GPst

ISSUE 16

GP IN ZANZIBAR

MEET DR JON REES

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS
UK INDEMNITY, ADVICE & SUPPORT

Welcome to your GPst

FROM confusion over similar-sounding names and illegible handwriting to selecting the wrong item from dropdown menus, there are many risk areas in prescribing. My article on **page 12** offers advice on avoiding the most common pitfalls.

It is an essential part of GP consultations, but safety netting should not just be a means of passing diagnostic uncertainty onto the patient. Risk adviser Alan Frame gives a practical overview on **page 7**.

Recent media reports of a patient who was kept alive by doctors against her wishes highlighted how advance care planning can go wrong. On **page 6** medical and risk adviser Dr Gail Gilmartin takes a closer look at this difficult issue.

Stress is not uncommon in general practice, but there are ways to make it work *for* you. GP and trainer Aman Arora talks goal-setting and meditation on **page 5**. GPs have to make dozens of decisions every day, but are you making the right ones? Dr Allan Gaw lists his top 10 tips for good decision-making on **page 4**.

He has cycled around an African island three times, pedalled his way from London to Paris and had a close encounter with a pop star - all in aid of charity. On **page 10** GP Jon Rees talks about his work with the HIPZ project providing vital healthcare in Zanzibar.

Pursuing an interest in sport and exercise medicine offers GPs the chance to combine two passions. Find out more in our career article on **page 8**.

Our case study on **page 14** highlights an alleged delayed diagnosis of DVT in the case of a patient presenting with a swollen leg.

• **Dr Susan Gibson-Smith**
Editor

COVER PHOTOGRAPH: DR JON REES

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UK INDEMNITY, ADVICE & SUPPORT

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STATE-BACKED INDEMNITY UPDATE

GPs in England can expect further details in May on state-backed indemnity plans for general practice, according to an update by the Department of Health and Social Care (DHSC) and the BMA.

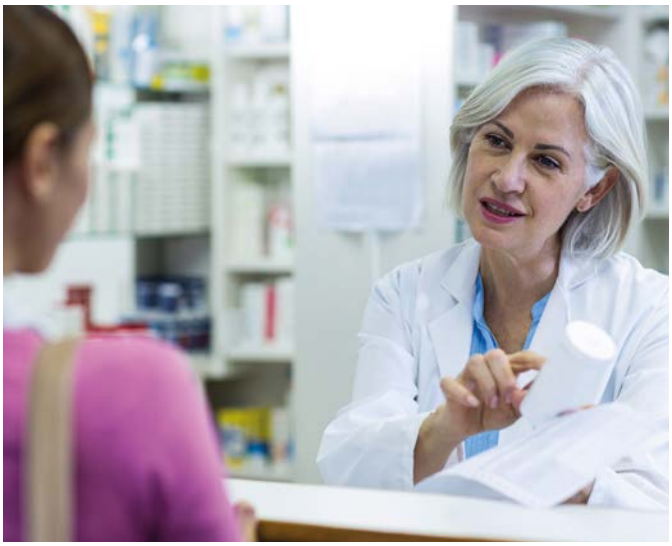
The statement confirms that Government has "started work with GPs and their representatives to develop a more stable and more affordable indemnity scheme for general practice. This will require significant complex work before it can be implemented, including further work with GP representatives and other parties to develop our plans.

"We expect to announce further details of the scheme in May 2018, with the scheme going live from April 2019."

A survey of GPs and other healthcare professionals working in general practice will be conducted to "draw on an informed and up-to-date view of the GP indemnity market as we design the scheme".

The DHSC is urging GPs in the meantime to continue to ensure they have appropriate indemnity cover in line with GMC requirements to enable them to practise.

MDDUS is working with Government and all other interested parties including the BMA and RCGP to ensure the interests of our members are fully represented in ongoing negotiations over indemnity.



PHARMACIST FIRST FOR MINOR ILLNESSES

A NEW health campaign from NHS England is urging patients to contact local pharmacists first for clinical advice and treatment for minor health concerns.

The Stay Well campaign aims to increase public trust in community pharmacy teams and encourage people to use pharmacies rather than visit GPs as the first port of call for minor illnesses. The campaign focuses on three key symptoms: sore throats, coughs/colds and tummy problems.

All pharmacies, GP and dental surgeries will receive a campaign toolkit including posters, information cards and briefing sheets along with other resources. National pharmacy organisations have also compiled a one-stop resources hub, with clinical resources to help in the management of minor illnesses and identify red flag symptoms. Pharmacy teams are being encouraged to use the hub and share it with colleagues.

RCGP chair Professor Helen Stokes-Lampard said patients should seek advice from a pharmacist "where appropriate", before making a GP appointment.

But she added: "[I]n an emergency or situation where genuinely unsure, patients should always seek expert medical assistance, particularly if parents see potentially serious symptoms in their child such as a very high temperature that doesn't respond to simple measures, features of dehydration or lethargy."

GMC ACCEPTS NEW ENGLISH LANGUAGE TEST

OVERSEAS doctors who want to work in the UK can now sit an alternative, more practical English language test.

The General Medical Council will now accept the Occupational English Test (OET) as an alternative to the International English Language Test System (IELTS) which it already accepts as proof of language competency.

The IELTS has faced criticism for being overly academic and irrelevant to day-to-day healthcare. Example writing tests have included the history of elephants and how to make jam.

In contrast, the OET is designed specifically for healthcare professionals and includes real scenarios similar to those they would be likely to encounter in typical workplace situations. The test is already accepted by the UK's Nursing and Midwifery Council, the Nursing and Midwifery Board of Ireland, and authorities in Australia and New Zealand.

GMC chief executive Charlie Massey said: "We are giving overseas doctors an alternative way of demonstrating their English skills, but without reducing the high standards."

REVIEW OF GROSS NEGLIGENCE MANSLAUGHTER

MDDUS has welcomed the announcement by Jeremy Hunt of an urgent review of gross negligence manslaughter in healthcare in light of the High Court case involving Dr Hadiza Bawa-Garba.

Professor Sir Norman Williams' review will report back by the end of April 2018. It will look at lessons to be learned by the GMC and other professional regulators, as well as how reflective practice, openness and transparency can be protected so that mistakes are not covered up but recognised as learning opportunities.

The review should also provide much-needed clarity to doctors about where they stand with respect to criminal liability and professional misconduct.

MDDUS joint head of medical division Dr John Holden said: "It is vital that doctors experience an open and honest working environment and that they are able to learn from mistakes. We fully support any steps to encourage a learning culture that protects both patients and doctors."

PLANS REVEALED TO TACKLE MEDICATION ERRORS

AMBITIOUS new plans to reduce medication errors in England have been unveiled by the health secretary as new research suggests they could contribute to as many as 22,000 deaths each year.

An estimated 237 million medication errors occur every year, ranging from delivering a prescription an hour late to a patient being given the wrong drugs. The new research suggests mistakes may cause around 1,700 deaths each year and cost the NHS £1.6 billion.

