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WHAT'S BROKEN

Exploring medicine through art

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RESPIRATORY MEDICINE

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DISCHARGE FORMS

AN MDDUS
PUBLICATION





Welcome to your FYi

AS the new year gets underway, I am delighted to be taking over as editor of *FYi*, with a big thanks to former editor Dr Anne Parfitt-Rogers for all her hard work over the past three years. Having trained in medicine and law, I've worked as an MDDUS medical adviser since 2013 and look forward to sharing insights from our expert team of advisers and contributors.

I remember well being a busy foundation doctor with a seemingly endless to-do list. One inevitable - and crucial - job is completing the discharge form. My article on [page 10](#) offers advice on getting this right.

As more patients seem to be researching their symptoms online, MDDUS medical adviser Dr Greg Dollman advises doctors not to rush to dismiss them, but to listen carefully to their concerns ([page 5](#)).

With so many medical research articles and journals out

there, Dr Allan Gaw offers tips on how to stay up-to-date on [page 4](#). There's more practical advice on [page 6](#) where Dr Sophie Rogers shares her experiences of three more core skills that all F1 doctors must complete.

If you're looking for a challenging and varied career then the specialty of respiratory medicine could be for you. Read more on [page 8](#). Working in hospitals can be challenging in many ways, and on [page 7](#) Jim Killgore considers a recent report on bullying amongst trainees.

On [page 12](#), doctor and budding artist Katy Shorttle tells Adam Campbell how she finds time for both a medical and a creative career. And finally, our case study on [page 14](#) looks at how a seemingly mild headache turns out to be something far more serious.

• **Dr Naeem Nazem**
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COVER PHOTOGRAPH: COURTESY OF DR KATY SHORTTLE



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HOSPITAL COMPLAINTS POORLY INVESTIGATED

HOSPITALS in England are failing to conduct proper investigations into complaints about avoidable harm and death according to a quality review published by the Parliamentary and Health Service Ombudsman.

The report found that nearly three quarters (73 per cent) of hospital investigations into complaints about avoidable harm and death claimed there were no failings in the care given, despite PHSO investigations of the same incidents uncovering "serious failings".

The report also found that hospitals failed to class more than two-thirds (20 of 28) of avoidable harm cases as serious incidents and thus conduct proper investigations, and just under a fifth (19 per cent) of NHS investigations were missing crucial evidence such as medical records, statements and interviews. Only half (52 per cent) of the investigations about avoidable harm and death carried out by the NHS where conducted by a clinician who was independent of the events



complained about and 36 per cent of investigations that recorded failings did not adequately determine why they had happened.

Parliamentary and Health Service Ombudsman Julie Mellor (pictured) said: "Our review found that NHS investigations into complaints about avoidable death and harm are simply not good enough. They are not consistent, reliable or transparent, which means that too many people are being forced to bring their complaint to us to get it resolved."

She called on the NHS to help increase public confidence by introducing an accredited training programme for staff who carry out complaints investigations as well as providing guidance on how they should be done.

FOUNDATION PROGRAMME OVERSUBSCRIBED AGAIN

THE 2016 foundation training programme is oversubscribed.

The UK Foundation Programme Office confirmed that, as predicted, there are more applicants than places for the training which starts in August 2016.

It is the sixth year in a row there has been a jobs shortage. There was a record high number of trainees without a post at the start of the process in 2015 (399), but all eligible applicants were eventually found a place.

Final numbers for the 2016 oversubscription will be released soon. Top scoring candidates will be put on a primary list in March and the rest will be placed on a reserve list. Find out more at www.foundationprogramme.nhs.uk.



GMC PROMOTES DISCUSSION ON GOODDOCTORS

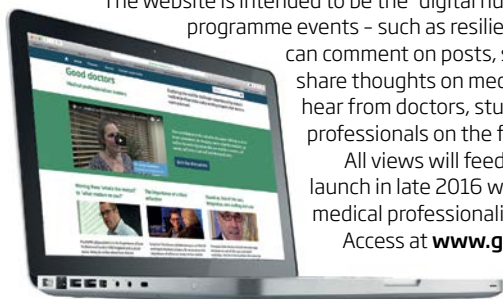
A NEW website for medical professionals has been launched by the GMC to provide a forum for discussion on the "real life challenges" faced in medicine today.

The GoodDoctors website has been developed as part of the Medical professionalism matters programme which the GMC is currently running with partners, including the BMA and RCGP.

The website is intended to be the "digital hub" for discussions on topics covered at programme events – such as resilience, compassion and collaboration. Site users can comment on posts, submit blogs or contact the GMC privately to share thoughts on medical professionalism. The GMC says it wants to hear from doctors, students, trainees, educators and health professionals on the frontline.

All views will feed in to a major report that the GMC plans to launch in late 2016 which will "reflect the current state and future of medical professionalism in the UK".

Access at www.gooddoctors.org.uk



FREEZE ON FEES FOR JUNIOR DOCTORS

THE annual fees paid by trainee doctors to stay licensed with the General Medical Council have been frozen for 2016.

The cost of provisional registration will stay at £90 while the fee to move from provisional to full registration will be kept at £200. The postgraduate certificate of completion of training (CCT) will also remain at £420.

The regulator plans to continue offering a 50 per cent discount for doctors earning below £32,000 a year.

The price freeze comes as the standard annual retention fee for doctors increases by £5 to £425, while doctors registered without a licence will pay an extra £2, bringing their total to £152.

The GMC has announced a series of cost-cutting measures in the hope of saving £6 million by 2018. This includes moving 130 jobs from London to Manchester and reforming its employee pension scheme.

The regulator is also exploring ways of generating additional sources of income, such as charging for some services internationally.

NEW APP TO RECORD CPD

DOCTORS can now record their CPD progress on a new mobile app launched by the GMC.

The free "GMC My CPD" app allows users to track their learning on smartphones and tablets.

Once registered, doctors can note their activities in various ways. This includes categorising learning according to personal development plan objectives, or by the domains of the GMC's *Good medical practice* guidance.

CPD credits can be assigned to activities and the running total tracked. A notes function allows users to reflect on their practice and the impact of new learning, while reminders can be set for a future date to consider the effects of any changes made.

The app also allows activities to be

exported to a PDF or Excel report, or to be transferred to another CPD, appraisal or revalidation system, such as those offered by royal colleges.

