

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Candles Chart A line chart is the simplest chart type. The prices used for the line chart are: By default the price used is close. To open this dialog use double click on the status bar, "Lines section". Area chart is similar with line chart. The difference is that the area chart is filled. The prices used for the area chart are: To open this dialog use double click on the status bar, "Area section". A bar chart shows more data then a line chart. The open, high, low and close price for a chart point are shown simultaneously on a bar chart. When a chart point is created, the first line that is drawn is the open price. Subsequent price movement will produce the high and the low price for the chart point. The final price for the chart point is close price. When you click the left mouse button, the bar at the same timestamp with the mouse pointer will be highlighted like in the example below. The same feature is available with the candles chart. By default the size of a bar is small. To open this dialog use double click on the status bar, "Bars section". By a right click on a bar you can report it "bad bar" or you can edit it. A candle chart shows the same information as a bar chart: In plus, the change in price is more evident on this type of chart because the difference between the open and close is shown in a graphical way. In the following example, the OC color is red. The color of candles can be changed. It can be opened by double-clicking on the status bar, "Candles section". By a right click on a candle you can report it "Bad bar" or you can edit it. Quotes Monitor "Quotes Monitor" shows the quotes and their evolution in time. You can have one or more tables with quotes. Each table can contain many rows at least one row. Every row contains data for a specified contract ES, S, When an update comes the cell will be highlighted. For example in the picture below the last for ESZ7 has changed and the cell is highlighted colored in grey. Drag-and-drop There is drag-and-drop at column level. You can change the order of columns in a table, simple by drag-and-drop. Drag-and-drop at row level allows you to change the order of the rows in a table. Row types There are three types of rows: An empty can change into a quote row by writing the name of the contract in the contract cell. You can also use empty rows for some delimitations in the table Titled Rows: On a title row you can write for example the name of exchange for a group of rows Quote Rows: Previous Indicator Post a previous settlement indicator P for the closing price of the last session for futures quotes. Not to be confused with the P from equity quotes. The coefficients are by default 11, 9, Yield to Maturity This calculates the interest rate for the future contracts by a default formula. Popup Menu If you right click a contract in the quotes monitor board a menu will appear. Here you can choose to Edit or Delete a contract. You can Copy the information to clipboard. Also you can choose to see a Tick Chart or a Volume Chart. Click on "All Contracts" and a table with all futures months of the clicked contract will appear. See the figure below.

Chapter 5 : Making general practice fit for the future | The King's Fund

Future Options for General Practice, Geoff Meads, Ian Carruthers, CRC Press. Des milliers de livres avec la livraison chez vous en 1 jour ou en magasin avec -5% de rÃ©duction.

