



CUTTING EDGE

The rise of women in surgery

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Welcome to your FYi

DOCTORS have a privileged position in society and patients trust us not to abuse that position. Key to that is maintaining appropriate professional boundaries - but the right course of action isn't always clear. My article on [page 12](#) looks at prescribing requests from friends, personal relationships with patients and Facebook friend requests.

Do you know what it takes to be a "good doctor"? Our article on [page 4](#) offers a useful overview of the GMC's professional guidance for trainees. Making the transition from F1 to F2 brings lots of new responsibilities. Read the latest advice from the UKFPO on [page 5](#).

The way doctors consent patients for treatment changed subtly but significantly last year. Find out what this means in practice on [page 7](#). All doctors have to do it - but what exactly

does reflective practice entail? MDDUS medical adviser Dr Greg Dollman provides some insight on [page 6](#).

Women currently make up just over 10 per cent of consultant surgeons in England - but one initiative is hoping to change all that. On [page 10](#) Miss Nicola Stobbs talks more about the Women in Surgery programme and the challenges of working in a "man's world".

With cancer diagnoses continuing to rise, the demand for specialists in the field of histopathology is sure to increase. Our article on [page 8](#) takes a closer look at the career opportunities in this fascinating speciality.

And finally, our case study on [page 14](#) highlights the case of an infected wound following knee surgery.

• **Dr Naeem Nazem**
Editor

WORKING CLASS STILL MINORITY IN MEDICINE

ONLY four per cent of doctors are from working class origins, according to a new report from the Social Mobility Commission.

Despite efforts to change the social make-up of the professions, the report found people from poorer backgrounds were largely locked out. While medicine fared the worst, the legal profession wasn't far behind with only six per cent of barristers from working class origins and 11 per cent of journalists.

The *State of the Nation 2016 - Social Mobility in Great Britain* report noted that, despite initiatives to improve attainment in schools, "the link between social demography and educational destiny has not been broken: over the last five years 1.2 million 16-year-olds - disproportionately from low-income homes - have left school without five good GCSEs." Only five per cent of children eligible for free school meals gained five A grades at GCSE.

The income gap, the report said, is larger than either the ethnicity gap or the gender gap in schools. A child living in one of England's most disadvantaged areas is 27 times more likely to go to an inadequate school than a child living in one of the least disadvantaged.

Medicine remained "one of the most inaccessible professions," said the report, with "80 per cent of medical school applicants coming from around only 20 per cent of schools, the majority of which were independent or grammar schools." The report also pointed out that there wasn't a single applicant for medical school from half of all the sixth forms in England between 2009 and 2011.



NEW GUIDANCE ON SURGICAL CONSENT

NHS trusts face a dramatic increase in litigation payouts if they do not make changes in patient consent processes prior to surgery, warns the Royal College of Surgeons of England.

The College believes clarification is needed in the understanding of patient consent in light of the 2015 landmark judgment given in the Supreme Court case of *Montgomery v Lanarkshire Health Board*. It's published new guidance to help doctors and surgeons understand the shift in the law and its implications, as well as give them tools to assist in improving their practice.

The NHS Litigation Authority (NHSLA) paid out over £1.4 billion in claims on behalf of NHS trusts in England during 2015/2016 and the RCS is concerned that this bill could go up significantly if hospitals do not take the Montgomery ruling seriously.

The Montgomery ruling set a legal precedent clarifying how the courts should view the consenting process. The court held that patients must now be made aware of any and all risks that they - not the doctor - might consider significant. Doctors can no longer be the sole arbiter in determining what risks are material to the patient.



UK INDEMNITY, ADVICE & SUPPORT

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CONNECT

Innovation in communication



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PRINT:

Printwell
www.printwell-ltd.co.uk

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FYi is published by The Medical and Dental Defence Union of Scotland, Registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Articles of Association.

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GMC PLEDGES "LIGHT TOUCH" TO ADDRESS DOCTORS' UNEASE



THE GMC has expressed concern at "unease" within the medical profession in its annual report *The state of medical education and practice in the UK*.

The regulator noted growing pressure on doctors, a "dangerous level of alienation" felt by doctors in training, and the impact which struggling healthcare services are having on doctors' education and training.

GMC Chair Professor Terence Stephenson and the then Chief Executive

Niall Dickson said: "There is a state of unease within the medical profession across the UK that risks affecting patients as well as doctors. The reasons for this are complex and multifactorial, and some are longstanding. Yet the signals of distress are unmistakable.

"There appears to be a general acceptance that the system cannot simply go on as before."

The report says the GMC has a role to play in addressing this unease by making regulation as "light touch as possible", reassuring trainees that they are valued doctors and addressing the anger and frustration which has built up during the ongoing dispute in England between the BMA's Junior Doctors' Committee and the Government.

The GMC has recently launched a special review to explore how postgraduate training can be made more flexible for doctors in the future. The regulator says it also wants to play more of a role supporting those engaged in workforce planning - to make sure doctors have the right knowledge, skills and standard of behaviour to serve patient needs in the years ahead.

"SOFT OPT OUT" ORGAN DONATION CONSULTATION

PLANS for a "soft opt out" system of organ donation - where consent is presumed unless the patient opted out - have been put out for consultation by the Scottish Government.

The move is a bid to find ways of increasing the number of organ and tissue donors.

Among the proposals are plans for a soft opt out - or deemed authorisation - system. This would allow organ and/or tissue donation to proceed when a person dies in hospital unless they had opted out via the NHS Organ Donor Register or had told their family they did not wish to donate.

The consultation also wants views on whether clinicians in Scotland should be given guidance to encourage them to refer potential organ or tissue donors to specialist donor staff, so that the possibility of donation can be explored at an earlier opportunity.

The NHS in Scotland has already seen a 29 per cent increase in deceased donors in the eight months since April compared to the same period last year - rising from 60 to 85. As at December 4, 2016, there were 531 people in Scotland on the active transplant waiting list.

The consultation is open until March 14, 2017 on the Scottish Government website tinyurl.com/hqjpsqg



HEAVY WORKLOADS ERODE TRAINING

OVER 43 per cent of doctors in training have reported their workload as 'heavy' or 'very heavy', prompting concern at the GMC that training time is being eroded.