It aims to simplify the process of filing large numbers of certificates from conferences and seminars. Users can take a picture on their device and append them to their chosen learning activity on the app.

A hot topics section highlights potential learning opportunities, and there is also access to tips and case studies.

The app is available for iOS and Android from the Apple and Google Play stores.

• MDDUS members can use the app to track their progress and learning from the wide range of resources in the Risk Management section of mddus.com.



ONLY HALF OF DOCTORS ENTER UK SPECIALTY TRAINING

THE number of doctors entering specialty training in the UK has hit a new low, according to a new report.

Only 52 per cent of those who have finished foundation year two (F2) have started training in the UK to become a GP or hospital specialist. This is a sharp drop since 2011 when just over 71 per cent of F2s entered specialty training.

The UK Foundation Programme Office's *Career Destination Report 2015* surveyed 7,168 trainees.

Results show an increase in the number of doctors taking a career break, rising from just under five per cent in 2011 to just over 13 per cent in 2015. Of those not in specialty training, almost nine per cent said they were still seeking UK employment as a doctor, while 9.2 per cent had taken up a UK non-training (service) appointment.

A number of F2s said they had taken up another appointment in the UK, such as an

anatomy demonstrator or further study, while 6.2 per cent had taken up other positions outside the UK, and 0.4 per cent had a non-UK specialty training post.

There are concerns the large number of doctors avoiding specialty training could exacerbate recruitment problems.

Dr Johann Malawana, chair of the British Medical Association's junior doctors committee, told the *Guardian*: "To see such a large number of doctors leave the NHS in such early stages of their careers is incredibly worrying, and can only worsen the recruitment crisis we are already seeing in many parts of our NHS, such as A&E."

"The government must focus on ensuring we have the valued and motivated workforce needed to meet rising demand across the country, as to lose any more doctors in the early stages of their careers would be a disaster for the NHS".

HOW TO BE **WELL READ**

With so much literature to read, how can junior doctors stay up-to-date? **Allan Gaw** offers some advice

THE medical and scientific literature can be daunting – sometimes in its complexity but always in its scale. New articles are being published every day in a growing number of journals and any hope of keeping up might seem forlorn.

We need to read in order to stay abreast of new developments in our field, but we also need to read in order to learn how to write. Both are essential professional skills in modern medicine and to achieve these ends we need to find an efficient and economical way to read the literature. Fortunately, the scientific paper is designed to help us do just that, and we should make use of its structure with a layered approach to our reading.

Our first meeting with a paper will usually be on a results page of a search engine, where we will be given the title, authors, date of publication and journal. These pieces of information are all you need to decide whether you want to spend any more of your precious time on the paper. Is the title relevant? Are the authors recognised in your field? Is the paper recent and is the journal of sufficiently high impact to merit your attention?

If you decide, based on this assessment, that the paper merits further reading, you will, usually at the touch of a button, be able to obtain the abstract. This summary of the paper has been written specifically with you in mind – the busy reader. But I suggest you don't read the whole abstract, just look at the last sentence. There you will usually find the main conclusion of the paper – the take-home message – and that combined with the title

you have already read, should make it clear whether this paper deserves more work. If it does, then read the whole abstract and if your interest is still piqued, turn your attention to the main paper.

The paper itself is written in defined sections. These are usually introduction, methods, results and discussion. There will also be an acknowledgements section, a list of references and assorted tables and figures. Where do you start? Well, not at the beginning because a scientific paper is not a novel and is not necessarily designed to be read in a linear fashion from start to finish.

As you first approach the scientific literature it might seem that everything is interesting, well-executed, cogently argued and better than anything you could hope to produce. With time and the benefit of experience, scientific papers become less convincing.

As you develop your own critical faculties you will be harder to convince and more questioning of the conclusions of others.

At that point the most important part of any paper will be the results section. These are the only truly unique contribution the authors are making. The question they have set out to answer has probably been addressed by others, their methods may be well-known and their conclusions are only one interpretation. Their results, however, are unique, and this aspect of the paper will be the part where you will increasingly wish to focus. The written results section is, however, often one of the most tedious parts of a paper; much better to

study the tables and figures where the results are presented in a more readily digestible format.

So, after you have read the title, the last sentence of the abstract and then the whole abstract, turn your attention to the figures and tables with their associated legends. This will quickly tell you the story of the results. If you are still interested you may then turn your attention to the introduction. If you are familiar with a topic it is unlikely that anything in this scene-setting section should be new to you, but it might be. Turn your attention next to the discussion and only if you are still interested look at the methods and written results sections.

Throughout this process you should be reading actively. This means on a practical level you should always read with a pen in your hand or at least with some way of making notes and recording any questions you might have about the paper. Those questions are important, for a scientist is a sceptic – someone who takes nothing at face value. And never forget, just because it is published does not mean it is necessarily true.

How we read and how much time we spend on a paper will depend on its level of interest for us. Some papers will be skimmed, others read in more detail, and yet others will be practically learned by rote. In every case, you should read the paper in layers, unwrapping each and only stopping when the paper has nothing more to offer. For a paper of little relevance this may be at the title; for one that is at the core of your interest this may be only after you have read every word.

Dr Allan Gaw is a writer and educator in Glasgow

As patients increasingly rely on potentially misleading internet medical advice, **Dr Greg Dollman** advises doctors to be careful not to overlook valid concerns

FOR INSTANT

AS modern life gets faster, more and more shortcuts become available to us. Order your coffee via an app on your way to work and pick it up on the run. Have your groceries delivered any time you want. Same-day delivery? You got it. If only we could get that same instant gratification for our health...

Some believe this is possible. Patients are increasingly relying on the internet to self-diagnose. The reasons seem obvious enough: urgent appointments may not be readily available, the internet has all the answers (doesn't it?), and large sections of the public feel it is a chore to visit a doctor.

The rise in self-diagnosis

A recent survey by the Astellas Innovation Debate revealed that three-quarters of GPs noticed a marked increase in the number of patients "self-diagnosing" from the internet over the last year. These range from the worried well, to the proactive and genuinely interested, as well as to those seeking a particular quick fix ("Doctor, I think I have X. Will you write me a prescription for Y?")

Such is the pervasive role of the internet, it seems inevitable that some people will look up their symptoms online. It can be a fine balancing act for doctors when faced with patients who, prior to the consultation, have already sought a "second opinion".