There are many strategies available that limit risk and maximize return. With a little effort, traders can learn how to take advantage of the flexibility and power options offer. This is a very popular strategy because it generates income and reduces some risk of being long stock alone. The trade-off is that you must be willing to sell your shares at a set price: To execute the strategy, you purchase the underlying stock as you normally would, and simultaneously write or sell a call option on those same shares. In this example we are using a call option on a stock, which represents shares of stock per call option. For every shares of stock you buy, you simultaneously sell 1 call option against it. It is referred to as a covered call because in the event that a stock rockets higher in price, your short call is covered by the long stock position. Investors might use this strategy when they have a short-term position in the stock and a neutral opinion on its direction. Check out my Options for Beginners course live trading example below. In this video, I sell a call against my long stock position. The holder of a put option has the right to sell stock at the strike price. Each contract is worth shares. The reason an investor would use this strategy is simply to protect their downside risk when holding a stock. An example of a married put would be if an investor buys shares of stock and buys 1 put option simultaneously. This strategy is appealing because an investor is protected to the downside should a negative event occur. At the same time, the investor would participate in all of the upside if the stock gains in value. The only downside to this strategy occurs if the stock does not fall, in which case the investor loses the premium paid for the put option. With the long put and long stock positions combined, you can see that as the stock price falls the losses are limited. Yet, the stock participates in upside above the premium spent on the put. Check out my Options for Beginners course video, where I break down the use of a protective put to insure my gains in a stock. Both call options will have the same expiration and underlying asset. The trade-off when putting on a bull call spread is that your upside is limited, while your premium spent is reduced. If outright calls are expensive, one way to offset the higher premium is by selling higher strike calls against them. This is how a bull call spread is constructed. Watch me break down a bull call spread in my Advanced Options Trading course video below: In this strategy, the investor will simultaneously purchase put options at a specific strike price and sell the same number of puts at a lower strike price. Both options would be for the same underlying asset and have the same expiration date. It offers both limited losses and limited gains. An Alternative To Short Selling. The trade-off when employing a bear put spread is that your upside is limited, but your premium spent is reduced. If outright puts are expensive, one way to offset the high premium is by selling lower strike puts against them. This is how a bear put spread is constructed. This strategy is often used by investors after a long position in a stock has experienced substantial gains. This is a neutral trade set-up, meaning that you are protected in the event of falling stock, but with the trade-off of having the potential obligation to sell your long stock at the short call strike. Again, though, the investor should be happy to do so, as they have already experienced gains in the underlying shares. In my Advanced Options Trading course, you can see me break down the protective collar strategy in easy-to-understand language. This strategy allows the investor to have the opportunity for theoretically unlimited gains, while the maximum loss is limited only to the cost of both options contracts combined. A Simple Approach to Market Neutral. This strategy becomes profitable when the stock makes a large move in one direction or the other. Watch how I break down a straddle in easy-to-understand language, from my Advanced Options Course: This could, for example, be a wager on an earnings release for a company or an FDA event for a health care stock. Losses are limited to the costs or premium spent for both options. This strategy becomes profitable when the stock makes a very large move in one direction or the other. Watch me as I break down the mechanics of a strangle in plain, easy-to-understand language. This is an excerpt from my Advanced Options Trading course. Butterfly Spread All of the strategies up to this point have required a combination of two different positions or contracts. All options are for the same underlying asset and expiration date. For example, a long butterfly spread can be constructed by purchasing one in-the-money call

option at a lower strike price, while selling two at-the-money call options, and buying one out-of-the-money call option. A balanced butterfly spread will have the same wing widths. An investor would enter into a long butterfly call spread when they think the stock will not move much by expiration. Maximum loss occurs when the stock settles at the lower strike or below, or if the stock settles at or above the higher strike call. This strategy has both limited upside and limited downside. In this strategy, the investor simultaneously holds a bull put spread and a bear call spread. The iron condor is constructed by selling 1 out-of-the-money put and buying 1 out-of-the-money put of a lower strike bull put spread , and selling 1 out-of-the-money call and buying 1 out-of-the-money call of a higher strike bear call spread. All options have the same expiration date and are on the same underlying asset. This trading strategy earns a net premium on the structure and is designed to take advantage of a stock experiencing low volatility. Many traders like this trade for its perceived high probability of earning a small amount of premium. The further away the stock moves through the short strikes lower for the put, higher for the call , the greater the loss up to the maximum loss. Maximum loss is usually significantly higher than the maximum gain, which intuitively makes sense given that there is a higher probability of the structure finishing with a small gain. In this strategy, an investor will sell an at-the-money put and buy an out-of-the-money put, while also selling an at-the-money call and buying an out-of-the-money call. It is common to have the same width for both spreads. The long out-of-the-money call protects against unlimited downside. The long out-of-the-money put protects against downside from the short put strike to zero. Profit and loss are both limited within a specific range, depending on the strike prices of the options used. Investors like this strategy for the income it generates and the higher probability of a small gain with a non-volatile stock. The maximum gain is the total net premium received. Maximum loss occurs when the stock moves above the long call strike or below the long put strike. Trading Center Want to learn how to invest? Get a free 10 week email series that will teach you how to start investing. Delivered twice a week, straight to your inbox.

Chapter 6 : Exploring Veterinary Career Options

General Practice The GP: A Vision for General Practice in the future NHS outlines the RCGP's aspiration for the future of general practice and patient care - along with what will be needed to deliver it.

