HOW TO THRIVE AS A GP TRAINEE

M H Shakir

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For my wife and children, whose patience and support made this possible – and for every GP trainee striving to grow

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FOREWORD

Welcome to the broadest of all medical specialties. What a great book you have in your hands. Dr Shakir, a GP with a wealth of experience practising and teaching in England, has produced a worthy successor to Peter Stott's *Milestones – the diary of a trainee GP*, which I treasured during my GP training.

The life of a modern GP is, with no doubt at all, a demanding one. It draws on every part of us as human beings. It uses our every skill, and often, all our energy. I don't know how Dr Shakir managed to fit writing this book into his busy clinical life.

The book reminds trainees that they need to be kind not just to their patients, but to themselves. There is lots more wise advice, too. It will augment what trainees learn from their supervisors – and the supervisors will learn from the book too. The advice is up to date, and will remain up to date, because wisdom remains useful, even as decades and generations pass.

The British tradition of General Practice is proudly efficient and evidence-based. Dr Shakir's book is also knowledgeable; caring and humane; wise and never cynical. He has brought together top tips from the General Practice tradition and his long experience; numerous gems that will be treasured by every trainee.

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PREFACE

General practice is rarely dramatic, often unpredictable and almost always human.

When I began my journey as a GP trainee, I thought the hardest part would be mastering guidelines, learning prescribing thresholds and remembering referral pathways. With time, I realised that thriving in general practice is not about memorising algorithms. It is about learning how to sit with uncertainty, how to listen beyond words and how to make safe decisions when the picture is incomplete.

This book was born from years of clinical practice across very different settings: rural and remote communities, busy UK surgeries, out-of-hours visits, and long-term patient relationships built over decades. Each consultation, each near-miss, each difficult diagnosis and each moment of quiet reassurance has shaped the lessons within these pages.

General practice is a privilege. Patients invite us into their stories at moments of vulnerability. A frightened parent with a feverish child. A teenager asking for confidential contraception. A middle-aged man dismissing his fatigue as ageing. A woman struggling silently through perimenopause. They do not come to us with textbook presentations. They come with fear, hope, confusion and trust.

As a trainee, it can feel overwhelming. Ten minutes. Multiple problems. Uncertainty. Risk. Safeguarding. Documentation. The quiet voice in your head asking, "Have I missed something?"

You will not always have complete certainty. But you can always practise safely, thoughtfully and compassionately. That is what this book aims to support.

Within these chapters, you will find practical frameworks: what to ask, what not to miss, when to escalate and how to safety-net well. You will also find reflections. These are not shared to impress, but to illuminate. Some are stories of early detection and lives changed. Others are reminders of the weight we carry and the humility this profession demands. A few are cases that have stayed with me long after the consultation ended.

Thriving as a GP trainee is not about perfection. It is about developing judgement. It is about balancing reassurance with vigilance, curiosity with caution,

empathy with efficiency. It is about learning that listening is as powerful as prescribing, and that sometimes the most important intervention is the question you almost did not ask.

General practice will stretch you. It will test your knowledge, your resilience and your emotional capacity. But it will also reward you in ways few other specialties can. You will witness continuity. You will see children grow into adults. You will support families through grief and celebrate new beginnings. You will become part of a community's fabric.

If this book does one thing, I hope it gives you confidence. Confidence to pause. Confidence to probe a little further. Confidence to trust a parent's instinct. Confidence to revisit a plan. Confidence to admit uncertainty and seek advice. Confidence to care deeply without losing yourself in the process.

Thriving is not about doing more. It is about doing what matters, consistently, safely and humanely.

This book is offered to you not as a manual of perfection, but as a companion in practice. May it steady you in uncertainty, sharpen your clinical instincts and remind you that in general practice, small decisions often shape very big outcomes.

And remember, you may not always save a life in ten minutes. But you may add ten years to it.

Hussain Shakir

ACKNOWLEDGEMENTS

No book like this is written alone. It is shaped by the people who walk alongside you throughout your professional and personal journey.

First and foremost, I would like to thank my wife, **Rehana**. More than a decade ago, she first suggested that I should write a book of this nature for GP trainees. At the time it felt like a distant idea. Over the years, her encouragement, patience and unwavering support helped turn that idea into reality. This book would not have been written without her belief in its value.

I am deeply grateful to my family, whose understanding and support allowed me the time and space to reflect on years of clinical experience and translate those lessons into writing.

My sincere thanks also go to the many colleagues, trainers, nurses, healthcare assistants and practice staff I have worked with over the years. General practice is a team endeavour. The lessons shared in this book are shaped not only by my own experiences but also by the wisdom, conversations and shared reflections of those around me.

I would also like to acknowledge the patients and communities who have trusted me with their stories. Every consultation carries a lesson. Many of the reflections in this book grew from those encounters. While identities and details have been carefully changed to preserve confidentiality, the learning they offered remains deeply appreciated.

I would like to extend my sincere thanks to **Dr Jonathan Williams**, a long-standing colleague and someone known to me through my wife's professional circle. Despite very short notice, he kindly took the time to review the manuscript in detail, offering valuable advice and thoughtful suggestions, and generously contributing a foreword. His support at a crucial stage of the book is deeply appreciated.

My special thanks go to **Dr Jonathan Ray** at Scion Publishing, who supported this project from its earliest stages and kindly accepted my original book proposal. His encouragement and thoughtful editorial input throughout the process played an important role in shaping this book. I am equally grateful to **Clare Boomer**, Production Editor at Scion Publishing, for her meticulous

copy-editing, careful attention to detail and professional guidance during the production process.

Finally, this book is written for **GP trainees and early career doctors**. General practice is one of the most challenging and rewarding specialties in medicine. If the pages that follow offer reassurance, clarity or confidence at difficult moments in training, then the effort behind this book will have been worthwhile.

CHAPTER 6

Mental health challenges

"You won't always have the answers, but showing up with empathy is already half the work."

Mental health is not a niche part of general practice, it is everywhere. It walks in disguised as fatigue, sleep issues, back pain or not feeling quite right. It may arrive quietly or unravel in tears. These are the moments where your presence matters more than your prescriptions, where your questions need to be both kind and clear, and where a patient may be opening up for the first time, not for solutions, but to feel understood.

You don't need to fix it, but you do need to hear it. Some of your most important work happens in silence.

This chapter focuses on low mood, anxiety and risk, offering a toolkit for safe, compassionate consultations.

6.1 The presentation

A 32-year-old woman tells you she has been feeling not quite right. She is tearful in the consultation, not sleeping, off sick from work and irritable at home. Her words are scattered, but what she is really saying is that she is not coping. You do not need a diagnosis in five minutes. You need to listen and open the door for honesty.

Explore gently, but do not be afraid to ask.