Although the internet can be a helpful starting point in some cases, there is also a lot of inaccurate and misleading information. Patients should nevertheless be encouraged to take an interest in and be responsible for their own health, and discuss any concerns with their doctors. By working in partnership, patients may gain a better understanding of any condition or symptoms. At the same time doctors can improve their knowledge and achieve a greater insight into both their patients' symptoms and the reasons for their presentation.

Listen

Undoubtedly patients know their bodies far better than a doctor ever could, and it is important for clinicians to listen when they talk about their symptoms, especially in chronic conditions ("Doctor, this feels like an



DIAGNOSIS ...

CLICK HERE

exacerbation of my COPD"). Doctors should acknowledge a patient's central role when formulating diagnoses and making decisions, being careful to remain professional in the care they provide. The GMC's *Good medical practice* reminds doctors that they must adequately assess a patient's condition, taking into account their explanation of symptoms as well as their views and values, before undertaking an appropriate examination.

Doctors may feel uncomfortable, intimidated or even threatened when presented with a dossier of information, complete with diagnosis, sourced from an app or the web. This can be exacerbated where the doctor is unfamiliar with the symptoms or condition described. Furthermore, doctors may feel the consultation loses its usual structure when patients arrive with a diagnosis in mind, and time that should be used to examine the patient may instead be spent looking through a patient's findings. Healthcare professionals, fortunately, are usually skilled in adapting their practice to meet each individual's needs, and resultant discussions can often help to build the doctor-patient relationship.

Working in partnership

Whatever your views, it is important to acknowledge a patient's research and not be dismissive, even when the proposed diagnosis seems improbable. Patients may feel that a doctor dismissing their concerns is also dismissing them. This can be damaging to your relationship and a source of complaints.

Patient-initiated research can provide a helpful starting point for investigating concerns and to dismiss it risks overlooking potentially serious health issues. Involving patients in their care is also beneficial for compliance, as research suggests they are more likely to engage with management plans that they have helped formulate.

There is much to learn as a doctor and it is impossible for us to know it all. So when a

patient offers a considered and subjective review of their own symptoms and circumstances, it can be a helpful opportunity for professional development.

Work within your competence

MDDUS has handled many cases where patients have requested investigations or treatment as a result of internet research, and it is important that doctors use their professional judgement. The GMC expects doctors to work within the limits of their own knowledge and expertise, and clinicians are not obliged to provide treatment simply because a patient wants it.

GMC guidance *Consent: patients and doctors making decisions together* states: "If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment."

Doctors should then explain to the patient why they don't want to provide the treatment and explain any other options that are available, including the option to seek a second opinion.

In future, patients will likely have more and more information at their fingertips. While some may attend with a plausible diagnosis in mind, doctors are obliged to interpret this information following a focused history and examination, applying their clinical acumen and experience. As technology evolves, so too will the relationship between patients and doctors. Perhaps this is the true partnership that professionalism requires of doctors. For all its advances, however, the digital age cannot offer the skilled unravelling of clinical clues instantly, at the click of a mouse.

Dr Greg Dollman is a medical adviser at MDDUS

Jim Killgore considers a GMC report on bullying and “undermining” in medical training

BULLYING is nothing new in medical training. Indeed, it’s almost cliché, the stuff of vintage hospital dramas and comic novels – the crusty senior consultant maltreating his lowly housemen in a benign rite of passage. But for many UK trainees it’s no joke.

In the General Medical Council’s 2014 *National Training Survey* (NTS) eight per cent of doctors in training reported experiencing bullying or harassment, and nearly 14 per cent reported having witnessed someone else suffering these behaviours. Even more trainees experienced undermining (18 per cent). The NTS defines bullying as behaviour that “hurts or frightens someone who is less powerful, often forcing them to do something they do not want to do”. Undermining is behaviour that “subverts, weakens or wears away confidence”.

These findings prompted the GMC to further investigate bullying in a representative sample of 12 UK hospitals where concerns had been raised. The review focused on obstetrics/gynaecology and surgery departments, as these specialties have been identified as having particular issues with bullying and undermining. In March 2015 it published the findings of this investigation.

Stop “making trouble”

GMC visitors to the selected sites spoke to trainee doctors in small groups. Among the behaviours reported was criticism from senior doctors that made trainees feel “belittled or humiliated”. Sometimes these criticisms were made in front of other healthcare professionals or even patients. A few trainees reported outright threats of the consequences for their future careers if they didn’t stop “making trouble” by raising concerns over the quality of their training.

Other doctors in training complained that criticisms made in workplace-based assessments were not discussed constructively. This was coupled with an overall failure to demonstrate concern for their educational needs, by failing to engage with trainees or consistently prioritising clinical efficiency over training.

There were also reports of favouritism, with some trainees given access to resources (such



PHOTOGRAPH: VIC FILMS/GFD/THE KOBAL COLLECTION/IAN JEVES

not required

as study leave or training opportunities) denied to others. Other concerns involved the failure to acknowledge the importance of doctors in training having a personal life or to consider their stress levels and workload.

Research cited in the report shows that “undermining and bullying in the workplace is bad for patient safety, bad for the health of those involved and bad for the quality of training”. Doctors in training who report having been bullied are more likely to have made mistakes at work and are also less likely to work well in a team – a serious issue of concern as effective teamwork is a proven factor in avoiding clinical mishaps.

Perhaps most worryingly, the report states: “doctors who are bullied at work may be less likely to raise concerns they have about patient safety, for fear of the consequences they may suffer”.

Nothing less than perfection

The GMC investigators found that – for the most part – those consultants perceived as bullying were not malicious in intent but were most often described as “perfectionists”. They had exacting standards for both clinical performance and dedication to work and they expected trainees to live up to those standards. This led to rebukes or criticism relating to clinical knowledge or performance, or bypassing the doctor in training, ignoring them or not allowing them to perform their expected duties. As a result the quality of training was diminished, with some anaesthetists, surgeons or other operating theatre staff preventing trainees from operating so that cases could be finished more quickly.

Even more demoralising, the report states that “some consultants or other staff members gave doctors in training the impression that they had little or no interest in them either as doctors in training, or as people”.

