FYi

ISSUE 04

DOWN THE RABBIT HOLE

TAKING THE PLUNGE INTO A SPECIALTY

MDDUS

PHOTO: WALTER NEILSON

Welcome to your FYi

AS JUNIOR DOCTORS, LEARNING how to make the right decisions under pressure is all part of studying medicine. But not all difficult decisions are clinical. Choosing your specialty is one of the most important moves a junior can make. So how do you make the right choice?

After much deliberation, I chose psychiatry and on page 4 I offer my own perspective on how I arrived at that decision. Indeed, this fourth issue of *FYi* is something of a psychiatry special, with an article on page 8 focusing on what you can expect from a career in "one of the most interesting and eclectic of all medical specialties".

Meanwhile, FY2 doctor Sarah Birney offers advice on page 12 on what is increasingly becoming a day-to-day part of the job for many doctors – treating patients who speak little or no English. How can you be sure patients understand proposed examinations or treatments and have provided informed consent? When is it best to call in a medical interpreter?

On page 6 solicitor and medico-legal expert Denise McVeigh explains the importance of maintaining appropriate boundaries with your patients and gives some practical advice on how to avoid getting into difficulty. She tackles common misconceptions about doctor-patient relationships and highlights some key risk areas.

The issue of data security is never far from the headlines these days and on page 14 we look at some important steps junior doctors can take to keep confidential information safe. And on page 10, *FYi* associate editor Joanne Curran looks at the UK's proud tradition of medical dynasties, with some stretching over hundreds of years.

Medicine can often be a family affair (as it is in my own)!

Dr Maggie Cairns
Editor

A FAIR DEAL ON TRAVEL

A NEW deal has been struck over travel and relocation expenses for junior doctors in Scotland.

Years of negotiations between NHS Scotland and the BMA's Scottish Junior Doctors Committee have finally ended in agreement. Health minister Nicola Sturgeon MSP intervened in the talks and agreed that the expenses should apply equally to all junior doctors as they are moved around various work placements across the country.

Chair of the Scottish JDC Dr Gordon Lehany said: "This has been a long and drawn-out process and I am pleased that the cabinet secretary has recognised the fairness of entitling junior doctors in all grades to claim for the travel and relocation costs that they incur during their rotations across Scotland."

Ms Sturgeon said the new agreement should apply "fairly to all doctors in training in Scotland" and "should be based on equity of treatment to all doctors in training whilst making the most efficient use of public sector finance." She said she hoped the new deal would be in place "as quickly as possible."

Specialty 'taster' guide

A NEW GUIDE to making the most of taster days has been published online by the BMJ.

The implementation of Modernising Medical Careers means junior doctors must choose a specialty earlier in their career. To help juniors make that all-important decision, the UK Foundation Programme Office introduced specialty taster days. Each trainee is entitled to 10 days – or five per year – trying out any specialty in a bid to boost their understanding of it.

This guide offers insights from a Dr Peter Craig who spent five days in trauma and orthopaedics for his taster week as well as tips from consultant orthopaedic surgeon Scarlett McNally.

Read the guide at **http://tinyurl.com/yzoqdno**

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EWTD review

EARLY DETAILS are emerging of a review into the impact of the European Working Time Directive on doctors' training.

Professor John Temple is the independent chair leading the review, which began in January and will make its final report in April 2010. He admitted that so far surgeons have made the strongest representations about the impact of the directive. Concerns have been raised that restricting junior doctors' hours to an average 48 per week could deprive them of sufficient training time.

Professor Temple, a surgeon, told BMJ Careers: "I would hope they would accept that I'm an honest broker and will come to a proper judgment at the end of the process. One of my biggest problems [with this] is that it has been a gradual thing, yet we come to D-Day and we are still worrying about it."

Health secretary Alan Johnson first announced the investigation last May. It will look at concerns raised by professionals that the introduction of a 48-hour working week may have had a negative effect on junior doctors' training. Medical Education England commissioned the inquiry, with the Postgraduate Medical Education and Training Board looking at how training might need to change to reflect the shorter training time available.

The inquiry has also begun a UK and international literature review and has so far met once. It is calling for written evidence from various organisations and individuals including professional, educational, patient and academic groups as well as from across the NHS. Professor Temple will also interview chiefs at the Royal College of Surgeons.

The European Working Time Directive was introduced fully in August 2009. Some specialties within some trusts, however, have applied for a temporary derogation from the directive, allowing doctors in those specific areas to work an additional four hours a week for up to two years (until 2011) and, exceptionally, three years (to 2012).

Hospital feels the EWTD pinch

A SHORTAGE of junior doctors has forced a hospital to stop night-time emergency admissions.

Llandudno General Hospital in Wales cannot admit emergency patients after 10pm. Recommendations have now been made to turn the hospital into a diagnostic, treatment and rehabilitation centre.

The health board said the difficulties in recruiting and retaining juniors had been compounded by the need to comply with the European Working Time Directive which came into force in August 2009. The directive limits junior doctors' working hours to an average of 48 hours per week. Health board spokeswoman Betsi Cadwaladr said: "Despite ongoing recruitment efforts, medical posts remain vacant and changes need to be made to staffing at both Llandudno and Ysbyty Gwynedd, to ensure patient safety."

A health board spokesman said that because of the shortage of juniors, the hospital would not be admitting emergency medical patients whose clinical needs are "beyond the agreed safety limits for the hospital".

Spotting the sick child

An updated version of an online educational tool to help healthcare professionals in the assessment of the acutely sick child has been launched.

The new interactive version of 'Spotting the Sick Child' now includes the presentation of swine flu. The learning resource is entirely online and features over 5 hours of new video footage of real patients and is aimed at emergency department staff, paediatric doctors and nurses in training, general practitioners, FY doctors and medical students. The online tool was commissioned by the Department of Health after recognising that healthcare professionals are often anxious about assessing children.

Doctors can access the service free of charge until March 2010. After that, a small registration fee will be charged to ensure further improvements. Go to www.spottingthesickchild.com

JUNIOR DOCTORS TRAINING THREAT

CALLS HAVE been made for an end to the Department of Health review of training funding amid fears junior doctors could lose out on millions of pounds.