Trends transforming the futures of General Practice and Practitioners: Or is there a doctor in your future s? More important is opening up the future to alternative interpretations. This allows a discussion, a debate, of alternative presents. Basic assumptions of what we believe is most significant, what we think is the true state of affairs, and how best we desire to change the world can thus be questioned. To understand the future, futurists tend to use a range of methods. These issues are often irrelevant to immediate strategic concerns but crucial to map as they can sidetrack any strategy. Scenarios can be global, operational, convergent or divergent. This said what are the likely futures of general practice in the next ten to fifteen years? Which trends are opening up the future and which are constricting what is possible? To understand the future we must find a balance between our personal and collective desires as well as with structure -real economic, political, technological, cultural drivers and forces that are already creating the future. Indeed, while many claim the future five to ten years hence requires a crystal ball, the opposite is true. The short-term future is the known future, forces, giant waves of change, are already underway. While we can ride these forces, little can be changed. Merely desiring other futures in the short run, while important in setting up alternative action steps, generally can change very little. Thus the need for an expanded time horizon in which real change is possible. Globalisation, the internet revolution, the genetics revolution, the multicultural swing and ageing. The first two are full blown trends while the latter three are emerging, and will, I believe, create futures that we are unrecognizable to us today. For the general practitioner what is relevant is that Globalisation leads to: More and quicker access to news and technological breakthroughs elsewhere. This is true for doctors as well as patients. Moreover, under the pressure of Globalisation, universal definitions of health are far more difficult to hold on to. The corporatisation of businesses, partly the buying out of national business to global players, but as well the adoption of the corporate business model for all service providers. For small practices, corporatisation usually means vertical integration. At the national and global level, it means the merger of giant pharmaceutical companies. Doctors will have to develop strategies to fend off vertical integration through strategic alliances or through setting up of their own national corporation or at the very least ensure that corporatisation occurs on their terms. Globalisation is also a direct challenge to the welfare state model, in the health field to the idea of universal cover. Globalisation also changes the governance context of health futures. It makes national boundaries far more porous. While not eliminating the nation-state, it certainly makes action at the very local level the shire council , the associative with local and transnational non-governmental organisations and at the very global the entire host of UN families, WHO , far more potent. However the de-evolution of responsibility has generally not come with concomitant funds, thus changing the local-federal power relations and expectations. However, this loss of local funding has been partly solved by an expanding civil society, the gamut of local and international nongovernmental organisations, from Medicine sans Frontiers to Amnesty International. The Internet Revolution IR Working in tandem with globalisation, indeed, accelerating this process is the. While currently this is web-based, very soon this will expand to higher levels of virtualisation. This will lead to the always on, wearable computers, or web-bots. The internet revolution will take away business for certain GPs. Individuals are already going to doctors. Overtime this will lead to therapeutic assistance. The smart get smarter and instead of diminishing returns there are increasing returns. They will grow and have an advantage over traditional practices as well as later cyber med entrants. Moreover, our understanding of cyberspace should not be limited by its current function. For example, in the near term future, sensors will be developed that detect health problems through the smell of breath and alert doctors for early diagnosis. They will provide individualized immediate feedback to our behavior, for example, letting us know caloric intake, the amount of exercise needed to burn off the pizza we just ate. They will also let us know the make-up of each product we are considering purchasing, helping us to identify allergies, for example. Writes health futurist Clement Bezold: Future approaches to heart problems