The report recognises that consultants and

senior doctors are often under increased pressure with rising patient demand and ever tighter resources. It goes on to highlight factors that can help mitigate a culture of bullying and undermining and can contribute to a positive and safe environment. These include:

- doctors in training feel valued and supported
- strong clinical leadership
- effective senior leadership and departmental cohesion
- appropriate time and resources for training with extra staff employed if necessary
- strong communication with doctors in training and acknowledgement of training issues.


Niall Dickson, GMC Chief Executive, said: “There is a need to create a culture where bullying of any kind is simply not tolerated. Apart from the damage it can do to individual self-confidence, it is likely to make these doctors much more reluctant to raise concerns. They need to feel able to raise the alarm and know that they will be listened to and action taken.

“We are working with those responsible for postgraduate education at local level to respond to this feedback from doctors in training. We need to develop a supportive culture that actively encourages doctors in training to feel confident in raising concerns at an earlier stage.”

Jim Killgore is an associate editor at FYi

Link:

Access the GMC’s report, *Building a supportive environment: a review to tackle undermining and bullying in medical education and training*, at: goo.gl/nQSFpZ



Dr Sophie Rogers shares her experiences of carrying out three core skills that all trainees must perform

CORE **SKILLS** CHALLENGE

F1 DOCTORS must demonstrate competence in 15 procedures to become eligible for full GMC registration. Here are some helpful tips on male and female urethral catheterisation, and airway care including simple adjuncts.

Urethral catheterisation (male)

I first inserted a male catheter on my first job on a geriatric ward when I had a patient in urinary retention who needed to be catheterised urgently.

I went to the treatment room in search of all the items I needed. I checked with the nursing staff which catheter size was most suitable and to double check I had selected a male catheter. After finding a trolley and cleaning it, I made sure I opened all my items out into my sterile field being careful not to contaminate anything, using aseptic non-touch technique (ANTT). I placed the catheter bag under the trolley.

At the bedside I explained to the patient what I was going to do and why. After putting on an apron and using alcohol gel I remembered to pour the water for cleaning into the sterile tray before donning my sterile gloves. With the nurse as a chaperone and an extra pair of very helpful hands, I cleaned the patient ensuring I maintained the "clean hand, dirty hand" technique, something that I still have to actively think about during these procedures to maintain sterility. I inserted 10ml of the lubricant with local anaesthetic into the urethral opening/meatus and waited a few minutes.

At this point I changed my sterile gloves and opened the inner sterile catheter package. I inserted the catheter, ensuring the distal end was over the tray to catch any urine likely to appear – in this situation at high pressure. I inflated the balloon with the prefilled 10ml syringe and pulled gently back on the catheter until there was resistance. It is important to ensure the patient isn't in discomfort during balloon inflation as there is a risk of rupturing the urethral sphincter as you do so. I attached

the catheter bag with the help of the nurse, I told the patient the procedure was all done and cleared away the rubbish. Remember to replace the retracted foreskin to avoid paraphimosis, ensure you keep the catheter labels for documentation purposes and also send a urine sample.

Urethral catheterisation (female)

I inserted my first female catheter again on a geriatric ward during my first job, this time for a lady with a neurogenic bladder who required a long-term catheter. In this case, I had to remove a catheter to insert a new one.

Again I identified the correctly sized catheter, this time for a female, and made sure it was suitable for long-term insertion. I gathered and prepared my equipment in the clean environment of the treatment room. After explaining the procedure, I ensured I had all the correct equipment laid out in the sterile field at the bedside using ANTT.

I removed the current catheter and then began the cleaning process in a downward motion, ensuring not to contaminate already clean areas. I find it useful to take more gauze than is provided in sterile packs for cleaning during catheter insertion; in reality it is never enough.

Making sure the patient was informed of what I was doing at all times but being mindful of the non-soundproof curtains, I explained why, where and how I was going to proceed with the catheter insertion. Confident I had identified the urethral opening, an area of female catheterisation that can be challenging, I inserted 10ml of anaesthetising lubricant and waited for it to take effect.

After changing my sterile gloves I introduced the catheter, with the distal end over a tray to catch any residual urine. Once urine was flowing I inflated the balloon with 10ml of water and retracted the catheter until I felt resistance. I attached the catheter bag and informed the patient I had finished. I peeled off

the catheter stickers for documentation and cleared away my rubbish.

Airway care including simple adjuncts

Using simple airway adjuncts isn't something I have often had to do. There are a few options to choose from in situations where a patient is unable to maintain their own airway and has a decreased level of consciousness such that they can tolerate an airway adjunct. If jaw thrusts and/or head tilt chin lift are insufficient then you may want to use an oropharyngeal or nasopharyngeal airway. For both of these airway adjuncts it is important you use the correct size for the patient.

The nasopharyngeal airway (NPA) most commonly used in adults is 6-7mm in diameter. These cannot be used in patients who have had a head injury. They are inserted, with lubrication, horizontally into the patient's nostril – usually the right nostril due to the angled tip of the NPA. It is commonly said that you should attach a safety pin to the distal end of the NPA to avoid losing it up the nostril! Often pins are already in place on the crash trolley NPAs to save time.

An oropharyngeal airway (OPA) is a curved, rigid plastic tube which is inserted upside down then twisted 180 degrees in the patient's mouth to avoid initially pushing the tongue backwards and occluding the airway further. There are different ways of measuring oropharyngeal airways: I use the angle of the jaw to tragus method. You put the tip of the OPA at the angle of the patient's jaw, directing the flat end of the OPA, up to the patient's tragus; you should use the size that is long enough to reach both those anatomical points.

Remember if you find yourself in a situation where you need to use an airway adjunct, you should be informing a senior and seeking their advice on further management.

Dr Sophie Rogers is a foundation year one doctor based in Bolton

BREATH OF FRESH AIR

The ever-expanding specialty of respiratory medicine offers a varied and challenging career for doctors

VARIETY is a core part of respiratory medicine where specialists deal with more than 30 different acute and chronic conditions across a wide age range.

This diverse field covers a broad spectrum of disorders, some very common and some rare. They range from inherited conditions like cystic fibrosis, infective conditions like pneumonia and empyema, as well as others such as vasculitis, lung cancer, and chronic obstructive pulmonary disease (COPD).

Respiratory conditions are among the UK's biggest causes of mortality, accounting for almost a third of all acute admissions and costing the NHS billions of pounds every year. In addition to acute care, many also require lifelong outpatient treatment for chronic disorders, giving specialists the chance to build long-term therapeutic relationships.

