FYi

ISSUE 02

ONWARDS AND UPWARDS

GETTING TO GRIPS WITH FY2

MDDUS

PHOTO: WALTER NEILSON

Welcome to your FYi

FOUNDATION YEAR DOCTORS form an odd diaspora. We work in a wide variety of settings – hospitals, wards, practices. The hours are long and often irregular with barely time to catch breath. So it would be a stretch to call us a 'community'. And yet we all face the same ordeals – the crises of confidence, the mistakes, the fears, the laughs, the tears. Sounds a bit like a Sinatra song.

Fostering a sense of community – no matter how scattered – is part of the impetus behind *FYi*. We welcome your ideas, your views and opinions, and any evidence that we all have a life beyond medicine. The editors will endeavour to incorporate any contributions to the magazine. So please do get in touch.

In this second issue of *FYi* the focus is on practical issues. As undergraduates we all had some exposure to medico-legal issues and ethics (even if you were asleep in that particular seminar). But how useful would that be if you were actually called to offer medical testimony in court? On page 6, solicitor and medico-legal expert Lindsey McGregor runs through some likely scenarios and offers practical advice. And on page 12, MDDUS medical adviser Gail Gilmartin highlights how good note taking has value beyond clinical matters – it could someday save your career.

On page 8 we look at safety at work. Two years ago FY2 Johannah Langmead was brutally attacked by a patient at a GP practice. Here she speaks to Adam Campbell on personal security and how she has struggled to come to terms with a horrific ordeal.

And on page 4, I offer my own take on the move from FY1 to FY2. Not everything is new again.

• **Dr Maggie Cairns**
Editor

Debt bars social inclusion

Rising levels of medical student debt could derail government plans to increase social mobility in medicine, says the BMA.

Medical student leaders warn that unless the government addresses the soaring debt levels faced by some students social mobility will remain only an aspiration. The comments come in response to publication of the government's 'New Opportunities White Paper'.

Louise McMenemy, a member of the BMA's medical students committee said: "At present medical graduates leave university with £21,000 worth of debt on average, a figure that could rise as high as £37,000 in the next few years now that variable top up fees have been introduced".

"In view of this worrying situation the BMA remains concerned that talented individuals from lower socio-economic backgrounds will either be discouraged or simply unable to pursue a career in medicine because of the spiralling debt burden."

DOCTORS FOR DOCTORS

BMA members, their families and medical students have access to a confidential counselling service for discussing personal, emotional and work-related problems. The service can also help address alcohol or drug misuse.

Call **08459 200 169** and you will be given the choice of speaking to a counsellor or the details of a doctor-adviser who you can call directly. This service is available 24 hours a day, 365 days a year.

NHS constitution launched

The first ever 'NHS Constitution' was launched on 21 January. The Constitution, viewed as a 'bill of rights', defines what staff, patients and the public can expect from the NHS in England, emphasising both rights and responsibilities.

Doctors and patients, however, fear that it will have little impact. Katherine Murphy, director of the Patients Association described the document as consisting of largely "optimistic pledges" without real incentives to bring improvements. "We do not expect this document to make any difference to the care patients are receiving," she said.

However, Health Secretary Alan Johnson described the launch as "a momentous point in the history of the NHS".

He said: "Following on from Lord Darzi's Next Stage Review, the launch of the NHS Constitution shows how its founding principles still endure today and have resonance for staff, patients and public alike. It will ensure that we protect the NHS for generations to come".

MDDUS

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Time is running out on EWTD

NEARLY HALF OF ALL JUNIOR DOCTORS are still working rotas that exceed 48 hours despite an August 2009 deadline for full compliance with the European Working Time Directive, according to recent figures from the BMA.

Another survey of over a thousand surgical trainees by the Association of Surgeons in Training (ASiT) found that 90 per cent of trainees are exceeding their rostered hours on a weekly basis, and 68 per cent reported deterioration in the quality of training and operative skills as a result of shift-working patterns brought in to meet working time regulations.

Medical leaders are concerned that trusts and health boards are still not prepared for the change to reduced hours and urges them to take action now, rather than compromise patient care by breaching health and safety legislation next year. They are also worried that training quality may be compromised in preparation for the changes.

Dr Alan Robertson, Chair of the BMA's Scottish Junior Doctor Committee, said: "The 48 hour working limit is going to have a massive impact on training and service delivery and the NHS is not yet prepared".

Checklist saves lives

A year-long global pilot of a WHO surgical safety checklist saw operative deaths and complications reduced by a third among 8,000 surgical patients across eight countries.

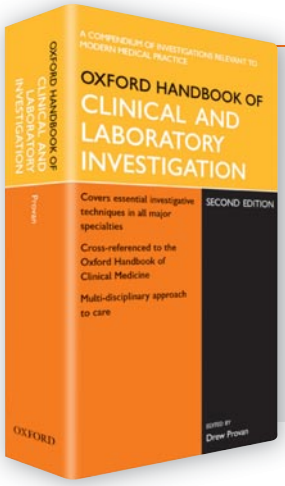
All healthcare organisations in England and Wales will now be required to implement the checklist by February 2010 for every patient undergoing a surgical procedure.

Health Minister Lord Darzi, who chaired a WHO working group that played a key role in developing the checklist, said: "The beauty of the surgical safety checklist is its simplicity and – as a practising surgeon – I would urge surgical teams across the country to use it".

The checklist includes simple action points such as:

- **Has the patient confirmed his/her identity, site, procedure and consent?**
- **Is the surgical site marked?**
- **Has it been confirmed that instruments, swabs and sharps counts are complete (or not applicable)?**

Access the WHO Surgical Safety Checklist at www.npsa.nhs.uk.



Book discounts

One of the many benefits of MDDUS membership is a discount on a range of medical books and journals. Discounts of between 15% and 20% are available from a wide selection of publishers including Elsevier and Oxford University Press. Simply go to the 'Discount for Members' page at www.mddus.com for further instructions. Remember to have your MDDUS membership number handy when contacting the publishing company.

CAUTION URGED IN FACEBOOK PROFILES

Foundation year doctors and medical students should give some consideration to personal security when using social networking sites such as Facebook.

The University of Birmingham recently issued guidance to students on making best use of Facebook after it emerged that former patients had been contacting medical students via the website.