Health and social care secretary Jeremy Hunt said that, while the "vast majority" of prescriptions dispensed in the NHS are safe, more must be done to reduce patient harm and improve safety.

His new measures include:

- New systems linking prescribing data in primary care to hospital admissions. This will allow NHS staff to see if a prescription was the likely cause of the hospital admission.
- New defences for pharmacists who make accidental medication errors, with less focus on prosecution for "genuine mistakes". This aims to ensure the NHS learns from mistakes and builds a culture of openness and transparency.
- Accelerating the introduction of electronic prescribing systems across more NHS hospitals this year, which could reduce errors by up to 50 per cent.

Currently only a third of trusts are said to have a well-functioning e-prescribing system. Mr Hunt also called for cultural change within the NHS and said there must be a move "from a blame culture to a learning culture so doctors and nurses are supported to be open about mistakes rather than cover them up for fear of losing their job."

RCGP chair Professor Helen Stokes-Lampard said the College would welcome "any additional resources or technology that will help to further minimise the risks of making a medication error."

She added: "Systems better linking prescribing data in primary care to hospital admissions sound like a particularly good and a necessary step forward."

MULTIMILLION POUND PAYOUT FOR GP INNOVATION

TEN companies will share in a multimillion pound windfall to develop new technologies aimed at easing GP workloads.

Awards ranging from £700,000 to £1 million will be used to fund innovations such as a low-cost test for sepsis, a self-care asthma monitor and a device that can tell the difference between viral and bacterial infections.

A total payout of £8.7 million has been announced by SBRI Healthcare, the NHS England initiative championed by 15 Academic Health Science Networks.

SBRI said the funding was in response to concerns over increasing GP workloads and was aimed at "future-proofing primary care and GP services." The successful companies were chosen by a panel of experts who were "looking for game-changing technologies with the highest potential value to patients and the health service."

Other winning technologies include a device that can perform immediate bacterial infection diagnosis and antibiotic susceptibility testing on urine samples within a GP setting, addressing the rising incidence of antimicrobial resistance that threatens to render current antibiotics ineffective.

MAKING GOOD MOVES

Allan Gaw offers his top 10 decision-making tips

A DAY in general practice can be challenging for many reasons, but often the real sticking points can be the numerous decisions you have to make. Many are small and apparently insignificant, some have more recognisable consequences for you and your patients and every now and then we find ourselves confronted by the momentous.

Successfully navigating through these decisions can mean the difference between a stressful, unfulfilling day and one where we feel we have made a positive impact.

But how do we make good decisions? Here are the top 10 things you should consider.

1. **Do you know how you make decisions?**
We're all a complex mix of different decision-making styles. Some styles can predominate over others and some we prefer, either consciously or sub-consciously, for making certain kinds of decisions.

2. **Are you rational?**
Are you the logical type who likes to make a list, carefully tallying the pros and cons to compute the right decision? Many with scientific backgrounds claim to rely on such 'hard facts' and it's certainly a useful approach when picking a new bank account, but not so good for finding love.

3. **Do you listen to your gut?**
Do you go with your gut, not really knowing how the decision has been reached, but somehow knowing it's 'right'? If so, you're probably using heuristics, or mental shortcuts. These make some decisions, especially some life-saving ones, easier and quicker to make, such as deciding to run away from a fire, but it's a poor way to decide on a drug dose.

4. **Do others influence your decisions?**
Before making a decision, do you ask yourself: is this the way we do things here, is this what I ought to do? Again, this is inbuilt to our decision making and we inevitably adjust any purely logical or instinctive strategy we might adopt by considering the bigger picture. Is it legal, is it right, is it professional?

5. **Are you biased?**
If we use information that's most easily accessible to inform our decisions, or give more weight to memories that are more readily retrievable because they are vivid, or if we make choices that fit with our established ideas, then we are subject to bias. Such biases affect everyone, but be sure to recognise them and keep them at bay to avoid making poor decisions.

6. **Do you understand the risks?**
Decisions have consequences and these may be unfavourable. Often our decision making is driven by a desire to minimise harm and that requires us to understand the risks involved. We often read about how poorly our patients understand the concept of risk, but doctors are not immune to misunderstanding either. We have to consider what might happen, how likely it is to happen in reality and what sort of impact it would have if it did.

7. **Do you sidestep the traps?**
Too often we find ourselves locked into a particular way of thinking about a problem simply because of how it's framed. Questionnaire designers know that how a question is phrased will inevitably determine its answer. Similarly, by thinking about a decision from only one angle, we may unknowingly dismiss several possible options before we start.

8. **Do you realise any decision is usually better than none?**
"In any moment of decision," said Teddy Roosevelt, "the best thing you can do is the right thing, the next best thing is the wrong thing, and the worst thing you can do is nothing." The procrastination that can result from our inability to decide often leads to stress and may leave those around us high and dry.

9. **Do you learn from your mistakes?**
Mark Twain said: "Good decisions come from experience. Experience comes from making bad decisions." However, we might add that we also have to reflect on those 'bad decisions' and learn from them to count them as experience.

10. **Do you waste time on trivia?**
Some decisions are difficult and they're often the important ones we have to make. All difficult decisions can seem equally important to us when in reality a lot of those conundrums are actually rather trivial. But because we think they must be important we spend too much time on them. Choose which decisions really need your time and which are only masquerading as important because of their complexity.

Dr Allan Gaw is a writer and educator in Glasgow

GP and trainer **Aman Arora** offers practical tips for preventing burnout

MAKE STRESS WORK FOR YOU

STRESS can be a challenging but sometimes unavoidable part of GP training. If left unattended it can lead to immense difficulty and burnout, but if recognised early and appropriately managed it can be a positive driver for excelling in all aspects of life.

Having worked with thousands of GPs in training, I have all too often seen the challenges that balancing stress in life can bring. Below are four techniques that can help reduce the potential negative impact of stress and enhance its beneficial effects.

Recognition

Accepting that there will inevitably be stressful times – and that it is perfectly okay for this to happen – means it can be targeted early and therefore adequately countered.

The first step to managing stress effectively is learning to recognise it. What manifests as stress in one person can be very different in another – being aware of your own signs is crucial. Whether that is increased snappiness, an overwhelmed feeling or simply a sense of apathy, try to observe these in yourself (if you are feeling brave perhaps ask someone else for your signs!)

Failing to recognise your own signs of stress limits your ability to effectively manage it, eventually leading to the stress managing you. ***Action:*** *Consider three signs that you know occur when you are stressed. Make a plan to do something about it as early as possible the next time you notice one.*

Three mini-goals a day

Keeping things small and manageable in your mind allows for a more productive and stress-free day. If your mind is continuously bombarded with 10 or 15 things to get done in a day, it can feel overwhelmed and become counter-productive.

Focus on three things that you must achieve each day. Set aside a few minutes before you sleep, or a few minutes in the morning to focus on what you want to achieve that day – and commit to it. Write it down on paper or make a note in your phone. Whether that is to ring the patient that you've been meaning to contact for over a week, finally arrange a date for your educational supervisor's report or pick up that anniversary card on the way home from work.