These findings emerged from the 2016 national training survey in which the GMC canvassed opinions from around 55,000 doctors in training. While most continue to rate their training experience positively, there were areas of concern.

Among those trainees reporting their daytime workload as 'very heavy' or 'heavy', this was most marked in emergency

medicine (78 per cent), gastroenterology (63 per cent), respiratory medicine (61 per cent), general internal medicine (60 per cent) and acute internal medicine (59 per cent). All these percentages have increased over the last five years.

The survey also revealed that over half of doctors in training reported working beyond their rostered hours, and up to 25 per cent said their working patterns left them sleep-deprived on a weekly basis - another worsening trend in recent years.

Doctors with excessive workloads said

they were more likely to have to leave teaching sessions to answer clinical calls and were forced to cope with clinical problems beyond their competence and often with inadequate handovers from colleagues.

GMC Chief Executive Charlie Massey said: "Those responsible and accountable for the delivery of medical education locally must take appropriate steps to ensure the training of doctors remains protected."

Dr Pete Campbell, BMA junior doctors' committee chair, added: "Patients and the public may be shocked by these findings, but no junior doctor will be surprised. It is still far too common that junior doctors are left sleep deprived after regularly working beyond their rostered hours, on rotas that are desperately short of doctors. We cannot accept a situation where vital training time is being sacrificed in the face of rising pressures on services."





THE **GOOD** DOCTOR

Do you know what it takes to be a good doctor? The General Medical Council has some practical new advice for trainees

WITH so much to learn as a trainee doctor, it's easy to put off thinking about the professional standards that form the backbone of clinical life. But the sooner you get to grips with these, the sooner you can establish positive habits that will set you in good stead for the rest of your career.

The General Medical Council has drawn up practical guidance: *Achieving good medical practice: guidance for medical students*.

One of the first lessons for would-be doctors is that they are expected to maintain a high standard of professional behaviour at all times – both in their clinical life and in their personal life. As the GMC explains, your behaviour “must justify the trust that patients and the public place in you as a future member of the medical profession.” All doctors must register with the regulator and “the GMC won’t register medical graduates who are not fit to practise medicine.”

The new guide is wide-ranging but areas of concern include a lack of engagement with training, poor communication skills, being rude to patients/colleagues, and an unwillingness to learn from feedback. Also problematic are misleading patients about their care, breaching confidentiality or engaging in racist/sexist or other forms of harassment.

Competence

It can be daunting for trainees treating real patients during clinical placements, and one of the most important skills the GMC highlights is recognising your limits and working within your competence. Don't be afraid to ask for help when you need it and make sure you clearly explain your level of competence to supervisors so you aren't asked to do anything you are not trained to do.

Similarly, always introduce yourself to patients and check they are happy to have a medical student present. Be honest with

patients if you don't know the answer to their questions – they appreciate you are there to learn.

Confidentiality

This is key for all healthcare professionals and something you must always be conscious of, whether you are on the wards, chatting socially with friends or commenting on social media. You must not disclose patient-identifiable information without their consent. That said, appropriate information sharing is essential to provide care but the GMC adds: “you must never share confidential information about a patient with anyone who is not directly involved in their care without the patient's permission.”

Raising concerns

Medical students have a duty to “raise any concerns you have about patient safety, dignity or comfort promptly”. The regulator appreciates trainees may not be comfortable reporting an issue to their supervisor/senior clinician, advising: “Wherever possible, follow your medical school's formal policy.”

Your health

Medical students with health problems that may risk patient safety must disclose it, again following your school's guidance. This can be as simple as a common cold which could harm those with compromised immune systems. It also extends to issues relating to stress, anxiety and addiction. The guidance suggests seeking help in the first instance from your GP or other appropriate sources, and that adjustments can be made to your training or practice if necessary. Always seek help early.

Team work

The GMC encourages students to contribute

to team work and treat all colleagues with respect. You must “work collaboratively with your teachers, trainers, administrative or support staff and fellow students, including those from other healthcare professions.”

Respect

The GMC is clear that doctors must always maintain appropriate professional boundaries and avoid “expressing your personal beliefs to patients in ways that exploit their vulnerability or would cause them distress.” Showing respect also includes being open and honest when something goes wrong in the care you've provided. The GMC advises telling your supervisor as soon as possible. “Your supervisor will support you, and if necessary will help you to put things right, which may include explaining to the patient what has happened and offering an apology.”

In summary, medical students are asked to:

- recognise the limits of their competence and ask for help if they need it
- be honest when they don't know something
- raise concerns about the safety, dignity and comfort of patients
- protect patient identifiable information
- seek help from their medical school if they have a health condition which may affect their studies
- be open and honest when something goes wrong in the care they've provided.

Link:

- GMC – *Medical students: professionalism and fitness to practise* – tinyurl.com/zv24c3d

Joanne Curran is an associate editor of FYi

Get ready to transition from
F1 to F2 with these practical
tips from the UK Foundation
Programme Office

TAKING THE NEXT STEP

STARTING your first year of foundation training is a big step and there is plenty of advice around for new doctors getting ready to take the plunge.

Moving into your second year of training (F2) is just as challenging, yet specific guidance is a little harder to come by. This transition brings new duties and responsibilities, and there are a number of key areas to consider.

Leadership

As an F2 doctor you may no longer be the most junior person on the medical team. Chances are you will have F1 doctors (and possibly also medical students) looking to you for advice and support, and you will be able to start developing your leadership skills. As well as starting to supervise others, your individual responsibilities will increase. In some F2 posts you will need to make important decisions about admission to or discharge from hospital; this is particularly the case in posts such as A&E. You may also start to consent patients for a wider variety of procedures – it would be worthwhile to familiarise yourself with the GMC's guidance *Consent: patients and doctors making decisions together*.

Legal differences

When you gain your full General Medical Council registration as an F2 doctor, there are certain changes in what you are allowed to do. For example, you will be able to write outpatient prescriptions and detain patients under section 5(2) of the Mental Health Act, both of which you were unable to do as an F1 doctor.