Profile pages on Facebook can contain detailed personal information including telephone numbers, home addresses and employment history, as well as personal photographs. Students have been advised to use Facebook's 'private' setting which only allows nominated individuals access to their details.

A University of Birmingham spokesman said to the *Sunday Mercury* newspaper: "Two students reported unwanted attention via Facebook to the Medical School. As a result officials thought it would be useful to give guidance to others who may find themselves in a similar situation. Some people may be unclear about how to handle the situation". The university urged anyone experiencing distressing approaches via their Facebook page to contact their year tutor.

MDDUS urges FY doctors in similar circumstances to heed the same advice – contact your tutor or supervisor or an MDDUS adviser.

WARDS WARDS ON UP AND

FYi editor **Maggie Cairns** recalls her welcome, though occasionally unnerving, transition to foundation year two

MY FINAL ward round as an FY1 was full of goodbyes: a poignant and emotional journey towards the exit or perhaps more appropriately the entrance to FY2. This was not just saying goodbye to a job description but to colleagues and a health team, all of whom had become firm friends.

It was also farewell to a comfort zone and hello to a new stage in my medical metamorphosis.

My educational supervisor had confirmed full competence by delivering a 'stamp of approval' to the certificate of completion of year one. This was akin to receiving a 'Willy Wonka Golden Ticket' to the next level in foundation training. My confidence level was certainly higher than on that first day as a newly qualified doctor. Progress indeed!

'The Chocolate Factory' to which I was dispatched was of the older variety than what I had left behind. The hospital entrance was adorned with the slogan, '21st century medicine in a 19th century building' – clue to the building decay but also to the high level of care delivered.

Ward round

My first day was an introduction with the proverbial bang. New responsibilities were expected of me as a fully certified FY2. The sister in charge, with dignified authority, suggested that the ward round would 'require your presence'. Instinctively I looked over my shoulder for my registrar. 'She must be talking to someone else,' I thought. This was sadly not the case. A solo effort was required.

The fear that I had initially felt on that first day as a junior doctor again raised its ugly head. Trolley in tow, I commenced the lone journey helped by sympathetic smiles from colleagues I didn't yet know. Nearing lunchtime and feeling physically exhausted, I saw my last patient. I sought some acknowledgment from sister of the completed task. Her reply was to give me a cup of sweet tea and an assurance that it hadn't been the longest ward round she had ever experienced. My initial euphoria was quickly dashed when it was pointed out that I was expected at an outpatient clinic in the afternoon. 'Outpatient', I recoiled, Glasgow's answer to Nemesis, the Goddess of Retribution.

Outpatient clinics

In truth, my first exposure to the responsibilities required of attendance at clinics was never the terror expected. Rather, I found myself shadowing the registrar who was doing his best to impress whilst honing his sapiential authority. In essence, he taught very well and I was a willing learner.

On a more serious note, outpatient clinics are a great opportunity to increase your medical knowledge and sharpen your decision-making skills within a protected environment.

Your outpatient work is not finished simply when the clinic doors are shut. Dictation! Herein lies a lesson that needs to be learned quickly and which comes with a warning to current and future foundation doctors – take a crash course in dictation! Performing this task efficiently will not only ensure your desk remains clear but will also enable you to avoid the wrath of the unit secretaries – a skill I have yet to master!

Acquisition of new skills

The first few days of FY2 introduced me to more challenging procedures than I had previously been exposed to. Lumbar punctures and ascitic drains became second nature. Such complicated procedures were all carried out under the auspices and guidance of senior colleagues. Gone were the days of the dreaded venflon... there was now a new FY1 to do that!

FY2 is a continuation and widening of the skill base initiated at FY1 level. The rule of thumb remains the same: 'see one, do one, teach one'. The success of this depends on one's willingness to join in, to be hands-on and

"You must resist the temptation of leaving your achievements unrecorded"

above all to be receptive to the acquisition of new skills. Being involved at this greater level increases your confidence and self esteem. It enhances your reputation as a member of the team and whets your appetite for further education. This education can be broadly split into two camps: the first being medical education and the second a more broader education in aspects of legal status and audits. It helps at this stage of your foundation career to become more than familiar with subjects such as governance and patient safety, and to acknowledge your role in attaining best results in both.

E-portfolio

The new rite of passage of current foundation doctors entails a dedicated recording of one's clinical development within an e-portfolio. Resist the temptation of leaving achievements unrecorded. Don't rely solely on memory. A written record is worth its weight in gold when it comes to interviews for specialty training programmes. FY2 offers the best opportunity to promote talents whilst enhancing your chance of obtaining a training post in a chosen specialty. Application deadlines come fast and furious so prepare well in advance. Update the CV weekly and never be afraid to recognise any supposed weakness in your knowledge and skill base. Seek more senior help in rectifying such gaps.

Audits

Another way of ensuring a potential successful application is by participation in clinical audit. An invitation by your consultant to participate in an audit should be viewed as a worthwhile opportunity and should receive an immediate and positive reply. Audits, properly conducted, yield valuable information and can form the basis of future best practice in clinical management. It's also another valuable thing to add to your CV.

