FYi

ISSUE **07**

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AN **MDDUS** PUBLICATION

PHOTO: WALTER NEILSON

Welcome to your FYi

THERE are lots of new challenges for trainee doctors to handle as we start our medical careers – and managing patient complaints is likely to be one of them. No matter how hard we try we will undoubtedly have to deal with negative feedback at some point, which can be a daunting prospect. But MDDUS medico-legal adviser Mr Des Watson offers some advice on how to defuse complaints in his article on page 10.

As doctors, our relationships with patients must stay strictly professional but this can be increasingly difficult in the age of social media. On page 5, contributing editor Jim Killgore looks at new BMA guidance for doctors who might be tempted to 'friend' patients online.

New doctors often worry about mistakenly harming patients, and evidence shows managing diabetes is one of the most likely ways in which this might happen. Dr Matthew Young and specialist nurse Janet Barclay offer expert advice on page 4. New doctors in Scotland might one day be asked to give evidence at a Fatal Accident Inquiry and on page 14 we report on a mock FAI run by MDDUS.

Deciding on a medical specialty is a big decision, and on page 6 emergency medicine trainee Dr Craig Brown discusses why he chose the field and what the job is like. Then on page 8 we look at what it takes to follow a career in geriatric medicine.

Professor Sue Black is something of a celebrity in the field of forensic anthropology and human identification. On page 12 she talks to *FYi* about her important work identifying victims of war crimes and in helping to prosecute killers.

• **Dr Rebekah Skeldon**
Editor

TOOLKIT LAUNCHED TO CUT HANDOVER ERRORS

A TOOLKIT designed to reduce errors during patient handovers has been launched by the Royal College of Physicians.

The document defines the principles behind good handover practice, what the handover framework should contain and how to avoid mistakes.

It makes a number of recommendations for the handover process including determining clear arrangements for ongoing care of patients, defining who is relinquishing responsibility and who is now responsible for care and establishing standardised systems of communication.

Professor Humphrey Hodgson, RCP Education Vice President, said: "The shorter working hours for medical trainees under the European Working Time regulations, and the increasing use of short-stay medical admissions units, so that patients may well be transferred between teams, are only two of the reasons why a robust and effective handover system is needed for patient safety and high quality care."

The toolkit is the first of a series aimed at offering guidance on best quality care. It can be downloaded at: **www.tinyurl.com/63tlaq2**

SUPPORT FOR FITNESS TO PRACTISE REFORMS

THE GMC is claiming broad support from doctors and patients for many of the proposals detailed in its recent consultation on fitness to practise procedures, including plans that would see doctors able to accept a sanction without going to hearing.

The fitness to practise reforms consultation was launched in January 2011 and the GMC received 217 written responses from patient groups and individuals, as well as the BMA, Royal Colleges, CHRE, NHS Employers, individual doctors and medical defence organisations, including MDDUS.

Among the proposals is a mechanism by which doctors can accept a sanction without going to a full hearing, thus providing a quicker resolution to cases. Other proposals would see doctors with convictions for certain crimes, such as murder and rape and possibly fraud, automatically struck off the medical register.

However, plans for doctors to be able to share information with the regulator on a 'without prejudice' basis will not be pursued after respondents voiced concerns.

Niall Dickson, GMC Chief Executive, said: "We will now develop the plans in detail, working closely with doctors and patients to make sure the changes continue to ensure there is widespread confidence in our fitness-to-practise procedures."

MDDUS

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EXTEND GP TRAINING TO BOOST DEMENTIA SKILLS

GP TRAINING should be extended to include sufficient training on treating dementia, according to a report by an influential group of MPs and peers.

The All Party Parliamentary Group on Dementia said the training programme should be lengthened in line with other specialties because GPs lack the confidence and skills to effectively treat dementia. The group also recommended the introduction of ongoing specialist community training.

Dementia treatment cost an estimated £20billion in 2010 and the figure is expected to reach £27billion by 2018. But fewer than half of those with the condition are diagnosed, leaving many people to struggle without much-needed support, the report says.

The report concluded: "The confidence and skills of some general practitioners in recognising dementia continues to be inadequate. Increasing the length of GP training so that it is equivalent to other specialisms would allow for improved coverage of dementia within the GP curriculum."

Local areas should also consider how best to develop ongoing training, the report goes on to say, suggesting "brief targeted sessions run by specialist dementia services at GP practices". Such interventions may prove extremely helpful for GPs as they take on new commissioning responsibilities.