Highlighting three, very achievable 'goals of the day' gives them high importance in your mind and you will automatically focus on ways to get them done. Once these are achieved, anything that you do beyond these seems a bonus. At the end of the day you'll feel highly productive, something that can automatically reduce stress.

Action: *Write down three mini-goals for today or tomorrow. Start acting on them right away.*

Pre-set catch-up action slots

Despite our best intentions there are inevitably busy periods in life. However busy GP training is, your non-work life will always be running alongside. Weddings, birthdays, parenting etc – all can lead to falling behind in aspects of GP training such as exam preparation or e-portfolio completion.

Consider scheduling predefined 'action' or 'catch-up' days in the diary – perhaps one Saturday a month or two evenings a month. Nothing else can go in these slots – they are purely for those (often mundane) tasks that usually get put behind everything else. All too often these small tasks creep up on us, leading to increased stress levels. Keep a note of things that will slot into those days and add to the list as you go along.

Adequate planning is a huge component of stress reduction. Knowing that tasks are accounted for (even if a few weeks away) allows your mind to be less cluttered, and consequently more effective.

Action: *Schedule your first 'catch-up' slot and start a list of what you will do in it.*

Meditation

This one is not for everyone but don't dismiss it out of hand - you will never know if it is for you until you try.

Forget the stereotype about sitting cross-legged for hours in a trance. For me, meditation simply means refocusing the mind away from the daily hustle and bustle. This refocus can be to your breathing, a memory, a colour, a word – anything that gives your mind a break from the stresses and 'business' of daily life. This does not have to be for extended time periods (I meditate for six minutes in the morning and three minutes in the evening) but the shift in focus to something that *you chose* can be liberating as well as extremely calming.

As a certified meditation trainer I have introduced simple meditation techniques to many doctors and have seen first-hand how it can help reduce stress, both with exam preparation as well as with daily life. Consider giving it a go... it may make all the difference.

Action: *At some point today, close your eyes for 60 seconds and focus completely on something of your choice.*

There are many other methods to counter stress and what works for one person may not work for another. GP training is long and eventful, with many ups and downs. Having a good grasp of your own stress management needs is crucial in order to make it as enjoyable and rewarding as possible. Always remember there are many sources of support in GP training – from educational supervisors to programme directors – never fear approaching someone for advice or guidance.

Dr Aman Arora is a portfolio GP who runs Arora Medical Education (www.aroraMedicalEducation.co.uk). He has previously been a GP VTS programme director, GP appraiser and GMC PLAB examiner.

A recent case highlighted how advance care planning can go wrong. **Dr Gail Gilmartin** offers some advice

ADVANCE DECISIONS

BRENDA Grant had thought carefully about her future care and planned ahead should she one day lack the capacity to make her own treatment choices. She made an advance decision to refuse treatment should certain circumstances arise, fearing degradation and indignity. This decision specified that she did not want life-prolonging treatment. This included the refusal of food, though any distressing symptoms should be controlled by pain relief, even if this might shorten her life.

However, although Mrs Grant had properly exercised her right to make an advance decision the document was misplaced by the hospital treating her, and her family were unaware of its existence. When Mrs Grant suffered a debilitating stroke she was then treated and had a PEG tube inserted: all contrary to her wishes.

Ultimately Mrs Grant's GP identified that the document existed and supported the family in challenging the hospital. The inappropriate treatment was withdrawn and Mrs Grant died a few days later.

Her family are quoted as saying: "She had a fear of being kept alive because she had a fear of going into a nursing home…She never wanted to be a burden to anybody."

The hospital wrongly kept Mrs Grant alive for around 22 months and later agreed a reported £45,000 out-of-court settlement with her family. The hospital also offered a full apology and said in future the existence of an advance decision would be noted on the front page of a patient's records.

The case highlights two key points: the importance of patients discussing their wishes with family, and the risk for doctors in 'misplacing' vital information amongst large files of patient notes.

If Mrs Grant had told her family about the advance directive, it is likely her wishes would have been respected. But patients may be reluctant to broach such an unpleasant topic with loved ones and ultimately the choice is theirs. GPs may wish to discuss with patients the advantages of informing family of the existence of such a document and, better still, disclosing their precise wishes.

These are important medico-legal papers and essential in order to respect a patient's care wishes. Knowledge of their existence is paramount along with ease of access to them should the patient lose capacity. This therefore requires appropriate filing and flagging on a patient's records. As the case above demonstrates, treating a patient against their will does lead to liability.

Mrs Grant's case arose in England where advance decisions have legal status, conferred in the Mental Capacity Act 2005 if the patient (P) has made an advance decision which is:

"(a) valid, and (b) applicable to a treatment, the decision has effect as if he had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued."

The Act, which also applies to Wales, details the requirements for a valid advance decision, including that it is specific for the circumstances arising and if made in regard to life-saving treatment it must be "verified by a statement by P to the effect that it is to apply to that treatment even if life is at risk". It should be in writing and signed by the patient and a witness.

In Scotland, patients can make an advance directive in which they set out their treatment choices and refusals in the event that they lose mental capacity. When a patient loses capacity their treatment must comply with the Adults with Incapacity Scotland Act 2000. This does not enshrine the status of the directive in law, as is the case in England and Wales, but when doctors are making treatment decisions they must take into account the person's wishes and feelings. It is likely, though not yet tested in the Scottish courts, that such directives would be deemed to be binding. The Scottish Government is currently consulting on whether there should be "clear legislative provision for advance directives in Scotland" which should add clarity.

In Northern Ireland there is no statute (specific piece of legislation) to support advance decisions/directives. However, in line with good practice patients can make statements about their wishes regarding healthcare and the circumstances and types of treatment they want to refuse; these should be taken into account when treatment decisions are being made.

In all jurisdictions General Medical Council guidance must be followed. It clearly states: "If the patient has made an advance decision or directive refusing a particular treatment, the doctor must make a judgement about its validity and its applicability to the current circumstances. If the doctor concludes that the decision or directive is legally binding, it must be followed in relation to that treatment. Otherwise it should be taken into account as information about the patient's previous wishes."

Advance decisions and directives, often referred to as living wills, are important documents when treating patients who have lost capacity. It is essential to bear this in mind when treating such patients and remember to consider whether your patient has made such a decision or directive. Systems should allow for the easy identification of such documents so that the correct treatment can be provided.

Dr Gail Gilmartin is a medical and risk adviser at MDDUS

It is an essential part of GP consultations but safety netting should not just be a means of passing diagnostic uncertainty onto the patient

PROVIDING A SAFETY NET

A REVIEW of MDDUS cases reveals a certain inevitability surrounding some missed diagnoses in medicine. Patients present at different stages of their illness and often red flag signs and symptoms may be absent, or do not present until later on. Safety netting is a diagnostic strategy or consultation technique to effect timely re-appraisal of a patient's condition.

