

# What's up **DOC?**

MEET STAND-UP COMIC DR AHMED KAZMI

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TAKE CARE

AN **MDDUS**  
PUBLICATION

**MDDUS**  
UK INDEMNITY, ADVICE & SUPPORT



## Welcome to your GPst

PROVIDING care to transgender patients is becoming an increasingly common occurrence in practice but it can leave some GPs feeling out of their depth. My article on [page 10](#) offers practical advice on issues such as prescribing, referrals and name changes.

From bingo to Bollywood and bird watching, GPs are being encouraged to prescribe social activities to fight loneliness. But does it work? Find out more on [page 4](#).

State-backed indemnity schemes have now been launched in England and Wales – but GPs still need protection from a medical defence organisation like MDDUS. Our article on [page 6](#) explains.

Remote patient monitoring is becoming more popular as healthcare technology improves – but there are risks. On [page 7](#), senior risk adviser Liz Price highlights the importance of

staff training, following agreed protocols and carefully setting alert triggers.

Taking his career in an unexpected direction is GP and stand-up comic Ahmed Kazmi. He talks skinny jeans, burnout, life changes and much more on [page 10](#).

For many people, the field of urology conjures up images of endless consultations about men and their prostates. But this varied specialty offers so much more – and not just for hospital specialists. On [page 8](#), Dr Jon Rees gives his personal take on life as a GP with a special interest in this specialty.

Our case study on [page 14](#) follows a morbidly obese man suffering from breathlessness who is denied a GP home visit with tragic results.

• **Dr Susan Gibson-Smith**  
Editor

## FRESH PUSH TO BRING BACK GPs

A NEW campaign has been launched to persuade hundreds of doctors to return to general practice.

It will highlight government pledges to invest billions in extra funding and recruit 22,000 health professionals to support GPs and ease workloads.

NHS England and Health Education England hope the campaign will encourage more doctors to take part in the Induction and Refresher scheme (I&R) which has so far attracted almost 800 applicants since its launch in March 2015. Of these, 279 have fully completed the programme and rejoined the GP workforce in England.

The scheme targets doctors who have taken a break from general practice, whether to retire, raise a family or work abroad or in a different profession. It promises to provide “a safe, supported and direct route for qualified GPs to join or return to NHS general practice in England”, offering financial and practical support.

Find out more at: [www.gpretuner.nhs.uk](http://www.gpretuner.nhs.uk)

## NHS STAFF ENCOURAGED TO USE EMAIL

HEALTH and Social Care Secretary Matt Hancock wants the NHS to stop relying on pen and paper and use more secure forms of digital communication such as email instead.

He has outlined an ambition for healthcare staff to email patients directly with information on appointments to reduce delays, boost cyber security and cut wastage.

The Department of Health and Social Care has said that NHS organisations will be able to use any secure email provider – not just NHS Mail – if it meets the

required security settings. This is meant to empower NHS bodies to choose the best service for their needs and encourage innovation.

The Government has announced that digital services and IT systems will soon have to meet a clear set of open standards to ensure they can “talk to each other” across organisational boundaries and be continuously upgraded. It has said that any system not meeting these standards will be phased out and contracts ended with the provider.

The move is part of Mr Hancock’s tech vision for the NHS.

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## DEATH CERTIFICATION E-TRAINING

DOCTORS in Scotland are being encouraged to complete two e-learning modules on death certification.

The modules have been produced by NHS Education for Scotland (NES) in partnership with Healthcare Improvement Scotland's Death Certification Review Service (DCRS) and are designed to support certifying doctors to complete Medical Certificates of Cause of Death (MCCDs).

Module 1 is entitled *Death Certification: Identifying Common Mistakes* and is intended for doctors who are completing MCCDs in Scotland or doctors who have finished a training module on death certification and wish to confirm or improve their

understanding of the subject.

Module 2 – *Certification of Deaths in the Community* – is primarily intended for doctors who are working in general practice in Scotland and may need to deal with sudden or expected deaths in the community.

DCRS Senior Medical Reviewer Dr George Fernie said: "These modules are a key component in helping DCRS to deliver its overall aim of improving the quality and accuracy of MCCDs and we would encourage certifying doctors to log on and complete them as a matter of priority."

Access the modules at: [www.sad.scot.nhs.uk/atafter-death/death-certification](http://www.sad.scot.nhs.uk/atafter-death/death-certification)



## GENDER REASSIGNMENT SHOULD BE INITIATED IN SPECIALIST CARE

GENDER reassignment is a specialist area of medicine and treatment for trans patients should be initiated in specialist care, says the Royal College of GPs.

RCGP honorary secretary Dr Jonathan Leach said trans patients, like all patients, should be treated in general practice "on the basis of need and without bias."

He said it is important that GPs and their teams are mindful of the terminology and language they use when talking to trans patients, and that it should be based on each patient's individual preference, as well as any individual health needs they may have.

But he emphasised that new presentations of gender reassignment are "exceptional" in general practice, adding: "It is a specialist area of

medicine, and treatment should be initiated in specialist care."

He acknowledged that access to specialist gender reassignment services in the NHS was "inadequate", and that was frustrating for trans patients and their families. But he said: "GPs should not have to bear the brunt of poor access to specialist services by being put in a position where they are being asked to prescribe treatment that they are not trained to prescribe or monitor safely without expert support."

A new RCGP e-learning course for GPs on gender variance is due to be launched later in 2019. It has also received funding from the Government Equalities Office to develop resources to support GPs and other healthcare professionals to deliver quality care for LGBT+ patients.

## NEW STANDARDS FOR END OF LIFE CARE

A NEW set of standards in providing end of life care has been agreed for GP practices.

The Royal College of GPs has joined forces with charity Marie Curie to create the Daffodil Standards, designed to support primary care teams in caring for patients living with an advanced, serious illness, or at the end of their lives, and their loved ones.

Practices who adopt the eight standards commit to making improvements in at least three of the eight core aspects of care each year, with the aim of having reviewed all of them within three years. Those practices will also be able to display a "daffodil mark" to show their commitment.

### The Daffodil Standards are:

1. Professional and competent staff
2. Early identification of patients and carers
3. Carer support - before and after death
4. Seamless, planned, co-ordinated care
5. Assessment of unique needs of the patient
6. Quality care during the last days of life
7. Care after death
8. General practices being hubs within compassionate communities.

A survey carried out to coincide with the launch found that 92 per cent of GPs agreed it is important for them to spend time caring for terminally ill or dying patients, and another 87 per cent said that caring for terminally ill or dying patients is a rewarding part of their job.

However, it also revealed an overwhelming majority of GPs (85 per cent) felt they did not have as much time as they would like to care for patients at the end of their life because of their workload. Sixty-two per cent said there were not enough community resources to give families and carers of terminally ill or dying patients the emotional support that they need.