NEW NHS LEADERSHIP ACADEMY ANNOUNCED

PLANS HAVE been unveiled for a national leadership academy to help NHS staff develop their skills as non-clinical managers.

Health secretary Andrew Lansley said the academy would give all staff an equal chance to develop the skills needed "to drive a truly world class NHS."

The move followed a report by health think tank the King's Fund earlier this year which criticised the lack of involvement of doctors in management as "one of the defining weaknesses of the NHS over the decades."

King's Fund chief executive Chris Ham welcomed the new academy as "a positive step".

SIGN UP FOR YOUR FREE 2011 YEARBOOK

THERE'S STILL time to place your order for your 2011 school yearbook.

The yearbook is free if you take up graduate membership with MDDUS, which offers access to medico-legal assistance and professional indemnity for just £10.

For a graduate application form, get in touch with Olivia McCulloch at MDDUS on **omcculloch@mddus.com** or **0845 270 2034**. The yearbook offer applies to all medical schools in Scotland.

STRONG SUPPORT FOR ETHICAL OBJECTIONS

A SURVEY of 733 medical students has found that just under half support the right of doctors to refuse to offer any procedure that conflicts with their personal, moral or religious beliefs.

An article published in the *Journal of Medical Ethics* reports on the survey in which medical students were asked: "Do you think that doctors should be entitled to object to any procedure for which they have a moral, cultural or religious disagreement?"

Overall, 45 per cent said yes, 14 per cent were unsure and 40 per cent said no. Support was highest among Muslim students at 76 per cent. Across the entire group of medical students, one in five objections were on religious grounds, almost half were on non-religious grounds and around one in three were a mixture of both.

Among 11 specific practices, medical students were least willing to treat patients requesting an abortion.

Dr Sophie Strickland, author of the report said: "In light of increasing demand for abortions, these results may have implications for women's access to abortion services in the future. The Department of Health has issued statistics showing that, although there are an increasing number of abortions taking place in the UK, fewer doctors are willing to perform them."

GMC guidance *Personal beliefs and medical practice* states that doctors must make patient care their first priority and treat patients with respect whatever their life choices and beliefs.

It states: "If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You must be satisfied that the patient has sufficient information to

enable them to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role."

THINK GLUCOSE

THE TRANSITION from medical student to fully qualified doctor with responsibility for patients is a major step. The fear that you might do something wrong that injures or kills someone is frequently present. Evidence shows that managing diabetes is one of the most likely ways in which that might happen and yet it is relatively straightforward to prescribe safely and effectively and improve care for patients with diabetes. Here are some facts and handy tips to help you to help your patients.

The size of the problem

Diabetes is a common long-term condition and is significantly over-represented in hospital patients. Whilst around 4 per cent of the UK population have diabetes, around 15 per cent of hospital inpatients are known to have diabetes. The vast majority (86.7 per cent) are admitted as an emergency and once they are admitted, the average length of stay is eight days, three days longer than the typical stay for all inpatients.

Patients may be admitted either as a direct consequence of diabetes complications, such as short-term glucose disturbances including ketoacidosis or hypoglycaemia, or due to long-term complications such as foot disease or renal failure, or for an unrelated matter with diabetes in the background. Therefore, diabetes patients can be found in every hospital specialty from neonates to geriatrics and surgery to psychiatry.

What goes wrong?

Whilst the management of diabetes with tablets can be fraught with pitfalls – such as the need to always stop metformin treatment before any contrast radiological procedure including CT scans or angiograms – it is insulin prescription and adjustment where the most significant problems tend to be found. According to a recent audit of inpatient diabetes care in England and Wales (**www.tinyurl.com/6j6swex**), over one-third of inpatients with diabetes experienced at least one medication error during their admission. On closer inspection a quarter of their charts had prescription errors and a fifth had one or more medication management errors. Excess amounts of insulin can result in potentially fatal hypoglycaemic episodes ('hypos') and insufficient insulin can lead to diabetic ketoacidosis (DKA) which, if unrecognised and untreated, can also prove fatal.

The audit found that patients with medication errors had more than twice the rate of hypoglycaemia (18.1 vs 7.9 per cent) than those without definite prescription errors. Although the fact that nearly 8 per cent of patients had hypos in hospital with the "correct" insulin prescription is also a little alarming to us. Perhaps even more worryingly, 0.4 per cent of the inpatients surveyed developed DKA and 2.4 per cent had hypoglycaemia severe enough to require injectable treatment such as glucagon or IV dextrose (only ever use 5 or 10 per cent and never 50 per cent dextrose to treat hypoglycaemia).