Taster weeks

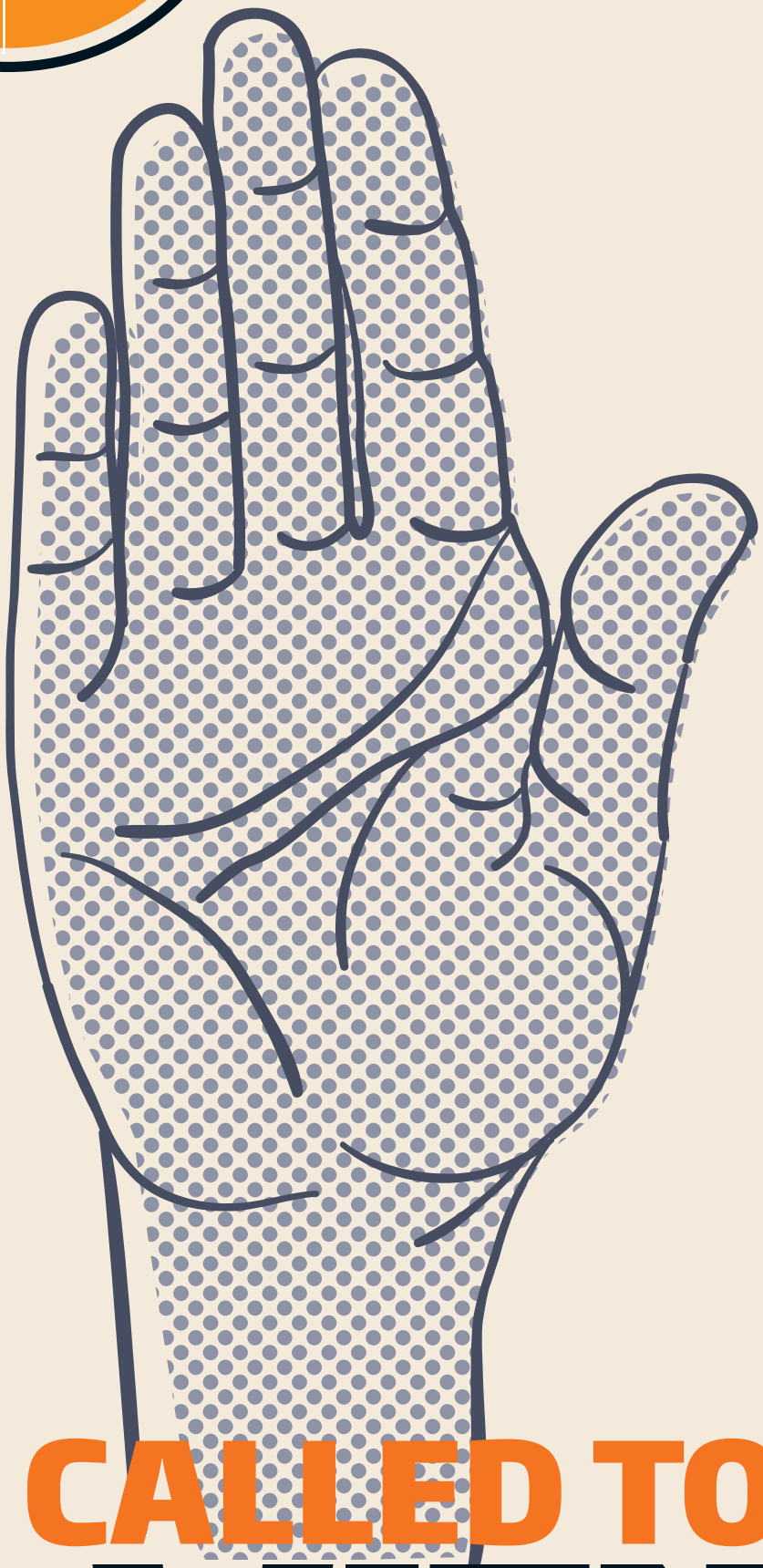
Built within foundation training is the concept of taster weeks. This new approach gives current year two trainees the opportunity to experience a clinical specialty before committing themselves. In reality it may be difficult to convince more senior colleagues of the purpose and advantage of such a scheme and eliciting their support in obtaining time off for such matters. Current FY2s should promote this as being worthwhile in relation to their professional career development, and work with colleagues to attain this.

Personal life

As ever, a career in medicine could simply be filled with medicine. I can't emphasise more the importance of extracurricular activities to offset the sometimes-overwhelming workload. Doctors, like other professionals, should adopt a more holistic approach to life, thus ensuring maximum efficiency at work and preventing undue stress and burnout potential.

Nearing the end of my foundation programme, I now have the opportunity to reflect upon my experiences of being a new doctor. Overall, I believe I have made a positive contribution and have grown in knowledge and confidence through my own endeavours and the support of my colleagues. With this in mind I am reminded of the battle cry 'Onwards and upwards'. Here's to the future.

Dr Maggie Cairns is in her foundation year two programme at Stobhill Hospital, Glasgow



CALLED TO WITNESS

Giving evidence in court as a medical professional can be daunting – but a little preparation goes a very long way. Solicitor **Lindsey McGregor** offers some guidance

DURING your undergraduate training you will have had some exposure to the legal aspects of medicine. Whilst complex ethical and medico-legal issues involving treatment of patients may have been examined and discussed, it is important that you are also equipped to deal with this aspect of medicine in practical terms. The purpose of this article is to illustrate how you may become involved in legal proceedings. Advice is provided on how to cope with the daunting prospect of appearing in court.

There are a number of situations which might involve you interacting with solicitors to give a statement and ultimately providing evidence in court. These include:

- speaking as a factual witness to the medical records of a patient who has been involved in a road traffic accident or assault
- speaking as a factual witness to the medical records of a patient who is making a civil claim against the hospital or you for negligent treatment
- providing evidence as a factual witness in a fatal accident inquiry (FAI) into the death of a patient following treatment
- offering testimony as a defendant or witness at the GMC as a result of a complaint in relation to the practice of either yourself or a colleague.

"Very often a case is heard many years after the incident."

This is not an exhaustive list but provides examples of the more common situations in which you could find yourself before a court or tribunal. In the last issue of *FYi*, Dr Jim Rodger dealt with GMC issues and this article will, therefore, focus on the more common occurrence of being called to court as a witness to give evidence to 'speak to your notes'.

Who will ask you?

You could be contacted initially by the solicitor acting for the pursuer (claimant) who is making the claim or by the defender's solicitor who may be representing a health board or GP in a clinical negligence claim, or indeed an insurance company if the claim involved a road traffic accident. The first contact will usually be a request to meet with you to take a statement in relation to your notes.

It is important to know who is asking the questions because if it is a clinical negligence claim the solicitor should make a request through the NHS Central Legal Office (CLO), who manage claims on behalf of the health board, or through your solicitor if you are being indemnified by your medical defence organisation (MDO). Your solicitor should be present for your statement, so do not agree to this if you are approached directly.

If the case relates to a fatal accident inquiry (FAI) the procurator fiscal or a solicitor representing others at the inquiry, including the family, may contact you. Consider if you are likely to be criticised yourself during the inquiry and whether you should have a solicitor present. Take advice from your MDO or the CLO.

If the case proceeds it's possible you will receive a citation (court order) requesting your attendance at court, with which you must comply.

What will you be asked?

Medical notes require to be spoken to by their author before the court unless the records can be agreed as true and accurate in advance by the lawyers. Some medical notes, however, which are controversial or in dispute will not be agreed and you will be asked to speak to them. In the context of an FAI, medical notes are not regularly agreed in advance.