Demand for treatment seems unlikely to decrease for the foreseeable future – indeed areas such as lung cancer and sleep services are continuing to expand to meet growing needs. Add to this the increasing opportunities in research, and it is fair to say specialists in this field will never be short of a challenge.

Entry and training

The first step to enter specialist training in respiratory medicine is to complete two years of core medical training (CMT or Acute Care Common Stem (ACCS)) and to gain membership of the Royal College of Physicians (MRCP) or pass a recognised equivalent examination. Higher specialty training then begins at ST3 level, by which point the British Thoracic Society (BTS) recommend doctors have at least one period on a unit with a specialty respiratory interest. The BTS says: "Ward-based practical skills can be developed during this time and there is sometimes an opportunity to begin to learn bronchoscopy and pleural USS. This may help crystallise your decision to pursue a career in the specialty."

Commitment to the specialty can be further demonstrated by gaining research experience, often carried out after entering specialty training.

Core/specialty training generally lasts six years in total and covers both general and respiratory medicine. There are options to train

less than full time (LTFT) which is commonly 60 per cent whole time equivalent. Many doctors choose to dual qualify and gain an additional certificate of completion of training (CCT) in general internal medicine which usually adds one extra year to specialty training. Those interested in this pathway must complete an officially designated dual CCT programme.

The General Medical Council's *Specialty training curriculum for respiratory medicine* contains detailed information about the various clinical and practical competencies expected of doctors. This includes inpatient and outpatient training and experience; knowledge of respiratory anatomy, physiology, pathology, microbiology and pharmacology; intensive care medicine; and radiological and imaging techniques.

It lists a number of "essential areas of training" for which doctors may need to attend an approved course, such as those offered by the BTS.

Desirable qualities for a respiratory specialist include an aptitude for practical procedures, an empathetic approach to patients with chronic disorders, and the ability to stay calm and make decisions in an emergency situation.

The BTS, said to be one of the most active societies in the UK with a reputation for being "friendly and progressive", also welcomes enquiries from doctors who are considering a career in the specialty.

The job

Respiratory physicians are almost exclusively hospital based, with a large part of their work providing acute inpatient care. At least twice a week they can expect to lead ward rounds with junior medical staff, ward nursing staff, and respiratory physiotherapists.

A career guide from the BTS describes how, as around one third of all acute medical admissions are due to respiratory problems, many respiratory physicians also choose to have a general medical commitment and

participate in "medical takes", which often entails looking after patients whose primary problem is not necessarily a respiratory disorder.

It adds that most respiratory physicians supervise non-invasive ventilation in the support of patients with acute respiratory failure in the high dependency unit environment, and many have sessions helping to run intensive care services and expertise in the management of adult respiratory distress syndrome.

In some regions, highly specialised respiratory units have been set up to offer complex care for issues such as lung transplant, sleep related medical problems and adult cystic fibrosis. For most units the care largely focuses on acute respiratory and general medicine.

As with many specialists, working within a multidisciplinary team is a prominent part of the respiratory physician's role. They have close relations with specialist respiratory





nurses, community respiratory teams, respiratory physiotherapists and specialist respiratory technicians as well as other medical staff. There are also close links between the specialty and both radiology and thoracic surgery.

In addition to clinical and research skills, specialists have considerable technical abilities. Common procedures include bronchoscopy (both diagnostic and, increasingly, interventional); pleural procedures including pleural biopsy and chest drain insertion; medical thoracoscopy for the more invasive investigation of pleural effusion; and non-invasive ventilation. They are also responsible for providing the non-invasive ventilation services as well as the sleep services in most hospitals.

Respiratory specialists have considerable expertise in cardiopulmonary physiology and run lung function laboratories in most hospitals for the interpretation of complex lung function testing, a cornerstone of respiratory diagnosis. In the outpatient setting, respiratory physicians run the services for lung cancer and tuberculosis (TB) in most

trusts.

There are great opportunities to subspecialise or remain general. While there are no formally recognised sub specialties, there are a number of important "special interest" areas: adult cystic fibrosis, pulmonary hypertension, lung transplantation, domiciliary non-invasive ventilation, lung cancer, sleep breathing disorders and TB.

The specialty has a strong future. It is increasingly recognised that respiratory physicians are best placed to manage asthma, while the number of adult cystic fibrosis and COPD patients requiring specialist care continues to rise. Technical skills are also increasing, with expansions in interventional bronchoscopy and more widespread use of medical thoracoscopy.

With such a diverse range of pathways to follow, respiratory medicine promises a challenging and ever-changing career for doctors.

Sources:

- The British Thoracic Society - *A career in respiratory medicine* - tinyurl.com/hqfdvt2
- *Specialty training curriculum for respiratory medicine* - tinyurl.com/hgz9ycs
- For doctors by doctors: <http://www.fordocorsbydoctors.co.uk/home/career-development>



Q&A

Dr Elin Roddy,
consultant
respiratory
physician at
Royal Shrewsbury Hospital

What first attracted you to respiratory medicine?

I did respiratory medicine as my very first job after qualifying, and then again as an SHO. The respiratory physicians I met during my early training were hugely inspiring - supportive, compassionate and knowledgeable. It wasn't until I went to Australia, though, and learnt to bronchoscope that I truly knew that my future lay in respiratory medicine.

What do you enjoy most about the job?

I really enjoy the huge variety that I experience from day to day, and the sense of team working. I have also been able to do a lot of my training flexibly, and now work part-time which is important for me as it means I can balance family life with a rewarding career.

What do you find most challenging?

The burden of the general medical take can sometimes make focusing on specialty issues a challenge.

Has anything surprised you about the specialty?

I'm surprised that I haven't yet found a respiratory physician I don't like!

What do you consider the most important attributes of a good respiratory specialist?

The ability to work well in a team and see others' points of view is crucial. Good

communication skills are vital for all doctors, but particularly in respiratory medicine where many of our patients have chronic disease and an uncertain prognosis. An interest in respiratory physiology and how it translates into pathology is vital, and the ability to think calmly and critically is crucial.

Is there any advice you could give to a final year or FY trainee considering respiratory medicine?