You should remember, however, that even F2 doctors are still required to work in "approved practice settings" (APS) until this requirement is removed by the GMC. This means new doctors have to work in a place that provides "appropriate supervision and regular appraisal". Systems must be in place to identify and act upon concerns about a doctor's fitness to practise; support the provision of relevant training and continuing professional development (CPD) for doctors; and provide regulatory assistance. More information is available on the GMC website at tinyurl.com/gtrnycr.

Different posts

During your F2 year, you may find that the type and setting of your placements are more

diverse. For example F2 posts in general practice, psychiatry and public health are much more common than they are in F1. This may place you in relatively unfamiliar environments, and help you develop more flexibility in your clinical practice.

For many trainees, F2 rotations are in the same hospital as their F1 year. This will allow for some continuity and will help make the change a little less daunting than if you were starting at a completely new hospital. While you may be working with different teams in each job, you may still see some familiar faces from the past year.

Study leave and budgets

As an F2 doctor, you will be entitled to around 30 days of study leave. Some of these days will be pre-allocated by your training provider/employing organisation (e.g. for in-house teaching, ALS course, etc.), however the remainder can be used for activities such as taster days, approved courses and research. With more than 60 medical specialties to choose from in the UK, tasters can provide a valuable insight for those struggling to decide which field is right for them. Those looking to take part can spend up to five days in a taster as they consist of either a single five day experience in one specialty or shorter periods of time in two or even three specialties. It is rare for a trainee to go on a taster that isn't conducted by their own employing organisation due to the need for checks, issues over employment status and financial constraints.

Although study leave can't be used to prepare for specialty exams, you are allowed to use a day to sit the exam itself. You will also be allocated a certain amount of money as part of your study budget that can be spent on events such as courses and conferences, although the exact amount varies between foundation schools.

Revalidation and ARCP

The beginning of F2 marks the start of a five-year GMC revalidation cycle that all doctors are required to participate in. This essentially involves demonstrating to the GMC every five years that you are up-to-date, fit to practise and are complying with the relevant professional standards. At the end of F2, and yearly throughout the rest of your training, you will also take part in the Annual Review of Competence Progression (ARCP), as you did during F1.

Future career planning

Many doctors make important decisions about their future career during F2. The core and specialty training application window comes along early in the year, so it is important to plan for this if you intend on applying. That said, many F2 doctors choose not to go straight into core or specialty training and take time out to decide on their future career path.

- Read the UKFPO's *Rough Guide to the Foundation Programme* (June 2015), at: tinyurl.com/hdq52fp



THE ART OF REFLECTION BEFLECTION

All doctors have to do it, but what exactly does reflective practice entail?
Dr Greg Dollman offers some insight

REFLECTIVE practice divides opinion like Marmite: doctors either love it or hate it. Mention reflection, and you're bound to get an emotive response. Some argue it is a box-ticking exercise, that it does not improve patient outcomes and leaves doctors vulnerable to criticism. But it is something we are professionally obliged to engage with. Recently, the argument against this practice was invigorated when a doctor's reflections written in their NHS e-portfolio was used against them in a legal case. This prompted the Academy of Medical Royal Colleges (AoMRC) to issue detailed guidance – more of which later.

What is it?

Reflection involves carefully considering a personal experience. It goes beyond a description of the incident, rather exploring your actions as well as the circumstances at the time, your thoughts on it with the benefit of hindsight and the comments of others, and what impact it has had on you going forward.

Reflecting is not telling a one-sided story. It is a process of interpreting your, and others', thoughts about an event. It is a critical analysis of your involvement in the scenario and includes an acknowledgement of your feelings, opinions and attitudes as a result.

Why reflect?

The GMC reminds doctors, in its *Leadership and management for all doctors* guidance, to reflect regularly on their performance and professional values. This is an essential part of maintaining and improving patient care, as well as helping a clinician's self-development. Doctors are obliged to be reflective, and those who reflect on their everyday practice are considered to be insightful. Medical professionalism requires that doctors learn from their experiences and put patient safety, care and quality improvement first.

How do I reflect?

There are many different approaches and methods to reflective practice. This article does not aim to summarise these (or propose one over the other); rather it seeks to provide a broad overview.

Reflection happens in our everyday practice often without us realising it. By looking back at our actions we can learn from them with the advantage of hindsight. As a starting point,

doctors may wish to consider which structured approach they will adopt. If new to reflection, you may find it helpful to try a number of different methods to determine which works best.

First, describe what happened (setting out both the positives and negatives: What went well? What went badly?) and why (What were the contributing factors?). Then consider how the incident affected you, as well as others. Finally, present a clear action plan (this is possible only with a good understanding of why the event occurred).

It may be helpful to use established criteria when setting a goal or objective in your action plan. You must be able to outline, for example, what action you will take, who will assist with this, how you will achieve this and assess progress, and in what period of time.

Once the action plan has been put in place, the event (and the associated reflection) should be revisited to ensure learning has taken place, change has occurred and there is improvement as a result. New action plans may then follow such reviews.

Reflection is not a one-off event – it should be seen as a cycle that can be repeated as necessary. A doctor should consider the impact of their frame of reference at the time of the incident and subsequent reflections, what

others have said, how their thoughts and emotions have changed as time has passed, and how they would act in a similar circumstance in the future.

The following three steps should get you on your way:

1. Ask for guidance from a colleague or look at examples of reflective writing.
2. Write about something that stood out in your day.
3. Practice makes perfect.

Confidentiality

This leads us back to the issue of concerns over doctors' reflections potentially being accessed by a third party and used to criticise them. Under the Data Protection Act 1998 (DPA), a person (or their representative) can make a subject access request to obtain any personally-identifiable information that is held about them. It is advisable that doctors appropriately anonymise their reflections.