The term "safety netting" was first introduced by Roger Neighbour in *The Inner Consultation* (1987). He considered it a core component of GP consultations and defined the term from a clinician's perspective as encompassing three questions:

1. If I'm right what do I expect to happen?
2. How will I know if I'm wrong?
3. What would I do then?

From a risk management perspective, it is essential to have safety-netting procedures in place – for example to advise patients of particular symptoms that they should alert their doctor to, if these develop.

At its core is a requirement to provide sufficient advice in the event of any deterioration, by devising a management plan which can be understood by the patient and putting a safety net in place should things not go as expected. The patient should be left in no doubt of the importance to seek urgent help should there be any serious deterioration in their condition or if they become concerned.

Once a history has been obtained, examination performed and an explanation provided, it is vital that the patient understands what to expect, and the implications of any red flag symptoms.

What should safety net advice include?

- **Explain uncertainty to the patient.** If the diagnosis is uncertain, this should be communicated to the patient so that they are aware to re-consult if necessary. Patients are often seen extremely early on in the illness process and some symptoms may be medically unexplained following initial assessment. If the aetiology is uncertain, explain this to the patient.

- **Highlight things to look out for.** If there is a recognised risk of deterioration or complications developing then the safety-net advice should include the specific clinical features that the patient should look out for. Patient information leaflets can be valuable in supporting this. It can be beneficial to gain an understanding of what the patient's thoughts and concerns are around their symptoms, in order to avoid a potential mismatch of doctor and patient agenda.

- **Signpost further help.** Give the patient specific guidance on how and where to seek further help if required. This may be as simple as booking a return appointment.

- **Map out a timeline.** Where the likely time course of illness is anticipated, safety-net advice should include this information. However, it should be made clear that if a patient has concerns they should not delay seeking further medical advice. Providing a realistic time frame may prevent unnecessary consulting for similar future symptoms, thus empowering and educating patients.

- **Check the patient has understood.** This is a key risk factor in the safety netting process. Research from 2012 suggests as many as 43 per cent of people aged 16 to 65 in England are unable to "effectively understand and use" basic health information. In its guidance *Good medical practice*, the General Medical Council is clear that doctors "must give patients the information they want or need in a way they can understand." Be sure to ask the patient to repeat what you have agreed, so that you are able to check their understanding.

- **Keep accurate and detailed records.** The safety-netting advice given should be documented within the patient's consultation notes.

Safety netting most often goes wrong when either it has not been given, particularly in high-risk situations, or it has not been properly heard or understood by the patient, or is insufficiently specific about what to look out for and what to do.

Many doctors give generic safety-net advice at the end of consultations (for example: "come back and see me if you're not feeling better") but do we really understand what this means to patients?

We know from our case files that inappropriate reassurance from a doctor that symptoms are not serious can lead to catastrophic delays in diagnosis and treatment. However, a downside of safety netting can be to cause unnecessary additional anxiety.

While it is important for general wellbeing that GPs continue to appropriately reassure the vast majority of patients who are well, safety netting does not remove the responsibility for diagnostic decision making by passing uncertainty onto patients. Indeed, safety netting should always be viewed as a positive component of the patient consultation process to reduce the likelihood of preventable harm occurring.

Alan Frame is a risk adviser at MDDUS

PHOTOGRAPH: PA

An opportunity to combine two passions in one career

SPORTING CHANCE

THIS month the Gold Coast of Australia is hosting more than 6,600 athletes and team officials from 71 nations at the 2018 Commonwealth Games. All four UK nations have sent not only athletic teams but "teams behind the teams" – these including squads of physiotherapists and highly trained sport and exercise medicine doctors.

Attending to elite athletes at major sporting events is a specialised role requiring not only core emergency skills and training in musculoskeletal medicine but also experience as a generalist. This might involve, for example, treating chronic asthma in an athlete without falling foul of complex doping rules and procedures.

This is peak specialism – but an interest and expertise in sports medicine can be just as essential on the sidelines of a school rugby pitch. And more often than not it is a GP providing that kind of medical cover.

There are numerous avenues for GPs wishing to pursue an interest in sport and excercise medicine (SEM). It could involve an all-encompassing career change with the goal of becoming a consultant specialist in SEM, or it could be a special interest undertaken alongside working in general practice.

SEM as a GMC specialty

Sport and exercise medicine became a recognised specialty by the General Medical Council in 2005. SEM trainees must complete a four-year training programme administered by the Joint Royal Colleges of Physicians Training Board. A GP can enter SEM training at ST3 level and by ST5 must have completed the Faculty of Sport and Exercise Medicine (FSEM) UK Membership Exam. Later upon completion of specialist training a certificate of completion of training (CCT) is awarded and an SEM consultant can join the GMC specialist register for SEM and apply to become a Fellow of the FSEM UK.

The medical care of injury and illness in sport is just one element of SEM. It also has much broader application in improving the health of the general public through exercise advice and prescription (exercise medicine) and general musculoskeletal medicine.

SEM doctors are involved in promoting physical activity and exercise medicine both to reduce and treat many non-communicable diseases. The role might include diagnosing musculoskeletal injuries or illness in patients for whom exercise would be beneficial and overseeing rehabilitation programmes, or it might involve a wider public health role in encouraging physical activity in the general population.

SEM specialists can be employed as team doctors for a sports club or organisation, or as a doctor for a specific sporting event or venue. In this role they support sportsmen and women in the medical care of injury and illness as part of a multidisciplinary team, maximising performance and reducing injury time and co-morbidity associated with sporting participation. This can involve treating a variety of conditions such as soft-tissue injuries of muscles and ligaments, or fractures.

It would be hard to describe a typical day for an SEM doctor. Work can vary from outpatient clinics reviewing sports injuries and NHS clinics to pitch-side immediate care at the highest level of elite sport. Some SEM doctors run specialist clinics performing image-guided interventional procedures; others may be concerned with assessment and rehabilitation of outpatients. SEM doctors also work in other areas, for example emergency medicine, and may be employed by universities, involved in research and education.

SEM as a special interest

GPs with a special interest in SEM can gain professional recognition in the field by sitting the FSEM UK membership exam. This skills and knowledge-based qualification

provides formal accreditation and is the national standard for doctors working across SEM. The British Association of Sport and Exercise Medicine (BASEM) defines a GP with a special interest in SEM as holding an NHS or equivalent post and often with considerable experience in sport medicine and a higher degree such as an MSc in SEM and/or the FSEM UK membership exam.

All GPs can now apply for membership of FSEM UK by taking parts 1 and 2 of the membership exam, which is recognised as a UK standard, aligned with what is expected of doctors in the field.

Full or part-time jobs for GPs might involve working in clinical exercise, health promotion or in sports science with national sporting bodies and professional clubs – or providing unpaid support for schools and at amateur sporting events.