What can we do to reduce these errors?

As an extension of the Scottish Patient Safety Programme, and the results of this audit, a new initiative, Think Glucose, is being piloted in a number of Scottish hospitals (**www.tinyurl.com/ydt29bb**). The campaign aims to improve diabetes care in hospitals, particularly insulin management, delivering the right insulin to the right patient at the right time. It promotes the self-management of insulin by patients (when appropriate), reducing the likelihood of incorrect prescriptions by doctors, details the times when patients should and should not be referred to hospital diabetes teams, particularly diabetes specialist nurses, and includes clear accountability for monitoring of diabetes, ensuring that corrective measures are taken for inappropriately low or high blood glucose levels.

As the FY doctor you can do your part in a number of simple ways:

- Always ask the patient how much insulin they take for a given meal. Not every patient gets their diabetes right every time but they generally have more experience than you. However, beware of the patient with a high glycated haemoglobin result who claims to take a large insulin dose as they may not take this dose for every meal.
- If the patient is not self-managing then ensure that insulin doses are written up at least one meal in advance. That way it can be given at meal times so there is no delay that might increase the risk of glucose disturbance. There is no need to wait for the blood glucose level to prescribe insulin.
- If the glucose is low or high it is the corresponding dose that precedes the abnormal level on the next day that should be adjusted. This is particularly true for breakfast insulins which should always be prescribed by the end of the previous working day. If a glucose level is high or low find out why. Did the patient miss a meal for a diagnostic test or have they been eating or drinking inappropriate foods or drinks? If so, the insulin may not need to be adjusted at all but that situation remedied.
- Learn how to recognise and treat hypoglycaemia appropriately.
- Become familiar with commonly used insulin in your area and their time actions.
- Most hospitals have a diabetes specialist nurse who looks after inpatients with diabetes. Find out how to contact them and don't be afraid to ask them for advice. Early referral to the diabetes nurse can aid earlier discharge.
- Follow the national DKA protocol and make sure patients on long-acting insulins still get them whilst on IV insulin infusions.

Overall, simple steps can ensure that diabetes patients, particularly those on insulin, have a safer time in hospital, which also speeds recovery and reduces length of stay, improving everyone's quality of life.

Dr Matthew Young, consultant in diabetes and acute medicine

Janet Barclay, diabetes specialist nurse, at the Royal Infirmary of Edinburgh

CAN A PATIENT BE A 'FRIEND'?

Not best advised according to new BMA guidance for doctors using social media

BE IT Facebook, Twitter, blogging or internet forums – there is no doubt that the rise of social media has led to a blurring of the personal and professional and this brings risks for anyone engaging in our brave new digital world. But for doctors the risks can be much more serious and far-reaching.

In July the BMA issued guidance advising doctors and medical students not to accept Facebook 'friend' requests from current or former patients. *Using social media: practical and ethical guidance for doctors and medical students* also urges doctors and medical students to consider adopting conservative privacy settings and to be aware that not all information can be protected on the web.

The Chairman of the BMA's Medical Ethics Committee (MEC), Dr Tony Calland, said: "Research has shown that while most doctors would not accept Facebook friend requests from patients, a minority said they would consider doing so. Yet accepting Facebook friends presents doctors with difficult ethical issues."

One obvious risk area is in maintaining appropriate professional boundaries with patients. The GMC provides no specific advice regarding social media but the same principles apply in doctor–patient relationships regardless if interactions are online or face-to-face.

MDDUS senior medical adviser Dr Jim Rodger, said: "Doctors are bound by guidance from the General Medical Council which states that they must maintain professional boundaries with patients.

"Any doctor pursuing a non-professional exchange with a patient via social media – no matter how innocent it may seem – runs the risk of falling foul of the GMC. So it's best not to go there.

"The GMC further states that if a patient displays inappropriate or sexualised behaviour – be it actions or words – the doctor should wherever possible treat them politely and considerately and try to re-establish a professional boundary."

Just what is meant by professional boundaries can be widely interpreted and it is important to understand that the GMC may still question a doctor's fitness to practise even if a relationship seems entirely open and consensual with no obvious adverse consequences for the patient. Such a relationship need not be long-term or even sexual in nature to attract censure. Exchanging personal details with a patient such as those commonly posted on sites like Facebook can increase the likelihood of ethical difficulties.