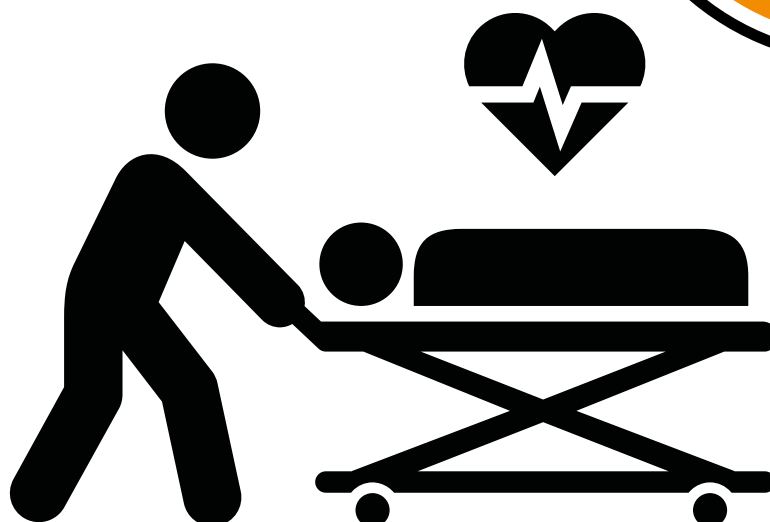
The GMC recognises that using information about patients is essential for education and training purposes and allows the use of anonymised data in these circumstances. Clearly in some cases the context alone may identify a patient. The AoMRC's new legal guidance on the disclosure of information in e-portfolios to third parties suggests the following:

- Anonymise all patient details as far as possible in reflective writings, including any distinctive medical facts. Healthcare professionals and other parties involved should also not be readily identifiable.
- If a subject access request is made and if it is established that the information within the log is a patient's personal data, it can be argued that a doctor's self-reflective log is exempt from disclosure under the DPA.
- In the event of litigation, the doctor could request a court order as their reflective writing contains third party information.

If in doubt, contact MDDUS for more detailed advice.

Dr Greg Dollman is a medical adviser at MDDUS





The updated approach to consent means focusing on the specific needs of the patient

PATIENT-CENTRIC CONSENT

CONSENT is one of the cornerstones of professional medical practice and it is a process that experienced doctors will have gone through thousands of times.

But in 2015 a landmark judgement given in the Supreme Court case of *Montgomery v Lanarkshire Health Board* signalled a subtle but significant shift in how this process should be undertaken. Essentially, doctors are now required to adopt a patient-centric approach to consenting – focusing on the specific needs of the patient, rather than simply on the risks the doctor thinks are important.

The case itself arose in 1999. When Nadine Montgomery gave birth to her son, Sam, staff had to resort to a forceps delivery aided by symphysiotomy after the baby's head failed to descend due to shoulder dystocia. Twelve minutes passed between the head appearing and delivery, during which time the cord was completely or partially occluded. Sam was diagnosed with significant cerebral palsy.

Later Mrs Montgomery – acting on behalf of her son – raised an action against the health board alleging negligence in that she should have been given advice regarding the risk of shoulder dystocia, being just over five feet tall and diabetic. She also alleged that it was negligent not to perform a caesarean section when abnormalities were noted on the cardiotocograph (CTG) traces.

The main focus of the appeal was in regard to the information given to Mrs Montgomery when she had expressed concern about being able to deliver her baby vaginally – though she had not asked specific questions regarding shoulder dystocia. Maternal diabetes is known to increase the risk of complications such as shoulder dystocia – which occurs in around 10 per cent of babies born to diabetic mothers. In around 70 per cent of cases it can be overcome by simple manoeuvres but a small proportion (much less than one per cent) result in permanent injury.

The consultant involved in the case did not advise Mrs Montgomery of the risk of shoulder

dystocia as in her view – supported by obstetric opinion – this was not warranted given the low probability of permanent harm. Mrs Montgomery argued that, had she been fully advised of the risks, she would have elected for a caesarean section. Mrs Montgomery took her case all the way to the Supreme Court in London and won.

The Montgomery case is important to all doctors involved in consent discussions with patients as it sets out what is expected in terms of information disclosure.

“Crucially, what a patient regards as significant may not accord with their doctor's view,” says MDDUS medical adviser Dr Naeem Nazem. “Therefore, a doctor is unable to determine, unilaterally, what is reasonable to disclose to their patient. Instead, doctors should seek to make a shared care decision with their patients, discussing every relevant issue for that individual patient.”

MDDUS has encountered cases in which there was a failure to effectively communicate the risks and benefits of a procedure to the patient. Cases have also arisen from a lack of detailed discussion between doctors and their patients regarding alternative treatment options and potential outcomes.

“This lack of communication and failure to involve the patient in choices regarding their care can erode the doctor-patient relationship,” says Dr Nazem.

As part of the consenting process, Dr Nazem says patients should be given sufficient information regarding diagnosis, prognosis, need for the procedure, potential material risks and benefits, likelihood of success and potential follow-up treatment as well as the alternative treatment options – including doing nothing. There are exceptions, such as when providing life-sustaining treatment in an emergency.

GMC guidance *Consent: patients and doctors making decisions together* states doctors should “share with patients the information they want or need in order to

make decisions” and “maximise patients' opportunities, and their ability, to make decisions for themselves.”

The Royal College of Surgeons (RCS) has also moved to highlight the importance of updating patient consent processes prior to surgery. They have recently published guidance and a decision-making tool for doctors alongside fortnightly podcasts.

The College states: “According to the judges in this case, doctors are no longer the sole arbiter of determining what risks are material to their patients. They should not make assumptions about the information a patient might want or need but they must take reasonable steps to ensure that patients are aware of all risks that are material to them.”

They set out a number of key principles underpinning the consent process including the need for discussions to be tailored to the individual patient. “This requires time to get to know the patient well enough to understand their views and values.”

Their guidance adds that material risks for all reasonable treatment options should be discussed with the patient and that the test of materiality is twofold: “whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely attach significance to it.” Consent should also be written and a careful note of discussions made in the patient record.

For more detailed advice, contact an MDDUS medical adviser on 0333 043 444.

Links:

- Royal College of Surgeons – Consent: Supported Decision-Making [tinyurl.com/zwcwcrxk](https://www.tinyurl.com/zwcwcrxk)
- MDDUS Risk Management eLearning centre – Consent video presentations - [tinyurl.com/j23u2ey](https://www.tinyurl.com/j23u2ey)

Histopathology involves more than peering down a microscope...

