FYi

ISSUE 05

PATIENT HANDOVERS

THE KEY TO GETTING THEM RIGHT

MDDUS

PHOTO: WALTER NEILSON

Welcome to your FYi

CARVING OUT A SUCCESSFUL career in medicine isn't an easy task. And while the secret to success is difficult to define, one crucial factor in getting the job you want is having the right CV. As medicine becomes increasingly competitive, junior doctors might find they are under greater pressure to have more than just academic qualifications under their belt.

As someone who has just finished year one of specialty training in psychiatry, I have made my fair share of job applications. In my article on page 14 I offer some advice on how to put together an effective CV and I also look at the role of voluntary work and other activities in shaping a medical career.

Patient handovers are sometimes regarded as the weak point in patient care and it is an area that has come under increased media scrutiny in recent months. Surgical trainee Tom Berry highlights the risks involved in failing to carry out an effective handover in his article on page 4. Management skills are becoming increasingly relevant for doctors these days and on page 6 Dr Yasmin Ahmed-Little and Dr Joe Collum argue that developing these skills makes sense for both doctors and the NHS.

Our careers article on page 8 focuses on the cutting edge field of general surgery while on page 10, associate editor Joanne Curran looks at the groundbreaking work carried out by the doctors and dentists behind the charity Medics Against Violence. And finally, award-winning author, columnist and specialist trainee Dr Max Pemberton talks about how his experiences as a junior doctor inspired his writing in our Q&A feature on page 12.

Dr Maggie Cairns
Editor

MAKE SPECIALIST TRAINING MORE FLEXIBLE, STUDY SAYS

MEDICAL TRAINING in the UK should be more flexible to help doctors choose the right specialty, a study suggests.

Doctors in training are forced to choose a specialty earlier than those in previous years due to changes to postgraduate training. Concerns have been raised that trainees are having to make decisions without knowing enough about their options. The 2008 Tooke report suggested junior doctors were being encouraged to make career choices before they were ready.

Researchers from the University of Oxford have called for a system shake-up to allow two entry points into the specialties, after the end of foundation training and again around a year later.

The team compared the early career choices of more than 15,700 doctors with the career they eventually ended up in. The results showed that 10 years after graduating, almost half the doctors were working in a specialty different to what they chose after three years.

There was wide variation amongst the specialties with only half of GPs choosing their field one year after graduation compared to 90 per cent of surgeons. The researchers concluded that years one to three following graduation was a key period for the formation of young doctors' career plans. They said that making medical training more flexible would let doctors choose their specialty later in their careers.

The study suggested "that at least two possible entry points should be available for most specialties - the first after one or perhaps two years of foundation training and the other at (say) three years."

56 hour week still common

MORE THAN HALF of trainee doctors questioned in a survey regularly work more than 56 hours over a seven day period, the BMA says.

And a third of respondents admitted to working more than 65 hours a week. The findings were revealed in a BMA survey into the effects of the European Working Time Directive. It showed those likely to work the longest hours were in neurosurgery, surgery and paediatrics. Respondents were more likely to work excess hours if there were vacancies on their rota.

The electronic questionnaire was sent to more than 14,700 junior doctors across the UK in December 2009, the *BMJ* reported. A total of 1567 responses were received - which represents five per cent of the BMA's junior doctor members.

Just over 40 per cent of those who responded to the questionnaire reported vacancies on their rota, which were mainly for hospital and academic or research posts. One in three of the vacancies were for specialty trainee year three to eight grades.

Just more than half of respondents said they had felt pressured to work extra shifts that were not recorded by managers. Respondents indicated that the implementation of the EWTD has had a negative effect on training, with an increased focus on service delivery, discontinuity in patient care and training and a move towards working more unsocial hours.

Of those who responded, two-thirds were concerned or very concerned that juniors could be pressured by their employer to opt out of the EWTD. But only one in ten said they had been pressured to do this. Most of those who had been asked to opt out had agreed to do so, largely to cover rota gaps.

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MRCGP exam changes unveiled

A NUMBER of changes will be made to the MRCGP exam from September.

The Royal College of General Practitioners unveiled its plans to revamp the Clinical Skills Assessment (CSA) and Applied Knowledge Test (AKT) components following a "rigorous review" of the exam process. The College said the changes would make the exam more relevant to "everyday working life".

The move means candidates applying for membership of the College will be graded on more cases in the CSA. The CSA pass mark will be set using the borderline group method – where each case will have its own pass mark – rather than the current system which requires passing eight out of 12 cases.

RCGP examiners will also now mark all the cases on the circuit, so candidates will be evaluated on 13 cases instead of the current 12. The cases will continue to be marked using the current three domains but candidates will receive the total score for all 13 cases instead of individual marks for each case. The pass mark will be set by the combined judgements of examiners for that day.

The RCGP said the borderline group method of marking will allow them to deal with the variability in difficulty of cases. Feedback statements have also been changed as part of the review, and take into account comments from associates in training and CSA examiners. Candidates will then be given more information and advice on how to improve performance.

The latest format of the computer-based AKT will pilot new questions, including free text answers where the candidate types in the answer rather than selecting from a list of options.

They will be able to use short video or sound clips and so-called Hot Spots, where the candidate clicks on a graphic to indicate the site of a clinical sign. The changes have been made in line with suggestions from the Postgraduate Medical Education and Training Board, which is now part of the General Medical Council.

Dr Sue Rendel, RCGP chief examiner said: "Candidates should not notice any difference in their experience of the exam or the way in which they prepare for it."

GMC confirms exam rules

EXAMS passed by doctors who are in specialty training, or about to start, will count towards qualification, even if they are taken in non-approved training posts.

The GMC confirmed the move in a joint statement released this month. The statement is signed by the BMA Junior Doctors' Committee, the Academy of Medical Royal Colleges, COPMeD and Remedy UK.

It states that doctors who are already in specialty training or who will enter by October 31, 2011, will be able to have any exams passed in previously approved national professional exams counted towards a Certificate of Completion of Training, even if they were taken outside approved training. The GMC will issue guidance by the end of October 2010 setting out their stance on the issue for doctors who may enter a CCT programme after October 31, 2011.

Claim your FREE junior doctor survival guide from MDDUS

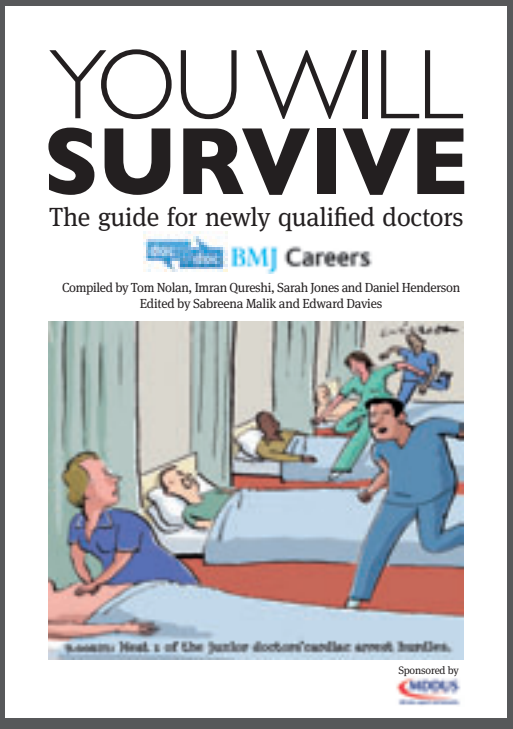
MDDUS ARE PROUD to sponsor the indispensible new guide for junior doctors – *You Will Survive*.