Your evidence will commence with your personal details and CV before consideration of the notes that have been made in the records, together with any investigations requested and results obtained. Evidence of your normal practice and your recollection of events in general may be asked. The history that you take when clerking in a patient can be particularly informative to solicitors as it may contradict previous statements given.

Where and when?

Civil cases are heard in the Sheriff Court or in the Court of Session, Scotland's Supreme Civil Court based in Edinburgh. Fatal accident inquiries are held in the Sheriff Court closest to the place of death.

Very often a civil case is heard many years after the incident. This is because a pursuer has three years from the date of the incident to raise an action. Due to court procedure and waiting time it could be a further 3 years before the case is allocated a court date. Don't be surprised if you are approached many years after the incident – another reason to make sure you have good, clear notes.

Often cases settle on the morning that the case is due to start. If a case runs or if it is a criminal case or an FAI you may spend time waiting to give evidence because it is very hard to timetable witnesses. You may have to come back to court on a number of occasions.

Jargon buster

Some helpful legal terms explained

FAI - The equivalent to a coroner's inquiry in England (but with a wider remit)

Initial writ - Served on the defender to initiate a civil claim in the Sheriff Court, setting out the pursuer's written pleadings

Pursuer - The equivalent of the English plaintiff

Precognition - A preliminary statement by a witness giving an indication of what he/she will say in evidence; this is not signed and is usually inadmissible

Procurator fiscal - The public prosecutor in Scotland

Proof - The hearing of evidence on the facts of a case

Sist - Equivalent to English 'stay of proceedings' - an action is put on hold

Summons - Served on the defender to initiate a civil claim in the Court of Session, setting out the pursuer's written pleadings

Witness citation - Equivalent to the English subpoena, court order summoning an individual to court

A fatal accident inquiry is generally heard within 18 months to 2 years following the death but again due to pressure on court time it can be delayed beyond that.

Checklist for giving evidence

Here are some practical points to keep in mind.

- Always keep legible, clear and full notes and sign them.
- If you are involved in the death of a patient you may be asked to produce a statement by the hospital management. If you are not, make sure you keep a note for your own purposes in case you are asked to give evidence at a later date.
- If you are contacted by a solicitor to give a statement, particularly if it involves a fatal accident inquiry or medical negligence claim, you should contact your medical defence organisation. The CLO will also want to be informed. If you are unsure how to contact them, consult the claims manager at the hospital.
- When giving a statement be clear about what you can actually recall and what is your normal practice.
- Be clear who is asking you to give a statement – ask for their business card.
- Always ask for a copy of the statement to be sent to you by the solicitor who has taken it.
- If you receive a citation to appear in Court, do not delay in contacting the MDDUS or Central Legal Office.
- When appearing in Court always look smart, speak clearly and slowly. Make sure you are familiar with the records that you are speaking to. Be prepared.
- Address the Sheriff or Judge as My Lord or My Lady.

Being involved in the legal process can be intimidating and daunting. However, you will be greatly assisted if your notes are of a high standard and you are well prepared. In addition, support and advice are always available from the extremely experienced medical advisers and in-house lawyers at the MDDUS and the solicitors that are instructed by them.

Lindsey McGregor is an associate solicitor and medico-legal expert at the law firm of Simpson & Marwick

Adam Campbell speaks to a former FY2 keen to draw something positive out of a horrific ordeal

FIGHTING BACK

UP UNTIL the day she was attacked, in March 2007, everything had been going according to plan for trainee doctor Johannah Langmead. She had been successful in her studies at Newcastle, her Foundation year 1 was complete and she was halfway through her Foundation year 2. She'd already completed two hospital stints and was three months into a four-month GP slot at Prudhoe Health Centre, west of Newcastle. There she was holding her own surgeries and "really getting to grips with it".

What's more, the 23-year-old had got through the GP entrance exams, and the forthcoming interview was now the only thing that stood between her and acceptance on to a three-year GP training programme.

Then, out of the blue, disaster struck. "I'd just finished my afternoon surgery, so it was about 5.30pm, and all the patients had left," remembers Dr Langmead. "I was closing up and thinking I might get off early, when this man burst into the room."

The man sat down momentarily, but then got up and started waving his arms about ferociously and shouting. "I thought he was psychotic. But it happened so fast. I turned to pick the phone up to ring through to reception, but that was about as much as I managed before he hit me," she says.

Long minutes

The attacker punched Dr Langmead repeatedly in the face, knocking her to the ground where he continued the violent assault. He later admitted it had been his intention to kill her. "The key thing in all this is that he locked the door," she says. "Help wasn't able to come in because they had to go and find the key, which was in reception."

As a result it was several minutes before her GP tutor, Dr Donaldson, was able to gain entry and stop the attack, which left her badly bruised and swollen and requiring stitches to her forehead. "There was a possibility of a fracture, but it was all conservatively managed in the end, so I was quite lucky in that I didn't have to have any operations. I had problems eating for a couple of weeks."

The man, a practice patient whom Dr Langmead had never seen before, ran off but was soon arrested by police. It turned out he had been diagnosed with mental health problems some years earlier but had recently stopped taking his medication. In the days leading up to the attack, he'd been playing a violent video game, which it is believed triggered a psychotic episode.

In the aftermath, Dr Langmead was off work for nearly two months. "I did try to go back to work three weeks later but just couldn't manage it at all," she says. "I was just breaking down in tears all the time, at any little thing." She did, however, manage to attend her GP interview eight days after the attack, bruised and battered and with two black eyes, and to secure her first-choice job. Two years on, she can laugh about it: "But then everybody's emotional at the interview, so I just kind of fitted in".

Despite the time off, thanks to a good training record Dr Langmead was allowed to complete her FY2 and she has nothing but praise for the way her case was handled. "I couldn't have asked any more of Dr Tiplady, the chief educational supervisor at North Tyneside. He was wonderful."

She is equally full of praise for the counselling she received to help her cope with the psychological trauma. "The occupational health department at North Tyneside had a psychologist attached who was really very good.

I had a meeting with her once a week. She helped me work through things."

A more secure environment

It was the kind of random event you could never really be prepared for, says Dr Langmead, who is currently doing an ENT placement at the Cumberland Infirmary in Carlisle as part of her GP training. No amount of role-playing dealing with aggressive patients who are unhappy with a diagnosis or looking for drugs – training she underwent at university – could ready you for a sudden and violent attack of this kind. She didn't even have time to think about the panic alarm under the desk – and with the door locked it may not have made any difference.