IT IS estimated that half of the UK population will be diagnosed with cancer in their lifetimes. This is a sobering statistic – and yet cancer survival is currently at its highest level ever. Recently Cancer Research UK commissioned some research on the implications of these trends on pathology services and found that the NHS faces some serious challenges in terms of capacity.

Staffing estimates suggest that the number of consultants in cellular pathology (encompassing histopathology and cytopathology) have increased but only by 1.2 to 3 per cent per year. In the next five to 10 years it is estimated there will be a serious shortage of consultants across all areas of pathology. The Cancer Research UK report concluded this will have the largest impact on cellular pathology as there is a shortfall of trainees compared to those leaving the profession.

No wonder the Royal College of Pathologists is keen to attract interested Foundation year doctors into training – and it is certainly worth considering whether histopathology might be the career choice for you.

Histopathology is essentially the study of changes in human tissue caused by disease. Histopathologists examine tissue sampled in clinics or removed during operations, assessing it both macroscopically and using sophisticated microscopic techniques. They work mainly in the laboratory in partnership with scientists and doctors from other clinical specialties and have an in-depth knowledge of both pathological and clinical aspects of disease.

The specialty is integral to cancer management through staging and the grading of tumours. Histopathologists also have key responsibilities in disease screening, such as for breast or cervical cancer.

DETECTING DISEASE

Entry and training

Following successful completion of foundation training, Health Education England (HEE) states that candidates applying for ST1 training in histopathology would be expected to have or develop a range of skills including:

- extensive breadth of knowledge, not just of histopathology, but of clinical and surgical practice
- an interest in the mechanisms of disease at the macroscopic, microscopic and molecular level
- an inquisitive mind and self-motivation
- good visual pattern recognition
- manual dexterity and hand-eye co-ordination
- good diagnostic skills to determine not only the type of disease, but also its severity and extent to ensure the right treatment is given
- excellent organisational and time management skills
- good problem-solving and decision-making skills
- the ability to work well alone and also within multidisciplinary teams (MDTs).

Entry into one of the UK's histopathology training programmes is



competitive and candidates would be expected to demonstrate an interest by involvement in activities, achievements and scientific meetings relevant to pathology, attendance at pathology courses and evidence of participation in audit/research projects that are relevant to pathology. You can download a full "person specification" from HEE at tinyurl.com/h4m76sj.

Training in histopathology normally takes five and a half years on the assumption that candidates will also be undertaking two optional training packages of three months each, either in cervical cytopathology, higher autopsy training or research methodology.

A Certificate of Completion of Training (CCT) is awarded on the recommendation of The Royal College of Pathologists following:

- evidence of satisfactory completion of the histopathology curriculum and the minimum training period
- satisfactory outcomes in the requisite number of workplace-based assessments (including multi-source feedback)
- attainment of the College's Year 1 Histopathology OSPE
- FRCPATH by examination in histopathology
- acquisition of annual review of competence progression (ARCP) outcome 6.

Doctors applying for a Certificate of Eligibility for Specialist Registration (CESR) in histopathology must be able to demonstrate equivalence to the requirements for the award of a histopathology CCT.



Q&A

Dr Rebecca Morrison,
ST1 in histopathology,
Imperial College Healthcare
NHS Trust

What first attracted you to histopathology?

Throughout medical school I was always most interested in the pathophysiology behind disease and I enjoyed the few pathology tutorials that I had. I didn't realise I wanted to train in histopathology until I fully understood the role of the pathologist by spending time in the pathology department and speaking with consultant and trainee pathologists. Moreover, trainees with an interest in research, like myself, are actively supported and encouraged to get involved, and there are many opportunities available for a career in academic pathology.

What do you enjoy most about the job?

As a trainee I get one-to-one teaching with a consultant almost every day and I feel valued within the department. The job itself is interesting; trainees will see a wide variety of cases from all specialties and you are required to recall and use your medical knowledge and problem-solving skills, which I felt I had not had much opportunity to use in my foundation training. Training in histopathology is like learning a new language: when I first started I felt completely clueless, however just five months in I have already learned so much.

What do you find most challenging?

As a first year trainee everything I do is supervised so there is some loss of independence compared to my previous work, and this can make me feel more like a student than a doctor at times. You really need to have a genuine interest in histopathology because the sheer volume of information that there is to learn can be overwhelming and you are required to put in a great deal of hard work and dedication in order to progress through training.

Has anything surprised you about the specialty?

I didn't fully appreciate just how much clinicians rely on pathologists: we really play a vital role in the diagnosis and management of patients in all specialties. This is especially true with cancer diagnosis, staging and management. A pathologist works very much behind the scenes and the importance of the job is under-recognised by clinicians and patients.

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

You must be able to spot subtle microscopic features to provide an accurate diagnosis and this requires excellent visual pattern recognition skills. The subsequent interpretation of microscopic findings requires problem-solving skills and ability to work under pressure, as there will always be a looming deadline and an awareness that your pathology report will determine what treatment a patient receives. We also play an important role in the MDT (multi-disciplinary team) and need to have excellent verbal and written communication skills to ensure that the patient receives the correct treatment.

What advice can you give to a final year or FY trainee considering histopathology?

I think it is an excellent career choice and there are so many facets to histopathology that there is something for everyone. However, entry is competitive so you need to show that you are genuinely interested in the specialty. Go to your hospital's pathology department and arrange a taster week in pathology. You will get a chance to see what exactly the job entails and can get involved in an audit or research project to make your application stand out.

The job


Much of the work of a histopathologist is laboratory-based and involves dissecting and examining histology and cytology specimens under the microscope and preparing clinical reports. These are then often presented at regular MDTs in which diagnosis and clinical management plans are discussed and formulated.

It is a rapidly changing specialty with new immunohistochemical and molecular methods coming into use on a continual basis. Biomedical scientists are increasingly undertaking more of the 'routine' cut-up of smaller specimens and also conducting microscopic examination and report writing. Some histopathologists have specific clinical roles, such as taking fine-needle aspiration cytology specimens in breast clinics, but patient contact tends to be limited. Others may spend time working in the hospital mortuary carrying out autopsies to help determine cause of death.