Similarly, 71 per cent of respondents said more resources were needed to help GPs and practice staff to cope with the grief of losing patients. Only two per cent said their practice held formal support sessions on dealing with grief and loss.

RCGP chair Professor Helen Stokes-Lampard welcomed the standards. She said: "Making sure that patients and their families feel supported at the end of life is an essential part of what we do, and in many ways, one of the most privileged aspects of our role." But she called for more funding to help GPs deal with rising demand.

The standards, which have already been recognised by the new Quality and Outcomes Framework (QOF) on end of life care and the CQC, have been piloted by a number of surgeries across the UK. Each standard comes with its own evidence-based tools, exercises and quality improvement steps.

Find out more at: [www.rcgp.org.uk/daffodilstandards](http://www.rcgp.org.uk/daffodilstandards)



# PRESCRIBING HAPPINESS

From bingo to Bollywood and bird watching, GPs are being encouraged to prescribe social activities to fight loneliness... But does it work?

IT HAS been described as one of the greatest public health challenges of our time and is linked to a range of damaging conditions such as Alzheimer's disease, heart attacks and strokes. Loneliness is said to be as harmful to health as smoking 15 cigarettes a day, but opinions are divided as to how best to tackle it.

The UK government unveiled its proposals to address the issue in October with the launch of its "loneliness strategy" for England and Wales. The plan gives GPs a central role, specifically in the practice known as "social prescribing", which allows clinicians to direct patients to a variety of arts and cultural activities such as cookery classes, walking clubs and more.

Health and social care secretary Matt Hancock describes social prescribing as an "indispensable tool" to tackle "ageing, loneliness, mental health and other long-term conditions." It is hoped offering non-clinical solutions could reduce demand on the NHS and improve patients' quality of life.

Similar strategies launched by the Scottish and Welsh governments also seek to expand social prescribing.

## Positive effects

While some doctors may be sceptical as to the effectiveness of such schemes, social prescribing has been backed by NHS England as one of its 10 high-impact actions aimed at freeing up GP time. Analysis by the RCGP also found it was one of the most effective of those 10 high-impact actions at reducing GP workload and called for dedicated social prescribing to be integrated into practices.

The King's Fund has published a range of information on the topic. It states: "There is emerging evidence that social prescribing can lead to a range of positive health and wellbeing outcomes. Studies have pointed to improvements in areas such as quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety."

The Fund highlights a study into a social prescribing project in Bristol

which found improvements in anxiety levels and in feelings about general health and quality of life. It adds: "In general, social prescribing schemes appear to result in high levels of satisfaction from participants, primary care professionals and commissioners." But it also accepts that robust and systematic evidence on the effectiveness of the practice is "very limited".

Practices who do adopt social prescribing have a wide range of activities to choose from.

## Parkrun

Parkrun has grown massively since its launch 15 years ago. It organises free, weekly, 5km timed runs at more than 600 locations around the UK and abroad, attracting more than 140,000 runners each week.

In 2018 the Royal College of GPs joined forces with Parkrun UK to "promote the health and wellbeing of staff and patients." Under the initiative, the College is encouraging practices to become official "Parkrun practices" and so far 700 across the UK have signed up.

Southport GP and Parkrun ambassador for health and wellbeing Dr Simon Tobin spoke at the 2018 RCGP Conference of his practice's success in encouraging patients (and staff) to take part. Parkrun, he says, gives people "a purpose and a community".

He told the stories of several patients (with their consent) who had benefited. He described how type 2 diabetic Gary had been considering joining a local Parkrun event but was reluctant because "I'm not a runner." Spurred on by Dr Tobin's reassurance that 25 per cent of Parkrun participants walk the route, Gary has since lost 13kg and has been able to come off his medication.

Another patient, Eileen, had struggled with her weight and alcohol intake in addition to depression and anxiety. On Dr Tobin's suggestion, she tried Parkrun and has since completed a half marathon. The GP adds: "It gave her a real self-esteem boost and her health is very much improved."



## Walking for Health

Walking for Health is England's largest network of health walk schemes, run by the charities Ramblers and Macmillan Cancer Support. Similar programmes are operated by Ramblers in Scotland (Medal Routes) and Wales (Let's Walk Cymru).

The Walking for Health website describes how every week they "support thousands of people to experience the benefits of getting and staying active, improving their mental and physical wellbeing, and reducing social isolation."

They tell GPs that "spending just 60 seconds recommending Walking for Health to your patients will encourage them to increase their levels of physical activity, ultimately saving lives and money, and reducing clinic numbers."

Practices are encouraged to either signpost patients to a local scheme or get help in setting up one of their own.

## "Nature prescriptions"

In October 2018 the *Guardian* reported that doctors in Shetland had begun prescribing birdwatching, rambling and beach walks. Health board NHS Shetland authorised the area's 10 GP surgeries to issue so-called "nature prescriptions" to patients to help treat mental illness, diabetes, heart disease, stress and other conditions.

Under the initiative, the health board set up a pioneering partnership with RSPB Scotland who produced an information leaflet and a calendar of seasonal activities that doctors hand out to patients at their discretion.

Speaking in October, GP Chloe Evans from Scalloway Health Centre said: "The project provides a structured way for patients to access nature as part of a non-drug approach to health problems. The benefits to patients are that it is free, easily accessible, allows increased connection with surroundings which hopefully leads to improved physical and mental health for individuals".

## Bingo, Bollywood and beyond

The King's Fund says that more than 100 social prescribing schemes are currently running in the UK, more than 25 of which are in London. One pilot project in the capital involves 37 GP practices in the borough of Croydon. With the help of £800,000 of NHS funding, doctors there can choose from a list of more than 100 activities including bingo, Bollywood dancing, boxing, coffee mornings and choir singing. The *Guardian* reported in November how, in the scheme's first year, there was a 20 per cent reduction in hospital outpatient referrals and a four per cent drop in emergency hospital admissions from Croydon's Parchmore medical centre. Dr Agnelo Fernandes, who leads Parchmore, said: "People who were previously isolated are getting out of their houses. It has provided an opportunity to meet people and do other things."

Social prescribing is not a new phenomenon – occupational therapists have advocated meaningful activities/occupations for over a century – but interest in encouraging general practice to play its part has certainly increased in recent years as healthcare strategy places greater emphasis on prevention, wellbeing and patient-centred care. If practices are given enough support and encouragement – with extra funding allocated to charities and community groups – then proponents of the approach hope it could go some way to reducing workloads and improving patient outcomes.

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*Joanne Curran is managing editor of GPST*

## Further information

- What is social prescribing? The King's Fund – [www.kingsfund.org.uk/publications/social-prescribing](http://www.kingsfund.org.uk/publications/social-prescribing)
- RCGP Parkrun practice initiative – [tinyurl.com/y5nt4e24](http://tinyurl.com/y5nt4e24)
- Walking for Health – [tinyurl.com/yyduq5pd](http://tinyurl.com/yyduq5pd)



# LESS IS NOT MORE WHEN IT COMES TO PROTECTION

GPs in England and Wales may believe that state-backed indemnity provides all the help and support they need in facing professional difficulties. But what about all the things it won't help with?