We have teamed up with the *BMJ* to produce the booklet, which is FREE to all MDDUS trainee doctor members, as well as BMA members. It includes hundreds of tips from qualified doctors on how to cope with issues like self-doubt, ward rounds and notes, on-call and nightshift as well as some cautionary tales.

You Will Survive offers words of advice on how to ask for help, de-stressing and which equipment to carry with you on rounds. It includes pearls of wisdom such as always having a spare change of clothes in case you get covered in blood or other fluids and always treating nurses with respect.

MDDUS' head of professional services, Dr Jim Rodger, said: "We are delighted to sponsor this book as it is full of valuable advice from your medical peers that we believe will help you survive some of the challenges of being a junior doctor."

For your FREE copy of *You Will Survive*, contact Jane McAulay by email at jmcaulay@mddus.com or call 0845 270 2038.



JUST ONE MORE TH

Surgical StR **Tom Berry** provides some hard-earned insight into the perils of patient handovers

BELOW are just a few of my favourite patient handover lines:
"Nothing much happening"
"No-one's sick"
"Nothing for theatre"
"Here's the page. Have a good one."

Brief lines like these could individually or together represent the totality of a handover. Would you feel secure and set for your shift having only the above to go by? If so you're a braver soul than I.

That's the way to do it

No less than the World Health Organisation, The Royal College of Physicians and the GMC all stress the importance of effective patient handovers, but that doesn't necessarily translate into good practice on the frontline. Take a wander over the web and you'll encounter horror stories to strike fear so deeply that you'll feel it's probably best to never leave work rather than hand over responsibility. You'll also find analogies likening handover to the weak point in the chain of care and suchlike. Look even further and you'll uncover examples of good practice – standardised handovers, audits of handovers and other shining, self-satisfied gems.

There are many types of handover within clinical practice: changes of shift within a department or ward, transfer from A&E to ward, theatre to ICU/HDU, GP to hospital, hospital at night meetings, and hospital to hospital to name a few. Handovers involving individual patients may occur three times a day and so it is essential that there isn't a progressive degradation and perversion of the facts until Mr M, 63, with an MI and ongoing analgesic issues is handed over as Mr M, 36, requiring an IM injection with ongoing anal issues.

Don't I know you?

We have all heard this before but it's only because it's true – preparation is key. Often there may be a lull prior to the end of a shift but even if there is no let-up, you still need to take a pause to ensure you know your patients. You can't hand over what you don't know.

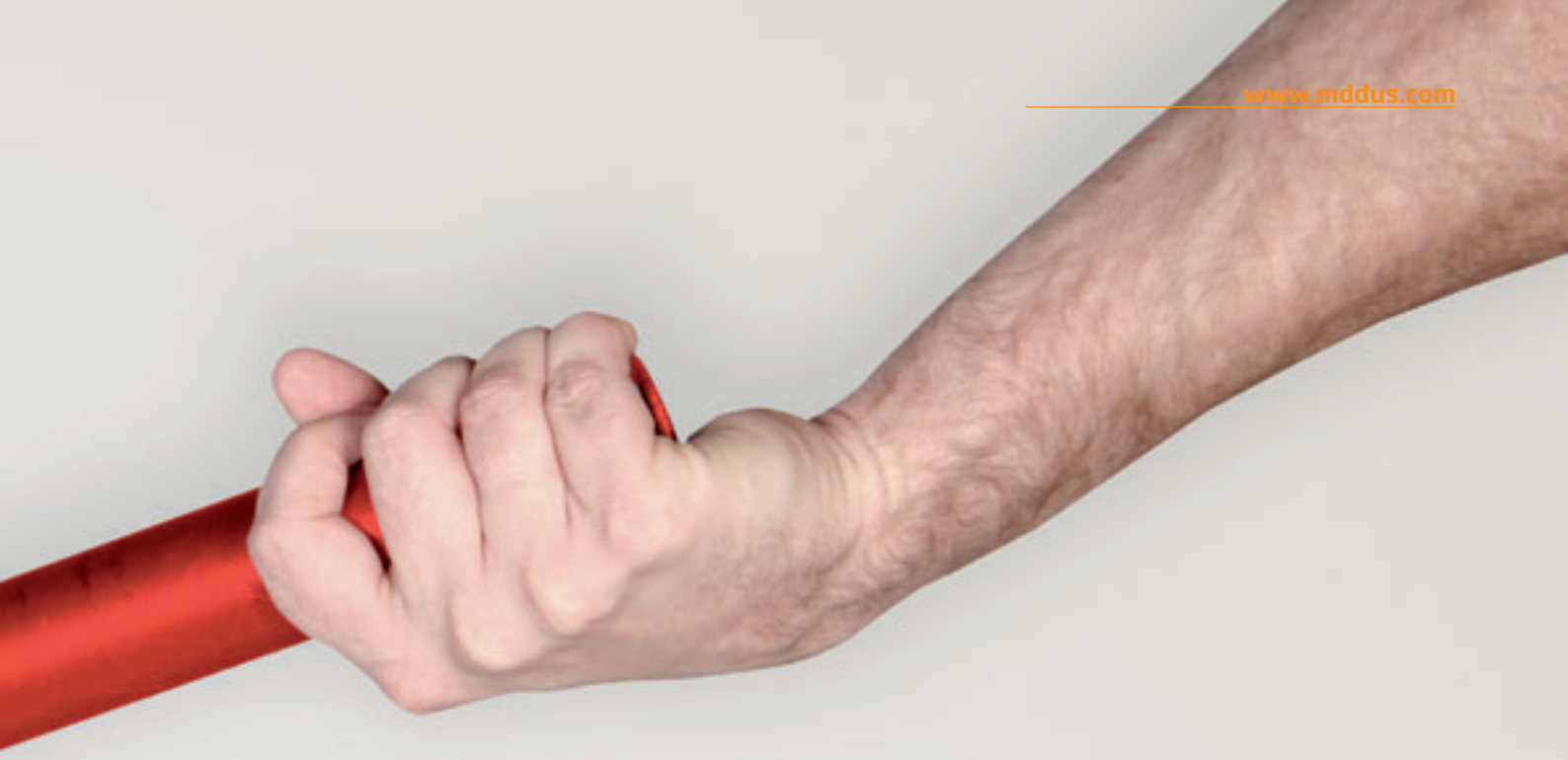
The website of the RCP refers to studies that demonstrate a stunning volume of information lost over subsequent handovers if they are purely verbal. The improvement with written notes is marked and even more substantial if standardised template forms are used. We live in an evidence-based world, therefore some form of standardised template for at least those patients that are complicated, acutely unwell or in some state of flux, would seem a cracking idea.