Histopathology can offer flexible working and often involves relatively little out-of-hours work, although there may be some occasional on-call. There is increasing sub-specialisation, with the traditional generalist histopathologist rapidly becoming a thing of the past. Histopathology also provides ample opportunities for further learning, research interests, audit and teaching.

Sources and further information

- Royal College of Pathologists at www.rcpath.org
- Histopathology training at nhshistopathology.net
- Health Careers NHS - tinyurl.com/j8nu2qr



Nicola Stobbs offers an insight into her work as a surgeon and the initiative encouraging more women to follow in her footsteps

NO LONGER A MAN'S WORLD

AS A female surgeon practising in the UK, it is safe to say I am in a minority. The number of male consultant surgeons stands at a whopping 90 per cent of the profession according to 2014 figures for England, with only 10.5 per cent female. That is despite 50-60 per cent of medical school undergraduates being women. But one national initiative that I am proud to be part of hopes to change that.

Women in Surgery (WinS), part of the Royal College of Surgeons (RCS), was formally created in 2007 with a mission statement to "encourage, enable and inspire women to fulfil their surgical ambitions". Its main aims are to raise the profile of women in surgery, encourage change in attitudes, understand the issues women face in surgery and support and provide advice to female surgeons at all levels.

Good progress has already been made: when the initiative launched, the proportion of female consultant surgeons in England was just three per cent. The numbers are rising steadily and there are currently around 5,000 surgeons in the WinS network, but there is still some way to go to reach gender equality.

Ancient origins

Evidence of female surgeons goes right back to ancient Egypt where wall paintings in tombs and temples from 3,500 BC show women performing surgical procedures, such as caesarean sections and the removal of cancerous breasts. There is also evidence of such practices in ancient Sumeria, Babylon, Greece and Rome. More recently, the status of the woman surgeon was limited throughout the 18th century but numbers increased in the 19th century – most notably, the Medical Act of 1876 allowed women to qualify as doctors in the UK for the first time.

The first female surgeon to gain the Fellowship of the Royal College of Surgeons (FRCS) was Eleanor Davis-Colley in 1911 but fast-forward to 1990 and there were still only 320 female fellows. Women are now represented at every level in every surgical specialty but uptake remains relatively low. The reasons for this are complex but research by the University of Exeter concluded that the paucity of women in surgery is not due to lack of ambition but due to a perceived inability to fit into the world of surgery and a lack of female role models. This is something that WinS is trying to address via events such as

their conferences, workshops and the WinS directory of surgeons who are willing to offer advice to colleagues and aspiring surgeons.

Personal journey

During my undergraduate and foundation training I didn't work with any female consultant surgeons, and although I wanted to specialise in ENT surgery from my final year of medical school I still wasn't 100 per cent sure. I went to my first WinS meeting in 2010 as an FY2, attending their London conference, which was a great networking experience and a source of valuable advice and information. It also gave me a much-needed confidence boost and helped me decide to pursue a surgical career. From there, I took part in the WinS mentoring scheme which I found really useful: both being mentored by a surgical registrar who could give advice about applications and training, and also having two medical students to support.

I have been involved in a number of events for WinS in recent years, including a panel discussion at the Manchester Scalpel undergraduate conference and contributing to the WinS video, *Surgery: No longer a man's world*, as part of International Women's Day.



Everyday sexism

In summer 2016 I was honoured to be appointed a forum member of the WinS committee. I wanted to get involved for many reasons but personally I was really frustrated with both patients and colleagues' perceptions of who a surgeon is. I am now an ST5 specialist registrar in ENT surgery and have done the same exams as my male counterparts, worked just as hard and am equally qualified but feel like I often have to prove myself or justify my actions.

Some of the issues that I have faced include patients telling me they didn't realise women could be surgeons, and others asking to see a male surgeon instead when they see that a "Miss" is treating them as they think that a man will be better. I have been asked to prove my qualifications and asked how many operations I have done. Patients will often direct their answers to my questions to male medical students or foundation doctors who are in my clinic observing; and during my ENT registrar interview I was mistaken for an admin assistant collecting forms rather than a candidate by the examiner - just because I was female.

These are issues that none of my male registrar or even core trainee colleagues have

had to deal with and when I was asked in my WinS committee interview whether there was still a need for the group my response was a definite yes!

Choosing ENT

My interest in ENT surgery was sparked during a fantastic week's placement as a fourth year student with a lovely consultant (Mr Wickham in Barnsley) who I have had the pleasure of working with as a registrar since. I did a final year special study module followed by foundation training posts in the specialty to gain extra experience. ENT is a varied specialty and surgery ranges from middle ear microsurgery and endoscopic nasal surgery, to open head and neck cancer cases such as laryngectomy and neck dissections, to even robotic surgery.

The clinics are diverse and interactive with lots of minor procedures. You deal with both children and adults, manage medical conditions in addition to performing surgery and overall it is a very varied and rewarding job. I am currently considering a consultant career in the subspecialty of head and neck oncological surgery but I need to pass my FRCS exams first and be signed off at the end of my training, of which I have another three and a half years to go.

No matter what specialty you go into you will have to work hard, do postgraduate qualifications and have active involvement in teaching, research, audit and management. Surgery is no exception and is one of the more competitive specialties requiring lots of dedication and sacrifice, something that I think is worthwhile as I absolutely love my job.

For those considering a surgical career, my advice would be to go for it - but be organised and plan ahead. Use taster weeks to gain experience, look at the application forms for the next level up, and tailor your CVs. Speak to senior colleagues about what the job entails, get involved with audits and projects, and use the e-logbook to record any minor procedures you do and any surgery you watch or are involved in. Consider joining the RCS affiliates scheme and if you are female get involved in WinS!

Miss Nicola Stobbs is a specialty trainee (ST5) in otorhinolaryngology and head and neck surgery based in Sheffield.

Link:

Women in Surgery (WinS) -
www.rcseng.ac.uk/careers-in-surgery/women-in-surgery

A STEP TOO FAR?