6.2 Key questions to ask

Think of this as emotional history-taking. Be structured, but stay human.

- When did this start, and did it come on gradually or after something specific?
- Have there been any changes in sleep, appetite, energy or interest in things they usually enjoy?

Reflection: The repeat request that raised the alarm

She was in her seventies, a patient I had not met before. Her request was simple, a repeat prescription for paracetamol for her chronic lower back pain. Routine, familiar and seemingly harmless.

A quick glance at her record made me pause. She had been issued 224 tablets of paracetamol just two weeks earlier, and the same amount two weeks before that. She was also on sertraline for depression and had a documented history of suicidal ideation. Suddenly, this was no longer routine.

I felt the weight of the prescription form differently that day. Could this be an unintentional overdose, or worse, a cry for help masked by familiarity? Paracetamol is available over the counter, but in large quantities it becomes a silent killer. I did not wait, I picked up the phone.

She answered. Calmly, she explained that her pain was constant and that she relied solely on "what the doctors prescribed". She denied using any additional over-the-counter medication. Even so, the risks were too great to ignore.

I halted further supplies and reduced future quantities to a safer level. I requested a community nurse home visit to assess for stockpiling. Although she declined a GP appointment, she agreed to attend A&E for a paracetamol level check. With her consent, I contacted the community mental health team and referred her to local wellbeing services.

Finally, I raised the case as a significant event analysis (SEA). The discussion at our practice meeting was constructive and sobering. We identified systemic vulnerabilities in repeat prescribing and developed action plans, including flagging frequent analgesic requests, mandatory reviews for patients with mental health risks and encouraging a moment of pause before approving prescriptions.

This SEA transformed a near-miss into a catalyst for safer practice. Our team walked away with a clearer understanding that vigilance does not slow us down; it protects our patients. This case reminded me that no task is truly routine. Every prescription, even for something as common as paracetamol, deserves a clinician's full attention. Most importantly, it reminded me never to lose sight of the human being behind the request.

Lessons and reflections

1. **Quantities speak loudly.**
   Large, repeated requests, particularly for high-risk medications, should never go unquestioned. Patterns in prescribing tell a story if we are willing to look.
2. **Systems support, but do not replace clinical judgement.**
   Electronic records are tools, not clinicians. It takes a human being to sense concern, notice a pattern and act on a hunch.
3. **Patient histories add meaning to data.**
   Knowing her mental health background gave essential context to the numbers, and context can save lives.

4. **Escalation is a lifeline.**
   A phone call, a home visit, a referral – these are not just administrative actions. They are moments of connection, protection and care.
5. **SEA as a culture of learning, not blame.**
   This was not about pointing fingers. It was about saying, "This could have ended differently; what will we do next time?" and using that question to build safer practice for everyone.

- Are they managing to function at work and at home?
- Have they had any thoughts of self-harm or of ending their life?
- Do they feel supported, or are they feeling alone with this?
- Is there a past history of anxiety, depression, trauma or other mental health difficulties?
- These questions might feel intrusive, but they are protective. Clarity can save lives.

Asking about suicide does not plant the idea; it can open a door to safety.

6.3 What you must not miss

Risk often hides behind vague complaints, so stay alert for:

- active suicidal thoughts, plans or intent
- a history of self-harm, particularly if it is recent or escalating
- psychotic symptoms such as hearing voices, paranoid beliefs or disordered thinking
- major functional decline; for example, not leaving the house, not eating, neglecting personal care or struggling to care for children
- domestic violence or coercive control
- undiagnosed postnatal depression, birth trauma or post-traumatic stress.

Do not assume safety, always ask.

6.4 The likely reality

Most patients will not need urgent referral. They are more likely to need:

- validation that their distress is real and understandable
- a plan, even if it is simple at first
- hope that how they feel now is not how they will always feel.

Many will benefit from guided self-help, talking therapies or lifestyle support. Medication has its place, but it is rarely a magic fix on its own.

SSRIs are not magic, but neither is doing nothing.

Reflection: The diagnosis that changed everything – recognising ADHD in a young man

For much of my medical training, neurodiverse conditions such as ADHD were barely acknowledged. They were rarely discussed, almost as if they did not exist. Until recently in the UK, ADHD was a term we hardly heard. Even many psychiatrists often labelled such patients with depression, anxiety, bipolar disorder or emotionally unstable personality disorder.

Yet ADHD has always been there throughout human history, unseen, unrecognised and untreated. Now, with increasing awareness, more clinicians are screening for ADHD, referring patients for assessment and seeing lives transformed by the right guidance, psychological support and medical treatment.

He came to see me after being released from a young offenders' institution. He was a bright teenager who had been bullied repeatedly at school. Despite his efforts to distance himself from his bullies, one day he lost his temper and lashed out. For that single assault, he was sentenced and spent time in custody.

When I met him, his frustration was palpable, but so was his potential. As he shared his story, I felt strongly that something deeper was going on. I initiated an ASRS (adult ADHD self-report scale) screening. The results were significant, so I referred him for a full ADHD assessment, which confirmed the diagnosis.

With the right support, including psychological therapy, structured guidance and medication, his life changed dramatically. Today he is thriving. No longer defined by impulsivity or frustration, he is now a high-flying banker with a bright future.

Lessons and reflections

1. **ADHD has always been there, we just did not see it.**
   For years, neurodiverse conditions such as ADHD went unrecognised. Many people were misdiagnosed with mood or personality disorders, missing the opportunity for life-changing treatment.
2. **One screen can change a life.**
   A simple ASRS questionnaire opened the door to the correct diagnosis. Sometimes the smallest step, asking the right questions at the right time, leads to the biggest change.
3. **Labels can limit or liberate.**
   Before his diagnosis, he carried labels of aggression and poor impulse control. The right label, ADHD, meant access to understanding, therapy and medication that transformed his future.
4. **Early recognition prevents lifelong consequences.**
   Untreated ADHD can contribute to disrupted education, unemployment, relationship breakdown, crime and imprisonment. Identifying and treating it early can change the trajectory of an entire life.
5. **Our role as GPs is to be curious.**
   By listening carefully, questioning patterns and using tools such as the ASRS, we can uncover conditions that others might overlook. Sometimes that quiet curiosity is what changes a patient's story.

6.5 What to do

For low mood or anxiety

- Use PHQ-9 or GAD-7 as conversational tools rather than rigid checklists.
- Signpost to trusted resources such as Every Mind Matters, Mind or local psychological therapy services (IAPT or equivalents).
- Refer to talking therapies early, even if there is a long waiting time.
- Support lifestyle changes, including sleep hygiene, regular movement, meaningful activity and reduction of alcohol or drugs.