It is very useful to spend some time with a respiratory consultant. Make sure that you go to some specialist clinics - lung cancer or cystic fibrosis, for example - and have seen a bronchoscopy being performed. It is good if one of your audits or QI projects has been based in respiratory, too - the British Thoracic Society do a number of annual audits for which willing data collectors are always required. Try to find a mentor within the specialty who can encourage and support you.

BEFORE YOU GO...

All foundation doctors have to fill out discharge forms for patients leaving hospital. **Dr Naeem Nazem** offers advice on getting this vital task right

THE life of a foundation year doctor is by no means a quiet one. Whether you are clerking new patients, providing ward cover or managing your own team's patients, the list of tasks to get done can seem endless.

One inevitable – and very important – job for all foundation year doctors is completing the discharge form. Whether your hospital uses an electronic system or remains with the more traditional hand-written form, most patients will need a completed discharge form before they leave the hospital.

You may be approached to complete discharge forms for patients at the end of a registrar or consultant-led ward round. Or you may be bleeped to be told that one of your patients is now fit for discharge. Perhaps the most disheartening situation is when you are on-call covering the wards and receive a bleep asking you to complete one (or often more) discharge forms for patients you have either never met or know very little about.

Bottom of the pile?

Foundation doctors quickly realise the necessity of prioritising their work based on clinical need. In most occasions it is simply not possible to complete jobs the moment you are given them. You may feel that patients needing discharge forms are fit to leave hospital and so they can wait until you have addressed the clinical needs of sick patients. Although no one could argue with your logic, patients and their families are often desperate to leave hospital as soon as they have been given the green light. It is therefore very helpful to inform ward staff at an early stage if you are swamped and won't be able to complete a discharge form so that they can manage the patient's expectations.

Some doctors take a different view. They consider discharge forms as "quick jobs" and are keen to clear them out of the way to make their task list more manageable. You may attend a ward to find several forms waiting for you and feel the urge to blitz through them at the same time

as you re-write the endless prescription charts that have run out. There is some rationale to this approach – it will certainly enable ward staff to turnaround the bed more quickly, making it available for the next patient.

Think differently

Whenever you feel the urge to hastily complete a discharge form it is worthwhile taking a moment to consider what happens once the patient leaves the relative safety of the hospital premises. From feedback we have received at MDDUS from GPs, the discharge form is often the only piece of information they have on the patient's hospital care and treatment. You may have commenced some medicines and stopped others, or asked the GP to monitor or follow-up an outstanding issue. In the absence of a complete discharge form, a patient's GP can only rely on the patient's recollection of events, which we all know can often be very poor.

The extra few minutes you take to complete a discharge summary thoroughly can make a huge difference to the patient's care after they leave your hospital. Unfortunately, GPs are under as much time pressure as hospital doctors and therefore often do not have the time to call hospitals to find out what treatment their patients received. It is therefore all the more important that their colleagues in secondary care provide them with all the relevant information they need to continue a patient's care in the community.

The GMC also provides guidance to doctors in their core guidance *Good medical practice* (2014) which states at paragraph 44 that doctors "must contribute to the safe transfer of patients between healthcare providers ... you must share all relevant information with colleagues involved with your patients' care".

Dual benefits

When you complete and sign a discharge form, even if it is for a patient you don't know that well, you are acting as the hospital representative





"Some doctors consider discharge forms as 'quick jobs' and are keen to clear them out of the way"

responsible for transferring the ongoing care from secondary to primary care. You are accountable for the information you provide to the community doctor and any potential harm that may occur if you omit relevant information.

MDDUS has dealt with numerous cases where the misreading of a discharge form, or absence of relevant information, has resulted in patient harm. An example includes when a medication has been stopped, but no reason or explanation has been recorded on the discharge form. As a result it is not noticed by the GP who may have received a pile of other discharge summaries that same day. The patient could then receive a repeat prescription from their local practice including the omitted medicine.

Similarly, we have encountered cases in which patients have not been followed-up in the community following a new diagnosis or abnormal result because it has either been omitted from the discharge form or was illegible.

Although you may anticipate the GP will receive more detailed correspondence from the hospital after your discharge form, unfortunately this often either does not take place or is lost.

Getting help

Many hospitals have their own proforma and guidance notes to complete

discharge forms. Your hospital may also use an electronic system, which should reduce the risk of legibility difficulties, although you should be mindful of the additional risk of predictive text errors and ignoring pop-up messages about drug interactions.

If you are unsure how to complete a particular discharge form, consider consulting a senior team member to make sure you have included everything that the patient's GP needs to know. The ward pharmacist and nursing staff are also valuable sources of information and support.

Help is also available from external bodies such as the British Medical Association or the Royal College of Physicians, which has useful guidance on record standards on its website (tinyurl.com/h2cq6t9). Section four of the RCP guidance provides suggested headings for discharge forms (both paper and electronic) and you may want to check your own form against this checklist. It also provides examples of what information, including relevant positive and negative findings, should be contained within each heading. If you find the boxes within your discharge forms are too small to fit all the necessary information, continue on an additional form. You should then number each form and indicate the total. This is much better than writing in a microscopic text to include everything on one form, which may be barely visible at all on the third carbon copy.

In summary

You have numerous demands on your time with colleagues asking you to do things as fast as you can to help them to do their job. In each case, try to make decisions that you are happy with, weighing up the need to provide a detailed discharge form with other clinical obligations and the wider needs of the hospital.

Dr Naeem Nazem is a medical adviser at MDDUS and editor of FYI

MENDING WHAT'S BROKEN



Adam Campbell talks with artist-doctor Katy Shorttle on the unique cross-fertilisation in her twin-track career

IF YOU want something done, ask a busy person, the saying goes – it's counterintuitive, but at some level we all know it makes sense. There are just some people who seem to be able to cram more hours into a day than the rest of us, to the point where you can't help thinking they must be working in their sleep.

For Dr Katy Shorttle, this turns out literally to be the case. Talking about the challenges of her working week, which up until recently involved simultaneously training to be a GP and doing a master's degree in illustration, she says of her art: "I think there is a lot of subconscious thought that goes on. You might be thinking about something and then you'll think about it in your sleep and when you wake up, you realise, oh yes, I could do this."

There has even been the odd occasion when sleep was not an option. "I once had a deadline for an art project after a series of night shifts in hospital where I was trying to do art work in between. I ended up finishing the night shifts on a Monday morning and staying up all day to finish my project to hand it in that afternoon," says the 29-year-old, laughing.