The BMA Junior Doctor Committee has called on the DoH to stop its review of the Multi Professional Education and Training Levy, which will decide the future distribution of NHS training funding. The review looks at the funding of both undergraduate education and postgraduate training for all healthcare workers.

Changes could come into force as soon as April and the BMA's JDC fears the junior doctor training budget could be slashed. JDC chair Shree Datta said: "We are seriously alarmed that the impact of this review has not been thought through. The idea that the NHS could press ahead with this is simply dangerous. The Department of Health needs to be very careful that they don't end up making the training of doctors so unattractive or the funding system so unstable that hospitals no longer want to do it."

Junior doctors' salaries are paid in part by their employer for the service they provide to patients and in part by the DoH for their time spent training. The review is threatening to reduce the training component of their salary, which will make it more expensive for hospitals to employ junior doctors.

DOWN THE RABBIT HOLE

Nearing the completion of her foundation year two, *FYi* editor **Dr Maggie Cairns** faced another life-altering choice – but in the end it was an obvious one

FY2 was quickly ebbing and the tide of change was once again upon me. It was time to choose a specialty – but how would I know which was the right one for me? The experience, as ever, would be lasting. Was I happy and contented? Well that depends.

This year brought me into contact with some of the 60-odd specialties that make up medicine. It was these experiences, and those from FY1, that my colleagues and I would have to draw upon to decide which specialty we wanted to work in for the foreseeable future.

For my big decision, I turned to Freud – who else? "Experience consists of experiencing that which one does not wish to experience," he said. Well, in other words, some decisions are easier to make than others.

I avoided the 'cut' in surgery and I left the 'GP circuit' to others. GP training statistically beckoned for the majority of the FY2 family but personally I drew on previous pre-medical experiences to galvanise my chosen route.

Where to begin

Before making a decision, I sat down to think about what exactly I had achieved during my foundation years – another stamp of approval ordained by senior signatures, a collection of scrubs to be washed (and returned) and a realisation that quality care can be delivered despite the condition of the building in which I worked (Stobhill Hospital). In a strange way, I had fallen in love with that edifice – a Victorian collection of endless corridors and tunnels. The place seemed to fit well with my vision of Lewis Carroll's classic novel *Alice in Wonderland*. But which rabbit hole would I choose for my escape into the world of specialty training?

"Play to your strengths, but don't lose sight of your weaknesses."

That tunnel had to go in the direction I desired. The specialty had to make use of what I perceived to be my best attributes. The journey I was embarking upon had to impact positively on patient care, whilst being an innovative and rewarding experience for myself. As Alice succinctly put it, "If you drink from a bottle marked poison, it's almost certain to disagree with you sooner or later". Decisions! Decisions! Decisions!

Taking the plunge

Psychiatry was my chosen career path and so it was off to Monklands. Wards 24 and 25 of this Scottish hospital are based below ground, accessible only by an endless maze of staircases and corridors which bear an uncanny resemblance to my interpretation of Alice's journey into the void that was the 'rabbit hole'.

Historical evidence demonstrates that this mental health unit in North Lanarkshire was conceived and constructed in the 1960s. Here those with mental illness are housed in a subterranean world with such diverse neighbours as the mortuary and pharmacy. It made we wonder if public attitudes of the

time perhaps were not the most enlightened when it came to mental illness? But NHS Lanarkshire are currently working on plans for a new, purpose-built acute mental health care unit in the area that could eventually replace this underground area with a modern treatment facility.

On my first day in my new specialty the welcome was warm and certainly appreciated. For me, it was the return to a hospital where I served my FY1 year. Although I was in familiar territory, I never imagined my decision would lead me back to my starting point.

The initial announcement that I wanted to work in psychiatry met with a mixed response in my peer group. Some visibly recoiled and most had negative views. If there was any semblance of doubt that a stigma was attached to psychiatry, then these views and reactions reminded me of such. "So you're leaving medicine after all, Maggie?" said one devotee of core medical training. "Stethoscope for sale?" another commented. I don't think so. Mental health patients also have physical health problems, a truth I'm reminded of almost daily in my clinical practice.

Tedious. Frustrating. I didn't recognise these adjectives that some attributed to psychiatry, but rather I have found the terms 'challenging' and 'rewarding' to be more reflective of my day-to-day work. In essence, my inner resolve to persevere was aided by supportive seniors and a well-organised training programme – elements that are unheard of in some medical specialties.

As well as my daily work within the hospital environment, psychiatry offers the opportunity to work as part of a well-organised and coordinated team which includes community psychiatric nurses, social workers and occupational therapists. Outside visits include trips to patients' homes, residential centres for the elderly and community clinics. Such diversity in both the composition of the multidisciplinary team and the surroundings is essential within psychiatry. It gives us as care providers a fuller picture of our patients' needs and illustrates quickly if our patients require more help and support to keep them well.

I haven't quite covered the entire psychiatric alphabet so far. However, a range of cases from addictions to phobias and anxiety to personality disorders have figured prominently in my work to date. I just can't wait to deal with my first cases from Q to Z!

Deciding factors

My personal attributes and previous experiences formed a major part in my decision to train as a psychiatrist.

I believe communication, no matter the specialty, is paramount. "Speak English. I don't know the meaning of half those long words, and I don't believe you do either." I have often thought the wise words of *Alice in Wonderland*'s Eaglet should feature prominently in every duty room as a reminder for all to keep in touch with patients. After all, they genuinely need and desire this.

A background of law coupled with a sense of justice for all and my voluntary work with both the homeless and within a hospice setting first made me aware of mental health issues. In particular, the experience of the homeless community of Glasgow honed my understanding of the dominant role played by poverty in undermining the confidence and physical well-being of this burgeoning subculture. Here, the realisation came that medication alone was not the total solution but an understanding and awareness of people's problems, their background and culture allowed me to fully appreciate the need for a more holistic approach to be applied. In essence psychiatry can nurture such an approach.

The Foundation Program served me well, but was no blinding light on the road to Damascus. It acted as a basis upon which further knowledge and experience could be built. In seeking a final decision I had to be prepared to look backwards before advancing towards a specialty. The final realisation dawned that my voluntary experiences had a bigger impact upon my decision to enter psychiatry than I first could have contemplated.

