FYi

ISSUE 03

READY FOR ANYTHING

THE CHALLENGE OF EMERGENCY MEDICINE

MDDUS

PHOTO: WALTER NEILSON

Welcome to your FYi

TALKING TO PATIENTS IS A SKILL often taken for granted in medical training. In the past, doctors were encouraged to focus largely on clinical aspects of medicine rather than on honing their communication and consultation skills. But that's all changing and now there's a greater emphasis placed on learning how to speak to patients in different situations, whether it's explaining a diagnosis or asking for their consent to treatment.

In this third issue of *FYi*, Dr Tom Berry, an StR 1 in surgery, offers advice (page 4) on what many see as the hardest part of the job - breaking bad news. Also in this issue is practical advice about medical negligence from solicitor and medico-legal expert Lindsey McGregor (page 6), who explains the concept and highlights ways in which trainee doctors can avoid getting into difficulty. And on page 12 we look at a related issue - clinical guidelines and their relevance in determining medical negligence. Is guidance from bodies such as NICE or SIGN legally binding?

On page 10, Peter Nelson, who teaches ethics at St Andrews University, raises some interesting discussion points on the field of complementary and alternative medicine. What started life as a collection of simple alternative therapies is gaining increasing public acceptance as a recognised medical specialty.

Last but not least, on page 14, we explore the perils of social networking sites like Facebook and Twitter, while on page 13 we look at the role of tasters in helping trainee doctors make that all-important career decision.

• **Dr Maggie Cairns**
Editor

Now tidy your room!

IT'S widely accepted as being part of the job description for students to have messy rooms and play loud music.

But it seems certain medical schools are taking a dim view of some of the more minor antics of their students by threatening GMC-style fitness-to-practise hearings for those who set off fire alarms or disturb the neighbours with their choice of tunes.

The hearings are normally reserved for addressing serious breaches by dangerous individuals who have put patients' lives at risk. But the BMA's medical students' committee has heard of some students being disciplined for trivial matters like untidy halls of residence, parking violations and failure to fill out optional feedback forms.

The news, which was highlighted at the BMA's annual representatives meeting, has caused alarm amongst student representatives who say would-be doctors must not be treated unfairly. Those hauled in front of a hearing face having a black mark against their name which can cast a shadow over their whole medical career.

Dr Hamish Meldrum, chairman of council of the BMA, told the conference it was "totally inappropriate" for the GMC to deal with minor offences like untidy bedrooms. Student leaders support the use of such procedures for serious issues such as plagiarising other's work or assaulting a patient, but not for trivial, non-medical misdemeanours.

FAB forum

ARE you satisfied with your foundation training? A new advisory group has been set up to gather FY doctors' views on their training programme.

The UK Foundation Doctor Advisory Board, or FAB, is the brainchild of the UK Foundation Programme Office (UKFPO) which oversees recruitment and selection within the foundation programme as well as the entire curriculum and how it is delivered. FAB is a means of "engaging with foundation doctors and taking their views and ideas seriously" in a bid to improve the existing programme.

The board held its first meeting in London in May and members plan to open a dialogue with Scots foundation doctors over foundation programme issues. Dr Ross Stewart, FY2 and new Scottish Foundation School Representative to FAB, said:

"All too often it appears that we are the last people to have our opinions heard regarding postgraduate training. This is a real and reliable vehicle for foundation doctors' input to modify and improve training for future UK junior doctors."

Ross plans to set up an online forum for Scots foundation doctors to encourage them to get involved with FAB.

MDDUS

EDITOR:
Dr Maggie Cairns

ASSOCIATE EDITOR:
Joanne Curran

DESIGN:
CMYK Design
www.cmyk-design.co.uk

PRINT:
Woods of Perth
www.woodsofperth.co.uk

CORRESPONDENCE:
FYi Editor
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

t: 0845 270 2034
e: jcurran@mddus.com
w: www.mddus.com

Mixed Sources
Product group from well-managed forests, and other controlled sources
www.fsc.org Cert no. TT-COC-002624
© 1996 Forest Stewardship Council

recycle
When you have finished with this magazine please recycle it.

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 Memorandum and Articles of Association.

Anger at debt burden

FUTURE MEDICAL GRADUATES FACE student debts of nearly £40,000, the British Medical Association has found.

The union surveyed more than 2000 students in England and Northern Ireland and discovered those beginning their five-year courses are likely to graduate £37,000 in the red. They warned that a medical career could one day become the preserve of the rich, as students from poorer backgrounds are put off by rocketing costs.

Policies such as tuition fees have been blamed for excluding would-be students from the poorest backgrounds. The survey found that those who started medical school before the introduction of charges in 2006 were graduating with debts of £19,000. But those who started after this date face an average debt of £37,000.

Tim Crocker-Buque, chairman of the BMA's medical student committee, said something must be done about rising costs. He said: "Medical education is becoming increasingly expensive, edging ever closer to the total exclusion of those without the access to the cash with which to fund themselves. Medical education should be about your potential to become a great doctor, not your ability to pay."

He called on the government not to increase the £3225 yearly cap on tuition fees because it could have a "crushing" effect on students. A review into fees will be carried out later this year and many fear universities will be granted powers to set their own charges. This could push fees as high as £20,000 a year in some schools.

Know your rights

JUNIOR doctors who need advice on contractual employment issues such as poor working conditions or part-time training can find out more information in a new BMA campaign.

Know Your Contract, Know Your Rights – led by the union's Junior Doctors Committee – aims to shed light on a range of issues affecting trainees, from money matters to working hours.

The union found many young doctors didn't know the basic rights as set out in their employment contract. The new campaign features fact sheets, e-mail alerts and video clips covering a wide range of topics on the contractual rights of trainees.

For more information log onto: www.bma.org.uk/contractcampaign or call askBMA on 0300 123 123 3.

FEWER GP APPLICANTS

THE number of doctors applying to train as GPs has dropped by a third to 6000 this year.

A number of UK deaneries in England and Scotland are expected to have vacancies left after the first round of recruitment. For the first time ever, the National Recruitment Office for GP Training could not find enough eligible applicants and was forced to hold a second round of recruitment to fill nearly 300 spaces.