But having survived such an incident, it is hardly surprising that security at work is something she has thought long and hard about. Indeed, she admits she went to her last GP placement armed with a screwdriver. She laughs as she explains it was not for self-defence: "I had to take the lock off the door".

Removing internal locks from GPs' doors was one of the recommendations of a report prepared by Northumberland Care Trust into the attack. Others included positioning patients so there is always an escape route, and installing keypad-controlled doors from the reception area to the consulting rooms. But Dr Langmead is critical of the fact that, despite being acted upon by the Prudhoe practice, the report and its findings were not raised with other trainees in the Foundation programme.

"At no point was it ever mentioned to the FY1s and FY2s who were going into GP training, even from the cohort after me. I had a friend in the year below and there was nothing extra on security mentioned," she says. "It could have been highlighted better, even if it was just a leaflet in the pack. The information wasn't really disseminated outside the parties that were already involved."

Dr Langmead never once considered giving up her GP training as a result of the attack, but she admits the experience continues to affect her to a degree. "I said I didn't want to do a psychiatric rotation, so in a way it has affected my training. I don't know if I'm ever going to be as comfortable with mentally ill people," she says.

On one occasion, a man came into her surgery who resembled her attacker. "I had quite a big panic, but other than that it hasn't really bothered me as much as I thought it would. I thought maybe any kind of 30 or 40-year-old male coming in might freak me out. But I take a couple of deep breaths and I get through it."

She is keen that something positive should come out of her negative experience and says this is part of the reason why she agreed to revisit the terrifying episode for this article. She wants to raise awareness of the safety recommendations and urge fellow doctors to think carefully about their working environment. "I've told all my colleagues that they have to be much more aware of things like: do they have an escape route, is there a panic alarm, could they get locked in?"

At the same time she understands that it's impossible to predict every eventuality – and difficult, too, to "waltz into a practice and start moving all the sockets and computers around" – but she believes that simple precautions and forethought really could make a difference.

She says: "I would hate for a similarly crazy, weird thing to happen to somebody else that could have been prevented."

"The key thing in this is that he locked the door. Help wasn't able to come in..."

Adam Campbell is a freelance writer, editor and lecturer living in Edinburgh

CHILD FRIENDLY

Popular but not prohibitively competitive - what makes paediatric medicine so special asks **Cherryl Adams**

PAEDIATRICIANS are often said to be the last of the true generalists in medicine. The specialty encompasses a wide and varied range of practice, from neonatal intensive care to the management of chronic disease and disability in the community. The most common career choice is general paediatric consultant based in hospital or community practice.

Paediatrics was established as a separate area of medical practice in the UK in the nineteenth century and it is thought that Great Ormond Street, founded in 1852, is the oldest children's hospital in the English-speaking world. There are now more than 4,000 career grade paediatricians working throughout the UK in 276 separate child health services.

Paediatrics takes a holistic approach, focusing on minimising the adverse effects of illness with the aim of allowing the child and family to live as normal a life as possible. The specialty also has a unique dimension whereby the diseases and conditions treated are ever changing due the continued growth and development of the patient.

Among medical careers, paediatrics remains popular though not prohibitively competitive. The rewards of working with children are many and being an advocate for children and the young is considered a privilege among paediatricians. Emotional strength and resilience are essential in this specialty as working with very sick children can be personally stressful and challenging.

Training

Modernising Medical Careers (MMC) replaced the paediatric SHO and registrar grades with a seamless run-through training grade which aims to take doctors from completion of foundation training through to Certificate of Completion of Training (CCT). Training is facilitated through The Royal College of Paediatrics and Child Health (RCPCH) and entry is applied for on a competitive basis.

The RCPCH state the following personal qualities are essential for a career in paediatrics:

- patience, sensitivity, empathy and emotional resilience
- good communication skills
- good team working skills
- comfortable with informality
- good sense of humour
- flexible and opportunistic
- commitment to promoting the welfare of children.

Training takes eight years from ST1-8 grades. The three-part MRCPCH exams should be completed within the first three years, and continual competence and performance assessments are undertaken throughout. ST1-5 is spent building a good working knowledge of all aspects of child health, involving posts within district hospitals and placements in specialised neonatology, community paediatrics and the sub-specialties. The final three years concentrate on the areas that the trainee wishes to pursue as a career path.

As a specialty, paediatrics is renowned for being very supportive to its trainees and almost 80% of trainees will obtain a consultant post within 12 months of CCT.

In practice

The majority of paediatric trainees will pursue general paediatric medicine as their career choice, some with a special interest in a specific area. Others will move into one of the 15 sub-specialties which include oncology, endocrinology, neonatology, respiratory medicine, neurology and community based paediatrics which involves working with long-term problems such as disability and behavioural issues.

Teamwork is very much the ethos: working within a multi-disciplinary team and with the child's family. This is especially the case when managing chronic illnesses and problems.

Paediatrics is a family oriented specialty and this is reflected in the structure of the training schedule; it has the highest numbers of part-

time training grade doctors out of all hospital specialties. It is possible to train flexibly for part or all of your paediatric training and, increasingly, job share posts are also available at consultant level.

The future

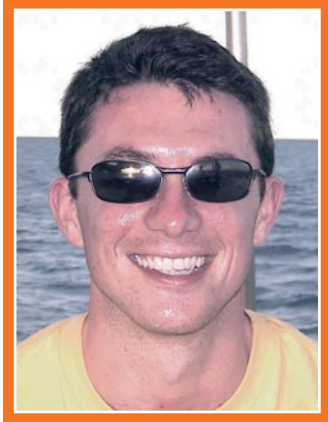
As with all branches of medicine there are challenges facing paediatrics in a rapidly evolving NHS. Changes to other areas in the service have a direct effect on the paediatric workforce, i.e. reduction in GP out-of-hours care results in increased attendances of children to A&E departments, and rising expectations of parents and educational providers increase referrals for assessment of perceived learning problems.

Essentially the future of paediatrics is evolving along the same lines as healthcare as a whole with the focus on outpatient units, enhanced local accessibility and fewer inpatient units in hospital settings. It has been well recognised that better linkage between agencies providing children's services is needed to ensure a coherent and safe service that transcends care levels and ensures a smoother transition into adult care.