THE new Clinical Negligence Scheme for General Practice (CNSGP) in England and the General Medical Practice Indemnity (GMPI) scheme in Wales have now been launched – and GPs may assume that these state-backed schemes provide all they'll ever need in terms of professional advice and support. Some may give hardly a second thought to the idea of retaining their medical defence organisation (MDO) membership.

However, it may come as a shock to discover that there are a number of key exclusions to NHS cover, leaving some unsuspecting clinicians having to pay hefty legal bills out of their own pocket.

It's been confirmed that GPs will be indemnified by the NHS for work done within an NHS contract. Trainee GPs placed in GP settings for training purposes will also be automatically covered for clinical negligence liabilities, with no payments required. The BMA has confirmed that comprehensive personal indemnity cover for all GP trainees will be funded by Health Education England until qualification.

GPs and GP trainees still need MDO membership as there are a number of key areas where CNSGP/GMPI will not provide assistance. The schemes will not cover non-NHS work, representation at inquests, GMC hearings and disciplinary investigations. Such situations can seriously impact careers and could ultimately result in a GP being struck off.

The schemes also do not include advice and support – something highly prized by MDDUS members. It is crucial to have access to support and guidance from experienced medico-legal advisers. This is evidenced by the fact that over the past 12 months MDDUS' team of expert medical advisers handled more than 6,500 calls

and opened nearly 4,000 new case files from GP members relating to issues NOT included in the government schemes.

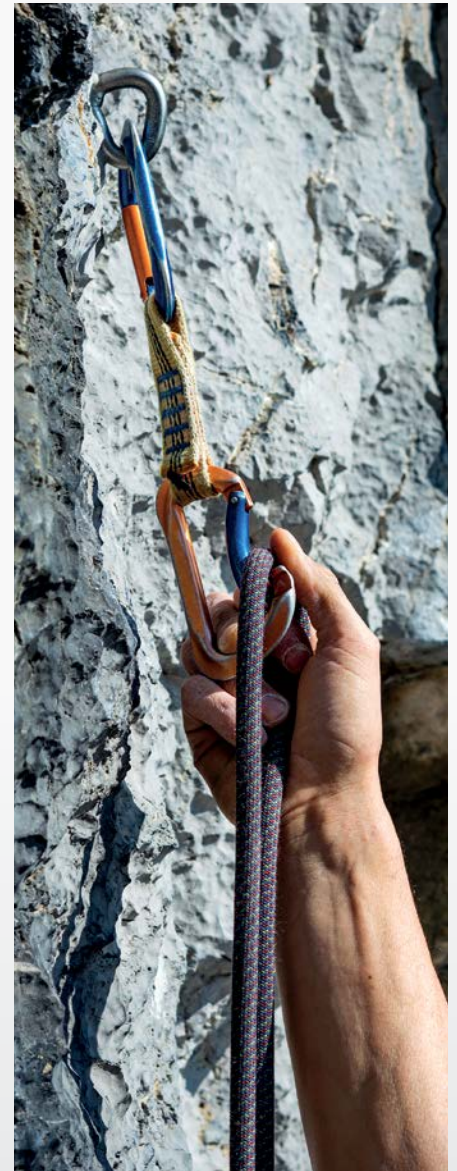
Also in the past 12 months, MDDUS assisted more than 200 GPs facing GMC investigations and advised 513 members who were called to appear at coroner's inquests. In addition, we helped almost 2,500 members deal with patient complaints – another key area that won't be covered by CNSGP/GMPI.

As these figures show, there is a huge range of areas where GPs will not get support from the new schemes and will need supplementary expert help. You can be sure that MDDUS will still be there for you.

## New MDDUS product

We have developed a new product specifically designed for GPs practising under CNSGP/GMPI that provides essential advice and assistance. MDDUS General Practice Protection (GPP) costs significantly less than our existing indemnity package and provides the following benefits:

- 24/7 medico-legal advice
- GMC representation
- Assistance with disciplinary matters
- Support with Ombudsman investigations
- Assistance with coroner's inquests
- Assistance with criminal matters (related to medical practice)
- Indemnity for private clinical work outside of your NHS contract\*
- Indemnity for writing insurance reports
- Indemnity for travel vaccination clinics
- Indemnity for worldwide Good Samaritan acts
- Assistance with patient complaints
- Advice on performers' list outcomes
- Assistance with HR and employment issues for practice staff
- A range of medico-legal publications
- Discounted medico-legal training.



MDDUS has sent information letters to all GP members in England and Wales about GPP, and you can also find out more at [mddus.com](http://mddus.com)

*\* Private work (non-practice-registered patients): we can extend your membership to include access to indemnity for a range of medical work outside of your practice setting.*

Remote monitoring is becoming more common as healthcare technology improves and more sophisticated devices become available

# HOME BUT NOT ALONE

**A** LONG with remote consultations, remote monitoring is part of a rapidly changing area of technology known as telemedicine. Telemedicine can be defined as the delivery of healthcare services, such as assessments or consultations, over the telecommunications infrastructure, allowing providers to evaluate, diagnose and treat patients without the need for an in-person visit.

Remote monitoring allows patients to be monitored in their own homes through the use of mobile medical devices that collect data. It's much more than just recording blood sugar levels, blood pressure and other vital signs. Advances in IT, combined with growing patient demand, could trigger a revolution in remote health monitoring over the next few years.

Integration of IT in healthcare is a key strategy for all UK governments. This winter some CCGs set up care home pilots which allowed patients to be monitored remotely, reducing the need for GP visits. The pilots consisted of a combination of automated recording and flow of data back to the clinician, alongside manual recording by a remote carer, with an agreed protocol allowing information to flow back into the practice.

Remote monitoring can improve care by giving patients and carers greater involvement in managing their health and providing continuous tracking of their symptoms, so that interventions can be made before any problems become acute. Technology is becoming more user-friendly and unobtrusive to wear, allowing patients to continue with their normal activities. Increasingly, tracking software can be integrated into everyday devices, such as smartphones, tablets and now smartwatches, which should help to speed up adoption.

However, this new technology is not without risks and trainees – or indeed any clinician –

should not use remote monitoring devices without proper training, understanding agreed protocols or having been directly involved in system setup.

A standard for the assessment and approval of safe healthcare apps (as with MHRA approval of healthcare devices) is currently being established, but in the meantime it is important for practice teams to conduct a comprehensive assessment before introducing new technology.

This should include carrying out a privacy impact assessment as required by data protection legislation. This is basically a risk assessment focusing on the potential impact of a data breach relating to the introduction and use of monitoring devices and software.

Clinicians will also have to set local standards for the use of remote monitoring by patients. These could be established through profiling different conditions. Patients will have to be aware that an alert might be triggered without their knowledge if the monitor is set up to send frequent daily readings.