Her twin-track career has its obvious difficulties. The seemingly endless process of getting through a medical degree and the subsequent training is gruelling enough on its

own – adding another degree to the mix might seem like folly. But when it comes to art, Katy says, there isn't really a choice. "I think that if you have to do it, you have to do it. It's just how you feel."

Drawing a diagnosis

This irresistible creative urge is what first led Katy to take a year out between her preclinical and clinical studies at Cambridge University in order to do a foundation in art. She had always done painting and drawing in her spare time but wanted some more formal training



"Being a doctor brings a level of maturity that I didn't have on my art course"

to bolster her range of techniques and ideas. Later, during her FY2 year, she discovered it was possible to do GP training on a part-time basis, and this was when she hatched her plan to embark on an MA in illustration at the same time.

By this time she had begun a blog entitled *Drawing a Diagnosis*, which included sketches of patients (drawn with their permission) alongside a description of their conditions. The blog developed out of a daily visual diary she had started during an elective in Cape Town, illustrating the effects of HIV and tuberculosis on people's lives, and she was increasingly finding that her medical experiences were informing the direction in which she wanted to take her art.

"I think being a doctor brings a level of maturity that I didn't have when I did my art foundation course. I struggled to find the subject matter that engaged me. By the time I applied for the MA I'd done only two years of working as a doctor but they were very formative years and those experiences focused me in terms of my art."

This focus led her to produce a fascinating body of work on frailty and the elderly, which was recently on display at Anglia Ruskin University where she did her MA. It was also featured in *The Guardian* newspaper. "It's a topic that I feel is really important. A lot of my jobs have been working with the elderly and that's one of the projects I'm most proud of, which I feel is most resolved in terms of its message."

Exploring frailty

The project features a series of teacups, each given a person's name and each one altered in some way to depict that person's situation.



PHOTOGRAPHS: COURTESY OF DR KATY SHORTTLE

Clockwise from below left: Doctor and artist Katy Shorttle; the "Shirley" teacup; "Bill"; an art installation featuring mumps; artwork focused on Ebola; and "Susan".

Susan, represented by a teacup set into molten soap, is chronically short of breath, barely able to ascend the stairs. It's a frustrating condition that has seen her waking up at night with the feeling that she is drowning.

Then there's Shirley, depicted by a broken cup haphazardly reassembled in combination with rows of tablets. In order to escape her chronic pain, Shirley once took an overdose of paracetamol. Bill, a former farmer disabled by a stroke – and also Katy's beloved grandfather – inspired a fractured cup supported on twigs and encircled with dried autumn leaves.

Bill, who recently passed away, was one of the inspirations for the project. "He was independent to the end," Katy says. "Even though he lived on his own, he would throw a Christmas dinner for the lonely elderly. He had his own iPad and was a kind of antidote to the normal stereotype of the elderly, which I found quite inspirational."

And the teacups? "They were just a vehicle," says Katy. "I think removing the literal representation of a person gave me the freedom to think about the issue more conceptually and communicate that, rather than depicting an actual person, which would be more limiting."

But, she adds, there's also something to be said about the function of a cup that is cracked or broken. "If you break them and then mend them, and they're decorative, is that a valid function or are they now defunct? That question is, I think, quite interesting in terms of society's interpretation of the elderly. Is that what people think of them? Do they still have a role?"

As with the frailty project, Katy's other projects also tend to be centred on medical

"Thinking about medicine more widely is bound to have a positive effect on your practice"



issues. She's looked at the spread of measles, mumps and rubella, in response to the falling numbers of children receiving the MMR vaccine. Another project examined the Ebola outbreak and the way it was reported outside of Africa, and she has even done a series of bittersweet illustrations of animals with ailments.

Art inspiring medicine

And just as Katy's medical experiences have had a positive influence on her art, so the

reverse is true. She says: "I think any time you spend outside the medical field reflecting, looking at your experiences or thinking about medicine more widely is bound to have a positive effect on your practice, because you're a more considered and thoughtful doctor. I think that's always helpful to do in a caring profession when you're dealing with people in difficult situations."

The harmonious nature of her twin careers has also helped to allay any potential fears that a split focus might cause one to dilute the other. Similarly, any concerns she might have had about training on a part-time basis, something usually associated with Olympic athletes or those having particular care responsibilities, have long been shelved. It has meant her full-time colleagues move on more quickly and she has to get used to working alongside new people a lot of the time, but there are positives as well as negatives in that, she says.

Her approach may not be for everyone, says Katy, but it is an option she would recommend to young doctors with a burning desire to pursue other ambitions in addition to medicine. In her case, she says, having another outlet has proved beneficial rather than harmful to her medical training.

"I found a balance by doing something that I'm really passionate about as well as medicine. I'm lucky to have found a way to combine these two things. I think taking a little step back from medical training has allowed me to enjoy it a lot more."

Adam Campbell is a freelance journalist and regular contributor to MDDUS publications

'MILD' HEADACHE



Day 40

A consultant at the rapid assessment clinic examines Ms B and notes that apart from the reported headache the neurological examination is unremarkable. He refers the patient for a CT scan. This reveals an acute on chronic subdural haematoma and Ms B is referred for urgent neurosurgical intervention. The procedure proves complicated due to long-standing blood clots and two days later Ms B suffers another bleed and requires a further procedure.

Day 39

Ms B is brought in to A&E by a friend suffering from a severe headache and unsteadiness on her feet. She is assessed by emergency staff and later discharged home with a referral to a rapid assessment clinic at the hospital the next day.

Day 1

Ms B is 64-year-old diabetic and attends her GP surgery for a routine discussion of her repeat prescription. In the consultation with Dr M the patient mentions that two weeks ago she had a spill on her bicycle and banged her head on the pavement though she was wearing a helmet. Since then she has been suffering some mild headaches. On further questioning, Ms B reports that there have been no associated symptoms such as loss of consciousness or visual impairment. The GP also checks her blood pressure and pulse and examines the central nervous system and no abnormalities are detected. Dr M advises Ms B to return if the headaches have not resolved within two weeks.