Starting SSRIs (if appropriate)

- Start low, for example, sertraline 50mg or citalopram 20mg, in line with local guidance and the individual's profile.
- Warn about initial side-effects, such as increased anxiety, gastrointestinal upset or sleep disruption, and explain that these usually settle.
- Arrange a review in two to four weeks, or sooner if there are concerns about risk.
- Document clearly, especially around suicide risk, safety planning and informed consent.

Holding space without rushing is a skill, not a luxury.

6.6 Safety-netting advice

Language matters, so say things in a way that invites return, not retreat:

- *"If things get worse, or you feel unsafe, please get in touch. Don't wait."*
- *"There's always someone here, whether it's us, 111 or a crisis line. You're not alone in this."*
- *"You've taken a really brave step today. Let's keep that momentum going."*

6.7 What I wish I had known

You do not have to fix everything. Your empathy is already a powerful intervention. Many patients will not remember every word you said, but they will remember how you made them feel. Asking about suicide will not cause it, but not asking may leave someone alone with frightening thoughts. Lean into the discomfort. That is often where the healing starts, and where trust in you, and in help, begins to grow.

6.8 One-liner summary

"You're dealing with a lot, and you're not expected to manage it alone, so let's put some support in place."

Reflection: A tragic loss – when mental health care overlooked physical risk

She was 60, a woman burdened by profound anxiety and depression. She lived with hypertension and, like many people struggling with long-term mental illness, had difficulty staying consistent with her medications. One day, she sought help, not at her local surgery, but from a renowned professor of psychiatry in the capital.

The consultation lasted five minutes. In that time, she was started on venlafaxine at 150mg twice daily, a total of 300mg per day. There were no baseline checks, no gradual titration and no evident discussion of her physical health.

A week later, she collapsed at home. Her blood pressure on arrival by paramedics was 180/120mmHg. A CT scan showed a catastrophic intracerebral haemorrhage. Despite intensive medical care, she died four days later. She was not just a patient, she was a wife, a mother and a grandmother. Her sudden and preventable death left behind a grieving family and an urgent call for reflection.

This was not simply a rare side-effect. It was a known risk, and it was avoidable, predictable and tragic. This case is not about pointing fingers; it is about pointing forwards. It reminds us that even experienced clinicians, working in high-pressure environments, can miss crucial steps when systems do not support reflective, holistic practice.

Patients trust us to treat their whole being, not just their mind or body in isolation. That means balancing pharmacological efficacy with physiological safety. It means taking time, asking the right questions and cross-checking our assumptions. This woman did not need a powerful dose of an antidepressant that day; she needed a plan, rooted in caution, connection and clinical wisdom.

Lessons and reflections

1. **Venlafaxine is not benign.**
   At doses above 225mg, venlafaxine significantly increases blood pressure through its noradrenergic effects. For patients with existing hypertension, it should be prescribed with great caution, or sometimes not at all.
2. **Start low, go slow.**
   The golden rule in psychiatry and in medicine more broadly. For a complex patient like this, an initial dose such as 37.5mg once daily, with careful monitoring and follow-up, would have been safer and more proportionate.
3. **Baseline blood pressure checks are essential.**
   Before prescribing any medication known to elevate blood pressure, a simple reading is vital. In this case, a baseline blood pressure could have prompted re-evaluation, dose adjustment or consideration of an alternative treatment altogether.
4. **Five minutes is not enough.**
   Mental health prescribing is not a transaction, it is a clinical conversation. In five minutes, it is almost impossible to explore medical history, medication adherence, cardiovascular risk and the patient's understanding and preferences. Time is a safety tool.

5. **Medication compliance should prompt questions, not judgement.**
   Her non-compliance was not a character flaw, it was a red flag. Exploring the 'why' behind missed doses, fears or side-effects might have opened a different path and, ultimately, could have saved her life.
6. **Holistic care requires collaboration.**
   When treating patients with known comorbidities, communication with their GP or primary care team is crucial. Shared notes, flagged concerns and collaborative planning can change outcomes. A brief message or letter to her GP may have highlighted the risks and prompted a more cautious, joined-up approach.

Reflective prompts:

- How do you feel when a patient starts crying in your consultation? What is your instinctive response, and does it help them feel safe?
- Think of a time you avoided asking about suicide risk. What stopped you, and what would you do differently next time?
- What language do you use when introducing mental health medication? How do you balance honesty about side-effects with reassurance and hope?
- Have you ever felt emotionally drained after a mental health consultation? How do you decompress or reflect afterwards?
- How confident are you in managing mild to moderate mental health presentations without medication? What else would you like to learn or practise?

CHAPTER 9

Gastrointestinal and genitourinary problems

"These are the symptoms people wait weeks to talk about, so when they do, listen properly."

Abdominal pain, changes in bowel habit and urinary symptoms are not only common in general practice, they are also inherently complex. They sit at the intersection of physical discomfort, fear of serious disease and deep embarrassment. Many patients delay raising these concerns for weeks or months. By the time they do, anxiety is often well-established, frequently driven by worries about cancer, ageing or loss of control.

Your response in these consultations needs to be calm, curious and clear. They are rarely glamorous encounters, yet they are often the ones where trust is built most firmly.

Do not allow embarrassment, yours or theirs, to delay careful thinking. This chapter focuses on lower urinary tract symptoms, bowel change, UTIs and men's health concerns, including the particular nuance required when discussing PSA testing.

9.1 The presentation

A 69-year-old man presents with increased urinary frequency, particularly nocturia, and a weaker urinary stream. There is no visible haematuria, no weight loss and no fever. He appears clinically well, yet he is clearly nervous.

This is everyday general practice, but it matters deeply to him. Beneath his measured description sits a quiet internal dialogue: is this cancer? Is this just ageing? Will I lose control of my bladder – or my independence?

In this context, a PSA test is not a simple tick-box investigation, it is the beginning of a conversation.

Reflection: From grief to gratitude – a transplant that transformed a life

It began in the outback, in a remote part of New South Wales. A 27-year-old man was brought to our clinic by his grandfather. He was visibly unwell: jaundiced, pale and exhausted. Only days earlier, he had buried his mother. His grief was raw and unprocessed; during the mourning period, he had been drinking heavily and admitted to 'popping paracetamol like Smarties' to manage persistent headaches and sleeplessness. Physical pain had merged with emotional distress, and self-medication had quietly escalated.

His blood tests were profoundly abnormal. His ALT was over 8000U/L, with other liver markers similarly deranged. This was not simply a red flag; it was a clinical emergency. He was in acute liver failure, most likely precipitated by paracetamol toxicity compounded by alcohol use. His condition was deteriorating rapidly.

Urgent arrangements were made for aeromedical transfer to Sydney, where he underwent liver transplantation. Against the odds, he survived.