In addition to key patient details, acute and chronic conditions, and treatment plans, some other facts are often useful. Note which consultant is responsible for the patient so it's clear who to turn to should there be a problem. Are there any contingency plans for likely changes in the patient's condition? What is the patient's resuscitation status?

Let's talk

Ensure adequate time for handovers is factored into rota construction. This requires an overlap of shifts and not just reliance on someone to start early or leave late. Make sure time is available within your rota and join with your colleagues in demanding or extending it if need be.

The common handovers for trainees are changes of shift and hospital at night (H@N). Both are opportunities to do more than simply



ING...

"Preparation is key for an effective handover"

spout a wealth of clinical information and then leave. At the very least it is a chance to discuss complex patients and take others' opinions and fresh outlooks. If the handover is a two-way process then there is a greater likelihood that the receiver of the information will draw out the salient points to be able to then give an opinion on management.

At H@N meetings the group atmosphere will need to be controlled to prevent a four-hour handover and a discussion on the best restaurant for work nights-out. A chairperson can focus the group, let each person make their contribution and see that a plan of action is in place. That also includes opportunities for learning. If a registrar is talking about a condition that you're unfamiliar with or a treatment option you've not encountered, then ask questions. Multi-specialty handover meetings can be a great chance to keep up-to-date with your favoured specialty even if your current post is elsewhere in the hospital.

And now for someone completely different

At any handover involving more than a single patient, a degree of prioritisation will need to take place. Be clear which patients need reviewed and the timeframe expected. A common pitfall is handing over patients in the process of being investigated. This is especially true in emergency medicine and many teams now gather at shift changes and formally discuss the patients in the department. In such situations you must remember to document in the notes that you are handing over the patient, what remains to be done and who you are handing over to.

Do not take anything for granted. I have seen a handover of a patient when working in A&E who, at the time of handover, was in the radiology department for a chest X-ray. The patient returned, underwent further investigations and was admitted to the wards. No-one reviewed the X-ray until later that day on a ward round; the patient had a pneumomediastinum and unilateral pneumothorax. It was admittedly a rare example of Boerhaave syndrome but, sadly, a poor example of clinical care. This should not happen.

We can work it out

In the busy post-EWTD clinical setting with foundation doctors frequently working a three-shift system and changing team or consultant on a weekly basis, it is hard to maintain a sense of teamwork and to be an authority on all your patients. Now, more than ever, it is crucial to utilise the handover as a formal, thorough and consistent part of the daily routine.

So make it an educational discussion. Write it down. Prioritise and assign tasks. Foundation doctors will possibly see more patients than anyone else during a shift and have the most to gain from properly conducted handovers; lead the way and you, and your patients, will benefit.

So the next time the pager is tossed your way with a cheery wave as they head to the door, do your best Lieutenant Columbo impression and catch them with a: "Just one more thing."

Mr Tom Berry is an StR 3 in general surgery in Glasgow

Helpful online resources

- Royal College of Physicians Handover resources - **www.tinyurl.com/2azyfg4**
- WHO Collaborating Centre for Patient Safety Solutions - Communication During Patient Hand-Overs - **www.tinyurl.com/lkukms**

LEADING THE WAY

Developing management skills isn't always a top priority in medical training but **Dr Yasmin Ahmed-Little** and **Dr Joe Collum** argue it makes sense for both junior doctors and the NHS

JUST over two years ago a small group of junior doctors were discussing the lack of opportunities for trainees to help change the way the NHS is run.

They talked about the barriers that they had to overcome to get involved in leadership and management, and the lack of understanding amongst trainee doctors about the organisational structures of hospitals, trusts and the NHS as a whole.

As a result of this conversation, BAMMbino was born – the junior doctor arm of BAMM, the British Association of Medical Managers. While BAMM (a charitable organisation) provided a network for the support and development of senior clinicians involved in management positions, BAMMbino aimed to provide the same for junior doctors interested in management and leadership in healthcare. The organisation aimed to empower junior doctors to help the NHS to work better, not just for those who use it but also for those who work within it.

Unfortunately, as you may be aware from the press, BAMM and therefore BAMMbino ceased trading on Friday, June 11, 2010. The details of this remain uncertain for now but the former BAMMbino Board are clear that a network for junior doctors and medical students interested in clinical leadership and medical management is still crucial.

Empowerment

So why was BAMMbino so important to its members? Before joining the organisation many clinicians felt isolated in their enthusiasm to change the way things are done. They often faced a series of disappointing "no's" when trying to suggest even the most minor changes to practice and ways of working in their own organisations.

It can be hard to experience endless dead-ends and not feel helpless in the situation. The change suggested may offer great potential but those proposing it may not have the skills or 'tools' to see their suggestion taken seriously.

The mindset "this doesn't apply to me" is common amongst doctors in training. However, many will find themselves responsible for budgets, teams and even directorates in their working lives. The responsibility for major organisational improvements is also likely to land on the shoulders of clinicians as time passes. It is therefore vital that the natural leadership tendencies we already possess are developed to make us effective leaders of the future.

One of the great strengths of BAMMbino lay in its ability to provide a network of like-minded individuals. Through regular regional 'night schools' members had the opportunity to meet and share ideas. One of the greatest impacts of this network of passionate people was that it created a true sense of empowerment: it gave many members confidence to know "it can be done." And when faced with those 'dead-ends' and 'stone walls', it gave support and inspiration to its members to 'keep pushing on through'.

Whilst we wait to find out what happens next with BAMMbino, it is useful to share some of the work we have done. Most of this can be replicated at a local level with very little, if any, funding required. Only vision, determination, hard work and enthusiasm are needed.

A strong start

Following its launch in 2008, BAMMbino membership and activity grew fast. The organisation provided an outlet for junior doctors who previously felt under-qualified to join in the debate. Or maybe those with a long-standing secret love affair with the 'dark side' of management and clinical leadership finally felt able to 'come out' and confess all, safe in the knowledge that there was a sizeable group of the similarly-minded ready to be heard.

This network of junior doctors met regularly at local and national events. Night schools provided opportunities to encounter senior colleagues and NHS leaders as well as peers with similar interests. The ambitions of participating members varied from those who saw management skills holding relevance in future careers as jobbing GPs or consultants, right through to budding medical directors and chief executives.

"It is vital that skills are developed to make us effective leaders of the future"

The night school series offered tangible personal development with sessions on MBTI and presentation skills. There were also sessions to "Meet the Board" and to gain hints and tips on getting involved in quality of care, patient safety and patient experience improvement projects. In addition to the sessions, BAMMbino

provided a 'Night School in a Box' SMARTkit for any junior doctor wanting to follow a step-by-step, do-it-yourself guide.

National events also brought leaders such as Professor Sir Bruce Keogh (NHS Medical Director) and former CMO Sir Liam Donaldson directly to junior doctors.