Links

For more information on careers in sport and excercise medicine check out:

- British Association of Sport and Exercise Medicine: **www.basem.co.uk**
- Faculty of SEM UK: **www.fsem.ac.uk**
- NHS careers: **tinyurl.com/y9sbb8qq**

Q&A

Dr Jonathan Hanson, consultant physician in sport and exercise medicine

• How did you first get involved in sport and exercise medicine?
I was sporty at school and university but also worked as a lifeguard as a student – so I combined sport and medicine from an early age. I did an intercalated degree as an undergraduate in Aberdeen on ACL deficient knees and MRI and was introduced to team work by my supervisor Dr Frank Smith – unusually a radiologist – but also the team doctor at Montrose Football Club. On my surgical rotation a very grumpy surgeon I worked for had a meltdown in theatre and advised me to get a job that lets me get outside. There and then I knew what I wanted to do and started shadowing other team doctors and volunteering for experience. One opportunity then led to another.

• What attracted you to the specialty?
I saw it as a specialty that sits with a foot in specialism and generalism, and gives a way of staying close to the team environment as well as being something that would always have to change. I wouldn't be "inside" the same building for the next 35 years of my career and there might be a chance to travel a bit and work with some amazing people. Basically I knew I would never be bored in SEM.

• What do you enjoy most about the job?
The variety: I work in clinics and pitch-side and consult in a wide range of settings from hospitals to hotels. I need broad, excellent clinical and non-technical skills to cope with unusual situations for individuals with unusual demands of themselves. The workplace: I am surrounded by driven individuals who want to get better and challenge me to be the best I can be every day. The niche: seeing a patient respond to a doctor giving them even just some basic rehab advice for an injury.

• What do you find most challenging?
The plate spinning. Most SEM doctors have portfolio careers with a few employers to keep happy. That's a good thing for skill retention but you need understanding employers – let alone families.

• What has been your most memorable experience in SEM?
For many years I was the team doctor for the British mountain running squad. The events would be unflashy long weekends to the mountains without any of the profile of some other World Championships – but the athletes were beasts and the racing was ridiculously tough and yet they were all completely down to earth people who just got on with it. I was there long enough to see some of the juniors come through to dominate the senior races. GB is a top nation in the world and some of the venues were remote and spectacular with extreme medical environments.

• What advice would you give to a trainee GP interested in pursuing a full or part-time career in SEM?
I'd definitely have a fall-back and probably keep your regular clinical skills up through a portfolio career. So, complete training and get your exams in another specialty. There are many ways to have an influence and not everyone is desperate to do elite sport. Contributing to local PCT musculoskeletal models or exercise policy can be equally as rewarding for some. It is a specialty so you need to do the hours like anything else: shadow, volunteer, gain experience, ask lots of questions. Those of us within want new blood to take the specialty on.

PHOTOGRAPHS: DR JON REES/HIPZ

THE ROAD TO

GP **Jon Rees** talks about his passion for improving healthcare in Africa... and his close encounter with a pop star

AS A KEEN cyclist, it was no surprise to Dr Jon Rees' family that he wanted to circumnavigate the East African island of Zanzibar on two wheels.

With the support of his wife, children and patients, the North Somerset GP battled through sweltering 38°C heat to successfully complete the gruelling six-day expedition.

But there is more to his African adventure than a personal cycling challenge – he was there to raise funds for the charity Health Improvement Project Zanzibar (HIPZ), of which he is a trustee.

That first ride in 2010 raised more than £80,000 which was used to build and equip a primary healthcare unit and a maternity service at the island's Makunduchi Hospital. Since then he has completed the feat twice more, with a 30-strong team of charity cyclists behind him, and pedalled from London to Paris, personally raising £20,000.

The father-of-three says the 2010 trip was "an amazing experience". "It was extremely hot, the roads were of variable quality, the bikes were of terrible quality, and it was challenging, but the amazing group spirit kept everyone going."

Jon had a brush with fame during his second bike ride around Zanzibar in 2013. Pop singer and reality TV star Peter Andre took part alongside an ITV2 crew as part of the fly-on-the-wall series, *Peter Andre: My Life*. The *Mysterious Girl* singer began supporting HIPZ after being operated on by urology consultant and HIPZ founder Dr Ru MacDonagh (Peter has since married the surgeon's daughter Emily).

Inspiration

Jon's involvement began when he worked alongside Dr MacDonagh as a urology research registrar in Taunton. Having already worked in a hospital in Zanzibar as well as Lesotho, South Africa and Tanzania, Jon was immediately keen to get involved with HIPZ and went back out to work in Zanzibar's Mnazi Moja Hospital.

He says: "I absolutely loved working out there and met so many inspirational people. It's an incredibly welcoming place, but the conditions in the main hospital were tough for the patients, and for the staff."

At one outpatient clinic, Jon describes seeing people everywhere. Many had travelled across the country and some slept in the grounds of the hospital to be there early for the first-come-first-served clinic. Just a curtain separated three clinicians consulting in the same room, making privacy almost impossible.

Jon says: "I saw advanced cancers and distressing cases, but the ability to cope with them and treat these people with compassion in those situations was so limited. I saw real human suffering."

So when Dr MacDonagh asked him to become a HIPZ trustee, the GP immediately agreed.

A different approach

The biggest draw for Jon was the different approach HIPZ took to their charity work.

"There was no doubt that there was a huge need, " he says, "but what really attracted me to working with Ru and HIPZ was that the charity was trying a different model of development aid than many other NGOs, working closely alongside the Zanzibar government. Ru has such good knowledge and a great network of contacts there, so we could work out what was really needed, rather than doing simply what we thought might help."

What started as a small kitchen-table

Clockwise from opposite page: *Dr Jon Rees embarks on his first bike ride around Zanzibar in 2010; the 2013 charity bike riders; Jon with singer Peter Andre who took part in the sponsored cycle in 2013; Jon and HIPZ founder Dr Ru MacDonagh meet Zanzibar's president Ali Mohamed Shein (centre) and other dignitaries.*

ZANZIBAR

charity in 2006 now provides essential healthcare to over 250,000 people across two district hospitals.

In 2007, the government in Zanzibar agreed a deal to sign over the running of Makunduchi Hospital in the south of the island to HIPZ for 10 years, now extended for a further five years. Then in 2011, with the HIPZ-run Makunduchi a success, Doctors Rees and MacDonagh were invited to meet the President of Zanzibar and agreed to take over a second larger hospital in the north of the island, Kivunge, which was in a poor condition.

To date, the HIPZ project has transformed healthcare in Zanzibar and raised hundreds of thousands of pounds from sponsorship and donations from groups ranging from Nailsea and Backwell Rotary Club to Comic Relief. A UK doctor is placed at Makunduchi and Kivunge to oversee clinical work, train staff and redesign services. HIPZ has also provided equipment and medical supplies; renovated the hospital's operating theatres, maternity unit and children's wards; and built a primary healthcare unit that treats more than 500 patients every week.

When Jon visited the new building for the first time he fought back tears: "It was an incredible achievement, to see the bricks and mortar standing there was very moving. Previously, the population of 75,000 people had no primary care."