But it's expected that some training posts will remain vacant even after the extra round. The shortfall comes as GP training programmes are set for major expansion. GP registrar posts in England are to rise from 2700 in 2009 to 3300 in 2011.

The drop in applications could spark moves to end the year-on-year reductions in the registrar's supplement as recommended by the Doctors' and Dentists' Review Body which some registrars claim is responsible for the fall in recruitment.

The BMA is surveying GP registrars about their hours and work load. An NHS Employers spokesman said they did not believe the low take-up of GP training places was down to the supplement charge.

THE HARDEST PART

Breaking bad news is never easy – for anyone. **Dr Tom Berry** offers some helpful insight

TO BE a doctor is a privilege but with it comes responsibilities that can be onerous, to say the least. If you have ever talked to a friend outwith the profession about breaking bad news they will likely have shaken their head and said "rather you than me".

This is a difficult part of the job but it also offers a chance to make a difference, to really be a doctor. It's a defining point in the remainder of that person's life. True, their personality, family support and other elements will affect how they deal with the news, but you can affect in what direction they set off.

We need to talk

The imparting of bad news is a skill that must be learnt and honed. Medical schools and post-graduate college exams have focused more on communication in recent years which is evidence of the recognition – albeit belated - that such skills are central to our work.

It may be awkward, but the only way to learn is to watch those who are more experienced. Like any other skill in our profession, you must observe and note good practice that you would hope to imitate. You must be in the room when bad news is broken, as unobtrusively as possible and only if the family and patient have no hint of an objection.

Be prepared

Neither the doctor nor the patient should ever be unsupported when ill tidings are in the air. This may not always be easy for a doctor in general practice, but in hospital a nurse or other colleague should always be there. They may help if you falter and, if you have to leave, they can stay on. This allows a feeling of

"It is natural to be upset...so take a few minutes before carrying on with work"

gradually withdrawing rather than a wholesale, "Right that's the way it is, we're all off then."

If an interpreter is required, make sure they will be there and discuss the salient points with them in advance. You both must be prepared and think about how they will phrase things and what words they will use. Remember, they may have significantly less training and support in breaking bad news. You may feel the news is coming from you but it is the interpreter's words they will hear and it is to them that they will turn and direct questions. Do not forget how the situation may affect the interpreter.

Facts of the matter

The *Oxford Handbook of Clinical Medicine* (the infamous 'Cheese'n'Onion') is one of many sources offering advice on breaking bad news and there are others online. The key elements are constant:

- Introduce yourself and be clear and concise if asked direct questions. If you have never met the patient before and you are asked: "Are you one of the doctors who looked after my Dad?" explain that you are not but that you are the doctor working this evening and you did not want the family to be kept waiting.
- Always use clear and direct language. Avoid euphemisms because the embarrassment and hurt that can be caused when details are misconstrued can be more damaging than the natural grief and distress caused when the plain facts are made clear.
- Have a plan for further meetings, referrals or palliative care treatment. This gives a more positive slant to the close of the meeting. Always document all such encounters and the salient points in the medical records.

We did everything we could

Breaking the news of a death follows a very similar pattern. If you do not already know the family, it is essential to establish their knowledge of the seriousness of the illness or trauma. When you state that the person has died do not rush to say any more than "I'm very sorry." Even if the news was expected there must be some time to allow it to sink in and nothing you say in those first few moments will be taken in.

Do not be tempted to go into great detail unless the family request it and question you. A further meeting later that day or the next may be the time to discuss matters in depth. I have seen families in bleary bewilderment whilst someone tries to describe in detail why the emergency surgery was unsuccessful. Anatomical terms, operative equipment, procedural names, the whole works are rarely appropriate.

It hurts me too

News of a terminal illness affects the patient, their family and friends, and you. Do not forget you. You cannot tell someone they are going to die, whether you've known them a year or a day, without feeling its impact. You may relate it to a friend or relative, to a previous case or you may play out imaginary and upsetting scenarios of how it will affect their family. Even avoiding thinking about it shows it is affecting you and, more importantly, that you are not dealing with it.

Patient confidentiality must be maintained, but you can still talk to friends or colleagues about a difficult day or having to tell someone terrible news. Do not feel that you must shoulder the burden alone. It is natural to be upset and disheartened so take a few minutes before carrying on with the rest of your work and be aware it may preoccupy you throughout the day.*

Don't avoid these situations and have someone else break the news. This is a key part of being a doctor and goes hand-in-hand with the privileges of being so intimately involved in caring for people. Developing these skills through reflective practice will help improve your confidence in such emotionally-charged settings and further your professional development.

Dr Tom Berry is an StR 1 in Surgery in Glasgow and a BMA Scottish Junior Doctors' Committee representative

MORE INFORMATION

- National Council for Hospice and Specialist Palliative Care Services: **www.ncpc.org.uk**
- Breaking Bad News... Regional Guidelines Feb 2003: **www.tinyurl.com/qcfm3v**
- Communication skills cascade in health care: **www.tinyurl.com/kv56js**

Doctors for Doctors: Should you find work-associated stress overwhelming, contact the BMA's 24-hour confidential counselling service for medics and their families to discuss personal, emotional and work-related problems. Call **08459 200 169 or access **www.tinyurl.com/m2u6zv** for more information.*

Breaking the news

BEFORE

- Adequate time allocated
- No bleep
- Know the facts
- Prepare for obvious questions
- Privacy for discussion

TO BEGIN

- Do they know why they are there?
- What do they know so far?
- Simple straight facts
- No overload of info
- Clear language

IN SUMMARY

- Written material if appropriate
- Clear contact details if any questions
- Perhaps plan to meet again

DAMAGE

Medical negligence claims are an unavoidable professional hazard for any doctor. But there are steps you can take to protect yourself, says MDDUS solicitor **Lindsey McGregor**

IT'S NOT a subject most doctors like to think about at any time in their career, much less when just starting out. But claims of medical negligence pose a risk to even the best clinician. There has long been a common misconception among the public that any mistake or adverse clinical outcome is negligent. Today's harsh economic climate has only increased the incentive for aggrieved patients to answer those adverts from law firms promising 'no win, no fee' legal representation.