"Be aware that not all information can be protected on the web"

"For example doctors could become aware of information about their patients that has not been disclosed as part of a clinical consultation," explains Dr Calland.

So what should you do if sent a friend request by a patient or former patient on Facebook? Some doctors might feel that simply to ignore such a request would be rude. The BMA recommends that doctors and medical students should politely refuse with an explanation of the reasons why it would be inappropriate to accept the request.

Doctors should also be careful not to invite unwanted attention from patients in first place. The BMA says that although doctors often "choose to divulge personal information about themselves during face-to-face consultations with patients, they are able to control the extent and type of this self-disclosure. The accessibility of content on social media however raises the possibility that patients may have unrestricted access to their doctor's personal information and this can cause problems within the doctor-patient relationship".

Taking care with private details can be as much a matter of personal security. In 2009 the University of Birmingham issued guidance to students on Facebook after it emerged that former patients had contacted two medical students via the website. The BMA warns:

"Some social media sites, such as Twitter and Facebook, have privacy settings that allow users to control and put restrictions on who has access to their personal information. The default settings for both sites however permit various types of content to be shared beyond an individual's network of friends. On Twitter for example, the default setting for accounts is 'public', allowing anyone to search for and access a user's profile page, while the recommended settings on Facebook allow 'everyone' to access status updates, photos and posts. Users therefore actively need to change the privacy controls to ensure their content is protected to the extent they would like."

Such steps should ensure that the risk of non-professional patient contact is kept to a minimum. You can access the BMA's *Using social media: practical and ethical guidance for doctors and medical students* at **www.tinyurl.com/66mjagq**

Jim Killgore, contributing editor

NEVER A DULL MOMENT

Emergency medicine trainee **Dr Craig Brown** discusses why he chose the specialty and shares his experiences of working on medicine's frontline

IT IS fair to say that no two days are the same in emergency medicine. In the space of just one memorable nightshift as part of the emergency department team, I had to manage an acute exacerbation of asthma, status epilepticus, a road traffic collision with haemorrhaging scalp laceration, congestive cardiac failure and cardiac arrest then, just before handover, a paediatric seizure. This was in addition to a string of other minor injuries including the intoxicated patient who thought it would be a good idea to put their fingers into the food processor at 3am.

Medicine is a career that offers something for everyone. From the nuances of auto-antibodies in the rheumatology clinic to practical skills in the operating theatre, career options abound for medical graduates. Deciding on a specialty is rarely easy but for me the choice was obvious.

One of the reasons I applied to medicine in the first place was as a response to the question – 'if someone collapsed in the street in front of me, would I know what to do?' Fortunately I've never been in this position but now, thanks to my training in emergency medicine, I can answer 'yes'.

A satisfying buzz

Throughout medical school and the foundation programme I found myself interested in the acute care aspect of treating patients, having had a number of acute foundation jobs including trauma and orthopaedics, general medicine, surgical admissions and emergency medicine. The satisfaction of diagnosing, stabilising and treating unwell patients was what gave me a buzz during the early part of my training and prompted a further desire to specialise in emergency medicine.

Emergency medicine (EM) is defined by the International Federation for Emergency Medicine as: "A field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development."

What most attracted me to EM during my foundation placement was the variety. The job was fast paced, and I could quickly apply theory learned in the lecture room in the resuscitation room.

EM involves all aspects of medicine: adults and paediatrics, acute medical and surgical emergencies, major trauma and resuscitation, psychiatry, minor injuries, orthopaedics and of course general practice. This diverse spectrum of presentations captured my interest and, as the saying goes, "there is never a dull moment".

I enjoy the challenges of treating an unselected group of emergency patients and being the first point of contact that they have with the NHS. Using my diagnostic skills and

PHOTO: SCIENCE PHOTO LIBRARY

implementing management plans are what make each day satisfying. Of course it's not all serious illnesses that present to the emergency department. Some memorable cases from my time in EM include a pole dancer who fell off the pole and landed on her neck (fortunately no major injuries) and learning about the art of parcour, or free running, from a 12-year-old child with a thumb injury.