Perhaps the secret of a successful transition from foundation to specialty training rests in your ability to play to your strengths but not lose sight of your weaknesses. If you can keep that in mind, the rabbit hole won't seem as daunting.

Dr Maggie Cairns is starting her specialist training year one programme at Monklands Hospital, Airdrie

- **MAKE THE MOST OF SPECIALTY TASTER DAYS. Each foundation year doctor is entitled to 10 days, five per year, trying out any specialty. This can give a valuable insight.**
- **WHAT DO YOU WANT FROM YOUR CAREER? It might help to consider what kind of hours you want to work; how much patient contact do you want; what setting do you want to work in – hospital or community? How intellectually challenging do you want your job to be?**
- **WHAT ARE YOU GOOD AT? Think about where your strengths and weaknesses lie and consider which specialty offers you the best chance for a successful and happy career. Also bear in mind the specific needs of the NHS as some specialties may offer more opportunities than others while some are more competitive than others.**
- **TALK TO SPECIALISTS. Try to discuss any specialty you may be interested in with someone who works in that field.**

STRICTLY PROFESSIONAL

MDDUS solicitor **Denise McVeigh** urges caution in any relationship with a patient outside a therapeutic context

DOCTORS have a privileged position in society and their work gives them privileged access to patients, some of whom may be very vulnerable. In its core guidance for doctors *Good Medical Practice*, the General Medical Council categorically advises doctors that: "You must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them".

In November 2006 the GMC expanded on this advice in a more comprehensive guidance document entitled *Maintaining Boundaries*. The guidance reflects changing attitudes towards the doctor-patient relationship. Long gone are the days of unquestioned reverence for those in the medical profession. Society now views the doctor-patient relationship as a two-way process and expects that respect will be shown on both sides. But in a relationship which makes mutual demands, it is important to remember that a greater degree of both responsibility and power still rests with the doctor.

In its expanded guidance the GMC recognises this potential imbalance of power and emphasises that an appropriate professional boundary is essential to ensure the maintenance of trust, both in terms of the individual doctor-patient relationship and also the general trust that the public at large should be able to have in the medical profession.

Abuse of trust

The potential for doctors to abuse this power in some cases is abundantly clear. For example, a patient may be either physically or emotionally vulnerable, or the doctor may control access to healthcare resources that the patient is reliant upon. Few doctors would doubt that a sexual relationship with a young or mentally troubled patient could lead to very serious professional consequences. The GMC has stated that a doctor whose conduct has shown that they cannot justify the trust placed in them should not continue in unrestricted practice.

But is this true of any relationship with a patient outside a therapeutic context? Certainly the requirement of a professional boundary is widely interpreted and it is important to understand that the GMC may still question a doctor's fitness to practise even if the relationship, on the face of it, is an entirely open and consensual one with no obvious adverse consequences for the patient. The relationship need not be long-term or sexual in nature to attract censure.

One case considered by the GMC's fitness to practise panel involved a male doctor who examined a female patient in accident and emergency and developed a personal relationship with her. The fitness to practise panel determined that the doctor's actions in giving the patient his personal mobile telephone number, responding to her text messages on matters unconnected with her medical condition, and engaging in flirtatious text messaging and conversation with her, whilst being a medical practitioner responsible for her clinical care, were inappropriate and an abuse of his position as a registered medical practitioner.

Timing and other factors

A common misconception is that relationships with former patients are unproblematic, provided the therapeutic relationship has come to an end. This is not always the case. Even where the relationship does not develop beyond the realms of a doctor-patient one until a considerable time after the provision of clinical care has ceased, there is still considered to be a risk that the previous professional relationship may be abused. For this reason it is unlikely that pursuing a sexual relationship with a former patient who was vulnerable for any reason at the time of the therapeutic relationship, will ever be considered acceptable.

"The GMC may still question a doctor's fitness to practise even if the relationship is consensual."

Similar problems can emerge if a doctor uses a professional relationship with a patient to pursue a relationship with someone close to that patient. The GMC makes it clear that a doctor "must not use home visits to pursue a relationship with a member of a patient's family."

Doctors who regularly encounter patients in a social setting – such as those practising in rural areas – may need to take extra care to avoid difficulties arising. The GMC suggests in *Maintaining Boundaries* that if social contact with a former patient leads to the possibility of a sexual relationship beginning, doctors should use their professional judgement and give careful consideration to the nature and circumstances of the relationship, taking account of the following factors:

- duration of the professional relationship and when it ended
- nature of the previous professional relationship
- degree to which the patient is, or was at the time of the professional relationship, vulnerable
- whether the doctor will be caring for other members of the patient's family.

Doctors not only have a responsibility for their own conduct when it comes to inappropriate relationships or behaviour, the GMC expects vigilance in relation to colleagues. *Maintaining Boundaries* states that if you have reason to believe a colleague has, or might have demonstrated sexual behaviour when with a patient "you must take appropriate steps without delay so that your concerns are investigated and patients protected where necessary". Advice on what steps to take can be found in the GMC's *Good Medical Practice*; *Management for doctors* and *Raising concerns about patient safety*.

Keep it professional

Conversely, if a patient makes sexual comments or advances towards their doctor, the practitioner is advised by the GMC to treat the person "politely and considerately" and make attempts to re-establish a professional boundary. In extreme cases it may be necessary to end the professional relationship with the patient concerned, but doctors should always refer to GMC guidance before taking this step.

In considering the appropriateness of any relationship with a patient, doctors should be mindful not only of whether they are abusing their professional position, but of whether they could be seen to be doing so. It is suggested that doctors take great care in making such judgements. Any member who is not sure whether a relationship could be viewed as an abuse of their professional position can seek advice from MDDUS. Alternatively, discussion with an impartial colleague or adviser is to be greatly encouraged.

The message is this: regardless of how natural the start of a new relationship may seem, doctors should remind themselves of the standards expected of them. An appropriate boundary with patients must always be maintained if professional integrity is to remain intact.