As a junior doctor you are unlikely to shoulder much of the responsibility for treatment decisions or the implementation of systems; however, it is always better to understand risk in order to more effectively avoid it. By adopting good habits early in your career you are less likely to face criticism in the future.

So what constitutes medical negligence and how is it proven? Every medical claim must be considered in terms of whether the injury resulted from negligence, which would give the patient a right to compensation, or from a misadventure in which case there is no such right. To be successful, the patient or pursuer (claimant in England) must prove the following factors:

- the doctor owed them a duty of care
- there was a breach of that duty
- the breach of duty was the direct legal cause of the patient's injury.

Duty of care

It's very rare for a duty of care not to exist in respect of a patient. NHS trusts and health authorities are clearly liable for the negligent actions of personnel and are responsible for the settlement of claims made against medical staff while under employment.

For a duty of care to exist, there must be reasonable forseeability and proximity of the damage. This means that it must be possible to have anticipated and thus prevented the damage. One such case in which this was at issue concerned a patient who threw himself out of a window *(Rolland v Lothian Health Board)*. The patient was suffering from mental confusion and his condition was well recognised and documented. The trust was sued on the basis that they owed a duty of care to the patient to prevent him from coming to harm. But there was no evidence to suggest that the patient had ever sought to jump or fall from a window before. The judge ruled that the patient's actions were not reasonably foreseeable and that a duty of care therefore did not exist.

Breach of duty of care

There is no statute which provides a definition for the term 'medical negligence'. Legal principles have been established by precedent in case law and each new case is judged on its own merits bearing in mind these principles.

The landmark case in Scotland was that of *Hunter v Hanley* which was decided in 1955. In his judgement Lord President Clyde wrote: "The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care".

In order to establish whether or not there has been a departure from normal practice, three facts require to be established:

- there must be a normal and usual practice
- the doctor has not adopted that practice
- the course adopted by the doctor is one which no professional man of ordinary skill would have taken if acting with ordinary care.

LIMITATION

A heavy onus is placed upon the pursuer in establishing whether or not a breach of duty has occurred. They must instruct their own expert to review the records and to provide an opinion which concludes that all three aspects of the *Hunter v Hanley* test have been met. If such an opinion cannot be given then the case will fail. When providing the report, the expert requires to take into consideration the experience of the doctor involved and the guidelines and state of medical knowledge at the time of the alleged negligence.

Causation

The pursuer must also establish a causal link between the alleged negligent act and the harm that has been caused. Even where liability is clear and perhaps even admitted, it may not be possible for the pursuer to prove the required causation between the negligence and the damage.

An example of this is the case of *Barnett v Chelsea and Kensington Hospital Management Committee*. In this case, the judge concluded that a casualty house officer had failed completely to treat a night watchman who had drunk tea contaminated with arsenic. Whilst the house officer was negligent in his treatment of the patient, there was no effective antidote which could have been given to the patient by the time he reached the hospital. It was the view of the court that the night watchman would have died in any event and therefore no loss could be attributed to the negligence.

The claims process

In any medical damages claim a court action must usually be served against either the hospital or the doctor within three years of the alleged adverse event. The main exception to this rule is in the case of children (in Scotland those under 16) who require to raise their action within three years of reaching majority. Time limits can also be extended for those under mental disability. The result of these time delays is that in some cases it can be many years before a doctor is required to give evidence in court.

Once an action is commenced there are processes to generate the many reports that are required to establish negligence, causation and quantum (value of the claim). It can take up to two years for a hearing to be fixed.

The delay between the alleged negligent event and the eventual court hearing can cause enormous stress to those involved, particularly when they may have no recollection of the patient concerned and are relying only on notes made at the time.

MDDUS medico-legal advisers and in-house solicitors will work closely with the member to guide them through the various stages in the claims process. If the claim arose whilst in the employment of a hospital, the Central Legal Office or the National Health Service Litigation Authority will manage the case on behalf of the hospital.

Avoiding risk

The main areas of risk arising in relation to claims are as follows:

- failure to make and keep adequate records
- failure to take proper consent
- lack of appropriate guidelines or protocols or failure to use them
- the use of new techniques with insufficient training, evaluation or audit
- poor supervision of junior staff
- failure to investigate adverse instances quickly
- failure to handle complaints adequately.

Perhaps the best advice on risk avoidance is to always keep good, clear and legible records. Often doctors in medical negligence cases have only their notes to guide them and may have no recollection of the consultation. Many cases turn on the adequacy of a consultation record and this can influence the decision either to defend or settle a claim.

So act now and be aware of the areas where risk can arise, and remember that the MDDUS is there to assist and provide advice if you are concerned.

Lindsey McGregor is a solicitor at MDDUS

READY FOR ANY

Looking for pace, challenge and unlimited variety? Emergency medicine may be the job for you

EMERGENCY medicine (EM) has been the inspiration for a string of medical dramas from *ER* in the US to the BBC staple *Casualty* – and certainly the specialty offers an exciting and varied career choice ideal for quick-thinking doctors who thrive on challenge.

EM is the only hospital-based specialty where a complete spectrum of illness and injury is managed. Emergency physicians are generalists in the broadest sense of the term – responsible for assessing and resuscitating patients with serious illness and injury before their transfer to hospital wards or operating theatres, as well as treating patients with minor ailments who may be sent home for follow-up care with their GP as required.

EM doctors are based in hospital emergency departments (EDs) where they must be prepared to deal with medical emergencies, major traumas and sudden deaths. They often face the added challenge of coping with violent patients with drug or alcohol problems as well as those suffering from psychiatric illness or social problems.

The specialty first emerged in 1952 when Mr Maurice Ellis was appointed as an Accident & Emergency (A&E) Medicine consultant in the UK at Leeds General Infirmary. However, it wasn't until 1972 that the specialty of A&E Medicine was officially established with the launch of a pilot project that created 30 consultant posts.

There are currently around 1300 doctors at consultant level in the UK, making it one of the smallest of the medical specialties.

Training

The College of Emergency Medicine lists the following personal qualities as essential for EM doctors:

- capacity to be alert to dangers or problems, particularly in relation to clinical governance
- ability to function under pressure
- good teamwork and leadership skills
- good problem-solving and decision-making skills
- ability to have empathy and sympathy with others
- good communication skills
- excellent time-management.