Building trust

One key achievement of HIPZ is building trust in healthcare among the community. Maternity services in particular received a boost.

Jon says: "Before we took over at Kivunge, only 70-80 babies were delivered there a month because people didn't believe in their local hospital – women delivered at home, which was very dangerous. Today 350-400 are delivered each month as they now believe their local hospital is a better place. The community has really gained trust in the hospital because of the work that HIPZ has done, which is fantastic."

Despite the improvements, the development work is far from over and the team continue to fundraise and visit Zanzibar regularly. In the last few years, HIPZ has begun a psychiatric service, improved dental care provision and started a clinic for managing high blood pressure.

"It is inspiring to see things have been done better but there is always more that needs doing," says Jon. "There will never be a moment when we say 'job done'. I do this because I believe very passionately about what we are doing and what we have achieved."

Balancing act

Besides his HIPZ work, Dr Rees is a busy executive partner at Brockway Surgery in Nailsea, North Somerset, and has a special interest in men's health and urology. He is a trustee of Action on Bladder Cancer UK and founder and chair of the Primary Care Urology Society.

Jon, who also enjoys cycling and photography, spends three days in general practice and the rest of the week doing community urology, seeing NHS patients in Bristol and Gloucestershire.

"How do I manage to balance everything? I enjoy being busy and having lots of things on the go. One of the reasons I love general practice is that it gives me the opportunity to choose how I work and when I work."

Away from the world of medicine, the busy GP is looking forward to a family holiday to Bali in August – but another two-wheeled trip around Zanzibar may well be on the horizon (pop stars optional).

Kristin Ballantyne is a freelance writer based in Glasgow

• To find out more about HIPZ and how to support their work visit **www.hipz.org.uk** The project is looking for volunteer doctors who are prepared to learn Swahili and can commit to a minimum of six months in Zanzibar. The hospitals also host medical students seeking elective placements. To apply, email: **admin@hipz.org.uk**

ATTENTION TO DETAIL

From similar-sounding names to illegible handwriting, *GPST* editor **Dr Susan Gibson-Smith** highlights the most common prescribing risk areas

PRESCRIBING is a common task for GPs but it is one in which even a simple error can have serious consequences.

Consider the following scenario:

The mum looked exhausted. She had been struggling to breastfeed for two months but it was becoming increasingly difficult with the vomits and the crying. The health visitor said it was reflux and to try ranitidine, but had not specified a dose. The BNF wasn't much help and I was feeling pressured. I checked the paediatric BNF and saw the dose for a child 1–5 months was 1 mg/kg three times daily (max. 3 mg/kg three times daily). The baby was crying and mum seemed annoyed I was taking so long. She told me the baby weighed 7.5kg so I gave her the prescription for 5ml three times a day as there was 75mg in 5ml. I was pleased at being able to work out the solution without having to ask anyone, and mum was happy that she had a medicine to help.

Later that afternoon the pharmacist called to say I had prescribed 10 times the recommended dose of ranitidine and that mum was very upset. How could this have happened?

Around 14 per cent of all GP claims handled by MDDUS relate to prescribing, from confusing similar-sounding drug names and mixed-up doses to failing to follow General Medical Council guidance. As a trainee GP, it is crucial to be aware of the most common prescribing pitfalls.

Patient names

Take care to check that the computer record you have open is for the correct patient. This may sound basic, but on a busy day it can be easy to confuse Mary Smith (DOB 21/5/42) with Mary Smith (3/10/51). Always check with the patient that they are who you think they are.

Generic or brand

We are all taught as medical students to prescribe generically but there are times when it is more appropriate to prescribe a brand name medicine. One key example is for patients with epilepsy where using the branded drug (e.g. Epilim) can be crucial to ensure the correct drug is given. Care should always be taken with HRT prescribing as a common mistake is to give a patient unopposed oestrogen instead of combined as the names can be confusing.

It is also important to note that brand name prescribing is sometimes cheaper than generic if the drug has come off patent. An example of this would be Longtec instead of the generic oxycodone. It is advisable to regularly check your CCG/health board's formulary to make sure you are up-to-date with the latest changes.

Handwriting

Particular care should be taken when a patient presents you with a handwritten letter from secondary care recommending a medication that may be difficult to decipher. If in doubt, phone the prescriber and check the dose, even if it means the patient has to come back and collect it later. The GMC's guidance *Good practice in prescribing medicines and devices* is quite clear that: "You are responsible for the prescriptions you sign and for your decisions and actions when you supply and administer medicines and devices or authorise or instruct others to do so. You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicines."

It is not a defence to say the consultant did not write clearly.

Beware the dropdown

Computer dropdown menus are designed to make your life easier, but if you are short of time it can be easy to let attention to detail slip. Drug names can look similar and may appear close together on the dropdown list. The MHRA highlighted its most common Yellow Card reports of harm following confusion between the following drugs:

- Clobazam and Clonazepam (both benzodiazepines)
- Atenolol (beta blocker) and Amlodipine (calcium channel blocker)
- Propranolol (beta blocker) and Prednisolone (corticosteroid)
- Risperidone (antipsychotic) and Ropinirole (dopamine agonist)
- Sulfadiazine (antibiotic) and Sulfasalazine (disease-modifying anti-rheumatic drug)
- Amlodipine (indicated for hypertension and angina) and Nimodipine (indicated for the prevention of ischaemic neurological deficits following aneurysmal subarachnoid haemorrhage).

Quantities

Take care when initiating new prescriptions, especially for patients with a new diagnosis of mental health conditions, to ensure that you are prescribing the appropriate quantity. For example, some IT systems automatically default to large amounts, e.g. sertraline to 56 tablets. Paracetamol also routinely defaults to 100 tablets. The risk of overdose should always be considered and it is good practice to limit the amount of medication to the time of the next review to help mitigate this risk.

Co-morbidities

The GMC's *Good medical practice* states that, in providing clinical care, doctors "must prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs."

Certain co-morbidities can influence prescribing. For example, care should be taken when prescribing antibiotics or statins for patients with chronic kidney disease (CKD) as the dose may need to be modified.

Poly-pharmacy is another risk area where it is important to be aware of the interaction between any new acute medicine you are prescribing and the existing medication the patient is on. An obvious example of this is for patients on warfarin. Beware pop-up fatigue: often during a consultation you can be bombarded by a barrage of warning messages, and the temptation is to ignore them when you are busy.

Allergies can also form part of the pop-up assault on the screen. Always ask the patient if they have any allergies even if none are showing on the system. Most practices have a system for recording allergies but this is not always fail-safe. Keep in mind allergy risks when prescribing during home visits where you may not have the full patient history available to you. If in doubt, delay prescribing until you return to the surgery and have checked the notes. Find out from the patient which pharmacy they use and agree to send the prescription there directly.

Repeats

Before signing a repeat prescription, take care to read it over. You are responsible for that prescription even if you did not initiate the drug. Key risk areas to look out for are repeat drugs that require monitoring, e.g. warfarin, DMARDS and contraceptives. Make sure you know the reviews have been done before you sign.