Several months later, he returned to the clinic. He was not only physically well, but deeply changed. He had become a public health advocate, openly sharing his experience to raise awareness about the dangers of combining grief, alcohol and readily-available over-the-counter medications. His recovery was not merely clinical; it was transformational.

This was more than a case of acute liver failure. It was a collision of emotional pain, accessible harm and timely medical intervention. What began as a tragedy evolved into a story of survival, responsibility and education.

Lessons and reflections

1. **Paracetamol is not innocuous.**
   Paracetamol is widely perceived as safe because it is easily accessible. In excess, however, it can be fatal. Many patients underestimate cumulative dosing, particularly during periods of stress, grief or illness, and especially when alcohol is involved.
2. **An ALT in the thousands demands immediate escalation.**
   ALT levels in the thousands should raise immediate concern for fulminant hepatic failure. This is a medical emergency requiring urgent discussion with secondary care and rapid transfer. Delay can be catastrophic.
3. **Alcohol and paracetamol form a dangerous synergy.**
   Alcohol lowers the threshold for paracetamol toxicity and may blunt early warning symptoms. Patients experiencing emotional distress may unintentionally place themselves at significant risk by combining the two.
4. **Always ask about over-the-counter medication.**
   Non-prescription medicines are frequently under-reported. It is essential to ask explicitly about paracetamol, combination cold and flu remedies, and other over-the-counter products, particularly in patients with jaundice, abnormal liver function tests or unexplained abdominal pain.

5. **Recovery is not the end of the story.**
   Survival from life-threatening illness can be a turning point. Some patients go on to become powerful advocates for prevention and education. As clinicians, our role extends beyond treatment to supporting patients in sharing their experiences safely and constructively.

9.2 Key questions to ask

These consultations benefit from a gentle but confident exploration of symptoms. Normalising sensitive questions helps patients answer honestly and fully.

Key areas to explore include:

- How long have the symptoms been present?
- Are symptoms worse during the day or at night, how strong is the urinary stream, and is there any associated flank pain or loin discomfort?
- Is there any pain, urgency, dysuria or blood in the urine?
- Have there been any bowel changes, loss of appetite or unintentional weight loss?
- Is there a family history of prostate or bowel cancer?
- In women, are there symptoms of incontinence, prolapse, pelvic pain or recurrent infection?

Many patients will not volunteer bowel or urinary symptoms unless asked directly. Your tone often determines whether they open up or retreat into vagueness.

9.3 What you must not miss

While many gut and genitourinary presentations are benign, certain red flags require prompt recognition and action, so be alert to:

- **Urinary retention:** suprapubic discomfort, a palpable bladder, overflow incontinence.
- **Visible haematuria:** which usually warrants urgent referral.
- **New bowel change** associated with weight loss: always consider underlying malignancy.
- **Systemic features of UTI:** fever, flank or back pain, and confusion, particularly in older adults.
- **Pelvic pain with fever:** consider pelvic inflammatory disease or prostatitis.
- **Testicular swelling:** exclude torsion and testicular malignancy.

A change in bowel habit does not always indicate cancer, but it always deserves careful assessment.

Reflection: When the headache came after intimacy – listening to the pattern that matters

He was middle-aged and otherwise fit and well. His complaint was unusual, but he described it with clarity and quiet concern: severe headaches occurring exclusively during or immediately after sexual activity. These were not fleeting or mild. They were intense, throbbing pains that lasted for hours and disrupted his ability to function.

He spoke openly, without embarrassment, but with a clear sense that something was not right. His GP shared that concern. While the precise cause was uncertain, the consistency and specificity of the trigger made this very different from a routine tension headache or migraine. This was not a story to reassure away.

Neuroimaging revealed the explanation. A CT scan of the brain demonstrated multiple cerebral aneurysms. Further assessment suggested intermittent leakage during periods of raised intracranial pressure, particularly during sexual activity. The headaches were not simply painful episodes; they were warning signs.

He was referred urgently to neurosurgery, where the aneurysms were successfully coiled, significantly reducing the risk of a future subarachnoid haemorrhage. Following treatment, the headaches resolved completely, and a silent but potentially fatal threat was removed.

This diagnosis did not arise from diagnostic certainty, but from attentiveness and clinical curiosity. A GP recognised that the pattern mattered, asked the right questions, and chose investigation over assumption. In doing so, a life was very likely saved.

Lessons and reflections

1. **Patterned headaches should never be dismissed.**
   Headaches consistently triggered by specific activities – particularly sexual activity, exertion, coughing or straining – warrant careful evaluation. These presentations should prompt consideration of secondary and vascular causes rather than reflex attribution to stress or migraine.
2. **Sexual activity can unmask underlying pathology.**
   Physiological surges in blood pressure during intimacy can expose previously silent vulnerabilities such as aneurysms or other vascular abnormalities. Awareness of this link is essential and can be life-saving.
3. **Neuroimaging is justified when the story is atypical.**
   In cases of unusual, activity-related headaches, early imaging is appropriate. A CT or MRI scan can rapidly redirect care and prevent catastrophic neurological outcomes.
4. **Psychological safety enables clinical safety.**
   This patient's openness was critical to timely diagnosis. Creating a non-judgemental space where sensitive symptoms can be discussed is not a 'soft skill'; it is a core clinical competency.

5. **GPs do not need certainty, only the courage to investigate.**
   The GP did not know the diagnosis at the outset. What mattered was recognising that this presentation was not routine. Curiosity, pattern recognition and the willingness to act on unease were the true diagnostic tools.

9.4 The likely reality

In routine practice:

- LUTS in older men is most commonly due to benign prostatic hypertrophy.
- UTIs are frequent, particularly in women over 65, yet are often over-treated without adequate diagnostic certainty or culture confirmation.
- Bowel change in younger adults is frequently related to irritable bowel syndrome, stress or dietary factors, although red flags should never be dismissed.

Trust what patients tell you – and also listen for what is implied rather than stated. Pay attention to phrases such as, "*It's probably been going on longer than I first said*", which often signal minimisation driven by embarrassment or fear.

9.5 What to do

Lower urinary tract symptoms in men

- Use an IPSS to assess severity and impact on quality of life.
- Perform an abdominal examination and, where appropriate, a prostate examination.
- Exclude red flags before considering PSA testing.
- Offer PSA testing only in the absence of UTI and following a shared decision-making discussion about its benefits, limitations and potential consequences.
- Provide lifestyle advice, such as reducing evening fluid and caffeine intake, and consider an alpha-blocker such as tamsulosin if symptoms are bothersome and there are no contraindications.

Urinary tract infections

- Use dipstick testing judiciously and send urine for culture when symptoms are present, particularly in older adults, pregnant women or those with recurrent infections.
- Prescribe antibiotics in line with local guidance, taking resistance patterns into account.
- In recurrent UTIs, review hygiene practices, sexual health and contraception, and consider options such as postcoital prophylaxis or vaginal oestrogen in postmenopausal women where appropriate.