Junior doctors looking for an appointment as a specialty registrar in EM will have completed two years' general professional training as a Foundation doctor, during which time they will usually have completed four to six months in EM. Training is facilitated through the College of Emergency Medicine and it is essential for trainees to pass the College's membership and fellowship exams to proceed through training and receive a Certificate of Completion of Training (CCT).

Training usually lasts six years after completion of FY1 and 2 and is divided into three years' core specialty training (CT1-3) and three years' higher specialty training (ST4-6). In Scotland the programme runs seamlessly through from years one to six (ST1-6).

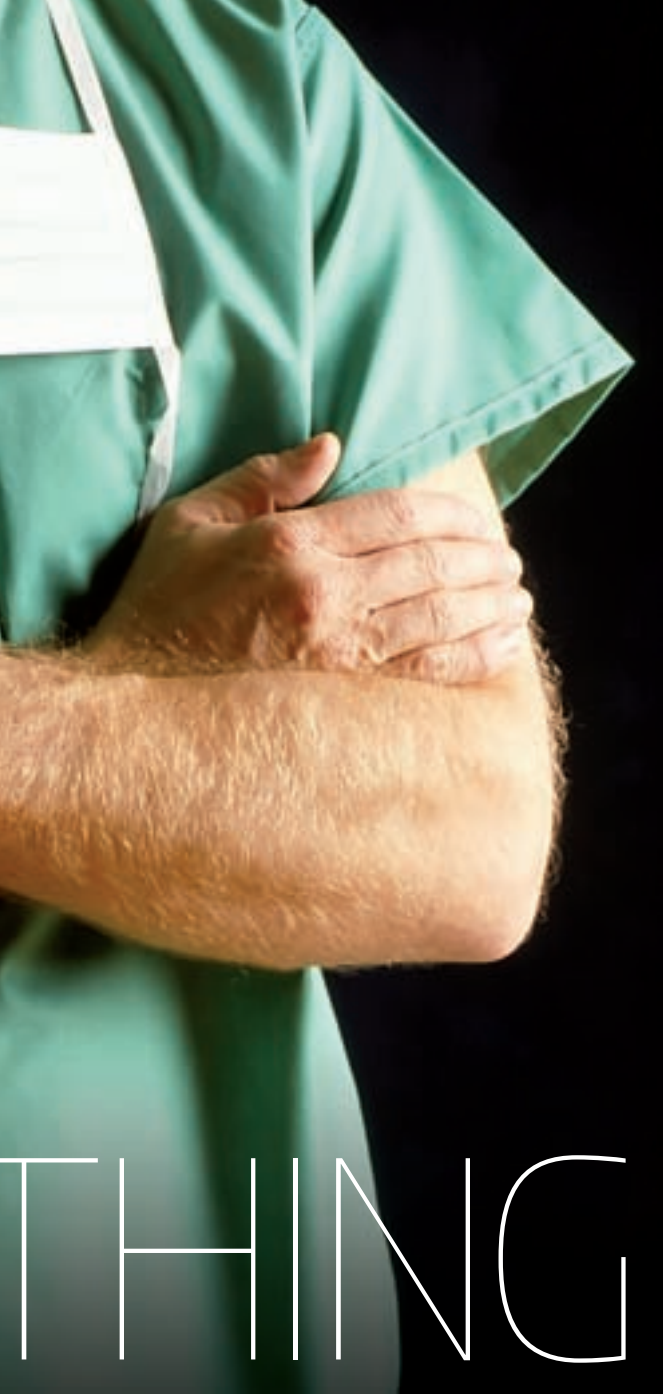
Core training involves two years' learning and experience in EM, acute medicine, anaesthetics and intensive care medicine followed by one year's learning and experience in how to care for children in the ED and how to care for musculoskeletal problems. Higher training is spent in EDs gaining additional clinical competencies and other EM-related skills.

In practice

Most emergency physicians provide hands-on clinical care in EDs (including review clinics) and clinical decision units. As a trainee there may be some on-call, but the majority of training programmes run as a full or partial shift system. Team working is key in a busy ED and doctors must learn to work alongside nursing staff, paramedics, in-patient specialists and GPs.

EM as a specialty lends itself to flexible training and working. The nature of the work is intense, but each patient contact is relatively short and follow-up responsibility is limited.

EM offers the opportunity to maintain a good general knowledge of most specialties. Additionally, emergency physicians may sub-specialise or even dual accredit in fields such as paediatric emergency medicine, acute medicine, pre-hospital emergency medicine



or intensive care medicine. Others develop interests in fields such as academic emergency medicine, poisoning or sports medicine.

The future

EM is expected to expand enormously in the coming years.

The Department of Health in England has committed to having eight consultants in each major ED by 2010 which will need a considerable expansion in consultant numbers. It is anticipated that consultant numbers will rise in line with the number of trainees expected to achieve specialist registration from 2011 onwards.

EM is one of the few specialties embracing a consistent 24/7 level of care while others are moving away from it. Consultants should expect to work late shifts, weekends and possibly even night shifts in the future to keep up with these changes. Many emergency physicians view the future as bright, presenting enormous opportunities for those prepared to continue to change and innovate.

Joanne Curran is associate editor of FYi

Q&A - Dr Fiona Burton, Specialty Registrar in Emergency Medicine

• What attracted you to emergency medicine?

I initially began my training in the surgical specialties with the intention of becoming an Orthopaedic surgeon. However, having spent a lot of time in the Emergency Department (ED) I found I worked well there. I was surrounded by positive role models who worked hard, enjoyed their job and always found the time to teach. I enjoy the camaraderie and being part of the team that is the ED. In the ED you see a huge variety of problems, from a sick baby to a polytrauma and an MI or two along the way. You have to be in a constant state of 'ready' because you never know what's coming through the door.

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

I find it difficult to choose one thing I enjoy the most because I love my job and being an emergency physician. Perhaps the most enjoyable thing for me is the people I meet, both patients and staff. Stabilising and treating a patient who is peri-arrest is pretty satisfying too.

• What is the most challenging part of the job?