Maintaining appropriate boundaries with patients is key for doctors – but sometimes the right course of action is not so clear. **Dr Naeem Nazem** offers some advice

DOCTORS should all be aware of their privileged position in society. There are few professions in which you can question an individual on the most personal aspects of their life, let alone examine them or perform invasive procedures. People, or more specifically patients, allow their doctors this liberty in order to receive appropriate treatment. In return they trust doctors not to abuse their position. And therein lies the cornerstone of any doctor-patient relationship: trust.

A friend in need

Any doctor would help a stranger on the street suffering a medical emergency and MDDUS provides access to indemnity for such “good Samaritan acts”. However, what do you do when the situation is not as clear?

Consider the scenario. A friend meets you as your Friday night shift is ending. They are going on holiday on Monday and forgot to pick up a repeat prescription for their thyroxine medication, which will now run out during the trip. Their practice is closed for the weekend so they ask you to write a prescription to cover them. What should you do?

The GMC states you should, wherever possible, avoid providing medical care to someone close to you unless in an emergency. But does this scenario qualify as an emergency? After all, your friend is unable to collect their prescription before going on holiday so it is an urgent situation for them. Or perhaps you could argue they are just a friend and not “someone close to you”? If you are going to prescribe how would you do it – can you use a hospital prescription pad because they are entitled to NHS treatment?

Although one or more of the arguments above may seem persuasive, the GMC’s guidance does start by saying “wherever possible”, implying that you need to exclude all the other possibilities before you make a decision to treat or prescribe. In this case there are lots of other options available. For example, your friend could attend one of the many walk-in centres in the UK that open at weekends. Or they could see a doctor in the country they are visiting and obtain a local prescription. By prescribing, in this case, you are likely not only to fall foul of the GMC’s guidance, but also your own Trust/health board’s prescribing policy and the restrictions within it.

A friend request

When it comes to maintaining boundaries, another important risk area is social media. Patients can often form close bonds with their doctor and many are tempted to look them up on Facebook and may even send a friend request. So what do you do if you receive one from a patient? Is it okay to accept? Or should you decline and potentially face awkward moments as you continue to manage their care?

If you feel declining a friend request may be awkward, imagine how you would feel knowing they had seen your personal photos and details of your friends and family. Or that they had read personal comments you had written or received. Would you feel as able to discuss treatment plans or difficult decisions with them? Do you think it would impact the level of professional trust between you?

The GMC’s guidance *Doctors’ use of social media* advises that using social media creates risks, “particularly where social and professional boundaries become unclear.” It goes on: “If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile.”

In the case described here, MDDUS would recommend that you decline the friend request and, if the matter is raised by your patient, politely explain the importance of maintaining a professional relationship. If they persist in seeking to engage with you through social media it may be helpful to get the support of your senior colleagues. As with nearly all difficult situations, it is also essential you keep a clear record of everything that is happening at the time it happens.

There are steps you can take to minimise the chances of patients contacting you via social media. Take a good look at your privacy settings to make your profile as secure as possible, and try to keep a clear line





"Is it ever appropriate to become romantically involved with a patient, either past or present?"

between your professional and personal pages.

More than a friend

Another common dilemma is whether it is ever appropriate to become romantically involved with a patient, either past or present.

As highlighted at the outset, trust is the foundation of any doctor-patient relationship. The GMC is clear that a personal relationship with a current patient is never acceptable. Doctors must never use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. Their guidance *Maintaining a professional boundary between you and your patient* also states you must not end your professional relationship with a patient solely to pursue a personal relationship with them.

But is it ever appropriate to become involved with former patients? There are no answers or set time limits in such situations and doctors must always exercise their judgement. The GMC explains that the more

recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate. The duration of the professional relationship may also be relevant. For example, a relationship with a former patient you treated over a number of years is more likely to be inappropriate than a relationship with a patient with whom you had a single consultation. Much also depends on whether there could be any perceived abuse of position. Factors which you would need to consider include the amount of time since you last saw the patient in a consultation, whether they are vulnerable, and whether you are still treating their family members.

It may be helpful to take a step back and think of how someone looking at your situation for the first time would judge it. If you think they may frown upon your actions, or you find yourself acting in a manner to conceal them, it may be time to take a second look.

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

SURGICAL INFECTION

Day 1

Mr K is 56 years old and has been admitted to hospital for surgery. He suffers from chronic rheumatoid arthritis in his right knee, with pain, stiffness and swelling. He had been referred to an orthopaedic surgeon and after discussion has opted for knee replacement surgery. The surgery is carried out successfully with no complications. Mr K is administered standard intra-operative antibiotics. Over the next 48 hours there is some swelling around the knee with slight oozing.



Day 5

Mr K is mobilising well. There is still some wound oozing but he is generally well and is discharged home with follow-up from the district nursing service.



Day 9

A nurse examines the wound, which is still oozing, and suspects infection. She phones the patient's GP - Dr R - and he prescribes flucloxacillin (the nurse does not have prescribing rights).



Day 18

Mr K re-attends the district nurse and she phones Dr R to report that the knee is hot and swollen and the sutures have burst in two places - but the patient is weight-bearing on the knee. He asks the nurse to take swabs and prescribes co-amoxiclav. Three days later the swab results are reviewed by Dr R. The report states that there was mixed growth of skin flora suggesting colonisation rather than infection. But it recommends a clinical assessment to decide significance.



Day 26

The district nurse phones the practice again and reports the wound is still leaking and "offensive". Another GP - Dr L - phones the patient and discusses the swab results and the state of his knee and general health. There has been no request for a home visit. Dr L prescribes metronidazole.



Day 29

Mr K attends A&E. The wound is weeping with yellow discharge and he feels hot and faint with shooting back pains. The ST on duty is concerned the knee replacement could be infected. Blood results show a raised white cell count and elevated CRP. Mr K is commenced on IV antibiotics. The wound is explored and cleaned in surgery but the infection does not appear to extend to the joint. Over the next two weeks in hospital Mr K requires further wound debridement but it is thought to be a superficial wound infection only.



Week 14

Mr K is seen in the orthopaedic outpatient clinic. He still complains of pain on movement but it is noted that the knee replacement is settling down following the wound dehiscence, with only a small area yet to fully heal.