Back to our scenario

As our scenario above shows, mistakes can easily happen in prescribing for children when the dose is dependent on the patient's weight. In our scenario, the trainee was under pressure during the consultation and unfamiliar with prescribing the drug in infant form. She had calculated the dose for the baby as 7.5mg three times a day but instead of 0.5ml of the 75/5ml solution she incorrectly worked it out as 5ml. Fortunately the pharmacist spotted the dose error before any harm came to the baby.

If in doubt, stop and double-check all the prescription details.

Dr Susan Gibson-Smith is a medical adviser at MDDUS and editor of GPst

REFERRAL

SWOLLEN LEG

DAY ONE
A 38-year-old woman – Ms J – presents to her GP practice requesting a sick note having had arthroscopic surgery for a meniscal tear in her left knee. The GP – Dr S – notes that the patient is mobile with the aid of crutches.

WEEK THREE
Ms J attends the surgery complaining of pain and swelling in her left leg. Dr S examines the leg and notes persisting left knee pain with minimal non-tender swelling and a very tight bandage in situ. He advises the patient to remove the bandage and to continue with analgesia.

WEEK FOUR
Ms J is still complaining of a painful and swollen left leg. On examination Dr S notes tenderness and swelling with the left calf 3cm larger in circumference than the right. The GP suspects a DVT and arranges a referral to the local thrombosis clinic but there is no record of a same-day referral.

ONE DAY LATER
A work colleague of Ms J takes her to A&E complaining of chest pain. A senior registrar notes the swelling in her left leg. Investigations reveal extensive left leg deep vein thrombosis (DVT) and a CT pulmonary angiogram shows a clot in the distal left pulmonary artery. She is admitted to hospital and treated with heparin and commenced on warfarin therapy. Later she develops a respiratory infection which is treated with broad-spectrum antibiotics.

ONE WEEK LATER
Ms J is discharged from hospital on warfarin under the care of the anticoagulation clinic. Her left calf is now soft and non-tender but she is prescribed further antibiotics to deal with a chronic chest infection.

A LETTER of claim is sent to the practice from solicitors acting on behalf of Ms J alleging clinical negligence in the care provided by Dr S. It is claimed that on two occasions the GP failed to urgently refer the patient to hospital for treatment of her DVT. This delay resulted in Ms J developing pulmonary embolism and requiring hospital treatment, with prolonged recovery complicated by a serious chest infection.

MDDUS instructs a primary care expert to provide an opinion on the case. In regard to the second consultation in which Ms J presented with a painful and swollen knee the expert argues that any potential sign of DVT would have to have been persuasive given the patient was recovering from knee surgery. However, failure to remove the bandage in order to examine the knee did, in his opinion, constitute a breach in duty of care – as it is difficult to speculate what signs might have been present.

The expert is also critical of the third consultation in which it was clear that Ms J was at risk of DVT. An urgent same-day referral should have been made so that anticoagulation could have been started promptly to prevent pulmonary embolism.

A respiratory consultant is also consulted for a view on the consequences of the GP's actions in the case (causation). The expert states that – on the balance of probabilities – Ms J did have a DVT at the second consultation. Removal of the bandage and examination of the leg at that point would have likely revealed tenderness and an enlarged left calf in comparison to the right – with a Wells score of two or three indicating a moderate to high probability of DVT. Urgent referral with a D-dimer test and ultrasound investigation would have confirmed DVT. Anticoagulation treatment with heparin and later warfarin would have prevented the pulmonary embolism.

Urgent referral on the day of the third consultation – rather than a delay of 24 hours – would also have likely prevented pulmonary embolism and the later chronic chest infection necessitating an extended hospital stay.

Given the unsupportive expert views MDDUS settles the case with agreement from the member.

KEY POINTS

- Consider expected post-operative findings masking other symptoms in diagnosis.
- Facilitate urgent referral in cases with clear risk.
- Record justifications behind clinical decisions.

Diary

SO MUCH absurdity, so few column inches. Welcome back to Diary where we ask for interesting and entertaining medical anecdotes from our readers, get nothing in reply and so make up our own. But let us not be bitter...

BROWN BEAR BUSTED A Sheffield GP – Dr Catherine Bell – has commented in the *BMJ* (albeit the Christmas issue) on the questionable practice of a certain ursine cartoon doctor appearing regularly in the popular children's TV programme *Peppa Pig*. Having observed questionable prescribing by Dr Brown Bear in three separate cases involving two piglets and a pony, Dr Bell concludes "exposure to *Peppa Pig* and its portrayal of general practice raises patient expectation and encourages inappropriate use of primary care services". The GMC has yet to respond.

● **POWER OF POSITIVITY** It's official – a positive mindset is good for your health. Well, maybe. A British study has found that being in a positive mood on the day of your flu jab can increase its protective effect. It found happy patients developed stronger antibody defences than those who merely feel so-so. Fortunately patients do not have to be in a state of joy at the precise moment the needle is stabbed into their arm – just feeling upbeat that day is sufficient to reap the benefits. For those struggling to raise a smile, Nottingham University researchers said the best method is "a combination of comedy, uplifting music and a list of funny things people say."

● **LOVE IS ALL YOU NEED** *Which?* magazine recently interviewed 15 doctors for an article entitled "10 ways to get the best from your GP". Top of the list: "Love your receptionist". The authors explained: "The old-fashioned view of receptionists acting as guard dogs to keep you away from your GP is outdated. Try to think of them as your ally in finding the person most skilled to help you... And don't hate them for asking 'is it urgent?'"