Working in the ED presents daily challenges. I find dealing with young people who are involved in drink, drugs and violence difficult. Glasgow has a high rate of violence particularly with regards to 'stabbing' injuries. Trying to talk to and educate these youngsters is difficult. A challenge that many people talk of is the shift work. Personally I enjoy shift work and people have to remember that medicine is changing and this will feature in most people's roles in the future.

• What's your most memorable experience so far?

My first night on call as the senior doctor in the department when the standby phone went off four times in a row with one ambulance after another calling in sick patients. We had a couple of trauma patients, a couple of medical patients and our resuscitation room was full. Everyone in both the ED and other specialties worked as a team. The nightshift ended well. It made me realise what care should be like and how I want my department to run to ensure the best care for all.

• Has anything about the role surprised you?

I feel that working in the ED has really opened my eyes to my home city and all of its problems. There are problems with deprivation, drinking, drugs, violence, homelessness etc - problems you would find in most cities. You are often in a position where you can speak up and make people aware of the problems on their doorstep. Many of my colleagues are currently involved in the group Medics Against Violence and are visiting schools. Hopefully through education we will see a decrease in future numbers

• Do you have any advice for young doctors interested in a career in emergency medicine?

Every job you do is important and offers something that can be brought to the ED. Get as much experience in the ED as you can, whether it be requesting it as part of your rotation or as a taster week. If you don't know, ask. If your senior is doing a procedure, volunteer and ask if they will supervise you. Keep up to date with your resuscitation courses. Be like a sponge and soak up everything because one day you will use it in the ED.

PLACEBO PARADOX

Ethicist **Dr Peter Nelson** considers some profound implications in the apparent benefits of complementary and alternative medicine

I RECENTLY noticed the epithet "….Recognised by the NHS…." in a magazine advert for one of those bracelets which are meant to somehow impart a form of therapeutic power. 'Recognised', in a regulatory context, means that an evidenced-based medicine protocol has been applied to a therapy and concluded there is a proven therapeutic effect. It can also mean that it has been 'noticed and identified as something which one knows about' without applying any measured attributes. In the latter sense, the NHS is not morally obliged to defend their stance and the perpetrator of the advert will suffer no recriminations.

What concerns me, in terms of medical education and practice, is a more pervasive issue. What started out as 'alternative therapies' and then surreptitiously (or covertly) became 'complementary therapies' transformed itself into complementary and alternative medicine (CAM). Then it became what we now know as a form of integrative medicine (IM). In Germany it is an accepted part of medical school curricula. In the UK there is a side door approach. The result is CAM therapies are currently 'recognised' as valid forms of medical practice in both of the above senses of the word.

Indeed, many universities in the UK and abroad have been offering courses leading to bachelors degrees in some of the most commonly utilised CAM therapies like acupuncture and herbalism: in other words, those which do not have separate colleges for the study of these disciplines (homeopathy, chiropractic and osteopathy). It is extraordinary that, although these courses defy scientific explanation, they are studied within the universities' science departments. Different commentators have said they would be less critical if these subjects were taught in sociology or anthropology departments.

Placebo effect

Until recently, there had been no concerted effort to demonstrate the therapeutic efficacy of these therapies. This is amazing considering the fact that more patients attend CAM practitioners than GPs in the UK and for very good reasons, including well-demonstrated social, psychological and cultural reasons. Perhaps the most significant factor of all which is presently being addressed by academics is the 'placebo effect'. This approach is seen as the best means to assess the value of CAM therapies on a firm scientific footing.

Professor Edzard Ernst of the Peninsula Medical School and colleagues have been systematically applying meta-analytical evidence based medicine to individual therapies to overcome the anecdotal assessment and the poorly constructed trials which have historically been used to test their effectiveness. So far, the therapies investigated have shown to be no better than the placebos against which they have been tested in statistically significant, controlled, double-blind trials.

Many researchers are now of the impression that CAM is no better than placebo and what we are dealing with is the placebo effect/response. In drug trials, there is often a

"More patients attend CAM practitioners than GPs in the UK and for very good reasons..."

significant percentage of patients in the control placebo group who receive a positive therapeutic effect equivalent to those receiving the tested medication.

Paradox

The dilemma in regards to placebo and its effect has been appropriately raised to a new level in a recent *BMJ* letter[1]. Robin Nunn thinks we had better 'stop thinking in terms of a placebo' because the term is losing its meaning due to the paradox it creates. What was meant to be inert and have no physiological or pharmacological effect is now eclectic in triggering an 'effect' which is real and, for many patients, effective. And this effect extends beyond the symbolic meaning attached to acupuncture needles and the purported 'memory' attached to some original homeopathic tinctures which have been diluted to one molecule in all the oceans of the world. The time has come to interpret the meaning associated with the practitioner-patient encounter rather than devote any more time in evaluating treatments which can have no scientific or understandable therapeutic connections to what they claim to treat.

What doctors have to come to terms with is what Howard Brody calls 'the Healer's Power'[2]. In addition to the scientific basis of medicine and the clinical skills our trainee doctors acquire, we must impart an understanding of the power of the doctor's personality. This is not just a communication skills exercise, but a reality which represents and demonstrates the core values of a good doctor (GMC). It begins with a representation of character as fundamental as *curiosity* (interest in human nature), and progresses to *empathy* and *compassion* when appropriate. At times the patient may realise that what they are witnessing is a matter of *integrity* when the doctor is acting as an *advocate* on their behalf in their struggle with illness.

There is nothing magical or mystical about it. What doctors do is steeped in science. However, the effect is brought about by the relationship that the practitioner has with the patient – and this is often just as important and effective. It is what CAM practitioners do, and it often makes the patient feel better (the placebo effect or response). Introspective practitioners have applied a scientific understanding to its effect – what Brody calls an 'inner pharmacy' or chemical neurotransmitters which are released when a patient feels that they are listened to, attended to and addressed with understanding and knowledge of their condition (not just the name of their disease process). Think about how the CAM practitioner takes what seems like a completely different and lengthy interactive history and pushes many of the right buttons for the expectant patient and compare that with the five minute interview with the GP which ends in the slip of paper for the chemist.

When 'push comes to shove' many CAM practitioners admit they do not understand why what they do works and they attribute their success to a 'holistic' approach. Which may just be another way of saying they achieve a placebo effect.