Practice clinicians should be aware of the proper response to alerts and the escalation strategy for each particular patient. Systems should be set up within the practice to ensure that monitoring alerts are dealt with in a timely manner. Without appropriate attention to alerts, a practice might miss an opportunity to deal with an emerging issue and prevent a serious problem.

'Alert fatigue' could also become a risk if system triggers are not set properly, leading to alerts being ignored – which can be very tempting if they are frequent and of a low level. Alerts are necessary to avoid information

overload at the point of contact with the practice, however it is important that they are set with care, and

are specific to patient needs.

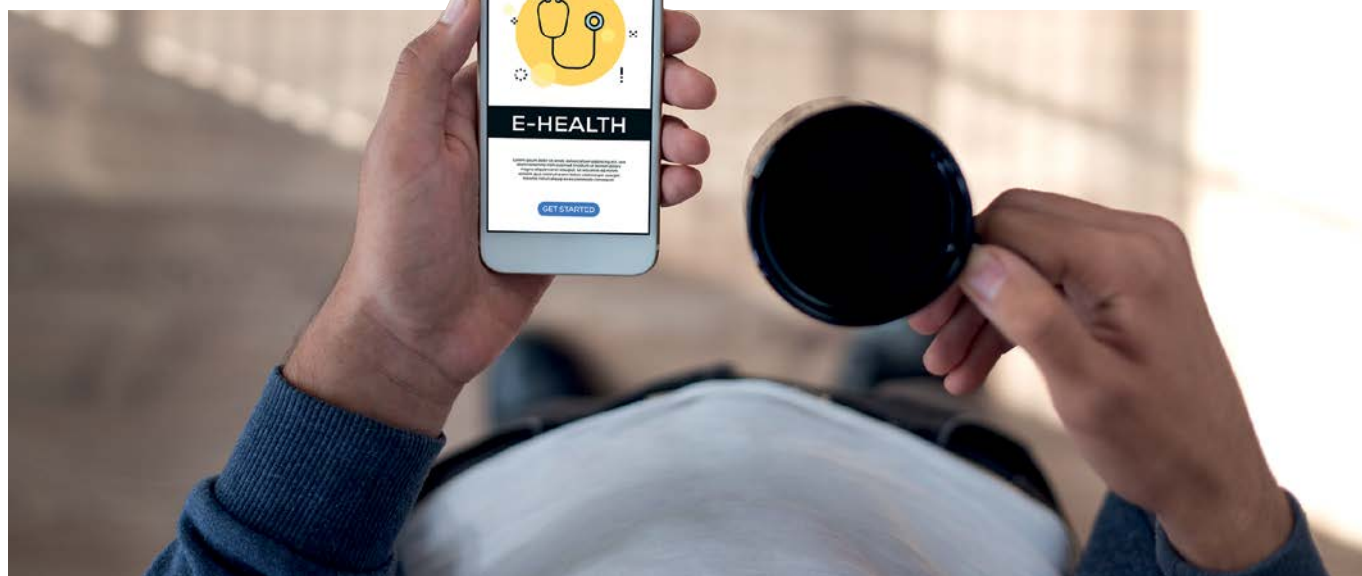
Doctors should be able to specify the alert trigger strategy for each patient so that they are aware of what is "normal" for that particular patient. It is also vitally important to agree how you will contact the patient to discuss issues for urgent follow-up. Additionally, the patient's family may need to be made aware of what is arranged so that if the practice has to contact, say, a wife or husband, there is no potential for a breach of confidentiality. All such issues should be discussed with the patient and recorded in the case notes.

Monitoring information must be compatible with the clinical system so that information can be stored in the patient record and retrieved easily. Responses to all electronic and remote person alerts should be documented, with an audit process in place to ensure adequate monitoring procedures. Monitoring information should also be regularly reviewed with the patient to reinforce adherence to care and treatment plans.

## ACTION POINTS

- The practice should undertake a privacy impact assessment before using a device.
- Specify and agree with each patient a "trigger strategy".
- Ensure you and the practice team are aware of the proper responses to alerts and the agreed escalation protocol.
- Review monitoring information with the patients at regular practice visits.
- Document all responses to alerts in the clinical record.

*Liz Price is senior risk adviser at MDDUS*





# MAKING A POSITIVE IMPACT

GPs working in urology can help improve patients' lives and reduce referrals

**F**OR many people, the field of urology conjures up images of endless consultations about men and their prostates. But this varied specialty offers so much more – and not just for hospital specialists.

More and more GPs are developing an interest in this area, often working in community clinics assessing, diagnosing and devising care plans for a variety of common urological conditions such as kidney, bladder or urinary tract problems. Taking the pressure off secondary care, such services can dramatically reduce both waiting times and patient anxiety.

GPs who develop an interest in this area can undertake a variety of roles in hospital or community settings or in educating fellow GPs.

## New framework

The Royal College of GPs recently launched a new framework for GPs with extended roles (GPwERs), the new term for GPs with a special interest (GPwSIs).

It states: "Since the dissolution of Primary Care Trusts in 2013 there has been no consistent process in England for the accreditation of GPwERs/GPwSIs.

"The RCGP is trialling GPwER accreditation in dermatology and skin surgery, and subject to the outcome of the trial we will seek to phase in accreditation in a limited number of other priority areas. For now, we advise GPs to follow the generic framework and contact providers and commissioners to understand local requirements."

*Q&A – Dr Jon Rees, GP with a special interest in urology, founder and chair of the Primary Care Urology Society*

## What attracted you to a career in urology?

I have to admit, I hadn't given urology a second thought as a medical student or as a house officer – no lifelong passion to help people pass urine better for me! I did my first urology job as an SHO, starting a surgical rotation at Musgrove Park Hospital in Taunton. I worked for two fantastic consultants – Ru MacDonagh and Mark Speakman – and the enjoyment of urology came from my time working for them.

I subsequently worked for Ru MacDonagh as his research fellow, spending three years on my MD thesis, looking at the effect of prostate



cancer on the quality of life of men and their partners.

However, it was during this research, much of which was spent interviewing men in their own homes, that I discovered there was a whole world of medicine outside hospitals, and the idea of switching to general practice followed. However, I did not want to abandon urology and have continued to work two days a week running community urology clinics in Bristol, North Somerset, Gloucestershire and now also in Wiltshire.

#### What do you enjoy most about the job?

Running the community urology clinics is a great way of maintaining a skill, and I enjoy having an area of medicine in which I feel I have more than the generalist level of knowledge. General practice has a habit of making you feel like a 'jack of all trades, master of none', and I think having a specialist interest can help maintain professional self-esteem.

I enjoy the fact that urology is a specialty that gives me the chance to make a significant impact on people's quality of life. I have a particular interest in managing lower urinary tract symptoms and recurrent UTI – highly bothersome conditions for patients – and there is great job satisfaction from helping patients with these problems.