For further information contact the RCPCH: **www.rcpch.ac.uk**

Cherryl Adams is Associate Editor of FYi

Q&A - Dr Damian Roland, paediatrician



• What attracted you most to paediatrics?

I certainly didn't go to medical school wanting to be a paediatrician (for some reason I can't adequately explain I had a burning desire to be an orthopod!). Paediatrics is certainly a vocation - you either love it or hate it. I really enjoyed my paediatric attachment and realised I hadn't actually been that interested in any adult medicine. Having spent time at school teaching youth theatre and sport to primary school pupils I probably should have realised I enjoyed working with children - there is certainly a lot less of the baggage than you get with adults.

• What's your most memorable experience so far?

I led a resuscitation on a boy with a heart condition who unfortunately subsequently developed a palliative (life-limiting) complication. We discussed with him whether he would want to have CPR performed again. "No" was the very definite reply. However, after a short pause he said if it happened before the World Cup in two weeks' time he would like to have a chance to watch England play. Very humbling.

• Now that you're in the job, what do you enjoy most?

I am a paediatrician who specialises in emergency medicine. I enjoy the frantic pace of the emergency department, dealing with a population who get ill and better again in a very short space of time. It's an observational specialty, and although there are specific practical difficulties, I love the challenge of guessing what is wrong with patients essentially just by looking at them. You have to have a calm temperament and not be frustrated by the belligerent child who won't let you do anything to them. My personality is suited to handling the large variation in patient acuity you see even on an hourly basis.

• Has anything about the role surprised you?

Rather perversely I enjoy breaking bad news - as long as I do it well. I never thought I would think that when I started the job! Explaining to anxious parents why their child is unwell, how you are treating them and what is going to happen to them is very challenging. It's very heart warming to hear parents thank you for all you have done for their child when you have done very little practically but simply just kept them up to date and informed.

• Are there any downsides?

It's a demanding specialty (but it's difficult to think of a hospital job which isn't now). The increased media hype regarding child protection makes every consultation potentially difficult, especially when you work in a front-line job like emergency paediatrics. Although it is rare, parents can be extremely rude to you and cruel to their children which is upsetting. However, as a child advocate you can gain a lot of satisfaction from knowing you have done the best from the child's point of view.

• Do you have any advice for young doctors wishing to pursue a career in paediatrics?

If you can manage four months exposure in your foundation years you can get a real taster. Juniors are very well protected but get a lot of exposure. Paediatricians are the friendliest of all specialists, and we are always keen to promote the subject so ask, ask, ask. If you think you want to do paediatrics as a career ask one of the SpRs if there is an audit project you can help them with - undoubtedly they will say yes and it looks very good on your CV.

MATTERS OF RECORD

Good notes make good medicine – and they can also be invaluable in cases of clinical negligence. Here are some tips from medico-legal adviser **Dr Gail Gilmartin**

THERE is an adage in medico-legal practice: "poor records, poor defence; no records, no defence". This applies equally well to both of the scenarios discussed below which are based on real cases from the files at MDDUS.

Case 1

A young GP is called out to the home of a 15-year-old girl complaining of severe headache, "shivers" and pains in her legs and back. The GP checks the patient's temperature which is elevated and examines the girl's limbs for any signs of rash or bruising and finds none. Written notes from the consultation offer no diagnosis and mention only "elevated temperature" and the GP's recommendation that the patient take analgesics. Four hours later a different GP examines the girl and finds evidence of purpuric rash on her arms and legs. Investigative tests later confirm meningococcal septicaemia. The girl survives but with below-knee amputations of both legs.

Case 2

A 72-year-old man with a pharyngeal pouch is referred to hospital. Surgery is advised and in the course of the operation there is a minor complication and the patient is left with a paralysed left vocal cord. A letter of claim is later received by the surgeon from solicitors acting on behalf of the patient who claims there was no discussion of the potential risks of the procedure. The surgeon disputes this but examination of the consent form reveals no record any such discussion.

See case analysis in the box opposite.

Not a legal document but...

It's important that you establish the habit of good note taking at the start of your career as a healthcare professional. Clear, concise and accurate notes are important for several reasons:

- Notes provide an account of the patient's management: such an account may prove valuable decades from now.
- Notes are key means of communication between health professionals.
- Notes provide information for audit and research.
- Notes constitute a record of patient care that may be used in legal proceedings.

Well-kept notes should, ideally, allow a reader to accurately reconstruct the facts and logic in a case, years after they were written. Good notes are also invaluable in defending against charges of clinical negligence. That is not to say that notes are intended to be a legal record – the prime function is to record and communicate the information that those providing care need to know. But if you keep a good clinical record, it's likely to be a good legal record too.

Key information

Note taking obviously varies between professions and specialties but generally a full patient record will contain accurate notes on:

- History: as applies to the condition. Provide patient responses to direct questions and also relevant past history including concurrent illnesses, medications and allergies; review previous notes where relevant.
- Examination of the patient: include both positive and negative findings. Record all relevant observations and measurements (e.g. temperature, BP).
- Diagnosis: clear, concise statement. Justify how the conclusion was reached and state any uncertainties or differentials.

"Notes are always more valuable than memory in a legal context"

- Investigations: detail and justify.
- Management: record drugs prescribed/ administered and dosage and other treatments.
- Follow-up and referral: include details of follow-up tests, future appointments and referrals.
- Patient information: include details of discussions regarding risk-benefit , treatment plan, prognosis, etc.
- Consent: record consent given, ensuring informed by above discussions.

Fundamental questions

From a medico-legal perspective all notes should answer some fundamental questions:

- Who? Notes should obviously identify the patient (name, date of birth, hospital number if relevant, address). They should also clearly identify the doctor who made the note, along with a signature to verify this.
- When? Record when the patient was seen, the test done, the blood taken, the drug given, etc. Note the date and time of the event, and also when the actual record or note was made if there has been a significant time lapse (hours, days). Detail the reasons for the delay in making the record.
- What? Record what was done, said, instructed, observed, checked.
- Why? It can be important to justify some decisions in your notes. Why are you calling a more senior colleague? Why are you concerned? This can be very important because it will perhaps determine future assessment of the urgency or seriousness with which a situation was treated.