reflect ongoing changes in health care and biomedical knowledge. In , our DNA profile will be part of our electronic medical record, and our genetically based proclivity to major diseases, including heart disease, will be known. There will be sophisticated, low-cost, noninvasive or minimally invasive biomonitoring devices; for example, a wristwatch device will provide very accurate, ongoing information on your health status. You will likely have powerful in-home expert systems, probably supplied by your health-care provider, which will not only aid diagnosis but also reinforce pursuit of your chosen health goals. The questions for gps is: Can GPs help design the content of these new health tools or will they be passive recipients? In the long run, this means that there will be smarter consumers who will check on research studies and be able to maneuver in a world of conflicting data and conflicting paradigms. Smarter and more empowered consumers should make the jobs of GPs easier. Every year these consultations cost 2. Or will health-bots become the new gatekeepers, that is, will the technology in itself become the new middle-man? And if so, will they be able to ensure patients rights, one of the key dimensions of the GPs work. The other dimensions being: Indeed, we can well see how globalisation and the internet revolution further individualize medicine reducing the probability of the community health paradigm. A question for GPs is: Should they recommend particular websites? Is it ethical to do so? How can they best use the new technologies and ensure they are not used by them? They will need to use them, already estimates of e-business are to go from 61 million in to 1. Next is gene therapy replacing a defective gene and therefore a disease causing gene with a healthy one. Further sophisticated and quite likely is body part cloning growing replica parts to replace faulty ones. Combined with the information and technology revolution, we will have hospitals on our wrists, actually, within our bodies. Genomics thus will identify what genes and what physical of behavioral characteristics genotypes and phenotypes are most relevant for determining how to treat a given condition. Will the GP need to become the genetic counselor as well? Or will the GP need to ensure that a genetic counselor is on board? Germ line engineering can as well pre-select ideal sperm and eggs for fertilization, thus affecting the germ lines of generations to come. It also changes biology from its historical machine metaphor to an informational metaphor. There appear at this stage few limits with science fiction even too timid. Researchers are "planning to create a series of designer bugs, with super efficient mechanisms for infecting target tissues such as cancer tumors, and then killing them [16] And if nano-technology delivers what it promises than our entire bodies will become a pharmaceutical factory, reading to detect, diagnose and react to imbalances, says Bezold. The required devices could be small enough to fit entirely within the cell, if need be. There is no reason such systems cannot be built and function as designed. By this I mean 1 the social construction of medicine movement, for example, mapping how diseases are named, called and treated variously in different nations. The data is stunning. But what accounts for this? Is it the deficiencies in conventional care? And what accounts for this when one can question the paucity of sound safety and efficacy data, ask many GPs. A major insurance company pays for individuals to attend his program. However, what may account for the interest and use in alternative therapies is that they empower individuals as alternative therapists tend to spend greater amounts of time with users and attempt to customize therapy. One suggestion is that patients are increasingly knowledgeable about CAM and seek a more egalitarian process within the consultation. It has been confirmed that patients seek CAM because of an intuitive feeling that it could offer them a more appropriate medical model for their illness. Patients may therefore not be seeking proof of efficacy of particular treatments, but meaning and context for their illness, thus allowing them the freedom to benefit from therapeutic consultations within their chosen milieu. Why should we impose our medical model on patients? Their use of CAM may be their process of empowerment, which in turn allows them to contain and manage their chronic illness. It is perhaps difficult for those of us educated within the conventional medical system to allow our patients the freedom to make such journeys in a truly egalitarian manner. Support for a model more in tune with the Australian population may also come from the changing demographics of medical students in Australia. While genomics, health-bots and alternative therapies may make us healthier, the data generally does not look good for the aged. The average person is sick or disabled for nearly 80 percent of the extra years of life he or she gains as life expectancy rises. Who will buy the stocks when baby boomers sell for retirement as there is no age cohort of that size and income level to follow? Moreover the WHO reports that while ageing is dramatic problem so the global teenager. By

the teenager cohort will have grown by million from two thousand million in There are a few distinct options: Multi-door health community centre which has a high tech component, a genetic counselor and complimentary medicine. While GPs might remain the gatekeepers, they will have to augment their understanding of the Net, becoming knowledge navigators. It is this multiple function in the context of respect and authority that will GPs ahead of the curve. We already know that generation x is more aspiration driven concerned about the environment and the community than previous generations.

Chapter 7 : Trends transforming the futures of General Practice and Practitioners:

Derivatives, Futures and Options. Doing business in today's global economy subjects companies to risks associated with changes in prices for commodities used or produced in their business, fluctuations in foreign currency exchange rates and interest rates, greenhouse gas regulation and compliance with myriad other laws, including the evolving law on manipulation in commodities markets.