"The satisfaction of diagnosing, stabilising and treating unwell patients gave me a buzz"

The variety of patient groups also interests me. On any given day I could be listening to war time stories from elderly patients, or hearing the intricate details of children's TV programmes like *Peppa Pig* in paediatric A&E. Working with sick and injured children can be difficult. Thinking of novel approaches to provide distraction from procedures and seeing the 'brave face' stickers proudly worn makes this another rewarding aspect to EM.

"Doing" medicine

EM also offers the chance to perform many practical skills and procedures, including the suturing and plastering of musculoskeletal injuries, interpretation of ECGs, defibrillation, chest drain insertion and airway management. I enjoy the "doing" aspect of medicine – being able to intervene in a patient's life and have an impact on them, their families and their medical conditions.

EM gives me a sense of job satisfaction in this respect, allowing me to see, treat and send home or alternatively diagnose, begin treatment and refer to definitive care. Since beginning specialist training the number of procedures has also increased with opportunities for FAST scanning in trauma, airway management and line insertion.

As a foundation doctor, what attracted me most to EM was seeing the acute and critically ill in the resuscitation room. I valued being part of the team involved in the care of these patients when they were most in need of a doctor and I wanted to gain the necessary skills and knowledge to look after them. A career in EM seemed the most logical way of achieving this, by becoming a true generalist in every sense of the word. When the poly-trauma arrives, your training kicks in allowing you to begin assessing, intervening and then reviewing your treatments looking for instantaneous improvement in physiological parameters.

My time as a foundation doctor in the emergency department opened my eyes to the challenges involved in being an EM physician – dealing with major incidents and multiple poly-trauma patients or tackling aggressive and disturbed behaviour, as well as managing families who have suffered an unexpected or traumatic death.

After deciding on EM as a career I embarked on the specialty training application process. In the UK, emergency medicine training involves joining the Acute Common Care Stem (ACCS) programme. It is structured in six monthly blocks comprising of emergency medicine, acute medicine, anaesthetics and intensive care followed by a year in your chosen specialty, in my case EM. This broad-based acute training allows further refinement of the skills required for managing acute and critically unwell patients.

Other challenges

In daily emergency practice, you must also be prepared for the many ethical and medico-legal issues that arise, including child protection and the documenting of assault injuries to be later presented in court, or trying to assess capacity for refusing treatment in the confused and agitated patient you think has diabetic ketoacidosis. The rota can also be challenging in that a large proportion of work is out of hours and weekends; however, the days off during the week help offset this.

No two days are ever the same in the emergency department and that is part of the attraction. From myocardial infarctions to major mountain trauma, airway compromise to the extremely chatty intoxicated head injury, low blood pressures to high blood sugars – EM physicians are experts in dealing with variety. You never know what the next ambulance is going to bring in.

While some doctors relish the long-term follow up of patients this is limited in emergency department patients. Sometimes you never find out what happened to the patient with chest pain you started on the acute coronary syndrome pathway and are left wondering "was the diagnosis right?" "Did they get angiography?"

But on the plus side there are few ward rounds, it seldom requires the holding of pagers and most of your work is done in one department with a team of nurses and doctors. The teamwork involved in managing a major trauma reminds you again why you do your job – for the benefit of that patient lying in front of you in the resuscitation room – with all members of the multidisciplinary team pulling together, doing their best.

Medicine offers a host of interesting and rewarding career options and you should choose one which stimulates and challenges you. That certainly holds true for emergency medicine where variety really is the spice of life.