Denise McVeigh is a solicitor at MDDUS

NOT A COUCH IN SIGHT

Medicine, psychology, neuroscience, sociology, philosophy – a career in psychiatry offers a fascinating mix

IN JUNE of last year *Channel 4 News* aired a story highlighting a "catastrophic" shortage of psychiatrists in the NHS as fewer and fewer UK-trained medics apply for posts. This has led to an over-reliance on overseas doctors to fill training posts. Just one in eight doctors sitting professional psychiatric exams in 2009 were UK graduates.

It's difficult to understand why psychiatry is facing a recruitment crisis in the UK as it is one of the most interesting and eclectic of all medical specialties.

"The combination of different scientific disciplines covering areas as diverse as neuroscience, psychology, and social science, all brought together within a person-centred approach, is hard to beat within medicine," writes consultant psychiatrist, Dr Alan Lee.

"I have never once regretted my decision to train as a psychiatrist."

Psychiatry involves the diagnosis and treatment of patients with mental health problems such as depression, anxiety, personality disorders, learning disabilities and schizophrenia. Management involves a combination of measures including drugs, psychological treatments, working to improve home environments and social networks, and – very occasionally – use of physical treatments such as electroconvulsive therapy (ECT). Psychiatrists work with a range of other professionals, including clinical psychologists, social workers, psychiatric nurses and occupational therapists. Teamwork is essential and the apparent non-hierarchical nature of psychiatric MDTs can seem unusual to new trainees.

Mental health disorders are not diagnosed with a laboratory test. Great communication skills are the most important asset for a psychiatrist. As an added challenge, some of the most seriously ill patients have no insight into their own illness and may need to be treated without their consent under the provisions of the Mental Health Act. A good psychiatrist uses his or her communication and persuasion skills, as well as legal powers, to convince patients that they should cooperate with treatment plans. Most importantly, psychiatric patients get better with treatment. Many patients with psychosis or severe mood disorders will

Dr Jon van Niekerk, ST6 in psychiatry

• What attracted you to psychiatry?

My medical student placement in psychiatry was incredibly interesting and varied but too short to do the specialty justice. I decided to do my elective at a big mental health hospital in South Africa and it was here that I became fascinated with the diversity and richness of the specialty. During my specialty training I have had many opportunities to further my understanding of psychology, psychotherapy, philosophy, law and neurology – all subjects that make the specialty even more interesting. I became increasingly curious about what made us behave, think and feel the way we do. It is a privilege to continue to have the opportunity to ask these important questions in life over the span of a career.

• What do you enjoy most about the job?

In psychiatry the doctor is the drug most prescribed. The doctor-patient relationship is crucial and communication skills are more important than ordering investigations or following a set algorithm. As a psychiatrist you have the time to really get to know your patients well. It can be incredibly rewarding to be able to make a real difference to patients when they are at their most vulnerable. It could be argued that we are the only medical profession that can claim to be truly holistic.

• Are there any downsides?

Psychiatry continues to suffer from stigma in the wider society, but also within the medical profession itself. The challenge is for us to advocate for our patients and for our specialty. Psychiatry has some of the most effective therapeutic interventions that medicine has at its disposal, but this is unknown to the wider general public.

• What do you find most challenging?

I find it frustrating when I see mental health patients receive poor physical healthcare. There remains an unfair difference between the physical healthcare that patients with a psychiatric diagnosis receive

recover, return to work and can rebuild their relationships and lives with psychiatric support.

Entry to the profession

First exposure to the practice of psychiatry for most doctors is during foundation training rotas. Most trusts and deaneries have created foundation posts in psychiatry but numbers around the country vary. On completion of FY2, trainees interested in pursuing psychiatry as a career must apply for specialty training. Entry criteria are based on the key competencies of a good psychiatrist: medical expert, communicator, collaborator, manager, health advocate, scholar and professional. Professor Rob Howard, Dean of the Royal College of Psychiatrists, advises: "If you are interested in people and want to be engaged and involved in the lives of your patients and make a difference to them and their families – then we want you in psychiatry".

Many of the qualities of a good psychiatrist can be developed with training but an ability to communicate with patients and their carers and liaise with other professionals are important starting points. This is assessed via a combination of the FY2 portfolio, CV-based questions, a structured interview and assessment of teamwork and empathy potential. There are other ways to demonstrate your commitment to the specialty such as working with voluntary organisations like the Samaritans and Sane Line, or arranging to shadow a local consultant psychiatrist to gain first-hand knowledge of the work.

"There is a misconception that psychiatrists never cure people - that's not the case"

Training and practice

Specialist training in psychiatry takes 6 years and is divided into 3 years of core training (CT1–3) and 3 years of specialty training (ST4–6). Core training is spent in a wide variety of posts lasting four to six months. To move on to specialty training, STs must pass three written exams and one clinical exam in order to obtain Membership of the Royal College of Psychiatrists.

ST4-6 training is spent in one of the six different psychiatry specialties: general adult, old age, child and adolescent, learning disability, psychotherapy and forensic.

Workload and duties for psychiatry trainees vary widely between jobs. STs are usually responsible for the day-to-day management of in-patients and community patients and review them regularly, presenting updates at ward or community rounds. They also see both new and follow-up patients in out-patient clinics. STs can be involved in administering ECT and assessing patients presenting to accident and emergency. On-call duties are usually less hectic than in the acute specialties and many rotas allow you to be on call from home.

The future

Considering the current challenges it's likely that the NHS will put more resources into the recruitment of psychiatry trainees. Increased investment has already meant that there are 64 per cent more consultant psychiatrists than there were in 1997. The College is also rethinking how the specialty is perceived among medical graduates and is very keen to show trainees just how much enjoyment and satisfaction a career in psychiatry can deliver.

"I think psychiatry has struggled to attract UK graduates in the past because it has an image of otherness and weirdness; and a misconception that we don't ever cure people," says Professor Howard.

"The fact is that psychiatrists play a vital role in getting people back to work, keeping them out of the justice system, and assessing who is at risk."

Or as Dr Alan Lee puts it: "In psychiatry you can really make a difference to people struggling with the most devastating illnesses and can help them to return to satisfying and fulfilling lives."