Denialism

What may be more profoundly disturbing is the harm that can arise from seeking CAM solutions to life-threatening disease – the extension that comes from patients abandoning proven traditional medical therapy for alternative therapies. Think about what South African president Thabo Mbeki and his health minister have done to the millions afflicted with AIDS in their own country[3]. They 'recognised' a chance to appeal to the cultural traditions of their country and, by making dogmatic statements and expressing their antipathy toward antiretrovirals, have suggested a host of alternative therapies as the African solution to AIDS. And doctors in South Africa have wept over the fate of their fellow country(wo)men.

That kind of denialism, now being extended to cancer and other life threatening conditions, is making inroads in the affluent world and will cause further harm as long as people continue only recognising and not truly understanding.

Dr Peter Nelson is Senior Teaching Fellow at the University of St Andrews Bute Medical School

REFERENCES

1 Nunn R. It's time to put the placebo out of our misery - Personal view. BMJ 2009; 338:1568

2 Brody, H. The Healer's Power. Yale University Press; 1992

3 Specter M. The Denialists. Annals of Medicine – The New Yorker; 12 March 2007

BOUND BY LAW?

Is guidance from bodies such as NICE or SIGN legally binding?

The *BMJ* published an online supplement in 2007 looking back on medical milestones since the journal was first published in 1840. Among the chosen 15, which included the development of anaesthesia and the discovery of DNA structure, was the emergence of evidence-based medicine (EBM) – defined as the process of systematically reviewing, appraising and using clinical research findings to determine optimal clinical care for patients.

The term was coined in 1991 by research clinicians at McMaster University, Ontario, and in just a few decades EBM has become a core element in the practice of medicine and perhaps no more so than in the NHS. Bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) use EBM principles coupled with health economic analysis to determine which treatments should be available to NHS patients. Other professional bodies – colleges and associations – also utilise EBM assessments to develop specialist guidelines ensuring consistency in the treatment of specific conditions.

Assuming clinical guidelines developed on EBM principles are the best that medicine can offer patients, can they be considered legally binding for doctors in order to avoid charges of medical negligence?

The short answer is 'no'. Medical negligence hinges on the question of whether a doctor has breached the 'duty of care' to a patient by failing to provide the required standard of treatment. In common law this standard is measured against responsible medical practice or what a 'professional man of ordinary skill' would have undertaken if acting with 'ordinary' care. This standard is not judged directly against any particular guideline.

Courts rely on expert medical evidence in determining if a doctor has breached duty of care. Experts review the medical records taking into consideration a number of factors including the experience of the doctor involved and the state of medical knowledge at the time of the alleged negligence (see p. 6 of this issue). A key feature of this opinion will usually be recognised clinical guidelines for specific treatments, including those of NICE or SIGN or one of the professional associations.

Departing from guidelines

So is it ever wise to depart from NICE or SIGN guidelines in the treatment of a patient?

"Health professionals must always be mindful of the relevant guidelines in their field of practice," says MDDUS medico-legal adviser, Dr Gail Gilmartin. "Any clinical decisions to depart from the guidelines must be clearly justified. This requires full discussion with the patient and in some cases appropriate specialist advice, with detailed and full notes. Departing from guidelines may not be negligent but defending such action will rest on the quality of the consultations and records, and will be dependent on a responsible independent expert's support of the chosen course of action."

In one MDDUS case a 56-year-old man attended his GP with significantly raised blood pressure (systolic greater than 200mmHg and diastolic greater than 120mmHg). At a later review the patient was put on hypotensive treatment but stopped taking his medication because of the side-effects. The GP decided it best to review the situation again after attempts at reducing weight and alcohol consumption. The patient was then lost to follow-up and did not re-attend the GP.

Some months later the patient suffered a stroke leaving him with significant neurological loss. Lawyers acting on behalf of the patient launched a claim of medical negligence on the basis that the management of his hypertension had not been in keeping with current guidance available from professional organisations such as the British Hypertension Society.

The GP was of the view that these guidelines were unduly aggressive and he was anxious that he did not over-treat otherwise healthy patients. Medical experts instructed in the case found no logical basis for the GP's departure from the guidelines and it was decided that the case was not defensible on the grounds of liability.

Foundation year doctors working for the NHS must fulfil their duty of care to patients. In doing so they are expected to be aware of guidelines established by NICE and SIGN as well as local protocols and care pathways in their employing hospitals or health authorities. MDDUS recommends that any decision to deviate from guidelines should not be undertaken lightly and should certainly be discussed and approved by a senior clinician.

Better safe than sorry – both for the sake of your patients and your future career.

Jim Killgore is editor of MDDUS **Summons**

A TASTE OF THINGS TO COME

Tasters can provide a valuable insight into medical specialties for junior doctors - but it may be difficult getting the support you need to make the most of them

WITH more than 60 medical specialties to choose from in the UK, it's no wonder foundation doctors have trouble deciding which career path to follow.

The Foundation Programme lets trainees experience around six specialties but they are required to make that all-important decision about applying for a specialty in the early part of FY2. And with so many fields left unexplored, a well-run taster session could form a key part of that decision-making process. These placements offer FY1 and FY2 trainees the chance to spend two to five days exploring a specialty, to find out what it's like to work in that field. They can help a trainee decide which specialty is right – or wrong – for them by allowing them to see senior clinicians and other key workers in action.

The UK Foundation Programme Office, which oversees foundation training for doctors, currently has no official data showing exactly how many trainees take part in tasters. At present, the organisation of tasters varies greatly between deaneries with some foundation schools investing more time in the sessions than others. Anecdotal evidence suggests tasters are popular and the UKFPO is supporting the development of high quality tasters in every foundation school area and encouraging the creation of a local register of tasters that are available to all foundation trainees.

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. Time off the wards is usually taken as study leave, but this may be tricky to negotiate for those in busy hospitals and requires advance planning and negotiation with colleagues. Tasters are usually undertaken in the junior doctor's own hospital which means the experience doesn't require study leave funding. It is rare for a junior doctor to go on a taster that isn't conducted by their own employer – i.e. outside their deanery – due to the need for checks, issues over employment status and financial constraints. FY1s and FY2s are not usually expected to carry out their normal duties during a taster as the emphasis is firmly on learning what a career in that specialty will entail, from skills and attitudes to lifestyle and work-life balance. But occasionally a trainee will be required to contribute to their usual on-call rota during a taster. Tasters should involve one-to-one time with senior clinicians and current trainees who can speak about their experiences in the specialty. They should be well planned out with activities and contacts defined for each day.