Day 27

Ms B attends the surgery complaining of neck pain shooting up into her head and around her ears. The pain is making it difficult for her to do her yoga class three times a week. Ms B mentions again the bicycle accident and the recurring headaches but says there is no pattern and speculates that it "probably has nothing to do with that". Dr M takes the accident into consideration and in the notes records that there is no reported vomiting, drowsiness or confusion. In the end he diagnoses neuropathic pain possibly associated with previously diagnosed cervical spondylosis. He prescribes amitriptyline and advises Ms B to contact the surgery again if the prescription is not effective or there are any side effects.

TEN months later Dr M receives a claim for damages from solicitors representing Ms B. It is alleged the GP failed to identify that the patient had suffered a severe head injury and then further refer Ms B for a CT scan that would have revealed a subdural haematoma. It is claimed that this led to Ms B suffering severe pain over an extended period of weeks and also more complicated surgical treatment.

MDDUS commissions a medical expert to assess the patient records and accounts from the GP and the patient. In her statement Ms B claims that she presented to the practice on two occasions with severe and intense headaches but this is at odds with contemporaneous notes in which the headaches are described as "mild". The notes also reveal that the GP considered the possibility of head injury in that he recorded that there were no associated symptoms.

In the second consultation the complaint is of neck pain. The expert concludes that again with no history of loss of consciousness, confusion, dizziness, vomiting or visual disturbance it would be perfectly reasonable to suspect a problem with the cervical spine given the patient's history.

The expert writes: "This is a diagnosis that any ordinarily competent GP would have arrived at".

On this basis the expert concludes that Dr M would have had no grounds to refer the patient for specialist neurology assessment after either consultation. Indeed he believes the evidence points to a deterioration of Ms B's condition sometime in the 12-day period after the second examination by Dr M.

MDDUS lawyers write back to the patient's solicitors denying the breach of duty of care. The claim is subsequently dropped.

KEY POINTS

- Disputing patient claims is difficult without adequate notes.
- Record relevant negative as well as positive findings.
- Have a high index of suspicion over persistent headaches following head injuries.

OUT THERE

SELFLESS TO DE-STRESS Tense doctors take note. Helping others can mitigate the impact of daily stressors, according to research published in *Clinical Psychological Science* journal. Even small gestures like holding open a door can increase positive emotions and help you cope with stress. Those less inclined to assist others were found not to handle stress as well.

SAD APP What's more depressing than being depressed? Well it could be relying on your smartphone to tell you so. Researchers in Chicago have developed an app that detects possible signs of depression. These include spending excessive time on your phone or being always at home or in fewer locations. Having a less regular daily schedule is also suspect. It's thought the app could be used to monitor people at risk and even offer help or to "deliver the information to their clinicians". Coming soon: the paranoia app.

TESTOSTERONE-FUELLED TRADING An experiment involving financial traders has found elevated testosterone levels led to more risky investing. Traders given doses of either cortisol or testosterone invested in more risky assets than a control group. Spanish researchers concluded that hormonal changes may explain reckless behaviour among traders in periods of financial instability.



WHAT ARE WE LOOKING AT?
Stumped? The answer is at the bottom of the page

PHOTOGRAPH: STEVE SCHMEISSNER/SCIENCE PHOTO LIBRARY

Pick: DVD - Still Alice



Directed by Richard Glatzer and Wash Westmoreland. Starring Julianne Moore, Alec Baldwin, Kristen Stewart.

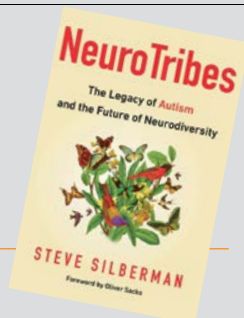
THIS critically-acclaimed drama tackles the emotive issue of early-onset Alzheimer's disease, exploring the toll it takes on linguistics professor Alice (Moore) and her family, including husband John (Baldwin) and daughter Lydia (Stewart). Moore's engaging (and Oscar-winning) performance is at the heart of this film's appeal. Opening

the story at the height of her career, a forgotten word signals the beginning of a sharp mental deterioration. The film's understated approach perfectly avoids slushy sentimentality or melodrama, instead offering an often biting honest and painfully sad portrayal of a woman forced to confront the loss of her very self. Alice's wealth conveniently side-steps stickier issues over palliative care costs, but it does offer some interesting insights into the effects of this cruel and devastating disease.

Book Review: NeuroTribes: The Legacy of Autism and the Future of Neurodiversity

Allen& Unwin; £11.89 paperback

Review by Jim Killgore,
publications editor, MDDUS



IN the introduction to his book *NeuroTribes*, science writer Steve Silberman admits that prior to embarking on his research: "Everything I knew about autism I had learned from *Rain Man*, the 1988 film in which Dustin Hoffman played a Savant named Raymond Babbitt who could memorize phonebooks and count toothpicks at a glance."

The genesis of the book - which has won the 2015 Samuel Johnson Prize for Non-Fiction - was an assignment to cover a "Geek Cruise" for *Wired* magazine, in which Silberman spent a week sailing up the Alaskan coast with a group of top software coders or "digital natives with their own history, rituals, ethics, forms of play, and oral lore".

In the course of writing the article he encountered a curious phenomenon - an apparent "epidemic" of autism among children in Silicon Valley near San Francisco, the so-called cradle of the information

technology industry. It had become cliché to joke that many of the programmers and engineers working at companies like Adobe or Intel were "on the spectrum". Indeed one supervisor at Microsoft told Silberman: "All my top debuggers have Asperger syndrome."

Was there a connection between these observations and the higher incidence of autism among children in the Valley?

This question is the starting point for a fascinating and amazingly comprehensive overview of more than 70 years of autism research starting in the early 1940s when the syndrome was "first" identified serendipitously by two doctors on opposite sides of the Atlantic: Leo Kanner and Hans Asperger.

The book also explores the desperate and heroic efforts of frustrated parents of autistic children looking for cures or simply the means to manage a debilitating condition among a morass of confusing research findings and often dubious theorising.

A central and recurring theme in the book is the notion that autism need not be regarded as a condition to be cured but as a naturally occurring "cognitive variation" with "distinctive strengths that have contributed to the evolution of technology". Surveying the history of science Silberman considers numerous examples of individuals who today would no doubt be diagnosed with Asperger syndrome, including the eccentric English physicist Henry Cavendish, who in 1797 used an ingenious apparatus of rods and lead balls to determine the mass of the Earth.

At the book's core is the idea that, given the right circumstances and support, many people "on the spectrum" can live happy, productive lives.

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