What is the difference between options and futures? By Mary Hall Updated November 1, â€" 3: Options and futures are two similar sounding trading products, but are very different in practice. Both products are used by retail traders and institutional investors, but often in different ways. The fundamental difference between options and futures lies in the obligations they put on their buyers and sellers. An option gives the buyer the right, but not the obligation, to buy or sell a certain asset at a specific price at any time during the life of the contract. Both contracts provide investors with strategic opportunities to make money and hedge current investments. Before an investor can decide to trade either futures or options, they must understand the four primary differences between the two. Option Contracts There are call options and put options. A trader can buy a put or a call, or a trader can write a put or a call. The risk to the call option buyer is limited to the premium paid. This premium is received by the option writer. The option writer is on the other side of the trade. A trader buying this option wants the price of the underlying stock to fall. The maximum gain for the writer of the put option is the premium received, yet the risk is that the price falls below the strike price and losses could mount. The put buyer may also choose to exercise, which means they utilize their right to sell at the strike price. They want to profit off the change in price of the futures contract. They do not intend to actually take possession of physical barrels of oil, or to have to deliver barrels of oil or other underlying product of a futures contract. Futures contracts allow companies to buy products they need or sell products they produce at agreed prices on future dates. For example, an oil futures contract is for 1, barrels of oil. But the buyer and seller are not required to put up all this capital up front. Contract Premiums Aside from commissions, an investor can enter into a futures contract with no upfront cost, whereas buying an options position does require the payment of a premium. The value of the contracts decays as the settlement date approaches. However, the premium price rises and falls, allowing users to sell their calls and puts for a profit ahead of the expiration date. Those who sell options can purchase call options to cover the size of their position as well. Compared to the absence of upfront costs of futures, the option premium can be seen as the fee paid for the privilege of not being obligated to buy the underlying security in the event of an adverse shift in prices. The premium is the maximum a purchaser of an option can lose. Another key difference between options and futures is the size of the underlying position. Generally, the underlying position is much larger for futures contracts, and the obligation to buy or sell this certain amount at a given price makes futures more risky for the inexperienced investor. Financial Liabilities When someone buys a stock option, the only financial liability is the cost of the premium at the time the contract is purchased. Futures contracts, however, offer maximum liability to both the buyer and seller of the agreement. As the underlying stock price shifts in the favor against either the buyer or seller, parties may be obligated to inject additional capital into their trading accounts to fulfill daily obligations. Buyer and Seller Obligations at the Time of Expiration Those who purchase call or put options receive the right to buy or sell a stock at a specific strike price. However, they are not obligated to exercise the option at the time the contract expires. Investors only exercise contracts when they are in the money. If the option is out of the money, the contract buyer is under no obligation to purchase the stock. Purchasers of futures contracts are obligated to buy the underlying stock from the seller of that contract upon expiration no matter what the price is of the underlying asset. Still, it is very rare for stock futures to be held to their expiration date. How Gains Are Received The final major difference between these two financial instruments is the way the gains are received by the parties. The gain on an option can be realized in the following three ways: The holder of this call has a bullish view on gold and has the right to assume the underlying gold futures position until the option expires after market close on Feb 22, The investor may instead decide to obtain a futures contract on gold. One futures contract has its underlying asset

as troy ounces of gold. The buyer is obligated to accept troy ounces of gold from the seller on the delivery date specified in the futures contract. If the trader has no interest in the physical commodity, he can sell the contract before delivery date or roll over to a new futures contract. If the price of gold goes up or down , the amount of gain or loss is marked to market i. If the price of gold in the market falls below the contract price the buyer agreed to, he is still obligated to pay the seller the higher contract price on delivery date. Investment Flexibility Stock options provide investors with both the right to buy a stock but not the obligation and the right to sell the same stock but not the obligation through calls and puts, respectively. But stock options also provide investors with a breadth of flexible strategies unavailable through futures trading. Each strategy offers different profit potentials for investors and speculators. Stock futures, on the other hand, offer very little flexibility once a contract is opened. As noted, investors purchase the right and obligation for fulfillment once a position is opened. Options One difference between futures contract and options is that a future is an obligation, whereas an option is the right not necessarily an obligation. With futures, both parties face a lot of risk as prices could move against them. This differs from an option contract where the buyer has limited risk and seller has large risk. Another difference is that the cost of an option is the premium, while futures traders put up margin and then may have to put up more capital if the price goes against them. The potential to have to put up more capital does not apply to option buyers, but does apply to option writers. Futures contracts are generally larger than default option contracts. For example, most option contracts are for shares of stock. Compare that to a standard gold contract which is ounces of gold. Therefore, the size of futures contracts can pose greater risk, since even small moves in the underlying price of the asset can mean big dollar amounts gained or lost on the futures contract. Option contracts are smaller by default, although it is possible to buy multiple contracts same with futures in order to increase the size of the bet. The Bottom Line Options and futures may sound similar, but they are very different. Options trading can be quite complex. Although, if buying options, risk is capped to the premium paid. One of the first questions an investor must ask is how much risk they are willing to take on in their investment strategies. Options trading provides less upfront risk for buyers given the lack of obligation to exercise the contract. This provides a more conservative approach, particularly if traders use a number of additional strategies like bull call and put spreads to improve the odds of trading success over the long term.