Reflection: When doing everything is not always doing the right thing

She was in her thirties and came with a concern that could not be ignored. Tiredness that had been creeping in for weeks, and now bloody diarrhoea that had persisted for two to three weeks. She was seen on the same day by a locum GP, a sensible and conscientious clinician who recognised immediately that this was not something to dismiss or delay.

The consultation was thorough. Blood tests were arranged; a faecal immunochemical test was requested; calprotectin was sent, along with stool samples for microscopy, culture and sensitivity. From a clinical safety perspective, nothing had been missed. Serious pathology had been considered, and the plan aimed to cover inflammatory bowel disease, infection and malignancy.

The patient left feeling heard. She later reflected that she was reassured by how seriously her symptoms had been taken. But reassurance did not last.

In the days that followed, something unsettled her. The number of tests. The breadth of what was being looked for. The implications, spoken and unspoken. Anxiety crept in, not only about what might be found, but about what it meant to need so many investigations at once.

At her follow-up, she raised her concerns directly, calmly and thoughtfully. She explained that she worked as a civil servant in London and was used to questioning systems and processes. She asked why so many tests had been ordered at the same time. Could they have been staggered? Was this the best use of NHS resources? Had anyone considered the psychological impact of being investigated for everything at once?

The questions caught the GP off guard. Not because they were hostile, but because they were precise and uncomfortable. The GP paused, listened, and, to her credit, reflected in real time.

She explained her reasoning. As a GP, she had wanted to be safe. She did not want to miss anything. Bloody diarrhoea in a young woman deserved attention, and she had erred on the side of thoroughness. But as the conversation unfolded, she acknowledged something important. While nothing had been unsafe, the approach may not have been proportionate.

Looking back, she felt that starting with blood tests and calprotectin to assess for inflammation and possible inflammatory bowel disease would have been reasonable. A follow-up appointment could then have been arranged to review results, symptoms and next steps. The FIT test, with its implicit link to bowel cancer, might have been better timed, introduced with context, or reserved for a later stage if indicated.

Nothing about this case was dramatic. There was no catastrophic outcome, no missed diagnosis in the traditional sense. Yet it offers a powerful lesson about modern general practice, where access to tests is broader, expectations are higher, and the line between reassurance and anxiety is thin.

The patient was not wrong to ask the questions. The GP was not wrong to want to be safe. But safety in primary care is not only about ruling out disease. It is also about sequencing, communication, and understanding how investigations land with the person sitting opposite you.

Lessons and reflections

1. **Safety includes proportionality.**
   Investigating appropriately does not always mean investigating everything at once. Thoughtful sequencing can protect patients from unnecessary anxiety while still maintaining clinical safety.
2. **Tests carry emotional weight.**
   Blood tests, stool samples and cancer screening tools are not neutral. They shape how patients understand their symptoms and their future. We must consider not only what we are testing for, but how that testing is experienced.
3. **Reasoning matters as much as action.**
   Patients may accept uncertainty more easily than unexplained thoroughness. Sharing clinical reasoning helps patients feel involved rather than overwhelmed.
4. **Be open to challenge.**
   This consultation was enriched, not undermined, by a patient who asked difficult questions. Good clinicians remain open to reflection, even when their intentions were sound.
5. **Over-investigation is not always benign.**
   While missing pathology is rightly feared, excessive investigation can also cause harm. Anxiety, misinterpretation and loss of trust can follow if testing is not carefully framed and paced.
6. **Learning does not stop at reassurance.**
   The GP had not missed anything clinically, yet still learnt something important. That is the essence of reflective practice, recognising that good care can always be refined.

Bowel change

- Ask specifically about blood in the stool, changes in consistency or frequency, tenesmus and abdominal pain.
- Consider a faecal immunochemical test (FIT) in patients over 50 with a change in bowel habit, but do not allow testing to delay referral when high-risk features are present.
- Perform an abdominal examination and, when appropriate, a rectal examination.
- Refer according to local cancer pathways if red flags are present or the FIT result is positive.

When someone finally speaks up about bowel or urinary symptoms, it is because the issue matters to them. Your listening, and your clarity, matter just as much as your investigations.

Reflection: When the test is right but the result is wrong

She was in her early forties and had been struggling for months with upper abdominal discomfort. Not dramatic pain, but a persistent gnawing sensation, worse on an empty stomach, sometimes waking her at night. She felt bloated, nauseated at times, and increasingly tired of feeling unwell without an answer. Like many patients, she had tried to manage it herself first. Antacids, dietary changes, and eventually a proton pump inhibitor prescribed elsewhere, which had helped a little but not completely.

When she came to see me, the story was familiar: epigastric pain, dyspepsia, and a sense that something was not quite right. She was worried about ulcers. She mentioned Helicobacter pylori, *having read about it herself. A stool antigen test was arranged, and she left reassured that we were finally getting closer to clarity.*

The result came back negative.

On paper, that should have been reassuring. In reality, it did not sit comfortably with the clinical picture. Her symptoms persisted. The pattern still suggested gastritis or peptic ulcer disease. She returned, confused and frustrated. If the test was negative, why did she still feel this way?

It was only then, during a careful review of the timeline, that the missing detail surfaced. She had continued taking her proton pump inhibitor right up until the stool sample was collected. No one had told her to stop. She had not thought to ask. The test had been done, but it had not been done under the right conditions.

The result was technically correct, but clinically unreliable.

We stopped the medication, explained why it mattered, and repeated the test at the appropriate interval. This time, the result was positive. The diagnosis that had felt elusive suddenly made sense. Treatment followed, and with it, genuine improvement.

What stayed with me was not the diagnosis, but the process. The test had not failed. The system around it had.

Lessons and reflections

1. **A test is only as good as the conditions under which it is done.**
   Investigations do not exist in isolation. Medications such as proton pump inhibitors can suppress *H. pylori* and lead to false negative results if not stopped in advance.
2. **Ordering a test carries responsibility.**
   Requesting an investigation is not a tick-box exercise. It includes ensuring the patient understands how to prepare, why preparation matters, and what might affect accuracy.
3. **False reassurance can delay diagnosis.**
   An unreliable negative result can be more harmful than no test at all. It may falsely close down clinical thinking and prolong patient suffering.

4. **Patients cannot follow instructions they are not given.**
   Most patients want to do the right thing. Clear explanations, both verbal and written, are essential if we expect accurate results.
5. **Always return to the clinical picture.**
   When results do not fit the story, pause. Revisit assumptions and ask what might be interfering. The patient's symptoms are often more truthful than the numbers on a screen.
6. **Good general practice lies in the details.**
   Much of our work is not about rare diagnoses, but about getting common things right. Attention to small details can make the difference between confusion and clarity.