For more information go to **www.rcpsych.ac.uk**

Jim Killgore is editor of MDDUS Summons

and the rest of the population. This is a challenge for both psychiatry and primary care and I would like to see much closer collaboration in the future. The mortality figures for those with severe and enduring mental health problems are unacceptable.

• What about the role has most surprised you?

I have been surprised by the compassion and kindness of carers. I continue to be amazed how these individuals are willing to put their own needs aside and take up these challenging roles for sometimes decades. A lot of our patients need the stability and continuity that carers provide to be able to function in a community setting. We would not be able to deliver care to a lot of patients without these individuals. In fact the whole of the NHS would probably collapse without carers.

• What is your most memorable experience so far?

I remember administering electro-convulsive therapy (ECT) to a patient that had a severe depressive episode. She was mute and had stopped eating and drinking and there were serious concerns that she might die. A few minutes after finishing the ECT clinic I was in the nursing station, when someone knocked at the door. A patient started asking me in a very assertive way, why the NHS complained about lack of money when they left windows open and the heating on. Much to my surprise I realised that this was the lady that was in a catatonic depressive state only minutes ago!

• What advice would you give to an FY considering psychiatry?

Despite psychiatry being the third biggest hospital specialty, we only have about 5% of Foundation posts. Therefore most of you will have to evidence your interest in the specialty in other ways. I would encourage those interested to join the free associateship that has been set up by the Royal College of Psychiatrists. There are several benefits, including free annual conferences, summer schools, an e-newsletter full of advice and free subscription to the College's journals. A taster session with a psychiatrist can also be invaluable and GP placements are also good to witness primary care psychiatric presentations. Audits are an easy way of showing interest as well. Psychiatrists are usually very approachable and willing to help.

KEEPING IT IN T

Britain can claim many famous medical dynasties – some stretching over hundreds of years. *FYi* associate editor **Joanne Curran** looks at a few of these remarkable stories

PHOTOGRAPH COURTESY OF GEORGE LYE

From left to right: the Lye family with the late Mr Richard Lye, surgeon (top left), and George Lye (top right), now an FY2 doctor; three of six generations of Maurice family doctors with Dr David Maurice (far right)

GEORGE Lye knew he wanted to become a doctor at the tender age of 16 when he first watched his father perform surgery to remove a brain tumour.

Now a 26-year-old foundation year 2 doctor at St George's hospital in London, George still remembers observing his dad, the neurosurgeon Mr Richard Lye, from a viewing area at the Royal Preston Hospital. It was an experience that cemented his desire to study medicine and helped steer him on his path towards one day becoming a surgeon himself.

There seems to be an almost hereditary element to the practice of medicine in some families – a desire passed down from parent to child like a family heirloom. George Lye grew up surrounded by medical influences and his choice to take up the profession seemed to him only natural. It was not just his accomplished father (sadly deceased in 2000) who inspired George but also his cousin Rachel Blackshaw who is an anaesthetist, his grandfather John Archibald who worked as a GP near Manchester and also served in the army medical corps in World War 2, and his great-grandparents who were both GPs in Glasgow in the early 20th century. George also qualified at Glasgow University and is now looking to start work as a specialist trainee in the field of head and neck surgery.

"When I was growing up, my dad always made it clear to me and my four brothers and two sisters how tough it could be as a doctor," says George. "He never wanted to glamorise it, but I knew fairly early on that I wanted to study medicine.

"I remember one Christmas when I was only about five-years-old and my dad took some of us into the hospital during his ward rounds to let my mum, Nanette, get on with things in the house. We would see all these patients with really bizarre contraptions on their heads. It was quite a sight for a kid, but it never put me off. I was about 16 when I knew I really wanted to be a doctor, so he let me observe a couple of surgeries and I would watch procedures like brain tumours being removed.

"My dad didn't get to see me start medical school but he knew that was where I was headed and I think he'd be pleased that one of his children is in medicine."

Generations of care

Four generations of doctors is exceptional enough but one of Britain's longest-running medical dynasties recently came to an end in the town of Marlborough, Wiltshire. There has been a Dr Maurice serving the community there for 217 years. But when Dr David Maurice stepped down from his post as GP last August, this remarkable tale of dedication came to a close. Dr Maurice's family have had a surgery in Marlborough for six generations, but he has decided to finally hang up his stethoscope to focus on his other vocation as an ordained deacon in the Church of England.

The first Dr Maurice set up a practice in the small market town in 1792 – back when blood-letting was still routine and more than 150 years before the creation of the NHS.

And while the current Dr Maurice has a

"The first Dr Maurice set up a practice in Wiltshire in 1792 - when blood-letting was routine and more than 150 years before the NHS."

THE FAMILY

PHOTOGRAPHS: DAVID HARTLEY

medically-qualified son, James, he has decided to work as a hospital doctor instead of a GP. Dr Maurice senior admits to having mixed emotions about his retirement. "It is sad, but I am enjoying it less," he said. "There is also an aspect of the way that we have to work now, the financial incentives are something that I am less comfortable with. But I will miss the patient contact and relationships that have built up over the years."

One of the oldest medical dynasties in Britain must surely be the Beaton family of Highland physicians who served the clan MacLeod and the Lord of the Isles, possibly from around the 14th century until the 18th century. A Beaton travelled with James VI's court to London and their story is detailed in David Hamilton's book *The Healers - A History of Medicine in Scotland*. Also mentioned in the book are the O'Connachers, a medical family who served the Argyles and held land in Lovat, while the McDonalds employed a family of McLeans as hereditary physicians.

Elsewhere, Fovant in Wiltshire had its first medical dynasty in the 18th century. A Dr Foot served the village for several generations from 1763, beginning with Dr Henry Foot of Broadchalke. He was followed by a Dr Henry Mitchell Foot of Donhead who was the father of Dr Robert Foot (senior surgeon of Fovant) who died in 1805. Dr Henry Foot (junior) of Broadchalke and Stephen were sons of Robert. It was Henry of Donhead who 'discovered' Foot's Cathartic mixture which, in an undated contemporary advertisement, was reputed to be a cure for "Inflamation in the Bowels And Intestines. Indigestion and all Bilious Complaints" and half-pint bottles sold for 5s/.