If I'm really honest, I also really enjoy being in a specialist clinic which allows me to concentrate on one problem in each consultation. It's quite nice to be able to occasionally advise people to see their GP for non-urological problems rather than having to deal with everything.

#### Are there any downsides?

Only the need to keep up-to-date in a specialty which does require extra work – but it's not a big problem.

#### What do you find most challenging?

I am a six-session partner in a large 32,000 patient, four-site practice, and am currently one of the executive partners, with extra responsibility for running the practice. So adding my urology interest alongside this means I am very busy and need to be pretty organised – definitely challenging.

#### What about the role has most surprised you?

Urology is an increasingly medical specialty, but with patients seen by highly trained and specialised surgeons. I am increasingly surprised by how many patients who are referred to secondary care could be successfully managed outside this highly specialised setting, allowing the surgeons to have a better chance of managing the huge workload of the patients who do need their level of expertise.



#### What is your most memorable experience so far?

Mostly too graphic or unpleasant to detail here! Let's just say, people sometimes insert very strange objects in places they shouldn't (and sometimes it is very hard to understand how they achieved it...)

#### What are the most common misconceptions about your job or about the specialty itself?

I suspect the most common misconception is that urology is just men and their prostates – in reality, it's a varied specialty – oncology (prostate / bladder / testicular / renal / penile cancer), stones, andrology, functional urology (e.g. urinary symptom management), infection etc.

#### Describe a typical working week

Monday, Wednesday and Thursday are spent in my GP practice. I see the usual wide range of problems, but do also see a disproportionate amount of patients with urological problems, as many patients are aware this is my area of interest. I also run urological research at the practice – currently we are recruiting for two trials for men with lower urinary tract symptoms.

Tuesdays and Fridays are spent in urology clinics, either hosted in my own practice, or in Bristol, Gloucester and Swindon. I also run an advice and guidance / referral management service for our local CCG, which requires me to look at all non-two-week wait referrals every evening.

In addition I have a number of other roles – charity trustee (Health Improvement Project Zanzibar [www.hipz.org.uk](http://www.hipz.org.uk)), journal editor,

*"I enjoy the fact that urology is a specialty that gives me the chance to make a significant impact on people's quality of life"*

Dr Jon Rees

and working with national organisations such as Prostate Cancer UK. It's a busy week.

#### What are the tools that you can't live without in your day-to-day work?

The obvious answer is a box of gloves and a tube of KY jelly! In reality, that is not far from the truth, but I also use the flexible cystoscope, the flow machine and bladder scanner etc. That's about it though.

#### What opportunities are there for a GPwSI/GPwER in urology?

There are lots of opportunities and there are not many GPs with an interest in this specialty – hospital roles, community roles, GP education etc are all possible. It's a fantastic opportunity to do something a bit different.

#### Is there any advice you could give to a trainee GP considering a career in urology?

Join the Primary Care Urology Society and meet other GPs who are interested in urology. It is free to join, and we hold an annual study day in London in November each year. Urology is a fantastic specialty to be involved in and I would strongly encourage any trainee GP who is interested to come to our meeting.

#### Further information

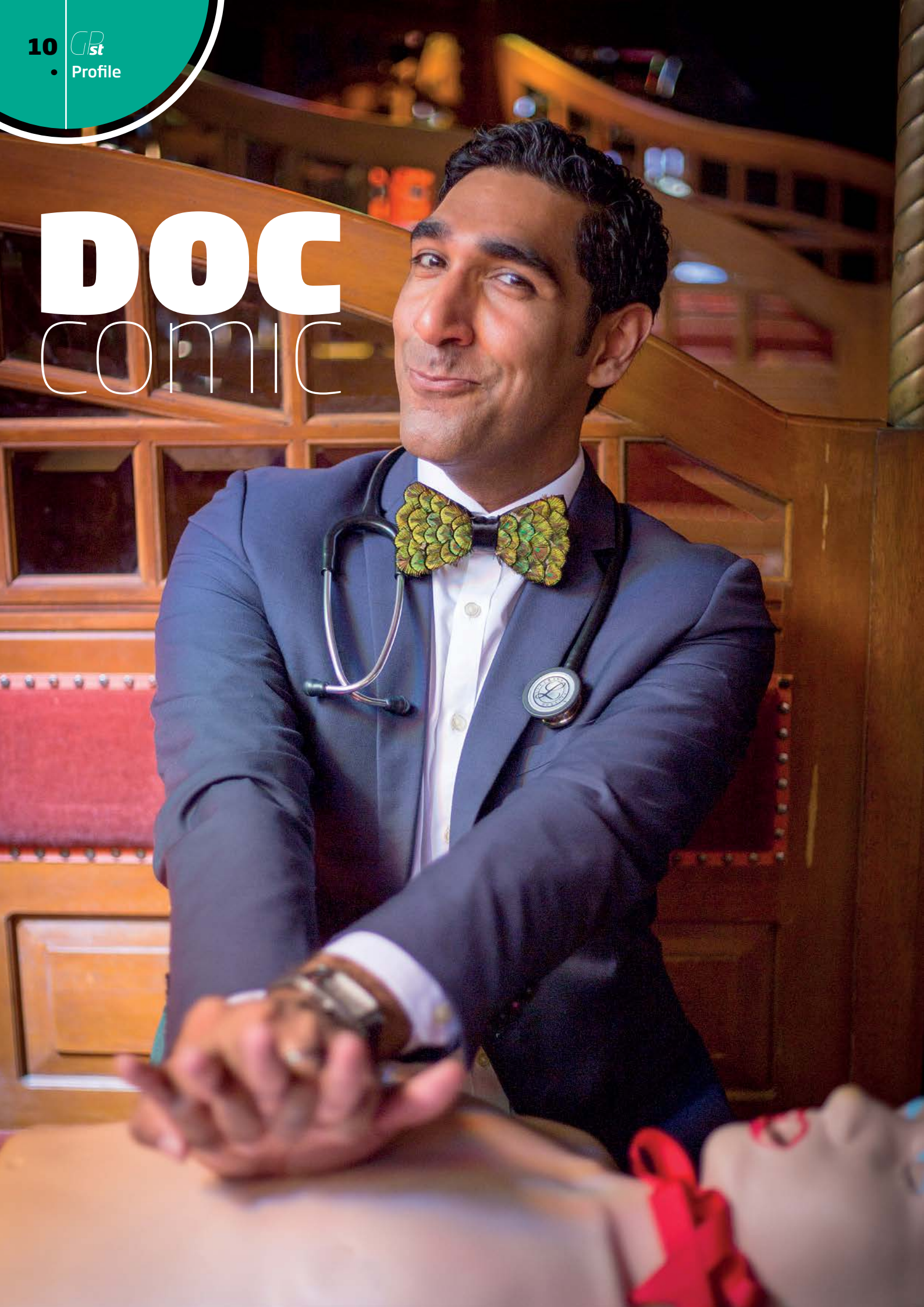
- RCGP Framework to support the governance of GPwERs: [www.rcgp.org.uk/training-exams/practice/general-practitioners-with-extended-roles.asp](http://www.rcgp.org.uk/training-exams/practice/general-practitioners-with-extended-roles.asp)
- Primary Care Urology Society – [www.primarycareurologysociety.org](http://www.primarycareurologysociety.org)

10

GP

• Profile

# DOC comic





## Jim Killgore talks death, skinny jeans, burnout, life changes and much more with GP comedian Dr Ahmed Kazmi

AHMED Kazmi was struggling. A UK GP working then in Perth, Australia, he had just lost his father to lung cancer. The grief combined with the weight of professional expectation – the “juggling act” of clinical duties and a lack of support – began to take a toll. He decided it was time for a change.