Memory is not reliable

Another adage to keep in mind is "If it wasn't written down, it wasn't done". Notes are always more valuable than memory in a legal context. How many patients will a doctor see in one session or one week or over a year? To recall the detailed circumstances of a single case would be exceptional (unless particularly rare or traumatic). Good notes also mean that a court will not need to make an assessment of your credibility as a witness; the notes will corroborate your evidence.

So start developing good practice now in note taking – it will be an essential skill in your later training and future career.

Top note-taking tips

- Ensure notes are legible – write in black ink, and use capital letters or type if your writing is not clear.
- Ensure notes are contemporaneous – write up notes as soon as possible after an event.
- Use only universally agreed medical and dental abbreviations.
- Be sure to identify other contacts cited in notes (consultant, nurse, relative, etc).
- Remember that negative results may be as important as positive ones.
- Ensure notes use neutral language and are in no way derogatory – patients or families have access.
- Changes/additions to notes should be annotated with signature and the date on which they were made.

Dr Gail Gilmartin is a medico-legal adviser at MDDUS

Case analysis

Case 1. The first GP would find difficulty in answering criticisms of his actions, having not recorded the results of examinations undertaken, i.e. of the patient's limbs (not written down, not done). He also did not offer a diagnosis or record specific findings, i.e. the patient's temperature.

Case 2. Expert opinion in the case pointed out that recurrent laryngeal nerve palsy is a recognised complication of pharyngeal pouch surgery. However, the fact that the surgeon did not record either on the consent form or in the notes any discussion of the potential complications constituted negligence on his part. The case was settled.

CALCULATED RISK

Is joining a medical defence organisation worthwhile?

DAVID is in foundation year two. After a hard week he and friends go out one Friday night for a few pints. The pub is crowded but they manage to find a table. A few rounds later a guy pushing his way through the crush spills a drink on David's girlfriend. Words are exchanged and David loses his temper and throws a punch. The bartender calls the police and David is later arrested and charged with assault.

David is mortified at his actions and tenders a plea of guilty. He pays the £100 fine and tries to put the incident behind him. But a few months later he is shocked to receive a letter from the General Medical Council. His conviction has been reported by the police and he has now been called to answer before a fitness to practise panel. He faces possible suspension from the Medical Register.

Where does David stand as regards legal advice in this case? Under his NHS employment contract he has legal indemnity for work undertaken as part of his foundation training. But this coverage does not include support and representation for GMC matters.

This scenario is based on a real case at MDDUS and demonstrates why membership of a medical defence organisation (MDO) should not be considered an optional extra for foundation trainees.

MDDUS is an independent 'mutual' MDO. Doctors pay an annual subscription fee and in return receive access to advice and assistance on legal, ethical and other problems arising from the practise of their profession. Members not under contract to the NHS (such as GPs) also receive access to legal representation and indemnity for damages and costs arising from judicial decisions or out-of-court settlements in clinical negligence cases.

Most medical students will join at least one MDO or sometimes more – if only just for the freebies handed out. But many will let that membership lapse upon entering foundation year two, relying upon NHS indemnity to see them through their training. It's a risky move. Even the GMC states on its website: "The protection that comes from employment in the NHS is by no means sufficient to cover all situations in which you may find yourself".

To be clear, NHS cover does not provide:

- Representation and legal support at GMC proceedings
- Assistance with disciplinary matters
- Legal representation and support at fatal accident inquiries and coroner's inquests
- Indemnity for Good Samaritan acts.

Over the past decade, 'non-claims' GMC, disciplinary and other such cases undertaken by MDDUS have risen steadily. MDDUS estimates that in 2008 only 20% of medical adviser time was taken up by professional negligence claims. A significant portion involved GMC matters. It's a hard reality but doctors remain on the Medical Register 365 days a year, 24 hours a day. In many ways the work–play split does not apply in medicine as it does in other professions. Questions of conduct or behaviour, such as breaches of criminal law or offences involving drug abuse and alcohol, can restrict and even end a medical career. With so much at stake, not making provision for costly expert legal advice and representation would seem foolhardy at best.

Even inadvertent errors can lead doctors into difficulty. One young doctor represented by the MDDUS carried out a rectal examination of a female patient who presented at A&E with bleeding but did not ensure that a chaperone was present. The patient subsequently made a complaint to both the GMC and to the hospital.

An MDDUS medico-legal adviser provided support throughout the GMC investigation, reviewing paperwork and case notes and liaising with lawyers. No further action was taken and the matter was referred back to the hospital. A meeting was arranged and the doctor admitted that no chaperone had been present but insisted that he had obtained consent for the procedure. In the end the patient accepted an apology and reassurance that in future the doctor would ensure a chaperone was present during intimate examinations and that fully informed consent was granted. No other disciplinary action was taken.

Had the doctor not been an MDDUS member the cost of legal advice and support in defending his actions both to the GMC and the trust would have been substantial by any standard.

So is not belonging to an MDO really worth the risk?

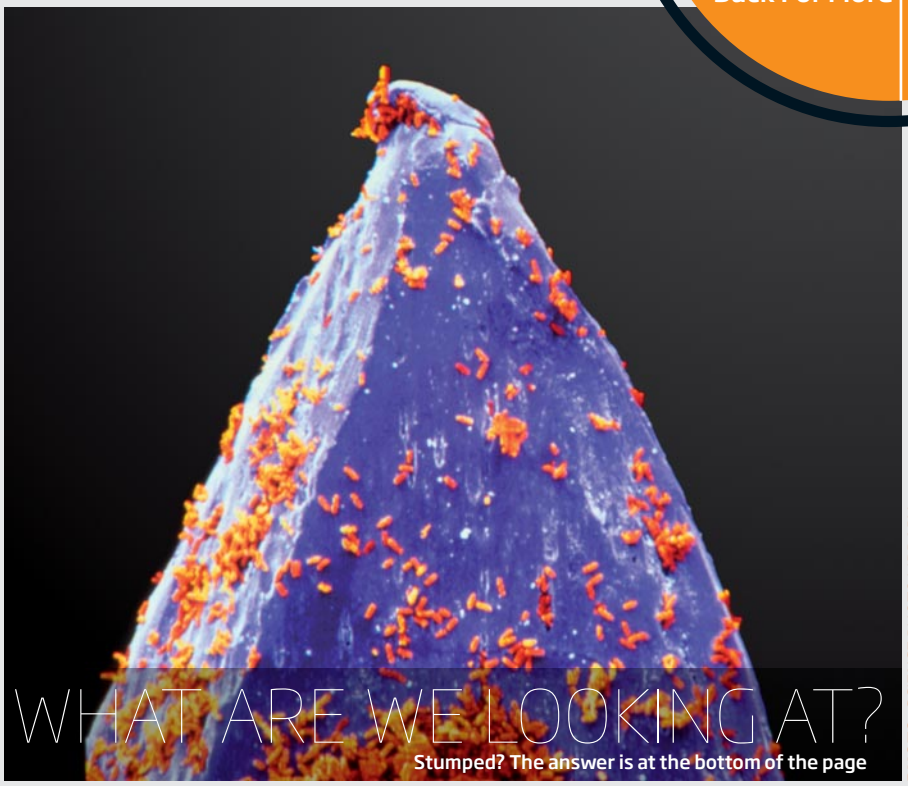
Dr Jim Rodger, head of professional services, MDDUS