Records from the village list four different doctors from 1800-1855, but three generations of Dr Clay also served Fovant from 1855-1970. Dr Robert Richard Clay was the first, followed by his son Challoner, who was village doctor and also surgeon to the Provident and Medical club. His son Richard Challoner Cobbe Clay took over the practice in 1917 until his death in 1971. Since then, six other doctors have gone on to serve the village.

An army of medics

Medical dynasties are not just a thing of the past. Noted cancer specialists and identical twins, Professors Trevor and Ray Powles may well have started a medical dynasty of their own. The 70-year-olds decided to pursue a career in medicine at the age of 18 when the NHS saved their lives after both had contracted tuberculosis. Ray had planned a career in the Army, but said: "When I spent seven months in hospital I fell in love with the idea of medicine."

His twin felt the same and both trained at St Bartholomew's School of Medicine in London. Trevor and Ray became two of the most eminent doctors in their fields. Leukaemia and myeloma specialist Ray carried out Britain's first bone marrow transplant in 1973. Meanwhile, Trevor became the country's first breast cancer physician and pioneered the use of Tamoxifen. They were both awarded CBEs in 2002 for services to medicine.

Now, 50 years after they qualified the twins have proudly seen four sons go on to do the same. Trevor's sons followed in his footsteps with James, 38, now an ear, nose and throat consultant at Torbay Hospital and 37-year-old Tom an oncologist at Barts and the London Trust. Ray's identical twins Sam and Luke also entered the family business after qualifying from Barts.

With such a medical pedigree there must be a fair chance the Powles family is a medical dynasty in the making.

Joanne Curran is associate editor of FYi

LOST IN TRANSLATION

Communicating with patients can sometimes be a challenge in the best of circumstances. But what if they don't speak English? FY2 doctor **Sarah Birney** offers some tips

THE PHRASE 'limited English proficiency' didn't mean much to me before I started my GP foundation training. But on day one of my rotation in a busy Glasgow surgery, I quickly found out what it meant. As I struggled to communicate with some of the people who came to the practice, I realised that the ethnically diverse community we serve would put my communication skills to the test.

Consulting patients with limited or no English was initially a daunting and uncomfortable experience for me and, I suspect, also for them. But now, a few weeks down the line, it has become a day-to-day occurrence and one I am getting better at dealing with. The significance of language and cultural differences between doctor and patient is such that the BMA has identified them as "the most important barriers to healthcare in Britain".

So how can we overcome these barriers and deliver the healthcare that patients deserve? Unless you happen to have enrolled in evening classes for every language under the sun, you're likely to need an interpreter at some point in your career. One useful resource is the Emergency Multilingual Phrasebook, produced for the NHS by the British Red Cross. It lists key medical questions in 36 languages to help first-contact staff communicate with patients and make an initial assessment while an interpreter is contacted. It tells you how to ask things like "When did you become ill?" and "Have you any bleeding?" in languages from Albanian to Vietnamese. It can be downloaded from the Department of Health website at **http://tinyurl.com/645423**

Establishing rapport

It is important to approach the consultation in the same way as you would any consultation, ensuring the patient is centre of your attention. This is likely to be even more important than usual in gaining their trust and establishing rapport.

Greet the patient directly in order to establish contact. Check via the interpreter that the patient is comfortable with the situation and explain that the same respect of confidentiality applies. Ensure the patient sits closest to you and is not tempted to shy away behind the interpreter. Maintain eye-contact and speak directly to them in the first person.

As always, be aware of tone of voice and your own body language, as well as the patient's non-verbal responses, but remember that gestures may have different meanings in different cultures. A good interpreter should be able to provide guidance if offence is likely to be caused. Finally, remember to document the presence of the interpreter and provide an account of the information shared. Make sure you also take note of the interpreter's name and contact details.

If you are dealing with a patient who speaks limited or no English, there are a few different types of interpreter to consider. These include:

- an 'ad hoc' interpreter (often a relative or friend)
- a multilingual healthcare professional
- a telephone interpreter
- a trained interpreter who attends in person.

'Ad hoc' interpreters

Patients may prefer to consult through someone they know. This can be an advantage because the interpreter in this case is likely to have some awareness of the patient's complaints, an appreciation of the purpose of the visit and can be a reassuring familiar presence for the patient, providing more empowerment for them in an unfamiliar culture and language.

But it's important to bear in mind that interpreting through a relative or friend is not without its disadvantages. There is always the worry that using an informal interpreter could undermine both patient confidentiality and the objectivity of the consultation. There is also no guarantee of how well the untrained interpreters understand both languages and whether they can effectively communicate what both parties are saying. They are unlikely to have the relevant experience of medical terminology and phrases of a trained interpreter.

The use of relatives or friends may also make it difficult for the patient to discuss sensitive issues. In more serious circumstances, these encounters may allow a relative to hide abuse or exert undue influence over the patient and their medical care.

In one case, concerns of sensitivity and control arose when a non-English-speaking teenager attended the practice to discuss her failure to conceive. The patient appeared timid and submissive while her rather pushy mother-in-law gave an account of the young girl's wishes and details of her sexual health and practices. Similarly, consultations can be awkward for the interpreting relative as well, such as the case of the 12-year-old son brought along by his mother to interpret during her smear appointment.

"Patience and perseverance may avoid repeated consultations."

Trained interpreters

The use of trained interpreters is preferable wherever possible and can help to avoid the medico-legal pitfalls that may arise from inaccurate translation within a medical consultation. Using a professional interpreter is more likely to result in effective communication between you and your patient. However, scope remains for misunderstandings and you can never be entirely sure of what message is conveyed by and to the patient. In one consultation, a trained male interpreter was booked to interpret for a 14-year-old female patient. The patient gained my sympathies when it became apparent that the complaint was of an embarrassing nature but had me bewildered when the interpreter explained she was worried because she had two breasts. Examination revealed the patient's accessory nipple and the interpreter's lack of terminology.