Ahmed reduced his working hours to take up a “hobby unrelated to my vocation” – stand-up comedy.

“Well, I had many patients who would say to me: ‘you are really funny’. And I had always used humour in my consulting style. So I thought why not make that a springboard?”

To most that might seem a fairly slim limb on which to risk a major life change (and only “after unsuccessful attempts at becoming a pole dancer and instagrammer respectively,” he adds) – but then Ahmed Kazmi is certainly not lacking in confidence or talent.

He decided to create a stand-up routine based around being a doctor: “something playful and entertaining while remaining respectful to patients and the profession”.

“I would write down anecdotes, stories, concepts and distil them into spoken word segments. Then I would read them out loud with friends and decide which lines to keep.”

His debut was pitched as a charity gig “so even if it was terrible something positive would come of it”. The result was the comic persona Dr Ahmed, with his comedy cabaret *Doctor in the House: What your doctor really thinks*.

“It debuted in this tiny back room of a restaurant in Perth to around 80 people – and it went really well. I got amazing reviews. People were queuing outside the door. I had to extend the season.”

The routine included things that “drive doctors up the wall” like patients wearing skinny jeans when they need a knee examined, or consulting Dr Google for un-vetted “lifestyle” websites offering medical advice. “That’s like using a tabloid newspaper to revise for an economics exam.”

He also writes: “If I had a dollar for every time someone wanted a repeat medication but didn’t know the name of their medication, I would not be driving a 1997 Toyota Corolla. Describing your medication as ‘white and round and with a line down the middle’ doesn’t help me either.”

Dr Ahmed later embarked on tours in Australia and the UK, appearing at the Melbourne International Comedy Festival and the Edinburgh and Bristol fringe festivals, with sell-out shows raising over £12,000 total for various cancer charities.

### Comic healing

Ahmed did not come from a particularly “funny” family – or so he claims. He was born in Canada to “migrant” parents. Both were professional people although artistic. “Everyone in my family has a

performance side. Both my parents were poets in Urdu and they actually published books. I have three siblings; two of them play instruments in bands. But they have gone on to have normal sensible jobs. I was the only who was like – I want this to be more than a hobby. I was very academically focused when I was younger but then later I thought: life is about balance and if you have the desire to pursue performance art there should be no obstacles to that.”

Ahmed had studied medicine at the University of Birmingham and spent his junior doctor years in London before completing GP training in his home county of Warwickshire. His move to Australia in 2014 was in part due to disillusionment over NHS policy towards general practice – but he returned to London in 2016 to work as a GP and specialty doctor in dermatology in a clinic at Ladbroke Grove.

Buoyed by his success on the fringe circuit, Ahmed set about planning a London debut. A venue was booked, new material written, music arranged – and then two weeks before the gig, tragedy struck his practice community. Less than a kilometre from the clinic fire gutted Grenfell Tower with the loss of 72 lives.

Ahmed later wrote: “I struggle to describe what I saw without getting emotional...The pathology is on a community level. How do you treat an entire community for bereavement? I did not receive that lecture at medical school. Grenfell bleeds into every consultation, whether they come for a repeat prescription, for backache, or for insomnia.”

He described weeping with patients expressing their joy at finally being released teeth and bones to bury.

Ahmed also faced another dilemma. Should he cancel the performance? “All the patients I spoke to said ‘we want you to do the show and we think it will bring some joy to us.’”

So he decided to invite Grenfell residents and the emergency services who helped during the incident as guests of honour. In the show he paid tribute to everyone affected, including the talented photographer Khadija Saye who tragically died in the fire. All the profits from the event went to the Grenfell dispossessed fund and raised over £2,000.

“It was this really beautiful evening of healing and bonding and laughter.”

### Love heckling

Playing such a gig would certainly daunt most comics but it was in many ways not so far removed from the basic intention in Dr Ahmed’s brand of comedy.

“I love humour with a point. I want people to be entertained and happy but there has to be some sense of purpose. I want to make doctors more three-dimensional, to connect with people outside the consulting room.

“I played a few different venues at different time slots and realised that late-night slots

don’t suit my humour. They tend to be more drunken. I don’t really swear... So it’s a bit wholesome, like family humour.

“I get loads of hecklers but I call it love heckling. People usually shout out nice things, fun things, praise.”

Does he worry about any conflict with the professionalism required in the day job, given the “edgy” nature of most comedy?

“I market myself as a doctor-comedian – I feel like I am representing my profession as well as myself. And I’m still practising medicine which is different from some of the other medical performers out there.

“So I’ve always crafted my show and my style such that people would still want to see me as a doctor after the show, or feel proud that I was their doctor or medical colleague. No one would feel like their story had been divulged or manipulated.”

Confidentiality is certainly a big issue for Ahmed. “In my show I don’t discuss any real-life individual circumstances. They are all general anecdotes, so I’ll say ‘children do this’, ‘men do this’, ‘women do this’. I am not discussing any real individual cases.”

### No guilt

Another issue Ahmed feels passionate about – and one that resonates with his own experience – is that of wellbeing and the weight of expectation on the profession. He is often asked to speak on the topic at conferences, medical schools, GP training schemes, LMCs and other organisations. He is also contributing to a formal wellbeing initiative with the RCGP.

“I love medicine and I love my career but I feel that when you’re younger no one says that you are allowed to balance that with your own needs. I have learned that lesson myself getting older and now I feel a bit evangelical about it.

“I want to tell other doctors and colleagues that you are allowed to craft a path for yourself that is good for the healthcare system and good for you. The two things can coexist.

“There is no guilt in taking a day off or going on holiday. There is no guilt in finishing on time. None of these things mean you are giving poor care. I like to remind people gently that if I want to be a singing, dancing, comic, GP dermatology doctor, that’s fine.”