A LETTER of claim alleging clinical negligence is received at the practice nearly a year later. Both Dr R and Dr L are named as at fault for not calling the patient in for review for a suspected wound infection. This put the patient at risk of deep infection in the replaced knee joint and led to further hospitalisation and a long recovery period.

MDDUS commissions a report from a primary care expert who notes that the patient was discharged into the care of a district nursing team skilled in wound management - probably more so than an average GP. In this respect he is of the opinion that Dr R could be confident that the nurse treating Mr K would have asked him to examine the patient if she felt it was necessary, and that the prescription of antibiotics on the two occasions was appropriate. The expert does state that it might have been best practice to refer the patient back to the orthopaedic team after the second district nurse contact in regard to the persistent wound infection but many GPs would wait to see if the condition settled.

Regarding Dr L, the primary care expert believes Mr K should have been assessed for further management and referral after the district

nurse's report at day 26 - and this constituted a breach of duty of care.

An opinion is sought from an expert orthopaedic surgeon who states that the knee replacement does not appear to have been deeply infected and is functioning reasonably well despite the patient complaining of pain on movement. He considers this normal and not resulting from the superficial infection, which appears largely to have cleared. Wound infection is not uncommon in knee replacement surgery and he believes the only effect of the failure to refer was to slow up Mr K's recovery.

MDDUS in consultation with the practice agrees to settle the case on behalf of Dr L without admission of liability.

Key points

- Ensure the competence of other staff treating patients under your care.
- Sepsis can develop rapidly and proper review is essential in post-operative care.

OUT THERE

CHOC CHOMPING Roses chocolates outperformed Quality Street in terms of popularity on hospital wards, according to a tongue-in-cheek study named recently as one of the *BMJ*'s all-time festive favourites. The median survival time for a sweet was 51 minutes, with an initial rapid "grab" phase. Nursing staff and healthcare assistants were identified as the biggest consumers, followed by doctors. Researchers called for more frequent chocolate deliveries to ensure all ward staff benefited equally.



DOG DOSH A dog owner plans to pursue her dream career in medicine after training her husky to pose for pictures. Grumpy Anuko's steely glare has taken social media by storm, notching up almost 37,000 Instagram followers and millions of YouTube views. He's been showered with gifts, earned modelling jobs, and has helped her raise £20,000 in the process.

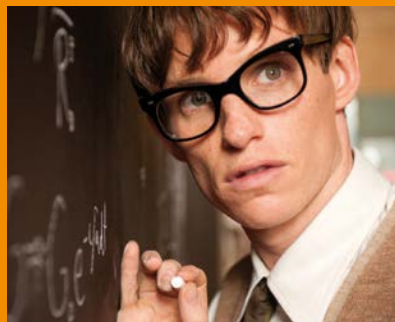
DOC DRIVERS Doctors are apparently the third worst drivers by profession, according to a recent report. Insurers 1st Central analysed claims in 2015 and found medics were amongst the most accident-prone, just behind solicitors and accountants.



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

PHOTO: STEVE GSCHMEISSNER/SCIENCE PHOTO LIBRARY

Pick: DVD - The Theory of Everything



Directed by James Marsh. Starring Eddie Redmayne, Felicity Jones, Maxine Peake.

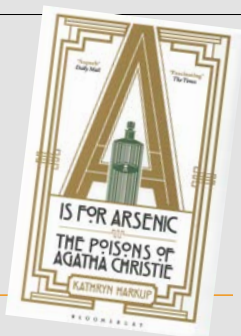
HE'S known as the man who beat the odds to survive motor neurone disease and pioneer the study of black holes, using that instantly recognisable computerised voice to communicate his brilliant ideas. But not so much is known about the private life of physicist Stephen Hawking and his complex marriage to first wife Jane which ended in divorce after 30 years when he left to be with his nurse (played by Peake). This intimate

study of the great man's private life benefits from a subtle performance from Redmayne while Jones is a fierce and determined Jane. Redmayne impresses with his moving, vulnerable portrayal of the professor who we see physically deteriorate and distort over the course of two hours. The film, based on Jane's memoir, charts the choppy course of their marriage which developed into a sort of open relationship. It shows the "friendships" developed by both partners and delicately explores all the frustration, depression and passion along the way.

Book Review: A is for Arsenic: The Poisons of Agatha Christie

By Kathryn Harkup. Bloomsbury, £9.99, paperback, 2016

Review by Jim Killgore, associate editor



IN 1921 a review of a book published by a first-time novelist appeared in *The Pharmaceutical Journal*, which declared: "This novel has the rare merit of being correctly written". Not exactly fulsome praise but it was a cherished compliment for the writer – a young Agatha Christie.

The book was *The Mysterious Affair at Styles* and first introduced the famous fictional detective Hercule Poirot. It was Christie's curiously accurate account of how strychnine was used in a murder that earned the praise of the scientific journal, assuming that the author must have some pharmaceutical training or the help of an expert.

Indeed, Christie was something of an expert when it came to drugs and poisons, having trained as an apothecary's assistant when she volunteered as a hospital nurse during World War I. Her extensive

chemical knowledge is the subject of a fascinating book by research chemist and science writer Kathryn Harkup, which was shortlisted in the 2016 BMA Medical Book Awards.

Agatha Christie used poison to kill her characters more often than any other method and in each of the 14 chapters of *A is for Arsenic*, Harkup takes a different novel and investigates the poison(s) the murderer employed – considering the origin of the substance, its development and use throughout history, how it interacts with the body to kill (or cure) and how it is obtained, administered and detected. Harkup writes: "Christie never used untraceable poisons; she carefully checked the symptoms of overdoses, and was as accurate as to the availability and detection of these compounds as she could be."

The book is a delight of fascinating facts and stories including real-life murder cases that inspired some of Christie's plots, such as that of Glasgow socialite Madeleine Smith, accused of putting arsenic in her lover's cocoa when he refused to break-off their relationship and threatened to expose private letters. Smith was found 'not proven' in the murder trial but she lived out her life under suspicion.

The book details succinctly how various poisons act to disrupt the body's basic biochemistry resulting in characteristic symptomology and fatal decline. Arsenic for example is particularly efficacious producing symptoms similar to those of food poisoning, cholera and dysentery. These and other such unsettling facts make for an excellent read.

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