Broadly speaking, there should be minimal difficulty in accessing tasters as sessions are usually organised in a way that accommodates the majority of trainees. That said, competition and demand can be higher for some specialties and a place on a taster is not always guaranteed. Trainees should speak to their local foundation programme director in the first instance for more information. Ideally, planning for a taster should start during FY1 with a view to taking part in the taster in the early stages of FY2.

Foundation trainees sometimes complain that the initiation and organisation of tasters is left to them, with little external support. This effort may repeat that of a previous trainee to arrange the taster. They can also report a lack of guidance for the trainee or the trainer on content or outcome and the results are not always a high quality experience.

Dr Melanie Jones, Special Advisor in Careers for the UKFPO, said: "Tasters are a great opportunity to explore something you have not been able to do during the foundation programme. They can help clarify your career thinking but they are an optional extra and might not appeal to everyone. UKFPO have recently issued guidance on tasters for trainees and their supervisors which is available on the UKFPO website."

An increasing number of junior doctors seem to be using tasters as a means of showing their commitment to a given specialty – an essential part of specialty applications – as well as to help them make up their mind about that field of medicine. But whatever they are used for, tasters can prove an invaluable career tool for junior doctors.

For more information on tasters: www.tinyurl.com/nqlh5h where you will find 'Guidance on Speciality Tasters for Foundation Trainees'

Joanne Curran is associate editor of FYi

TWITTER WITH CARE

Where not to air views on your boss, workmates - or your patients

IT'S the global phenomenon that has hundreds of millions of people hooked on sharing intimate details of their lives. But how many of us who use social networking sites like Facebook, Bebo and Twitter stop to think about the pitfalls of posting personal opinions and photos for all to see? Views tend to be fairly harmless observations about music or news events – but some internet users decide to spell out in graphic detail exactly how they feel about their boss, workmates or, in the case of medical professionals, their patients.

But what some users might regard as private comments amongst friends can soon become a public embarrassment. Facebook alone has more than 200 million active users worldwide and the site gets over a billion hits a month.

Twitter has almost 6 million while doctors.net.uk claims to have more than 160,000 registered UK medics on its books, with more than 30,000 logging on every day. With so many people accessing social networks (they have 13.7 million UK users), it's unlikely any 'private' comments posted online will stay that way for long.

Even if you 'lock' your web page to keep out the general public, controversial comments or images may still find their way into the public domain. There have already been many cases of accounts being 'hacked' or you may simply be reported by someone else using the site. Even deleted comments on sites like Twitter can still be visible for months, or longer, to people using search engines.

It might seem obvious advice to be careful about what you put on the internet, but that didn't stop a group of dental nurses creating a Facebook group called 'I'm a dental nurse and I hate patients'. They caught the attention of the General Dental Council last May when they described themselves as "dental nurses who are sick of patients and their bad attitudes, their stupid comments, their bad personal hygiene and the way they assume it's OK to burp in your face."

This was seen by Pam Swain, chief executive of the British Association of Dental Nurses, who posted a warning on the site. She reminded the nurses of the GDC's *Standards for Dental Professionals* that requires patients are treated with "respect and dignity" and that confidentiality is maintained. Dental nurse members were advised to leave the group before the GDC took action.

Similarly, the General Medical Council's *Good Medical Practice* guide requires all registered doctors to treat patients with dignity and to respect their right to confidentiality. The two biggest mistakes young medics risk making on social networking sites are breaching patient confidentiality and bringing the profession into disrepute. Both could attract the attention of the GMC, who has the power to launch an investigation, suspend the medic involved and – in the most extreme cases – have them struck off.

A recent case saw a trainee doctor being suspended over alleged offensive remarks about a senior on the doctors.net.uk site last August. The case sparked furious debate on both sides and the GMC said it would investigate.

MDDUS head of professional services, Dr Jim Rodger, said young doctors must take care with internet postings.

He said: "We are seeing a small but increasing number of cases of this type. So far they have not ended up at the GMC, but a doctor has previously been suspended.

"I would urge young doctors to be scrupulously careful because even if you don't name names, you can still breach confidentiality."

He cited a recent case of a doctor who described on Facebook how he treated a patient. But, because the circumstances were so unusual, it was possible to identify the patient involved.

Dr Rodger also warned of making defamatory or discriminatory comments.

He added: "What some young doctors see as harmless fun could seriously damage their careers."

TIPS TO AVOID TROUBLE

- Stop – and think carefully before posting comments or photographs online. These can still be found online long after they have been deleted.
- Never post information that could identify a patient or breach confidentiality.
- Never post comments that could be deemed critical or offensive about patients or work colleagues.
- Avoid posting comments or photographs that could be seen to bring the profession into disrepute – images of drunken antics etc are best kept out of social networking sites.