**Jim Killgore is an associate editor at GPST**

- Twitter: Dr Ahmed @DrAhmedKazmi
- Website: [www.doctorahmed.net](http://www.doctorahmed.net)
- Dr Ahmed will be performing in Pembrokeshire at The Big Retreat festival in May 2019: [www.thebigretreatwales.co.uk](http://www.thebigretreatwales.co.uk)



# GPs and transgender care

From self-medication to changing names, *GPST* editor **Dr Susan Gibson-Smith** offers practical advice on providing care to transgender patients

**T**HE number of people who identify as transgender or gender variant in the UK is thought to be between 200,000 and 500,000, or about one per cent of the population. This type of consultation is becoming increasingly common in practice and it is important that GPs are up-to-date with the relevant laws and professional guidance to ensure these patients are treated safely, sensitively and effectively.

The Government Equalities Office guidance, *Trans people in the UK*, defines trans as "a general term for people whose gender is different from the gender assigned to them at birth." For example, a trans man is someone who transitioned/is transitioning from woman to man, and vice versa. Trans people, it explains, do not feel comfortable living as the gender they were born with and take "serious, life-changing steps to change their gender permanently."

The Royal College of Psychiatrists (RCPsych) provides useful guidance on the assessment and treatment of trans patients, as does the General Medical Council's (GMC) trans healthcare hub.

Doctors can feel out of their depth when dealing with patients with such complex needs. Consider the following scenario:

*A quick flick through the notes before Jane arrived showed she had not seen a GP for several years. At 24 this was not unusual. When she came in she seemed anxious and began to explain that, for as long as she could remember, she had felt she was in the 'wrong body' and wished she had been born a boy. When she became depressed and anxious 18 months ago she started researching gender dysphoria on the internet. Then, last year, she decided she wanted to transition from female to male. She has now asked for her name to be changed in her medical records to James. She then admitted she started buying testosterone on the internet six months ago but is worried it's unsafe and asked me to prescribe it for her. She also wanted to be*

*referred for a bilateral mastectomy with a potential hysterectomy in the future. Most of all she wanted to talk about how she was feeling. I felt a bit out of my depth and was not sure where to start.*

In a first consultation like this there is a lot of ground for our GP, Dr B, to cover. It is important to focus on establishing rapport, to check the patient's clinical and mental wellbeing and offer support, referral and further appointments. The following information should help.

## Changing gender

A patient has the right to ask for their medical records to be amended to reflect their preferred name, gender and title. There is no need to provide an updated birth certificate – a signed and dated request is sufficient. A gender recognition certificate (GRC) is not required.

Patients who wish to go further and change their full record can ask the practice to inform Practitioner Services Division (PSD) in Scotland or National Health Application and Infrastructure Services (NHAIS) in England. They will confirm the changes in writing to the patient, advising them to speak to the practice about the implications for their care.

It can take a lot of courage for a trans patient to come to the practice, so be empathetic and ask what they would like to be called. Amending records for trans patients can be complicated, both medically and legally. It may be advisable to seek MDDUS advice to avoid potential pitfalls.

## Impact on healthcare

### Screening

It is important to emphasise that patients who ask for their gender to be changed on NHS computer systems (by PSD/NHAIS) will no longer be called automatically for national screening relating to their birth gender. In our scenario this means that James would no longer be called for cervical screening. If he does proceed with a hysterectomy he may still

be left with a cervix, so Dr B must explain this and advise which screening tests would be appropriate.

As a rule of thumb, conduct the screening according to the organs present. For example, trans men who have not had surgery would need to be invited for breast screening. Trans women who have developed breast tissue under the influence of hormones may need to be referred for breast screening. And don't forget trans women will still have a prostate gland.

For James, the practice should, with his consent, contact the National Screening Service and arrange for him to be invited to cervical screening. Where possible, arrange for reminders to be issued for future screening via the practice-based patient database. James should also be advised to make a note of when screening is due and to request this if he does not receive an automated reminder.

### Referrals

The Gender Recognition Act (2004) (currently under review) makes it an offence to disclose protected information acquired in an official capacity, for example the patient's gender transition or previous gender. In terms of clinical referrals, this means GPs must not include such information without the patient's consent.

This is emphasised in the GMC's guidance



*“The best way for doctors to prescribe is through a shared-care approach with a gender specialist”*

which states that seeking patients’ consent before disclosure of information “shows respect, and is part of good communication between doctors and patients”.

### Prescribing

The GMC has helpful prescribing guidance in their trans healthcare hub.

The key messages set out are:

- You can prescribe unlicensed medicines following the steps set out in GMC guidance
- You must take care to discuss the risks and benefits of treatment with your patient
- You will need to collaborate with experienced colleagues to provide care that best serves your patient’s needs.

In our scenario, James is not currently under the care of a gender identity clinic (GIC) and is

asking Dr B to prescribe unlicensed medicines. The GMC advocates a harm-reduction approach in keeping with the RCPsych’s guidance which states that clinicians “may prescribe ‘bridging’ endocrine treatments as part of a holding and harm reduction strategy while the patient awaits specialised endocrinology or other gender identity treatment and/or confirmation of hormone prescription elsewhere or from patient records”.

It adds that a bridging prescription may be appropriate, provided blood tests and health checks are undertaken to screen for contraindications.

A bridging prescription may be issued until the patient can be seen in a GIC to prevent self harm, either due to mental illness or from purchasing unregulated drugs.

Doctors should only consider a bridging prescription in the following circumstances:

- the patient is already self-prescribing or

seems highly likely to self-administer from an unregulated source

- the bridging prescription is intended to mitigate a risk of self-harm or suicide, and
- the doctor has sought the advice of an experienced gender specialist and prescribes the lowest acceptable dose in the circumstances.

The best way for doctors to prescribe is through a shared-care approach with a gender specialist, however GIC waiting lists can be long. For James, it would be appropriate for Dr B to assess his mental state and offer to discuss his case with a gender specialist with a view to prescribing at a future visit. It would also be advised to discuss prescribing, and any other areas you are unsure about, with your GP trainer.

### Resources:

- General Medical Council trans healthcare hub: [tinyurl.com/yd75ppm2](https://tinyurl.com/yd75ppm2)
- Royal College of Psychiatrists guidance: [tinyurl.com/y2xboap9](https://tinyurl.com/y2xboap9)

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

## MISSED DIAGNOSIS

## BREATHLESSNESS

## DAY ONE

Mr P is 52 years old and works as a dispatcher for a delivery firm. He suffers from morbid obesity and is divorced and living alone. He attends the GP surgery complaining of ulcers and cellulitis in his lower left leg and is referred to the nurse for dressings. Over the next few weeks he re-attends for further dressings and review.



## DAY 31

Mr P phones the practice to say he cannot attend a scheduled appointment with the practice nurse, stating he finds it difficult to walk, having pain in his left leg which he thinks could be a pulled muscle. A prescription is issued so that he can dress his ulcers at home.