9.6 Safety-netting advice

Reassurance is important, but it must be paired with specific follow-up advice. Clear examples include:

- *"If you notice any blood, new pain, or changes in your appetite or energy levels, please come back to see us."*
- *"If this does not improve over the next couple of weeks, we will arrange further tests or a referral."*
- *"This is a common problem, but if anything changes, we will take it seriously."*

Concrete phrases help patients recognise when to seek help again.

9.7 What I wish I had known

These consultations are rarely quick. They involve building trust, gently unpacking fears, and occasionally delivering life-changing news. You do not need to rush, but you do need to ask clearly.

A PSA test is not a neutral act. It carries the possibility of false positives, anxiety and further invasive investigations, alongside potential benefit. Patients deserve to understand what the test can, and cannot, tell them. Sometimes, not testing immediately is the most thoughtful and clinically sound choice.

9.8 One-liner summary

"These symptoms are common and often manageable, so let's explore the cause and take this step by step."

Reflective prompts:

- How do you approach bowel or urinary symptoms when a patient appears hesitant or embarrassed? What helps you open the conversation?
- Recall a time you felt uncertain about requesting a PSA test or referring for bowel symptoms. What did you learn from the outcome?
- What is your current approach to FIT testing? When do you find it helpful, and when does it complicate decision-making?
- Have you ever missed a red flag in a gut or genitourinary consultation because it was not mentioned directly? How might you detect it next time?
- How confident do you feel explaining UTI treatment plans or recurrence risk, particularly to older adults? What is your go-to phrase?

CHAPTER 10

Women's health essentials

"Women often carry a quiet complexity in their consultations, so listen beyond the first sentence."

Women's health presentations are shaped as much by how you listen as by what you treat. Conversations about bleeding, hormones, contraception or pain often sit on years of feeling dismissed, misunderstood or too embarrassed to speak openly. A well-handled consultation can do more than address a symptom; it can restore confidence, control and dignity.

Do not wait for women to raise these issues themselves. Many have learnt, consciously or unconsciously, to suffer in silence. This chapter focuses on period problems, contraception, perimenopause and common urogenital symptoms, helping you offer clarity and choice rather than reflex prescriptions alone.

10.1 The presentation

A 44-year-old woman reports heavier and more painful periods over the past six months. She appears tired and frustrated and tells you she is "done with this." She is not using contraception. There are no red-flag features in the bleeding history. Her BMI is 28, and she is a non-smoker.

You are hearing the physical symptoms: heavier bleeding and pain. But you are also hearing something else – a deeper emotional message that she is worn down and no longer feels in control of her body.

Bleeding is often the presenting symptom. Loss of control is frequently the underlying issue.

10.2 Key questions to ask

Ask clearly, kindly and without assumptions. These consultations benefit from structure and reassurance. Key areas to explore include:

Reflection: Beyond the hormones – recognising the hidden struggles of perimenopause

She was 49 and sat opposite me with a quiet sense of unease. "I just don't feel like myself"*, she said, struggling to put her experience into words. She was not tearful, nor did she meet criteria for clinical depression, but it was clear that she was not well.*

She described persistent tiredness, fragmented sleep, intermittent palpitations, and a growing irritability, particularly towards her partner and teenage children. These changes were subtle but cumulative, gradually eroding her confidence and sense of identity.

Her menstrual cycle had become unpredictable: light one month, heavy the next, occasionally absent altogether. Yet this was not her main concern. "I feel like I'm losing my spark"*, she said quietly.* "My confidence has gone".

Her blood tests were unremarkable: thyroid function, iron studies, vitamin D were all within normal limits. In a time-pressured clinic, it would have been easy to attribute her symptoms to stress or low mood and move on. Instead, something prompted a single, simple question: "Could this be the perimenopause?".

Her expression shifted. No one had ever suggested it before. As we talked through the symptoms together, including disrupted sleep, mood changes, cognitive fog, emotional vulnerability and irregular periods, the pieces began to align. She cried, not from despair, but from relief. For the first time, her experience had a name.

We discussed management options, including lifestyle adjustments, nutritional support, local peer networks and hormone replacement therapy. She left with a plan, but more importantly, she left feeling seen, validated and understood.

Lessons and reflections

1. **Perimenopause is frequently the missing diagnosis.**
   Despite affecting a large proportion of women, perimenopause often goes unrecognised. Many women live with symptoms for years without anyone naming what is happening to them.
2. **The presentation is often subtle and multifaceted.**
   Perimenopause is not defined solely by hot flushes. Mood changes, sleep disturbance, cognitive difficulties, and emotional fragility may appear early and can have a profound impact on daily life and relationships.
3. **One question can change everything.**
   Asking, *"Could this be perimenopause?"* can validate years of confusion and self-doubt. That single question may be the gateway to understanding, self-compassion and effective support.
4. **Midlife pressures amplify vulnerability.**
   Women in their late forties and early fifties are often balancing demanding roles at work, at home, and in caring for others. When physiological change coincides with these pressures, the effects can be far-reaching.

5. **Normal blood tests do not exclude real suffering.**
   In perimenopause, investigations are often reassuring, yet the patient may still be struggling significantly. Listening carefully and offering a coherent explanatory framework can be as therapeutic as any medication.

- Are her cycles regular, and how heavy is the bleeding? Are there clots or flooding?
- What is the nature of the pain – cyclical or constant – and does it radiate to the back or thighs?
- What is the impact on energy levels, work, mood, sexual relationships and sleep?
- Is there any intermenstrual or postcoital bleeding?
- What method of contraception, if any, is she currently using, and does it help or worsen symptoms?
- Is her cervical screening up to date?
- Is there a family history of endometriosis, fibroids or gynaecological malignancy?

You are not simply managing hormones. You are helping someone regain a sense of normality and control.

10.3 What you must not miss

While many women's health presentations are benign, certain diagnoses must always remain on your radar. Be alert to:

- **Endometrial cancer**: any IMB, PCB or postmenopausal bleeding.
- **Anaemia**: chronic heavy periods can be profoundly depleting, both physically and emotionally.
- **Fibroids or adenomyosis**: consider when pain is severe, bleeding is heavy, or the uterus feels enlarged.
- **Sexually transmitted infections or pelvic inflammatory disease**: particularly in younger or sexually active women.
- **Ectopic pregnancy**: always consider in women of reproductive age presenting with pain or bleeding, regardless of reported contraception use.

10.4 The likely reality

Most menstrual problems have hormonal or structural explanations, yet many women have internalised them as something to endure. Heavy menstrual bleeding is common and often treatable. Hormonal contraception can be both a contributor to symptoms and an effective solution.