Further information

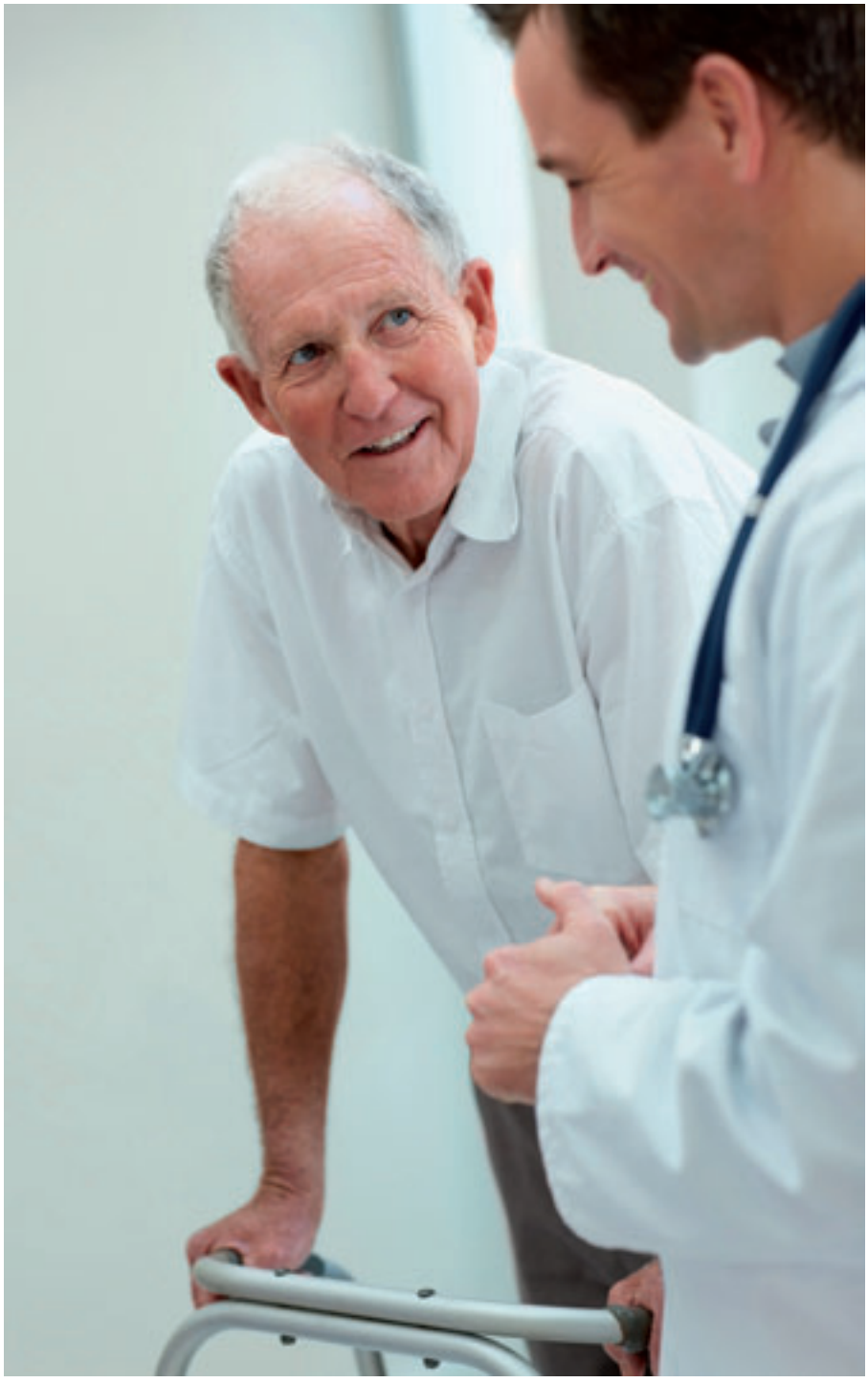
College of Emergency Medicine
www.collemergencymed.ac.uk

ACCS website
www.accsuk.org.uk

Dr Craig Brown is a CT2 in emergency medicine at Aberdeen Royal Infirmary

COMING OF AGE

The UK population is ageing and the proportion of older people in the community is greater than ever. What better time to consider the specialty of geriatric medicine?



IT'S A widely known fact that, on the whole, people in the UK are living longer. Average life expectancy is expected to reach 90 by 2015, a good seven years longer than in 1997. The knock-on effects of this are many, from a steadily increasing state pension retirement age to the need to overhaul the funding of elderly care and consider improvements in end-of-life care.

An ageing population presents unique challenges for the NHS and could present the specialty of geriatric medicine with a unique opportunity to grow.

Geriatric medicine is defined as the branch of medicine concerned with the clinical, preventive, remedial and social aspects of illness in older people. It is the largest specialty within the Royal College of Physicians (RCP) and involves close interdisciplinary working with nurses, therapists, pharmacists, dieticians, social workers and many other health professionals including GPs, old age psychiatrists and many hospital clinical specialists.

While it may not be viewed as the most glamorous of the medical specialties, the fact is that almost two thirds of general and acute hospital beds are in use by people aged 65 and older and 43 per cent of NHS spend is on this group. Geriatrics is said to be enjoyable, stimulating and rewarding and there is some argument that given the growth of this patient group, geriatric medicine should be a compulsory part of the medical school curriculum.