In the North West of England, in partnership with the Junior Doctor Advisory Team, we ran our first 'Dragon's Den' session with up to £50,000 up for grabs. Industry leaders grilled junior doctor applicants bidding for funding to support their ideas on how to improve patient safety, service delivery and education and training within a 48-hour working week. Read more about this at **www.tinyurl.com/34zoyoz**

We also ran the annual BAMMbinnovation awards to recognise innovative projects and set up working groups to get more juniors involved, while our medical student colleagues set up BAMMdot: Doctors of Tomorrow in autumn 2009.

Take the initiative

The NHS faces challenges. The pressures of increasing demand, restricted growth and the continuing advances in scientific discovery add to the pressure cooker of healthcare provision in the UK. How services continue to provide safe, relevant and worthwhile care is really up to the clinicians that work in them.

Providing these services amidst a changing political, social and economic context can seem daunting and overwhelming. The necessary abilities are not learnt in a classroom – neither are the skills essential for being an effective negotiator and savvy operator in this brave new world. These are best absorbed from stories, colleagues and seeing what works and why.

It is becoming clear that doctors in training are a significant untapped resource for change, innovation and improvement. As we face the major challenges of restructuring and budgetary restraint, the leadership capacity and creative capital within the junior doctor workforce is increasingly vital. When this potential is harnessed, nurtured and developed, the possibilities are endless.

We hope this has inspired you to get involved and perhaps start up your own group based on BAMMbino's experiences. For more information or guidance, contact Dr Ahmed-Little at **yasmin.ahmedlittle@gmail.com**

Dr Yasmin Ahmed-Little is a specialty registrar in public health in Manchester and was vice-chair of BAMMbino. Dr Joe Collum is a Medical Advisor with the Junior Doctor's Advisory Team for NHS Northwest.

A PERSONAL STORY: BAMMbino and me by Mona Stokes

From the beginning of my working life as a junior doctor I have always wanted to make things work more efficiently. This manifested as a house officer in the meticulous organisation of the filing cabinet in the doctor's office so that frequently used forms were in the top drawers and so that related forms were near each other. It was a small thing. But it did not go unnoticed and this act was my first of many to change things to make them better for all.

I was the mess president in my SHO years and met with the board to present junior doctor issues. I lobbied my directorate head for split nights, but I felt like a lone voice as many of my peers were happy to leave it to me. Many of these changes and actions sprang from my frustrations with the system and as time went on I felt increasingly disillusioned with my senior colleagues.

During my GP registrar training I was fortunate to be at a site where management issues were a top priority of the trainers. In realising that effective management was a key part of my future career I started to look for opportunities to develop this aspect of my professional life. BAMMbino was recommended by a colleague and I found it a really useful addition to my portfolio of interests. I often attended the night schools and after one of these events a colleague and I came up with the North West Junior Doctor Dragons' Den concept, which has been fantastic to be a part of. I have recently been involved with the North West Working Group and, if possible, hope to continue involvement with BAMMbino and BAMM, even after I get my CCT.

MAKING THE CUT

General surgery is not the most competitive among surgical specialties – but entry still poses a significant challenge

AN ANONYMOUS wit once said that a physician is someone who knows everything and does nothing while a surgeon is someone who knows nothing but does everything.

One thing at least is true: surgery as a profession has always been about practical skills and active intervention in medicine. And even with the vast diversity and specialisation of modern surgery this still applies.

Surgical specialties are among the most competitive in medicine. To make it as a surgeon you need both high technical ability and a keen intellect. You will also require drive, perseverance and a clear sense of direction in your career choice.

A career in surgery has many benefits: it can often be immediately rewarding in terms of patient satisfaction. Your professional skills will also be in high demand; thus it offers both job security and a decent income.

An integrated specialty

General surgery is one of the largest of the nine surgical specialties accounting for around 31% of the consultant surgical workforce. Traditionally it has been considered an integrated specialty consisting of vascular, endocrine, oncological and gastrointestinal work. The Intercollegiate Surgical Curriculum Programme (ISCP) states that "a shared syllabus and the ability at the completion of training to manage an unselected surgical emergency 'take', provide a common purpose across the specialty of general surgery at the time of writing (2007)". But as with many other disciplines there has been an increasing trend towards further specialisation within general surgery and the development of 'areas of special interest' including:

- upper gastrointestinal surgery (oesophagogastric and hepatopancreaticobiliary)
- colorectal surgery
- general gastrointestinal surgery or specialist GI surgery
- vascular surgery
- transplantation (renal, hepatic and pancreatic)
- breast surgery (including oncoplastic)
- endocrine surgery

Other less well-developed areas within the syllabus also include military surgery, general surgery of childhood, remote and rural surgery and academic surgery. General surgeons are expected to develop an area of special interest by the time they fully qualify.

All surgeons need a high degree of mental and physical stamina and general surgery is no different. NHS Careers describes the personal qualities needed to be a good surgeon as:

- the capacity to operate effectively under pressure
- the ability to remain objective when under pressure
- good communication skills
- the capacity to think beyond the obvious
- the capacity to monitor and anticipate situations that may develop rapidly
- effective judgement and decision-making skills
- leadership skills
- the capacity to manage time and prioritise workload.

Entry, qualifications and training

Upon completion of FY2, trainees with an interest in any surgical specialty must compete for entry into core training (CT) or specialty/run-through training in the regions where CT has not been adopted. Core training consists of a paid job in a hospital setting with experience provided in a range of surgical specialties but can also be 'themed' towards one particular specialty. Upon finishing core training a surgical trainee interested in general surgery can apply for that specialty along with other candidates. Selection for higher specialty training in general surgery then involves a further six years to achieve a certificate of completion of training (CCT).

Getting the job

Entry into surgery is obviously very competitive and planning should ideally begin

in medical school. Identify what area of surgery interests you and start now to create a portfolio of experience, knowledge and skills demonstrating your commitment and aptitude in that specialty. Remember that very few people are lucky enough to land the exact job they want so second and third-choice options are advisable.

Check the websites of the Surgical Royal Colleges and the ISCP for more information on required competencies for entry into surgical training. Think creatively about how to improve your career portfolio and don't limit this to work situations only. On their website, The Royal College of Surgeons of England suggests:

- attend/make presentations at courses, conferences, seminars
- join or organise a journal club
- explore membership of an association relevant to your career interests
- undertake self-directed learning
- teach and/or demonstrate (anatomy demonstration posts are particularly useful)
- take part in research
- write letters, articles, reports for publication
- take part in audit projects
- join and participate in local surgical societies.

You can also take part in 'taster weeks' during FY1 or 2 training and apply for surgical-related study leave in FY2.

Ensure you keep good records of the activities you undertake in order to easily compile your portfolio and write application forms. Ask for letters of support from any clinicians you have worked with outside the normal teaching programme. Check out the Pan-Surgical e-logbook (www.elogbook.org) established to allow surgeons in the UK and Ireland to record professional and personal development throughout their career. You can register at any time in your training.