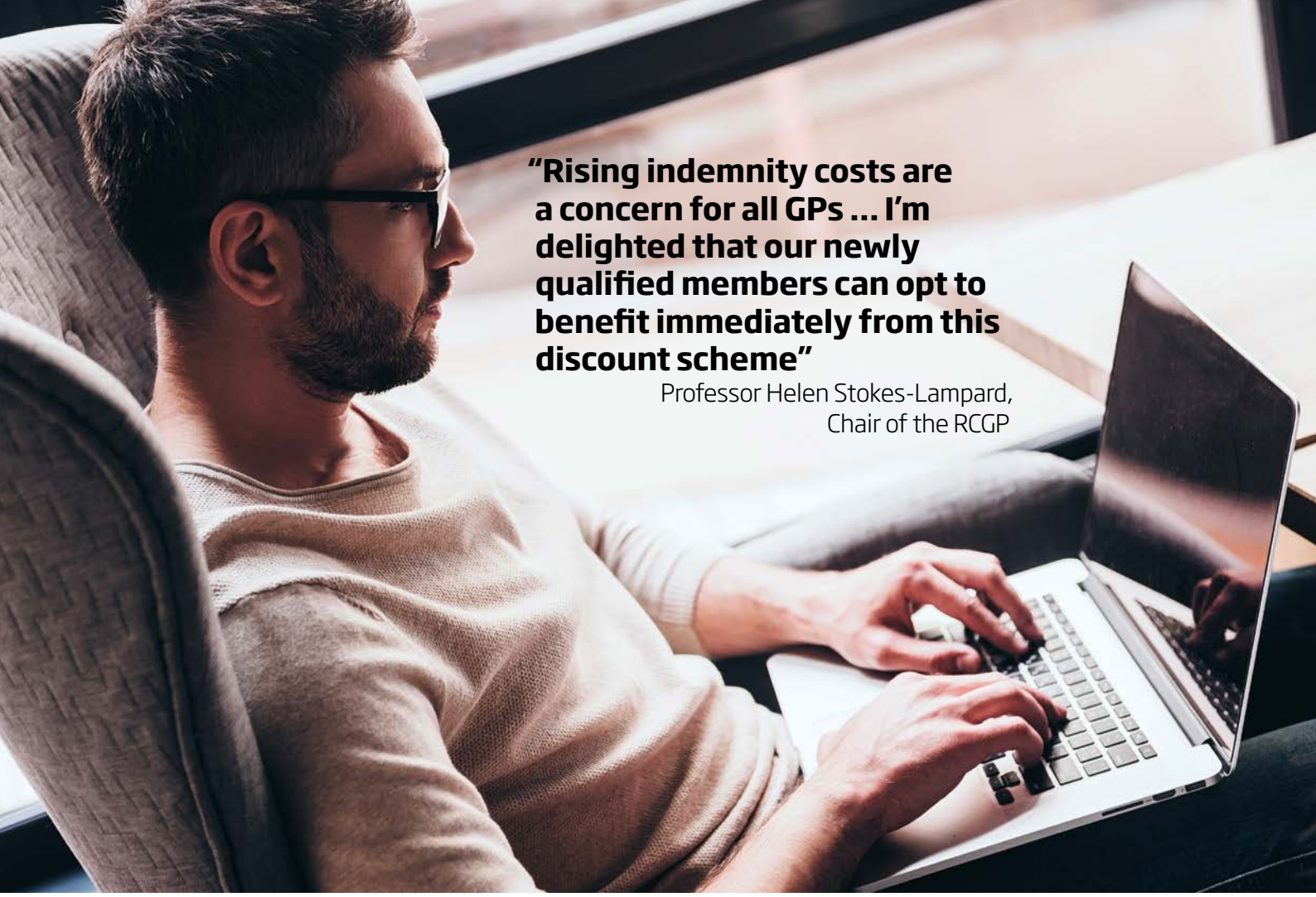
● **ELBOW GREASE** British rock band Elbow have been unveiled as the latest weapon in the ongoing battle to boost the GP workforce. They have given permission for their hit single *One Day Like This* to be used in Health Education England's recruitment campaign, entitled One career, endless opportunities. The song forms the soundtrack to a video in which GPs and trainees talk about their experiences of life in general practice, and why they chose the specialty. As the chorus goes: "It's looking like a beautiful day... One day like this a year would see me right." A sentiment many hard-working GPs could no doubt relate to.

● **SNOW SAVIOURS** Cutting nicely through the seemingly never-ending NHS-bashing headlines are some amazing tales of derring-do by practices caught up in the recent "beast from the east" snowstorms. A GP in Essex told *Pulse* how, with no buses running, one of his receptionists spent more than four hours walking to work, while a practice manager elsewhere slept in her practice to ensure services kept going. Another GP drove half way to his locum booking before completing his journey on skis. *GPOnline* reported that many practices had activated business continuity plans, with some closing early, switching to an emergency-only service or arranging for staff unable to travel to provide triage from home. One GP whose car wouldn't start walked to the nearest main road and hitched a lift in a passing 4x4 before trudging a mile and a half through the snow on foot. Dedication indeed.

● **CHOCS AWAY** Snackers beware: NHS England is after you. New restrictions on the type of food and drink sold in hospitals to staff, visitors and patients are due to come into force in April 2018. A 250-calorie limit will be placed on chocolate bars and other confectionary sold in canteens, stores, vending machines and other outlets. And there's no use seeking solace in a giant cheese baguette as unhealthy sandwiches and sugary drinks are also on the hit list. Trusts who don't comply could lose out on additional funding. GP practices may soon be enjoying increased availability of Alpen bars and dried fruit should Simon Stevens' anti-obesity campaign reach a vending machine near you.

● **EQUAL OPPS FLU** The term "man flu" is so ubiquitous that it has been included in the Oxford and Cambridge dictionaries. Oxford defines it as "a cold or similar minor ailment as experienced by a man who is regarded as exaggerating the severity of the symptoms." So begins a research paper (published in the *BMJ*) by the University of Alberta's Dr Kyle Sue exploring whether "men are wimps or just immunologically inferior". He analysed available evidence to determine whether men really do experience worse symptoms and whether this had any evolutionary basis. His findings suggest that men may actually have weaker immune systems than women and that testosterone may act as an immunosuppressant while oestrogen works in the opposite direction. The rather tongue-in-cheek study was given some credence by RCGP chair Professor Helen Stokes-Lampard who said that, while flu "is not sexist", there is some evidence to suggest respiratory tract infections may present more severely in men than women. "Most people, whatever their gender, will recover completely within a few days," she added.

● **THERE WILL BE BLOOD** Historical treatments for menstruating women included barber surgeons bleeding them from the ankle to draw the blood down and encourage smooth flow. Chinese medics suggested drinking yellow rice wine to harmonise the blood, while a special tonic laced with cocaine – called Hall's Coca Wine – was encouraged circa 1916 for "sickness, so common to ladies". Less appealing was hormone supplement Glanoid, produced from 1867-1930 by a meat-packing business. A more hi-tech solution came in the form of a battery-operated "electropathic belt" aimed at "suffering men and women". Marketed circa 1893 it was said to be effective for conditions such as nervous exhaustion, neuralgia and "ladies' ailments", promising wearers "new life and vigour". *Source: Wellcome Collection.*



"Rising indemnity costs are a concern for all GPs ... I'm delighted that our newly qualified members can opt to benefit immediately from this discount scheme"

Professor Helen Stokes-Lampard,
Chair of the RCGP

RCGP FIRST5 PARTNERSHIP

MDDUS has teamed up with the Royal College of General Practitioners to offer GPs in the first five years after qualification access to a tailored indemnity package and a contribution towards their College membership. This partnership provides a new cost-effective route for new GPs to get all the benefits of belonging to two innovative and complementary professional bodies.

Newly qualified First5 GPs will be able to take advantage of a 75% contribution to RCGP membership fees, as well as a tailored indemnity product at a competitive price. This exciting new package can offer **overall savings in excess of £3,000**.

To find out more and take advantage of this offer go to **www.mddus.com/join/rcgp-first-5-partnership**. The 75% contribution to your RCGP fees will be applied after your membership application is approved.

Existing MDDUS members who are RCGP First5 GPs will automatically benefit from the contribution at their next renewal date.

Contact Mairi Dixon on **0141 228 1267** or **mdixon@mddus.com** for more information.

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