Reflection: Between care and confidentiality – a contraception request from a teenager

It was a quiet afternoon in a semi-rural clinic when a 15-year-old girl attended alone. Her appointment had been booked as 'period problems', but once the door closed, the real reason emerged. She wanted contraception and she was clear that she did not want her parents to know.

She was composed, articulate and notably well-informed. She had already considered her options, discounted those she did not feel suited her, and asked specifically about the combined oral contraceptive pill and the implant, referring to friends who used both. Her understanding of effectiveness, side-effects and risks was impressive. Equally striking was her fear of disclosure. "If they know" *she said quietly,* "I'll never come to the doctor again".

In a small community, where confidentiality can feel fragile, her concern was not unfounded. This consultation was no longer simply about prescribing contraception; it required careful navigation of trust, ethics and legal responsibility. I explained my duty to assess whether she could make this decision independently. We explored her relationship, screened for coercion or exploitation, discussed sexually transmitted infections and safer sex, and talked through responsibility and consequences. Her responses were thoughtful, consistent and mature.

She was Gillick competent.

I prescribed the combined oral contraceptive pill, offered follow-up, and signposted her to local sexual health services. I also explained clearly that her confidentiality would be respected unless there were concerns about her safety or wellbeing. As she stood to leave, she paused and said, "I was so scared you'd call my mum". *The relief on her face was unmistakable.*

Lessons and reflections

1. **Teenagers are often more capable than we assume.**
   Adolescents, when listened to and supported, can demonstrate a high level of insight and responsibility. Approaching these consultations without judgement allows young people to engage meaningfully in their own healthcare.
2. **Confidentiality is foundational to engagement.**
   Respecting confidentiality within legal and safeguarding boundaries creates safety and trust. Breaching it unnecessarily risks disengagement not only from contraception services, but from healthcare more broadly.
3. **Gillick competence is a clinical tool, not a barrier.**
   Gillick competence provides a structured and protective framework that supports autonomy while ensuring appropriate safeguards. In this case, it functioned exactly as intended.
4. **Our duty is to the patient before us.**
   Community expectations, parental assumptions, or personal discomfort must not override our ethical responsibility to the individual patient. Providing safe, confidential care may be pivotal to a young person's long-term health behaviours.

5. **Small consultations can have lasting impact.**
   This was not a lengthy appointment, but it was significant. Being taken seriously, spoken to honestly, and treated with respect can shape how a young person views healthcare for years to come.

Perimenopause and menopause frequently begin years before anyone names them, masked by fatigue, anxiety, low mood or irregular cycles. For many women, the experience is confusing and unsettling.

Menopause is a clinical process, but it is also an emotional transition. Your role is to acknowledge and support both.

10.5 What to do

Heavy or painful periods

- Arrange baseline blood tests such as full blood count and ferritin.
- Consider pelvic examination or transvaginal ultrasound for persistent, severe or atypical symptoms.
- Discuss treatment options including the COCP, a levonorgestrel intrauterine system (for example, Mirena), or cyclical progestogens, tailored to individual needs and risk factors.
- Recommend cycle tracking, the use of NSAIDs to reduce pain and bleeding, and simple supportive measures such as heat therapy.

Contraception

- Begin by asking what matters most to her: lighter periods, fewer hormones, reliability, flexibility or ease of use.
- Discuss LARC options, such as intrauterine devices or implants, particularly when symptom control is also a goal.
- Check blood pressure and BMI when considering the COCP and review contraindications carefully.
- Be transparent about possible side-effects, including changes in bleeding patterns, mood or skin, and encourage review if these become problematic.

Contraception is not just about preventing pregnancy. It can be a tool for symptom control, cycle regulation, and restoring confidence in one's body.

Menopause and perimenopause

- In women over the age of 45, diagnose perimenopause or menopause primarily on clinical grounds; blood tests are often unnecessary.
- Discuss HRT, including patches, gels and oral preparations, covering benefits, risks, and the primary aim of improving quality of life.

Reflection: The 'trivial' leak – when urogenital symptoms uncover deeper distress

She was 62 and greeted me with a polite smile as she sat down. "It's just a bit of leaking"*, she said, almost apologetically.* "When I laugh or sneeze too hard"*. She gave a small laugh herself, as if to minimise it. Her request seemed straightforward:* "Can I get something to stop it?"

Her medical records were unremarkable, with no previous documentation of urinary or vaginal symptoms. She was postmenopausal, had two prior vaginal deliveries, and no significant gynaecological or urological history. On the surface, this appeared to be a routine presentation – one we encounter frequently in general practice.

Yet something in her manner gave me pause. The self-effacing tone, the hesitation beneath the smile. I asked a few more gentle questions, and the fuller story began to emerge.

She described increasing vaginal dryness, itching and discomfort during intercourse. Intimacy had become painful and, eventually, something she avoided altogether. She had experienced recurrent urinary tract infections and had begun to limit social outings, worried about needing the toilet urgently or smelling of urine. "I used to be confident and sociable" *she said quietly.* "Now I just feel… ashamed."

Examination findings were consistent with genitourinary syndrome of menopause (GSM), including thinning of the vulvovaginal tissues, local irritation and a mild degree of prolapse. We discussed management options, including topical oestrogen, pelvic floor physiotherapy, lifestyle adjustments and relevant support services. Just as importantly, we talked about how common this is, that it was not her fault, and that effective treatments were available.

Two months later, she returned, not to complain, but to thank me; "I feel like myself again" *she said.*

Lessons and reflections

1. **Seemingly minor symptoms may conceal major impact.**
   What is presented as 'just a bit of leaking' may mask profound effects on confidence, intimacy and social participation. Listening beyond the opening line is essential.
2. **Create space for what is not easily said.**
   Many women will not volunteer symptoms such as vaginal dryness, discomfort or incontinence unless directly asked. A few sensitive questions from us may unlock months or years of silent distress.
3. **Recognise genitourinary syndrome of menopause.**
   GSM is common yet frequently under-diagnosed. Management is not only hormonal; it involves validation, explanation, and restoring comfort and dignity in daily life and relationships.

4. **Holistic general practice makes a tangible difference.**
   This consultation was not simply about prescribing or containment products. It required listening, examination, explanation and follow-up. General practice is uniquely placed to offer this continuity and breadth of care.
5. **Acknowledgement is empowering.**
   For many women, hearing 'this is common and treatable' is transformative. It reframes shame into action and restores a sense of control over their own bodies.

- Offer vaginal oestrogen for urogenital symptoms such as dryness, discomfort or recurrent UTIs. This is usually safe, even in some women with a history of breast cancer, when guided by specialist advice and current guidelines.
- Support lifestyle measures including weight-bearing exercise, balanced nutrition, alcohol moderation, smoking cessation, and psychological support for mood and sleep disturbance.