You should also contact the Surgical Royal Colleges for other opportunities to further demonstrate your interest and enthusiasm for a career in surgery. The Royal College of Surgeons of Edinburgh runs an affiliate scheme for any medical student studying at university or trainee who has not yet passed their MRCS. As an affiliate, you receive a range of benefits, including careers support and advice, career development events tailored specifically to your needs and access to the college's library services and e-journals.

Being organised, focused and very determined will take you a long way toward getting your first choice of a career, be it in surgery or any medical speciality.

Jim Killgore is an editor at MDDUS

Q&A Mr Ben Stutchfield, ST2 in general surgery

• What attracted you to general surgery?

During my surgical attachment in final year medicine I was really inspired by the general surgical on-call week, particularly watching slick operators opening abdomens and directly sorting out the patient's problem. General surgery offers a great variety of patient presentation and operations – from emergency surgery controlling haemorrhage or sepsis, to major cancer resections. Alongside open surgery, laparoscopy and endoscopy are having an ever increasing role. It is this variety that has been a major attraction for me.

• What do you enjoy most about the job?

Operating is certainly the highlight and it is great seeing the change in patients postoperatively when their source of sepsis has been controlled or cancer removed.

• Are there any downsides?

Going hand in hand with operating is the responsibility it brings. This is certainly not a downside in itself but it can mean many anxious hours after an operation, no matter how major or minor, if for whatever reason there is concern about the patient's progress. This does not change, no matter how senior the surgeon is.

• What do you find most challenging?

The general surgical on-call can result in a long list of admissions. Assessing all the new admissions and reviewing previous admissions, ensuring the pertinent issues are covered before the morning theatre list starts can be quite a challenge. It is certainly a great test of organisation and efficiency.

• What do you think is the most important personal characteristic in a good surgeon?

Being an effective decision maker is vital in a good surgeon. When to operate and, often more importantly, when not to operate must take into consideration many factors. Whether the patient is going to theatre or not, the plan of action should be clear for every patient.

• What is your most memorable experience so far?

A middle-aged gentleman had suffered a ruptured abdominal aortic aneurysm while I was on call for vascular surgery. I had assessed the patient in A&E and he was rapidly transferred to theatre. During the operation the patient suffered a cardiac arrest but was successfully resuscitated and the aneurysm repaired. The patient was discharged from hospital fit and well ten days later. During the operation it had seemed like hope was fading fast for this gentleman. The case really highlighted the teamwork that was so important in getting this man through – from his quick transfer to theatre, the anaesthetic team leading the resuscitation during the operation, intensive care support postoperatively and then the nurses and physiotherapists working towards discharge.

• What advice would you give to a final year or FY trainee considering general surgery?

Decide where the weaknesses in your CV are and put together a plan early in your foundation years of how to address these, whether it be writing papers, presenting at conferences, sitting examinations or assisting in theatre. It is not particularly helpful to try to do every course or exam available, but sit down with a senior trainee or consultant and plan out what would be best for you, giving you the best chance of selection on to your chosen training scheme.

FIGHTING A CULTURE OF VIOLENCE

FYi associate editor **Joanne Curran** investigates a groundbreaking new project in which doctors and dentists are educating schoolchildren on the horrors of knife crime

DAY AFTER DAY they see the shocking damage that can be inflicted on the human body by a knife attack.

Thousands of victims of violent assaults pass through UK emergency departments every year and, in many cases, it is the job of oral surgeons to stitch them up and send them home. It is a cycle that must sometimes seem as hopeless as it is endless.

But one group of surgeons has made a bold move to stop this culture of violence in its tracks with a groundbreaking project using volunteer doctors and dentists to reach out to schoolchildren.

Medics Against Violence is a registered charity that aims to end the cycle of violence before it begins by educating young people about the dangers of knife carrying. It was founded in 2008 by leading oral surgeon Christine Goodall of Glasgow University's dental school and maxillofacial consultants Mark Devlin and David Koppel from Glasgow's Southern General hospital.

Disheartened

Their motivation for creating the programme is clear. They are pushed to the limit working in oral and maxillofacial surgery in Glasgow – a city which boasts the unenviable title of the most violent in Europe.

Last year, 1170 victims of knife crime were admitted to Scottish hospitals at a cost to the NHS of more than £500million. Goodall and her Glasgow colleagues treat someone with a facial injury every six hours. Of those, 70 per cent have been attacked by a bladed weapon and 80 per cent have been drinking to excess.

Goodall says: "We started it because we were so fed up seeing so many young people coming into hospital injured. I have worked for many years in maxillo-facial surgery and we have stitched them up and sent them home but have done nothing to address the problem.

"We were getting so disheartened by the number of young people coming in that we thought it would be a good thing to try to stop it in the first place. Some of the injuries you see are horrific and they have a big effect on people's lives and on their confidence. Over the years, I've often thought this must be preventable."

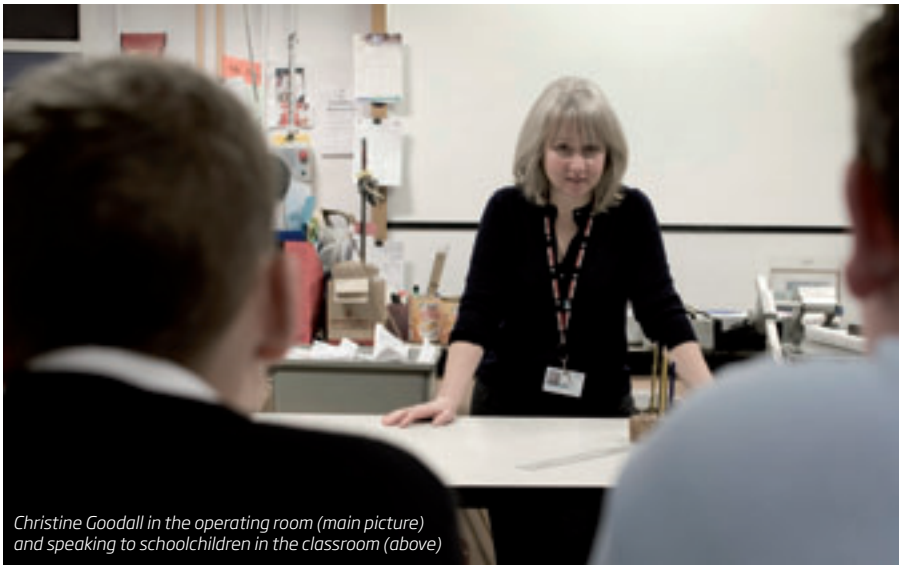
Faced with this daily onslaught, the surgeons teamed up with Strathclyde Police's Violence Reduction Unit and constructed an educational programme especially aimed at 14 and 15-year-olds. The programme has been praised by schools and there are already plans to expand it.

Reaching out

During the sessions, pupils are shown a hard-hitting 15-minute film which features stories from three people – a young murderer, a mum whose son was murdered and Scott Breslin who was paralysed from the neck down after being stabbed at the age of 16. It also includes some graphic images of stab wounds and CCTV footage of violent attacks.