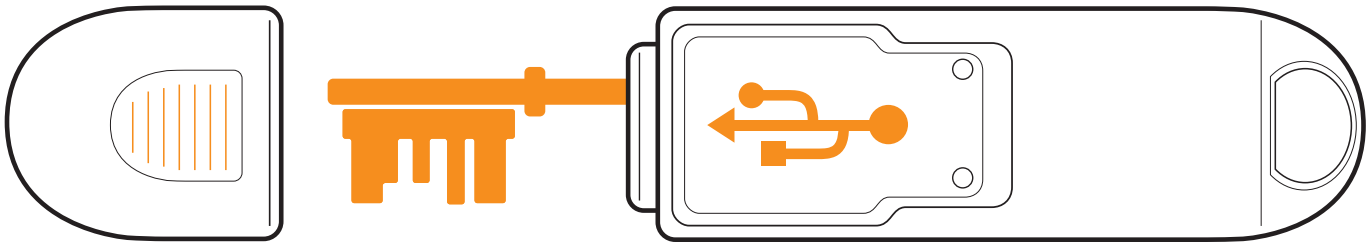
More commonly I find myself dubious as to whether or not all the information offered by the patient was actually translated. It seems that several minutes' worth of dialect between patient and interpreter can be translated in a few seconds of English. It may be that the interpreter is particularly efficient in identifying the relevant details or simply that the meaning is conveyed more easily in English, but whatever the reason it is worth establishing that you require to hear all the information offered by the patient.

In order to encourage an open and effective consultation a few rules of thumb can be applied:

- Speak slowly and in short sentences, and request that the patient does the same to avoid details being omitted.
- When you are speaking to the patient look at them, not the translator.
- Avoid the use of medical jargon and metaphors which may be difficult to translate.
- Ask only one question at a time and if the required information is important try asking in different ways to ensure understanding and consistency of the details obtained.
- Make sure that everything you say is translated (interpreters do at times need reminding).
- Make sure you say everything that you would if you were consulting with an English-speaking patient. Remember that these consultations will inevitably take longer as everything has to be said twice and often clarified so allow time for this. Patience and perseverance at this stage may avoid repeated consultations, unnecessary investigations and lead to timely effective management.
- For difficult meetings such as breaking bad news, it is helpful to meet and brief the interpreter first to ensure that the aim of the consultation and important issues are clear. This will allow the interpreter to clarify understanding and consider appropriate phrases where literal translation would not convey the meaning.

As with every experience, try to learn something from it. The interpreter may be able to provide you with advice for future consultations and help strengthen your cross-cultural communication skills.

Dr Sarah Birney is in her second year of foundation training



KEEP IT SAFE

A lost USB stick could mean more trouble than you imagine

IN OCTOBER 2009 a laptop containing the patient records of 33,000 diabetics is stolen from an unlocked retinal screening vehicle in Southampton. Earlier in July thieves take a laptop computer from an Audiology Department in Maidstone with sensitive personal data of 33 patients. This happens just a month after Ashford and St Peter's Hospitals NHS Trust reports that digital files providing full diagnosis and treatment records of cancer patients on three USB memory sticks have been either lost or stolen. The data is unprotected and saved in Word format so is easily accessible by anyone with access to a computer.

It seems there has been a flood of such stories over the last few years – and many more can be found on the 'Enforcement' page of the Information Commissioner's Office website (**www.ico.gov.uk**). The ICO is the independent government authority set up to "uphold information rights in the public interest" and part of its remit is the enforcement of the Data Protection Act. This is the legislation that governs the protection of personal data in the UK and part of the ICO remit is to investigate and take action against unwarranted breaches of patient confidentiality.

The increasing digitalisation of patient data has meant that large-scale breaches are becoming all too common. In the last two years NHS organisations were responsible for 30 per cent of the security breaches reported to the ICO, with most of these resulting from burglaries and theft. The majority of ICO enforcement actions are directed at Trusts and other healthcare organisations rather than individual doctors but this does not mean you are not at risk if treating patient data in a careless manner.

Know the rules

Most doctors are not expected to be experts on electronic data security. In its core guidance on confidentiality The General Medical Council states: "Unless they have a relevant management role, doctors are not expected to assess the security standards of large-scale computer systems provided for their use in the NHS or in other managed healthcare environments."

But the guidance does make clear that as a doctor you "should familiarise yourself with and follow policies and procedures designed to protect patients' privacy where you work and when using computer systems provided for your use. This includes policies on the use of laptops and portable media storage devices."

In general, sensitive data held on a laptop or other portable device such as an USB data key should be encrypted and accessible only by password. Such precautions require some technical expertise and this should be provided by your employing Trust or other body. Your main responsibility as a doctor is to follow these guidelines; otherwise you are likely to be subject to disciplinary procedures and possible sanctions from the GMC if you are found to be the cause of a data breach.

Should you feel that adequate procedures are not in place where you work the GMC is clear on the matter:

"If you are concerned about the security of personal information in premises or systems provided for your use, you should follow the advice in *Good Medical Practice* on Raising concerns about patient safety (GMP, 2006) including concerns about confidentiality and information governance."

Just having policies in place is sometimes not enough. In December 2008 a USB data stick used routinely to back-up clinical administrative databases went missing from Her Majesty's Prison Preston.

A thorough search never turned up the data stick which held medical details relating to over 6,000 patients who were or had been incarcerated at the prison. It later emerged that the data stick had indeed been encrypted but the password had been attached to the device on a piece of paper.

An honest admission

Such obvious failings may seem hard to credit but most often data losses are the result of healthcare staff not being aware of their responsibilities or simply thinking "it won't happen to me". In a recent MDDUS case a young doctor taking part in a clinical audit used his personal USB data key to transfer patient details to another computer. The data key then went missing and he phoned the MDDUS in a panic.

MDDUS medico-legal adviser Dr Gail Gilmartin commented: "The most important thing to do if you discover unprotected data has been lost or stolen is to be honest and report it as soon as possible to your supervisor or the data controller in the hospital or practice where you are working. To delay is only likely to make the situation worse."

She added: "Better though to have a good understanding of the data security policies and procedures where you work and stick to them. Taking short cuts is simply not worth the risk."