Joanne Curran is associate editor of FYi

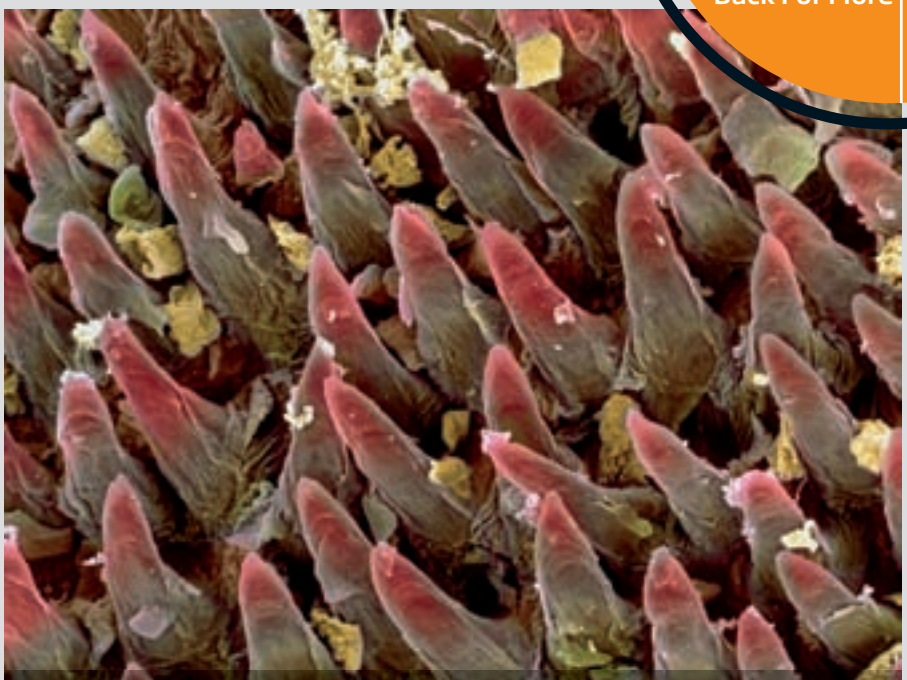
OUT THERE

IT'S GOOD TO SCRATCH Scratching an itch does help relieve itchiness, a new study has found. The University of Minnesota discovered scratching blocks activity in some spinal cord nerve cells. *Source: BMJ*

AND IT'S GOOD TO SWEAR **Swearing when you hurt yourself could make the pain easier to tolerate. Researchers at Keele University believe that cursing works by triggering the body's natural "fight-or-flight" response. *Source: livescience.com***

BODY SHOCK A lightning strike cured 51-year-old Serbian Nada Acimovich of a life-threatening heart condition. It's believed the force of the electric jolt fixed her arrhythmia by resetting her heart's rhythm. *Source: The Sun*

AND IN CASE YOU WERE WONDERING **Researchers at the University of Massachusetts comparing "hammering performance" in men and women have discovered that men hit the nail better in dim light but women were better in bright conditions. *Source: Science Daily***



WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: STEVE GSCHMEISSNER / SCIENCE PHOTO LIBRARY

PHOTO: THE KOBAL COLLECTION

Pick: DVD - One Flew Over the Cuckoo's Nest

Directed by Milos Forman; starring Jack Nicholson; Louise Fletcher; 1975

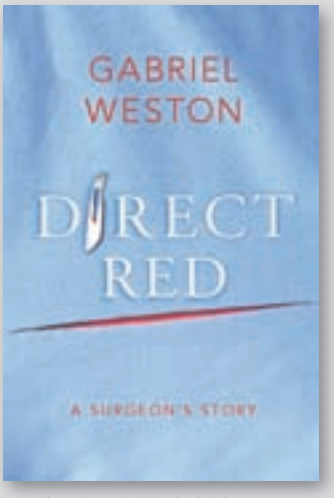
Jack Nicholson delivers his trademark off-the-wall performance in this film based on the 1962 novel by Ken Kesey. He plays Randle Patrick McMurphy – a wiseass convict who can hardly believe his luck when transferred to a mental institution for evaluation. Here he falls among a group of patients that he finds "no more crazy" than the world outside and urges them to rebel against the tyrannical Nurse Ratchet (Fletcher).

The film depicts a still all-too-familiar institutionalism where control – pharmacological and otherwise – takes precedence over any real attempt to improve the lives of patients. Among other stunts, Murphy leads a quixotic escape to take his new friends on a deep-sea fishing trip – all to remind them there is more to life than an interminable therapeutic process.

Can any one man beat the 'system'? That's the tragedy at the heart of this brilliant comic drama.

Book Review: Direct Red: A Surgeon's Story

Review by Joanne Curran, Associate Editor



Jonathan Cape 2009; ***£16.99***

SO YOU'VE GRADUATED FROM medical school and you sweep into the hospital ward on your first day with your brand new stethoscope and an overwhelming sense of purpose. You're ready to start saving lives and lay your healing hands on the needy hordes. For trainee surgeon Gabriel Weston, this idealistic start to her medical career quickly gives way to an alarming reality where her caring response to patients' needs is tempered by the need to make her mark in a predominantly male world, focused more on cure than compassion.

Now a part-time ENT surgeon in London, Weston recalls her first faltering steps in medicine with brutal honesty in a compelling memoir that is as beautifully written as it is gruesomely described. She strips away any preconceptions of all surgeons as selfless heroes whose only motivations are to save lives. At worst they are arrogant, lazy and incompetent with virtually no interest in communicating with patients. Often their medical decisions seem based as much on suiting their own needs as those of their patients.

There must be few places where a doctor so openly describes the shame of praying her patient is seriously ill, if only to justify a decision to operate to her superiors. Weston never flinches from discussing her true feelings, no matter how distasteful, when faced with an array of patient complaints and emergencies.

In one particularly painful encounter as a junior doctor, Weston is called at 3 am to a lonely and distressed 10-year-old boy named Ben who was admitted for investigation of headaches. Exhausted and unsure of how to speak to children, she doubles his pain medication, pats him on the shoulder and tells him things will be right by morning. He dies later that week from a sudden complication of an unsuspected brain tumour. She admits: "I still feel ashamed of how I behaved. I know now that what Ben needed from me that night was to give him whatever small amount of my heart's warmth I could afford. Without a parent nearby...Ben sought the nearness of another person. And he was unable to find this comfort in me."

Direct Red is a serious contender for a spot on all trainee doctors' required reading lists. It offers a fascinating insight into the closed world of surgery as well as tips and observations on a wide range of topics from coping with operating room nausea to sawing cadavers in half and surviving the unpredictable and emotionally charged world of medicine.

WHAT ARE WE LOOKING AT? *Coloured SEM of filiform papillae on the surface of the tongue*

MDDUS

Time is running out for you to join the BMA for free. Act now and join today!

Enjoy all the benefits of membership completely free until 30 September 2009. You have nothing to lose!

If you join to become a BMA member you will be able to enjoy advice and support on the following:

- Your contract of employment and what terms should be included
- What you should be paid and why (one trainee doctor gained more than £3,000 in back pay after a BMA negotiator worked out they were on the wrong pay scale)
- The hours you should be working (and what to do if your working hours are illegal)
- Your study and annual leave entitlements
- And much more...

Join online today www.bma.org.uk/join

BMA