Afterwards, the volunteer doctors and dentists discuss the main issues with the pupils and pose questions such as: "Is there a safe place to be stabbed?"

PHOTO: DAVID GILLANDERS



Christine Goodall in the operating room (main picture) and speaking to schoolchildren in the classroom (above)

Goodall says: "It's interesting what attitudes emerge from the children. Quite a few of them will say they think it's safe to stab someone in the buttocks, for example, but we explain to them how you can still bleed to death from an injury like that because there's a big artery in that area. It's a lot about myth-busting. The children watch these films in the cinema where people get stabbed or beaten to a pulp and keep on getting up so a lot of them might think it's not that dangerous to stab someone in a particular place, which is simply not true.

"We worked with an educationalist on the lesson plan because we wanted it to be easy for people to take out and present. The film does most of the storytelling, rather than us standing up and making up stories."

She says the story of wheelchair-bound Scott Breslin has particular resonance with pupils. "They can really identify with him. Young people often don't understand the consequences of what they are doing. They think they are invincible. We wanted them to see something of what we see every day."

Medics Against Violence, or MAV, was set up in November 2008 with an £80,000 grant from the Scottish Government. So far, volunteers have spoken to more than 4000 schoolchildren across the west of Scotland.

Expansion

Many of the schools visited by MAV and its army of 120 volunteers are in areas with a known gang problem where the young pupils may already be carrying knives. While most visits have been carried out across the west of Scotland, Goodall hopes to expand the project across the country. There are already volunteers in Ayrshire and the service is about to open in Dundee.

Co-founder Mark Devlin, a consultant cleft and maxillofacial surgeon, also features in the MAV video. He recalls treating four school friends who were the victims of knife attacks. He says: "We came from a similar background but I had a mum and dad who wanted something more for me. All the doctors come from different backgrounds and the children at the schools will be from different backgrounds but there is only one message – that they can make a choice."

"We were getting so disheartened... I thought it would be a good thing to try to stop the violence before it started"

A similar project – the Knife Crime Prevention programme – was announced by the Home Office in November 2009 and will run in several counties across England. It follows a similar approach to MAV and will see doctors and nurses collecting photographic evidence of knife injuries. These will then be shown to young people convicted of knife possession. Victims of knife crime and ex-criminals who have turned their lives around will also be drafted in to speak to young offenders.

But Medics Against Violence leads the way amongst the medical and dental community for its unique approach to tackling violence. It has already attracted the help of specialists from fields as diverse as emergency medicine, psychiatry, anaesthesia, oncology and even palliative care.

Volunteers

But Goodall is hoping to recruit even more medics, including GPs, junior doctors and trainee dentists. She says: "We are relying on people volunteering, which is very hard because everyone is so busy. We have a lot of people who go out time and again, but we are hoping to attract more doctors and dentists."

One volunteer is Dr Yvonne Moulds, a specialist registrar in emergency medicine. She says: "The school I visited was in a very deprived area and I was shocked by how much exposure some of the second year pupils had to knife carrying and gang culture in the local area. I told them how I had seen children not much older than them die from knife wounds and I think that got their attention. It was a really worthwhile visit and the kids shared a lot with us that surprised even their class teacher. By the end of it, a good number of them seemed to take our message on board and started really thinking about the choices they could make in life."

MAV has high hopes for the future. Goodall and her co-founders have already been honoured with a gong at the Scottish Policing Awards for their efforts in tackling crime through the innovative scheme. She now hopes to expand MAV's remit by tackling domestic violence by enlisting the help of medics to raise the subject with people they think might have been affected.

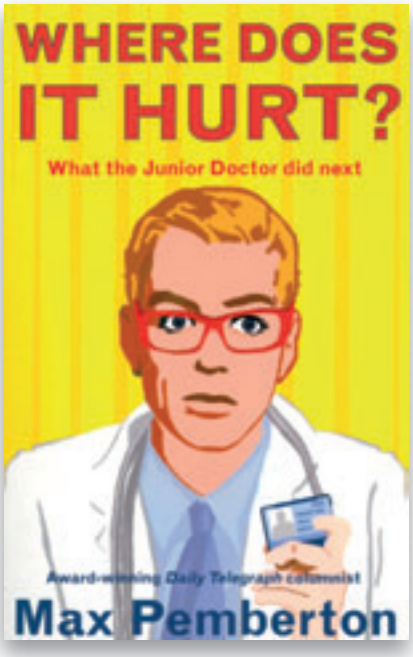
Despite the challenges ahead, Goodall is optimistic, saying: "We wanted to try to make a difference and I think we are doing something good that has the potential to change lives for the better."

For more information, visit **www.medicsagainstviolence.co.uk**

Joanne Curran is associate editor of FYi magazine

Author, award-winning newspaper columnist and specialist trainee in psychiatry **Dr Max Pemberton** discusses how his medical career inspires his writing

THE VOICE OF JUNIOR DOCTORS



THE trials and tribulations of his life as a junior doctor have proved a rich source of inspiration for Dr Max Pemberton.

His behind-the-scenes accounts of life on the wards were first published as a regular column for the *Daily Telegraph* and won the Royal College of Psychiatrists' public education award. The stories were then turned into his successful debut novel, *Trust Me, I'm a Junior Doctor* in which he reveals the desperation of long hours and a massive workload with stories that are terrifying and funny in equal measures.

He followed that up with a candid account of his experiences in FY2 working in a homeless outreach project in his second novel *Where Does it Hurt? – What the Junior Doctor Did Next*. He again mixed fiction (for example, Max Pemberton is not his real name) with autobiography to describe the harsh realities of frontline patient care.

He has just finished his third book which follows the same characters and is set in a hospital geriatric ward. A TV version of *Trust Me...* is also on the horizon after Max sold the rights to his debut novel.

Max studied medicine at UCL in central London and also has a first class anthropology degree. He started working as a doctor in 2003 and is currently a specialist registrar in psychiatry, based in London. He continues to write for a variety of publications.

When did you first know you wanted to be a doctor?

When I was very young I wanted to be a marine biologist, but when someone explained that I'd likely end up swimming in raw sewage counting barnacles, I reviewed my options. Around the age of 13 I settled on being a doctor and aged 15 I did work experience at a local hospital for older people and I loved it. An inspirational manager took me under her wing while I was there and showed me how medicine could be a force for good, advocating for the disenfranchised and challenging stigma and inequality as well as meeting and treating fascinating people. I left with a determination to become an old age psychiatrist – not the usual career aspiration for a teenager.

What was the most important lesson you learned as a junior doctor?

Eat. My friends and I lost so much weight in that first year because we simply didn't find time to eat properly. A well-stocked freezer is a lifeline when you're too tired to traipse to the shops. It's so easy to just eat junk food when you're busy and stressed but it's important to look after yourself if you're going to look after other people. Remember: a bag of Monster Munch does not count towards one of your five a day.

What inspired you to choose psychiatry?