OUT THERE

NO SCARY CLOWNS Can clowns reduce preoperative stress (or make it worse)? Doctors at the HaEmek Medical Center in Israel plan to run a trial in which patients about to undergo cataract surgery will be shown a 'medical' clown to determine if this will reduce preoperative anxiety and reduce the risk of cardiac arrest during surgery. *Source: BMJ*

HAZARD OF THE PROFESSION **Doctors and nurses pumping the stomach of a 34-year-old Japanese farmer who drank pesticide in a suicide bid had to be treated for breathing problems and eye sores after the man vomited the poison in A&E. Fire fighters were brought in to decontaminate the ward. The patient died. *Source: AP***

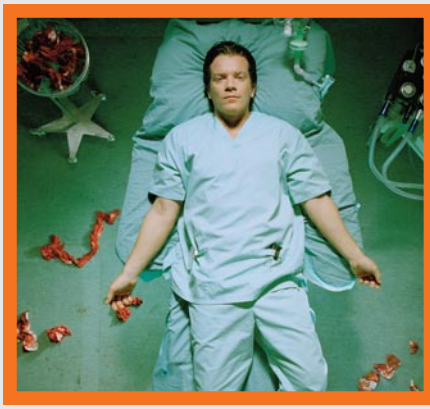
SECRET OF MY (LACK OF) SUCCESS. Male financial traders with ring fingers longer than their index fingers make the most money. A Cambridge University study of 44 men over 20 months found that London traders with greater relative ring finger length earned up to 11 times more than the less-endowed. *Source: BBC*



WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: SCIENCE PHOTO LIBRARY



Pick: DVD - Bodies (Series 1)

Directed by John Strickland (others); starring Max Beesley, Patrick Baladi; 2004

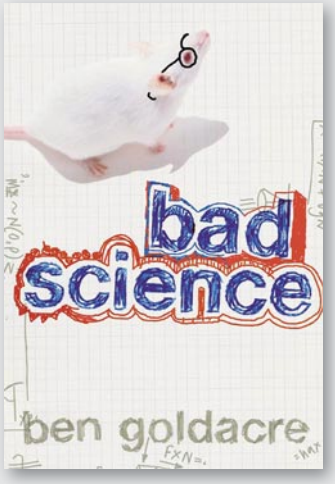
Consultant Roger Hurley is a disaster waiting to happen, as specialist registrar Rob Lake learns soon after joining the obstetrics and gynaecology department at fictional South Central Infirmary. Nurses, midwives, doctors – almost everyone knows but it remains a dirty secret. Sound familiar?

***Bodies* is medical drama that any hospital doctor will recognise – grim, bitchy, bloody and exhausting yet compelling. Writer and former medic Jed Mercurio scripts a tight storyline weaving in themes familiar to anyone working in the NHS: blame and the culture of covering one's back, the perils of whistle-blowing, battling with management and the personal heartache of an all-consuming career. The editing is fast and slick, and the medicine believable.**

Will Rob raise his head above the parapet as the toll of Hurley's mistakes escalates? Gripping stuff.

Book Review: Bad Science

Review by Jim Killgore, Associate Editor



Fourth Estate 2008; ***£12.99***

GILLIAN MCKEITH FIRST CAME TO the notice of *Guardian* columnist Ben Goldacre in a review of her Channel 4 series 'You Are What You Eat'. In the article the 'clinical nutritionist' was quoted as recommending eating spinach and the darker leaves on plants because they contain more chlorophyll and thus are high in oxygen and will "really oxygenate your blood".

Goldacre devotes an entire chapter to McKeith in *Bad Science* – a new book based on his column of the same name. He writes:

"Is chlorophyll 'high in oxygen'? No. It helps to make oxygen. In sunlight. And it's pretty dark in your bowels: in fact, if there's any light in there at all then something's gone badly wrong."

I have long been a fan of Goldacre's witty and unsparing attacks on pseudo-science and this book in no way disappointed. For anyone unacquainted with his writing yet frustrated at how evidence is endlessly contorted, misapplied or utterly ignored to support everything from homeopathy to autism by the MMR, *Bad Science* reads like a treat.

A full-time doctor with the NHS, Goldacre offers a refresher on the basics of the scientific method and how evidence is applied in accessing the efficacy of treatments. He points to the success of later-day potions and snake-oil treatments as testament of a general ignorance of basic statistics and the nature of risk.

"Today, scientists and doctors find themselves outnumbered and outgunned by vast armies of individuals who feel entitled to pass judgement on matters of evidence without troubling themselves to obtain a basic understanding of the issues," he writes in the book's introduction.

"The hole in our culture is gaping: evidence-based medicine, the ultimate applied science, contains some of the cleverest ideas from the past two centuries, it has saved millions of lives, but there has never once been a single exhibit on the subject in London's Science Museum."

But this makes the book sound rather turgid and worthy. It's not. Goldacre's special talent is the sharpness of his wit and the way he uses "trivial absurdities" to frame his arguments on the urgent need for education to demystify science, to stop people viewing it as "a monolith, a mystery, and an authority, rather than a method".

And the need has never been more keen than in medicine where high-profile errors seem to hit the headlines daily and undermine public confidence.

"Doctors can be awful, and mistakes can be murderous," he acknowledges, "but the philosophy driving evidence-based medicine is not".

WHAT ARE WE LOOKING AT? *Bacteria on the point of a syringe needle*