Jim Killgore is editor of MDDUS Summons

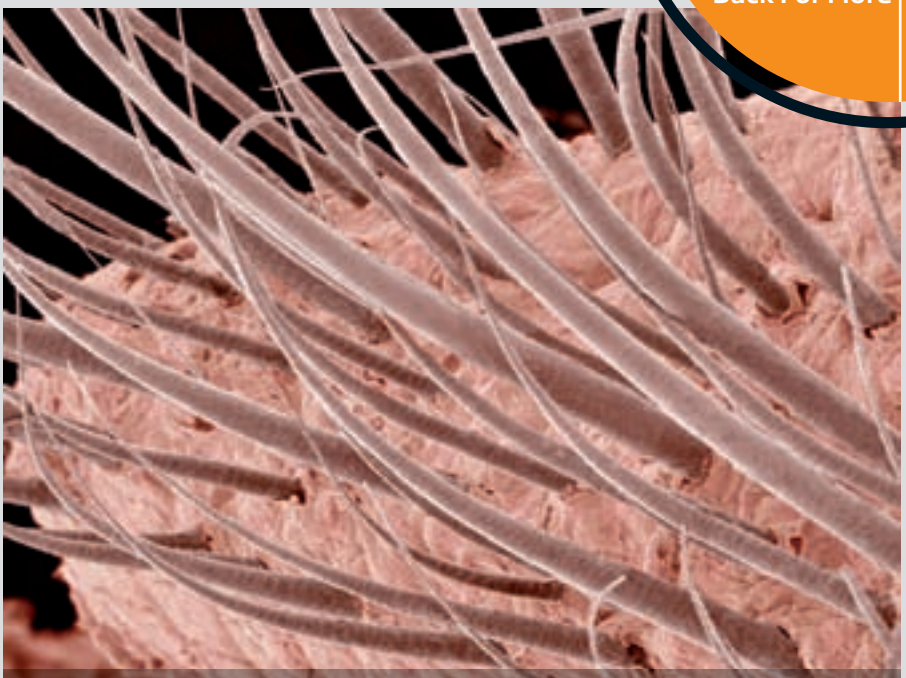
OUT THERE

SKILLED SKULL A pensioner who had part of his skull removed after an accident in the 1950s astounded doctors in England when a recent operation revealed that bone had grown back underneath the protective metal plate. *Source: Daily Mail*

STONE AGE SURGEONS **A skeleton found near Paris of a 7000-year-old man with an amputated arm proves early medicine was more advanced than previously thought. Archaeologists speculate that Neolithic surgeons used a sharpened flint stone and pain-killing plants for the procedure. *Source: Daily Telegraph***

DID YOU SAY LEFT? Taking out the wrong kidney might be understandable but doctors in Peru recently amputated the wrong foot of an 86-year-old man and then had no choice but to remove the other infected one. The hospital is investigating the matter. *Source: Big Pond News*

TIME FOR AN UPGRADE? **Fact: the storage capacity of the human brain exceeds 4 terabytes - basically a lot!. *Source: eBizarre.com***



WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: STEVE GSCHMEISSNER / SCIENCE PHOTO LIBRARY

PHOTO: THE PRESS ASSOCIATION

Pick: DVD - Sicko

Directed by and starring Michael Moore; 2007

IF ever there was a documentary to make you think carefully about the pros and cons of the US healthcare system, this must be it. Campaigning filmmaker Michael Moore shines a light on the harsh realities faced by an estimated 50 million uninsured Americans as well as many others who fall victim to insurance company fraud and red tape. He holds up his country's system for comparison with the universal healthcare systems in Canada, the UK, France and Cuba and asks some difficult questions in his unique, unflinching way.

While critics may accuse Moore of ignoring some of the facts in order to get his point across, it is the personal stories from those who have fought with insurance companies for treatment, or faced financial ruin, that stand out, including the middle-class couple who lost their home and had to move in with their children because of crippling hospital bills – despite having medical insurance.

Some may dismiss the film as over-simplified propaganda, but as President Obama struggles to bring in his landmark healthcare bill, the issue has never been more relevant.

Book Review:
Where Does it Hurt? – What the Junior Doctor Did Next
by Max Pemberton

Hodder & Stoughton Ltd; ***£12.99***

Review by Joanne Curran, Associate Editor

AN 80-year-old heroin-addicted drugs mule, a teenage prostitute and a homeless man who thinks he's God – not a typical patient list. But as junior doctor Max Pemberton learns on his first day at work in a homeless outreach project this is frontline care for some NHS staff.

He's in FY2 and his career choice has taken him onto the mean city streets, fuelled by little more than curiosity, enthusiasm and plenty of cups of tea. Following his successful first book, *Trust Me, I'm a Junior Doctor* – based on his FY1 year on the wards – Pemberton reveals what he did next in a book that is funny and frightening in equal measure.

A mix of fiction and autobiography, this behind-the-scenes account lifts the lid on the harsh realities of front-line patient care. Here, emotions swing from the hopelessness of fighting a rising tide of drug addiction and homelessness to the euphoria of changing even one patient's life for the better. But the desperation of long hours and an impossibly low success rate is tempered by Pemberton's wit. "Why couldn't things be nice and simple like on Holby City?" he wonders while trying to figure out how to solve the problems of mentally ill Mr Allsop, a man who sleeps outside Tesco and is convinced he's God.

His friends don't approve but Max learns to adjust to the unpredictable nature of his new job as he battles to make a difference to the chaotic and shattered lives of his patients. He copes with being spat at and occasionally being mistaken for a tramp or a pimp, all the while struggling along under the watchful eye of the stick-wielding, no-nonsense Sister Stein. His consultant, meanwhile, is the rather unorthodox Professor Pierce – a wild-haired man who looks more like a patient than a doctor.

Pemberton relays daily horror stories in a style that is both absurdly funny and well-observed. So will Max last out his year-long stint with the homeless or will the promise of boxes of chocolates from grateful patients that other medical specialties often enjoy prove too tempting? Based on his *Daily Telegraph* columns, *Where Does it Hurt* provides a sharp insight into the life of a junior doctor whose hopes of curing society's ills are quickly tempered by the enormity of the problem he faces.

WHAT ARE WE LOOKING AT? *Coloured SEM of eyelashes*