## DAY 42

That morning Mr P phones the practice and speaks to a receptionist, complaining of breathing problems and requesting a home visit. The receptionist asks if he can come in as the GPs are very busy. Mr P replies that no one is available to drive him and he has no cash for a taxi. He tells the receptionist that it's probably a respiratory infection and requests antibiotics. The receptionist agrees to pass the request to one of the doctors. She contacts the locum GP on duty – Dr Y – and informs him that Mr P did not sound breathless on the telephone and was able to speak in complete sentences. Dr Y decides that a home visit is not necessary and issues a prescription for amoxicillin 500mg. The receptionist phones Mr P to let him know that the prescription will be sent to his local chemist for collection.



## DAY 43

A neighbour checks on Mr P and finds him dead. The cause is later determined to be deep venous thrombosis (DVT) and pulmonary embolism (PE).

A LETTER of claim on behalf of Mr P's two children is sent to Dr Y alleging clinical negligence. It states that Mr P had been suffering from leg and calf pain and, on the insistence of his ex-wife, phoned the practice, reporting breathlessness and chest pain and requesting a home visit. It is alleged that Dr Y failed to speak directly to the patient in order to obtain a detailed history and assessment of his condition. It is also alleged that the GP should not have prescribed antibiotics without consulting first with the patient. It is claimed that had Mr P been adequately assessed he would have been admitted to hospital as an emergency and administered the anticoagulant heparin, thus preventing his death.

A GP expert is instructed by MDDUS to review the case. She takes the view that Dr Y did not provide an acceptable standard of care and at the very least should have spoken to Mr P directly to ascertain why he had requested a home visit. Further, the GP prescribed antibiotics without making any assessment of the patient.

MDDUS also requests an expert opinion

from a vascular surgeon on the consequences of the alleged breach of duty (causation). The expert opines that had Mr P been referred to hospital he would likely have been diagnosed with DVT/PE and treated urgently with heparin. This would have prevented further thrombosis forming in the leg veins and dramatically reduced the risk of PE.

A letter of response is sent by MDDUS on behalf of Dr Y admitting breach of duty in that the GP should have arranged to speak to Mr P on the telephone in order to assess his condition, and that he should not have issued a prescription for antibiotics without first seeing or speaking to the patient.

However, based on the symptoms described by Mr P to the receptionist as recorded in the notes (i.e. breathing problems and flu-like symptoms but no mention of chest pain or leg pain in this context), it is averred that even if Dr Y had arranged a telephone assessment it would have been unreasonable to suspect DVT/PE. Respiratory infection would not usually be an emergency situation with need to

be assessed by a doctor within 24 hours (either at home or in the practice) and thus the expected course of action would not have prevented his death. Causation is accordingly denied.

Even with the potential causation defence, MDDUS judges that the case would be risky to argue in court and a settlement is agreed with the member's approval.

## KEY POINTS

- Ensure non-medical practice staff are aware of the limits of their competence.
- Have a low threshold for arranging a face-to-face consultation.
- Telephone consultations can be useful in assessment/management but also have inherent risks.
- Do not (in general) prescribe medication without first assessing the patient either in person or by telephone.



# 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...

## ● POO-POO TO STOOLS

It's out with the stool and in with the poo at the [nhs.uk](https://www.nhs.uk) website. After much analysis of research and feedback, a team of content designers have revealed the words and phrases that they believe are easiest for users to understand. Among the most hotly contested areas is that concerning toilet habits. Diary can officially confirm that peeing and pooing is preferable to urinating and bowel movements. Diuretics are no longer "water tablets", but "tablets that make you pee more" and stools are something you sit on. They decided against "wee" as this can be too easily confused with "we" or "wee", meaning small. In a blog introducing Sara Wilcox admits: "We get A to Z list, content designer Sara Wilcox admits: 'We get some complaints when we use words like 'pee' and 'poo'. People tell us they see it as 'dumbing down', 'simplistic' and 'patronising language.'" But she defends the word choices and says most people describe the language as "clear, direct and pitched at the right level." So now you know. Get your vocab up-to-date at [tinyurl.com/yyx9pzxs](https://tinyurl.com/yyx9pzxs)

● **DOCTOR DOWN** Spare a thought for the rugby doctor who unexpectedly became part of the action during England's recent Six Nations win against Italy. Dressed in his hi-vis yellow vest, clearly marked with a capital D, he bravely ventured onto the pitch to assist a player while play continued around him. With 10 minutes to go and his job done, he made for the exit only to find himself on the wrong end of England wing Jonny May as he charged at an Italian flanker. There was no escape for the medic who ended up in a heap on the ground, with his bag flying out of his hand. Fortunately he was unharmed in the collision and was able to walk off the pitch unaided. And who says doctors aren't dedicated to their job?

● **CEREAL KILLER** It might be churlish to take The Association of Cereal Food Manufacturers to task when they say: "Breakfast cereals are an important source of fibre, vitamins and minerals". More interesting perhaps is what they don't say. A recent study published in the *British Dental Journal* found that some top-selling UK breakfast cereals are 35 per cent sugar by weight. The packaging does

recommend maximum portion sizes of 30g which is fine until - as the researchers observe - you look at the front of some cereal boxes with photographs of bowls "brimming to the top". Eating the estimated 90g of cereal in these images would lead to children aged four to 10 exceeding their daily limit of "free sugars" by 12.5 per cent with just a single bowl.

## ● JAM IN A JAM

Sticking with the theme of sugar shaming, it seems Public Health England (PHE) bears some blame for the drop in popularity of jam. Sales of the fruity spread in Britain fell by 2.9 per cent in 2017, down to £106 million. This follows PHE's drive to reduce children's sugar consumption by 20 per cent by 2020. Jam has fallen out of favour as it contains a whopping 10g of sugar per tablespoon. But jam's loss is peanut butter's gain, with sales of the nut spread up by nearly a fifth in 2017 thanks to the introduction of new "healthy" and less-sugary upmarket versions. Ironically, marmalade (which contains 12g of sugar per tablespoon) has seen its fanbase increase thanks to the popularity of the film *Paddington 2* which is credited with driving a three per cent surge in sales. Who said life is fair?

● **PRESCRIBING HAPPINESS** Having read the article on social prescribing on p4 of this issue, Diary couldn't help but cast a sceptical eye over a recent report in the *Times* highlighting a new US import to London - cannabis yoga. It seems a popular gym chain in the city is among the first to offer "cannabliss" yoga classes, which promise to help customers recover from their "static nine to five". Participants are given a patch infused with cannabidiol, known as CBD, before doing a series of stretches and yoga poses. The article is quick to emphasise that CBD is derived from the cannabis plant but does not make you high because it contains only tiny levels of tetrahydrocannabinol (THC), the psychoactive element of the plant. CBD, which comes in the form of an oil, has apparently become increasingly popular in Britain over the past year, with capsules for sale in Holland & Barrett. Those in favour of the practice say CBD and yoga "amplify each other's restorative gifts", but one yoga instructor admitted that some people felt no effect from the patches and that those who did might have been benefiting from a placebo effect. No word yet on whether cannabliss will make it onto the government's list of approved social prescribing activities...





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