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They focus on the health of the whole person combining physical, psychological and social aspects of care. Nature of the work General practitioners have an important role in looking after patients in their homes and within the communities where they live. They are part of a much wider team whose role includes promoting, preventing and initiating treatment. GPs look after patients with chronic illness, with the aim to keep people in their own homes and ensuring they are as well as they possibly can be. GPs are often the first point of contact for anyone with a physical or mental health problem and patients can be at their most anxious. This is becoming more important with terminally ill patients often choosing to stay at home. There are over 1. GPs occasionally work as part of teams attached to hospitals with roles in accident and emergency centres, discharge planning and in unscheduled care such as urgent care centres. In the community they may run clinics in schools and in residential and nursing care homes. A typical GP appointment is scheduled to last for ten minutes, during which time the GP needs to assess the patient. They also use their own knowledge to assess the likelihood of a certain illness being present over another. GPs look for patterns of symptoms to indicate or rule out different conditions. Depending on their examination and diagnosis the GP has several management options which they will discuss with the patient as they develop a shared and agreed plan. These can include giving reassurance, giving the patient information, advising on a certain course of action or prescribing medication. Alternatively they may refer the patient for further tests to confirm a diagnosis or as part of an on-going management plan. These can include x-rays, blood tests or referring on for a second opinion. Patients may occasionally attend the GP surgery with an urgent life-threatening condition, such as anaphylaxis severe allergic reaction or an asthma attack. In these cases the GP will provide life-saving treatment until an ambulance and further help arrives. GPs work as part of large multidisciplinary teams MDTs who all support the holistic care of any patient and these can include nurses, midwives, health visitors, pharmacists, physician associates, psychiatrists and care of the elderly specialists. They meet regularly to discuss cases and plan joint approaches to co-ordinate packages of care. Another important part of the work is preventative medicine and health promotion. This can include clinics for child immunisations and smoking cessation as well as advice on lifestyle during the GP consultation. GPs also have a vital role to play in safeguarding vulnerable children and adults, and involving appropriate agencies. GPs see patients of all ages from newborn babies to elderly people. The ongoing relationship that GPs are able to establish with their patients and being able to offer continuity of care is one of the most important and enjoyable aspects of the job. Patients are often quite knowledgeable about their own conditions and GPs will work with them together to decide on a mutually acceptable plan. GPs have an important role to play in the management of not just of acute problems but also of chronic diseases and the treatment of patients with multiple health conditions, particularly in an ever increasing older population. GPs play a significant role in cardiovascular , metabolic and respiratory diseases and mental health problems. They may run clinics at the surgery for patients with chronic conditions such as asthma, hypertension and diabetes. The work can vary depending on whether you are a GP partner or a salaried GP. This includes the financial aspects of keeping the business afloat and employing staff whilst ensuring the practice provides high quality care are generally committed to one practice for many years, which offers great continuity for both doctors and patients can influence the future direction of the practice and the range of services offered, for example deciding on the staff mix within the practice which can include employing nurse practitioners, paramedics or pharmacists to improve the running of the multidisciplinary team MDT and subsequent patient care are responsible for the financial success of their practice, even though some GP practices employ a business manager, Business functions such as financial management, practice strategy and policy, service development and recruitment are all part of the job. Whether you are a salaried GP or a partner, administration is a big part of the work. This includes reading and acting on letters received from hospital specialists and patients, signing repeat prescriptions, death certificates,

statements of fitness for work and preparing letters and reports. GPs also carry out audits to improve systems and outcomes of care as part of the Quality and Outcomes QOF targets system. Regular staff meetings are also part of life in general practice. There are lots of other opportunities to develop your role in general practice and embrace special interests. Want to learn more?

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