Psychiatry was the best career choice I could have made. I love listening to people and hearing their stories and this is precisely what psychiatry is all about. It covers so many different areas there's something for every taste and it's an incredibly friendly speciality. It is so intellectually stimulating plus you develop strong, enduring relationships with patients, which makes it extraordinarily rewarding. I particularly enjoy old age psychiatry because so often society throws these people on the scrap heap and – although it sounds a bit corny – you really can make a difference to their lives.

Any advice for those looking to pursue a career in psychiatry?

Psychiatry requires sound medical knowledge combined with excellent communication skills and the ability to empathise. Be enthusiastic, read around the subject and if you're still at medical school, try and organise your elective or special study modules in psychiatry. See if there's a psychiatry society set up at your university and go along to their events. If not, ask The Royal College of Psychiatrists about setting one up yourself – you'll win so many brownie points if you do.

How did you get into writing?

I started work as a journalist while at medical school, so I've been writing much longer than I've been a doctor. I was working on a consumer health website to fund my way through medical school, but I discovered I loved writing. As I got more experience and made contacts, I started writing for print media and my career grew from there. Just before graduating I approached the *Daily Telegraph* with an idea for a column detailing my first year of life as a junior doctor and a year later they asked me to continue by commenting on news, culture, ethics and the politics of healthcare, which I'm still doing. After the publication of my first book, I was approached by other magazines and newspapers and I started as a columnist for *Reader's Digest*.

How do you balance your medical career with your writing career?

It depends on what writing commitments I have but I tend to write very late at night. At weekends I'll go out and then come back and write until dawn. When I have a book to finish, I write furiously in the last few weeks before deadline and try not to go out (much). I don't have a television or children and I do think that not having these two things frees up an amazing amount of time.

What response have you had to your books from doctors?

My readership is quite broad and my writing is predominantly aimed at the lay public rather than doctors. Even so, most of the responses I've had from doctors have been very positive. All my colleagues know about my writing and have been tremendously supportive. A lot of medical students and would-be medical students contact me saying that they've enjoyed my books and asking advice. I get a very hostile reaction about a lot of my columns from government organisations and senior NHS officials, but as far as I'm concerned, that's mission accomplished.

How do you preserve patient confidentiality when you're writing about your job?

There is a process I have to go through to ensure that certain key aspects of patient information are changed to ensure that patients can't be identified. Most of the characters are composites although I usually start with one patient encounter I've had that raises a point or an issue and then layer the character details on top of that. There is a lot of legal input.

Do patients ever recognise you?

Yes, sometimes, and I occasionally hear people talking about it when they see me in A&E and it's never been a problem. In fact, people seem to quite like it and several of them have asked if they can be a character in one of my books. A lot of members of the public recognise me from my photograph in the paper and stop me when I'm out shopping. They're usually very kind, but they do often insist on telling me their life stories when sometimes all I want to do is grab a pint of milk and go home.

Any advice for those who want to get into writing?

In many ways breaking into journalism is far harder than getting into medicine. It's very competitive and a lot of it is down to pure luck and serendipity. Just don't give up. As a medical student I would spend Friday evenings writing pitches to magazines and newspapers, most of which I never even got a reply to. Also, practice writing and read as much as you can.

Interview by Joanne Curran, associate editor of FYi

THE KEY TO SUCCESS

A good CV is often about more than just academic achievement

HAVING NOW successfully completed two degrees, the Foundation Programme and a year of specialty training, I look back sometimes and wonder how I've managed to find myself in such an honoured position.

Currently a specialist trainee within psychiatry and content in the knowledge that my career choice has been wise, I have often been guilty of downplaying my own achievements. I tend to attribute them to a degree of luck or having been in the right place at the right time. Even my own mother has commented on my apparent good luck by saying that if I had the misfortune of falling into the River Clyde, I would undoubtedly reappear with a salmon.

But relying on luck as a method of career accomplishment is not something that anyone should do to achieve their goals. Looking back at my own achievements, I can see now that they have all been hard-earned. And in my experience, the key to success for medical graduates seeking a training place is often a well thought-out CV that is personalised and contains relevant information, conveying a true sense of your transferable skills and notable achievements to future employers.

As competition within medicine grows, employers are increasingly looking for CVs that offer more than just the standard academic qualifications.

The medical CV

The advent of 'modernising medical careers' may lead some doctors to think the medical CV is all but defunct. Entry to all specialties in medicine is based largely upon an electronic application form, comprising a series of boxes themed around a set of desirable 'core competencies'. This allows the applicant to illustrate their perceived strengths in areas such as teamwork and leadership, backed up by sufficient evidence.

However, basing these answers on a well thought-out and succinct CV should be the catalyst that propels you to a successful application in your chosen field. It also serves as a useful reference document during this arduous and often daunting process.

So what should your CV consist of? In my view, the purpose of a CV is to give candidates the opportunity to illustrate the various skills, abilities and achievements that they have acquired over a period of time and within a variety of different settings. I have always stressed the importance of the adoption of a more holistic approach to life. Reflection of this within your application will ensure success and illustrate your ability to have a healthy work/life balance – a must if you are to survive a career in medicine.

Valuable experience

Throughout my time in higher education – almost ten years – I had the opportunity to undertake voluntary work. This encompassed both auxiliary nursing and participation in the running of a soup kitchen for the homeless within the Glasgow area. Such experiences were both humbling and rewarding and it's only now that I've realised the impact and importance these activities have had in shaping my medical journey to date.

It cemented my ability to work and communicate effectively as part of a team. Moreover, I honed my ability to empathise with others' needs and circumstances, making me a more accepting individual and understanding doctor. These attributes cannot be forced or learned overnight but are gradually acquired over time and evidence of this on any CV will be viewed favourably.

There are also many important medicine-related achievements and activities which attract high scores.

Participation in a clinical audit and research is another way of increasing your chance of securing the training place of your choice. It illustrates your understanding of the importance of such practice in medicine in the development of clinical guidelines and protocols. Successful completion of a properly conducted audit may also give you the opportunity to present your findings at a national conference – ensuring praise from your consultant and a welcome addition to your CV.

Consider also writing articles or research papers for publication. While this can be difficult, it is not impossible and it illustrates an ability to work to time constraints under a degree of pressure.

Achievement of teaching experience has become a mainstay of the higher training application process. The most common way is to get involved in the teaching of medical undergraduates. This most commonly happens via clinical examination sessions at the bedside of a willing patient. This not only helps consolidate your own knowledge but allows the opportunity to develop your communication and leadership skills, which are fundamental to being a doctor.

Selling yourself

Medicine has always been considered an elite profession. The gradual reduction in training places and the concomitant increase in the number of medical graduates have resulted in greater competition for jobs. Long gone are the days where a consultant's 'nod' of approval would translate into a job offer. And being an alumnus of a particular medical school no longer gives you an advantage over other graduates. This welcome change has, however, placed greater importance on an individual's ability to 'sell themselves' to potential employers. One way of achieving this is by early recognition of the importance of being a well-rounded individual – rather than simply being awarded a medical degree.