10.6 Safety-netting advice

Effective safety-netting should be clear, practical and reassuring. Examples include:

- *"If your bleeding changes suddenly, becomes much heavier, lasts longer, or becomes unpredictable, please come back so we can review this."*
- *"If you notice bleeding after sex or between periods, please book an appointment promptly so we can assess it carefully."*
- *"We can try this approach for a few months. If it does not help enough, we can review and look at other options together."*

10.7 What I wish I had known

There is real power in a well-framed question such as, "*What would feeling in control look like for you?*" Many women respond with, "*I thought this was normal*", a sentence that often carries years of minimised distress and unspoken frustration.

Common symptoms are not necessarily acceptable symptoms. Seeing similar problems frequently should never lead to minimising their impact.

Earlier in my practice, I did not always hear what was not being said. Now, I try to listen as carefully for the pauses, hesitations and quiet admissions of *"I've just put up with it"* as for the spoken words.

Reflection: A hidden cut – the case that spoke without words

This case was shared at one of our monthly clinical meetings by an experienced practice nurse. It involved a 23-year-old woman attending for her first cervical smear. British-born, with family origins in East Africa, she had recently registered with the practice and this was her first sustained contact with primary care as an adult.

She was quiet, polite and composed throughout the consultation. The appointment had been booked as a routine cervical screening. There were no reported symptoms and no expressed concerns – a seemingly straightforward check-up.

During the examination, the nurse paused. The external genital anatomy was altered. Scar tissue had replaced normal labial structures. The clitoris was not visible, and the vaginal opening was significantly narrowed. It became clear that this young woman had undergone Type III female genital mutilation (FGM), also known as infibulation.

She had not mentioned it. No one had previously asked.

The nurse stopped the examination gently and spoke with calm compassion, checking in with her before proceeding further. The patient responded quietly, "Yes. It happened when I was little. I don't really talk about it".

They discussed her right to appropriate care and her right to safety. The nurse explained that specialist support was available and outlined referral to the local FGM clinic, including physical and psychological care. The patient agreed. As she was leaving, she said, "You're the first person who's ever asked me about this".

Lessons and reflections

1. **FGM is a UK safeguarding issue, not a distant problem.**
   FGM affects thousands of women living in the UK. Many were subjected to it as children, often overseas but sometimes within the UK. Primary care may be the first, and sometimes only, setting in which safe disclosure can occur.
2. **Routine consultations can uncover hidden trauma.**
   Cervical screening, contraception reviews and antenatal care are key opportunities for sensitive identification. What appears to be a routine appointment may reveal a history of profound physical and psychological harm.
3. **Observation alone is not enough – we must ask.**
   FGM is rarely disclosed spontaneously. Unless clinicians ask clearly, sensitively, and without judgement, many women will continue to suffer in silence, believing nothing can be done.
4. **Cervical screening can be re-traumatising.**
   For survivors of FGM, smear tests may be physically painful and emotionally triggering. Time, explanation, consent and the option to stop are essential to minimise harm and build trust.

5. **Know local referral pathways.**
   Specialist FGM clinics offer de-infibulation, psychological support and holistic care. Primary care clinicians should be familiar with local services and confident in discussing referral options respectfully.
6. **Safeguarding responsibilities extend beyond the adult patient.**
   Any disclosure of FGM should prompt consideration of safeguarding risks to younger siblings or family members. Clinicians must understand their legal duties, particularly where girls under 18 may be at risk, and follow local safeguarding procedures.
7. **One respectful question can begin healing.**
   The nurse's intervention was not complex. It was calm, informed and kind. That was enough for this patient to feel acknowledged and supported for the first time. Sometimes, asking the right question at the right moment is the first step towards safety and recovery.

Reflection: Beyond the referral – listening, lifestyle and fertility

It was a busy morning clinic when I met a confident woman in her late twenties. She attended with her partner, requesting a referral to the fertility clinic. Her manner was upbeat, but beneath the smile there was a quiet undercurrent of disappointment. They had been trying to conceive for some time.

She had never carried a pregnancy to term, but she had conceived twice. Both pregnancies had ended in early miscarriage, before ten weeks. Her partner confirmed that he had never fathered a child. Both appeared physically well and were in a stable, supportive relationship.

"I'd like a referral to the fertility clinic*", she said.*

In the pace of general practice, with a ten-minute appointment and what appeared to be a clear request, it would have been easy to agree and proceed. Something made me pause. Rather than moving straight to action, I asked whether we could talk a little more before arranging the referral. She agreed.

As we explored her history further, her lifestyle emerged. Weekends were filled with hiking, climbing, cycling and travel. She lived a high-energy, physically demanding life. Behind all that vitality, I found myself wondering whether the cumulative physical strain might be playing a role, not in conception, but in sustaining an early pregnancy.

We discussed this gently, without judgement or prescription. We talked about how early pregnancy places new demands on the body, and how, for some women, it may benefit from a period of relative gentleness – prioritising rest, hydration, nutrition, and easing back from intense physical exertion in those first fragile weeks. She listened openly and thoughtfully. I reassured her that referral remained an option and that we could revisit it at any time.

Several months passed.

She returned one day with a radiant smile and a small card in her hand. She was now the mother of a healthy baby daughter. Inside the card were just a few

words: "You helped me understand when I needed to slow down. Thank you for helping me become a mother".

Lessons and reflections

1. **Fertility is not only about conception.**
   Much of fertility care focuses on achieving pregnancy, yet early pregnancy loss deserves equal attention. Supporting a patient to sustain a pregnancy can require a different lens and a broader exploration.
2. **A pause for history can change everything.**
   Even in a time-pressured consultation, taking a moment to explore lifestyle, physical demands and stress can uncover modifiable factors and alter the entire direction of care.
3. **Gentle advice can have profound effects.**
   Effective guidance does not need to be forceful or directive. Thoughtful suggestions, offered with respect and humility, can be life-changing when they meet readiness and trust.
4. **Education empowers, instruction limits.**
   This was not a long consultation, but it was a meaningful one. When patients feel informed rather than told what to do, they are far more likely to engage and adapt.
5. **Look beyond the referral request.**
   A referral is often a doorway, not an endpoint. What seems like a straightforward administrative task may actually be an invitation to listen more deeply and offer care that is truly personalised.

10.8 One-liner summary

"You do not have to live with this. We have options to help you feel more in control again."

Reflective prompts:

- Think of a women's health consultation where you felt unsure or underprepared. What would you do differently now?
- How do you currently offer contraception choices? Do you begin with a list of options, or by asking what matters most to the patient?
- How comfortable do you feel discussing menopause and HRT? What is one area you would like to build confidence in?
- When a patient says, *"I've just put up with it"*, how do you respond in a way that honours her resilience while offering support?
- What language do you use to explain cycle regulation, hormone treatment or perimenopause to patients who are unsure what is happening in their bodies?