Dr Maggie Cairns has just completed her first year of specialty training in psychiatry and is editor of FYi

OUT THERE

LUCKY ESCAPE A four-leaf clover was found stuck to the back of a driver who was impaled on a post in a car crash in Northumberland. The wooden stick missed all of Raymond Curry's vital organs while two other fence posts hit the car and missed the 20-year-old by inches. He has since framed the clover on his bedroom wall. *Source: BBC News*

HITLER'S HALITOSIS Adolf Hitler suffered from gum disease, tooth decay and chronic bad breath according to research published by a German dentist. The study also reveals the Nazi leader underwent eight root canal treatments – one can only hope it hurt.

SPEED REJECTION A researcher submitting a paper to an academic journal believes he may have set a record for speed of rejection. The online manuscript submission system of the journal *PLoS One* responded in 1 minute 52 seconds with a rejection letter including the phrase "having discussed the paper with our internal editors." *Source: BMJ Minerva*

LOVE IS THE DRUG... Yearning for the lover who dumped you may be partly a matter of brain chemistry. US researchers found that subjects looking at images of exes who jilted them activated regions in their brains typically associated with "motivation and reward" and intense addiction to substances such as cocaine and cigarettes.

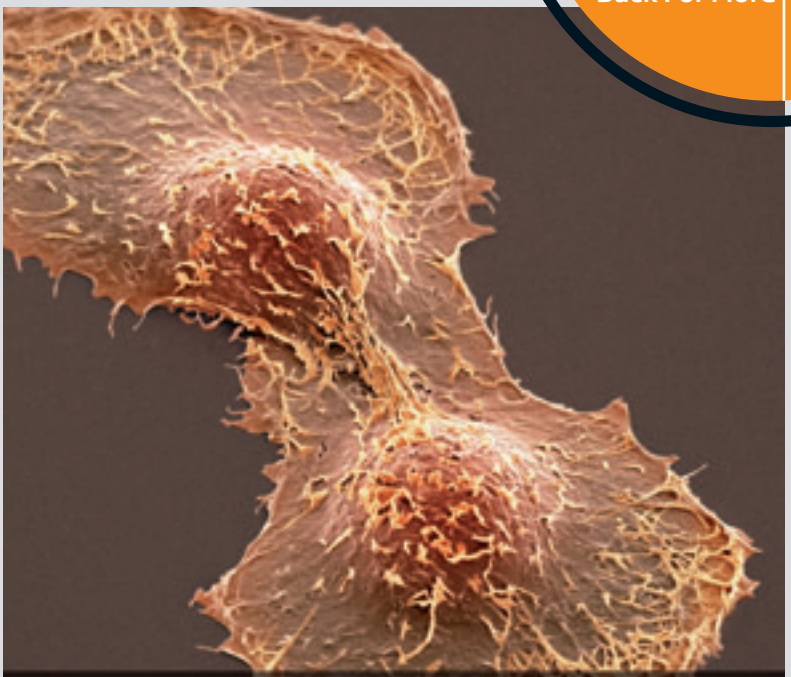


PHOTO: THOMAS DEERINCK, NCMIR/SCIENCE PHOTO LIBRARY

WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: THE KOBAL COLLECTION

Pick: DVD - Coma

Directed by Michael Crichton, starring Genevieve Bujold, Michael Douglas and Richard Widmark; 1978

BEFORE Michael Crichton scored a major hit with his TV series, *ER*, he brought us the creepy sci-fi hospital thriller *Coma*.

Based on the best-selling novel by doctor Robin Cook, Crichton – himself a doctor – cranks up the conspiracy dial to maximum for this tale of mysterious deaths and corporate cover-ups. Susan Wheeler is a surgical resident at Boston General Hospital whose best friend is left brain-dead during a routine procedure. After hospital chiefs dismiss her concerns, she digs into the hospital records and discovers an unusually high number of deaths amongst seemingly healthy patients.

Their bodies are all sent to the shady Jefferson Institute – but why? Wheeler, played by Genevieve Bujold, is convinced something untoward is going on but even her boyfriend Dr Mark Bellows (Michael Douglas) and kindly old Dr George Harris (Richard Widmark) struggle to take her seriously.

Coma might not always be entirely plausible but Crichton builds an authentic atmosphere for this chilling drama before allowing events to spiral into a nightmarish vision of the future of healthcare.

Book Review:
The Immortal Life of Henrietta Lacks
by Rebecca Skloot

Macmillan; ***£18.99***

Review by Jim Killgore, contributing editor

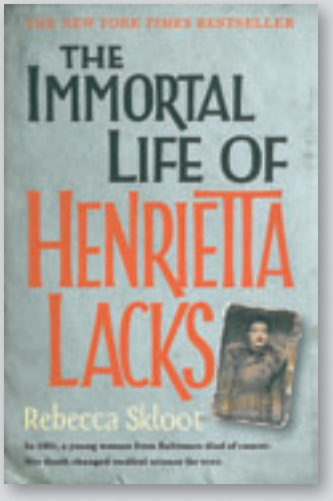
IN 1951 a working class 'coloured' woman named Henrietta Lacks attends the gynaecology clinic at Johns Hopkins Hospital in Baltimore complaining of a "knot on my womb". A few days later a biopsy confirms that the 31-year-old mother of five has cervical carcinoma. In an operative procedure a few weeks later a surgeon removes a small tissue sample from the tumour. No one asks her permission as the attitude then is that tissue samples form a sort of payment in kind for free treatment offered in public wards.

Just by chance a researcher at Hopkins called Dr George Gey has been trying for over three decades to develop a technique for growing malignant cells outside the human body. He is convinced this will provide an invaluable tool in understanding and curing cancer. All his attempts so far have ended in failure with most cell cultures taken from ward specimens surviving only a few days at most. But Henrietta Lacks' cells are different – they reproduce endlessly and are still doing so to this day.

The story of Henrietta Lacks and her "immortal" cell line is the subject of a fascinating book by writer and journalist Rebecca Skloot. It combines science, history, social criticism and medical ethics with a compelling personal story. Skloot recounts how Gey distributes HeLa cells to any scientist with an interest in cancer research – who in turn grow their own cells, spreading the line among laboratories across the globe.

Today countless trillions of HeLa cells are used to research everything from cancer and AIDS to gene mapping, and the effects of radiation and toxic substances, even micro-gravity in outer space. The cells played a fundamental role in the development of a polio vaccine by Jonas Salk and his team. Skloot estimates that over 60,000 scientific articles have been published on research done using HeLa cells with that number increasing by more than 300 papers each month.

Henrietta Lacks died in 1951 without the slightest inkling of the huge impact her cells would have on research. Much of the book is devoted to Henrietta's story and that of her children and extended family living on the edge of poverty while their mother's cells serve a billion dollar industry. It's an oddly fantastical tale told with wit and sensitivity – a curious mix of science and story-telling.



WHAT ARE WE LOOKING AT? *Coloured SEM of HeLa cell division*