Entry and training

The British Geriatric Society (BGS) recommend that doctors who are interested in a career in geriatric medicine gain experience either during F1/F2 on a general medical ward or apply for an F2 taster experience. They advise medical students to look at their choice of elective and ensure it offers relevant exposure to the specialty.

The BGS describes the personal qualities of a geriatrician as someone who:

- enjoys acute medicine and a variety of the medical specialties
- likes to sort out multiple and complex medical problems and is prepared to engage strongly with the social care sector
- is a good listener and communicator

- likes to enthuse others and lead by example
- would enjoy the challenge of practising a high standard of care for older people and has a down-to-earth, approachable personality

The Society also has a trainees group which offers opportunities for networking and provides experience in the governance of medicine.

Upon completion of F2, doctors undertake seven years of specialty training. This involves a two-year broad specialty programme (ST1 and ST2) in one of three types of training scheme, either Core Medical Training (CMT), Basic Neurosciences Training (BNT) or Acute Care Common Stem (ACCS). All three types of training programme can lead on to specialist training in geriatrics but the majority of doctors tend to do CMT.

ST3-ST7 involves competitive application to a five year specialty training programme in geriatric medicine leading to a CCT (Certificate Completion Training) in geriatric medicine. Competency in Level 2 Acute & Internal Medicine will also be achieved during this time which allows doctors to practise as a consultant physician managing an unselected acute medical intake in addition to specialty work.

Flexible training is above average in geriatrics and there are opportunities for those looking to work part-time. The specialty also offers

limitless opportunities for clinical and laboratory research – one year of research can be undertaken during ST3-ST7 and counts towards the award of CCT without prolonging the specialty training programme.

In practice

Most geriatricians are based in acute general hospitals, caring for patients admitted via the emergency units with acute illness. In addition to acute and emergency care, geriatricians are involved in rehabilitation and an increasing number work within community based services. The majority of geriatricians also play a significant role in the acute care of adults of all ages admitted via the medical take.

Presentations of illness in old age are often non-specific and the RCP describes how geriatricians focus on falls, immobility, incontinence and confusion as well as adverse drug reactions. They see a broad range of illnesses, particularly stroke, heart disease, infections, diabetes, delirium and the dementias. Some geriatricians deal with the whole range of geriatric problems, particularly those who spend time working in the community. Others specialise in areas such as orthopaedic geriatrics, stroke, falls and syncope, cerebral ageing and Parkinsonism.

Many geriatricians are on call for all adult medical emergency admissions with opportunities to be involved in private practice, with the work often orientated towards sub-specialty interests. There are opportunities to be involved in private practice, with the work often geared towards subspecialty interests. It also takes the hospital doctor into the community more than most other specialties.

Geriatric medicine is a large and growing specialty which combines intellectual challenge with human interest and deals with the whole person and their family, as well as diseases. It offers a varied and rewarding medical career.

For more information visit **www.bgs.org.uk** and **www.tinyurl.com/rcplgm**

Q&A Dr Suzy Hope, ST4 in geriatric medicine

• What attracted you to geriatric medicine?

My earliest shortlist was between GP or hospital medicine, but I realised I still loved hospital medicine. It was then a quick process of elimination that brought me to geriatrics. I'd done a lot of work as a healthcare assistant and loved the company of older people. The main thing that drives me is to try to help make people feel better, and this often requires more than just giving someone a pill – especially in the case of older people where there is also frequently more than one thing going on.

• What do you enjoy most about the job?

It is hugely varied, both in terms of the patients' conditions and in the training opportunities and responsibilities. Having to use basic communication skills and common sense keeps you grounded and is very satisfying. Sitting down to solve problems as part of a team is hugely rewarding. I like that our opinion as geriatricians is valued by other specialties and also enjoy advocating for patients and their families. Most geriatrics registrars do general internal medicine as well, which means we are on the medical registrar on call rota, which adds extra variety and experience to the mix.

• Are there any downsides?

Clinic appointments aren't always long enough. When there are staff shortages on the wards and bed pressures, it can sometimes feel like fire-fighting rather than being able to sort things out as much as one would like. But there's always the option of bringing them back to an outpatient clinic which is useful for follow-up.

• What do you find most challenging?

When I started, it was challenging being off the ward a lot due to other responsibilities and training, which means having to "let go" of the day-to-day medical running of the ward. With staffing shortages and juniors being moved at short notice to cover other wards the continuity of care can feel threatened at times. I do miss not knowing the patients as well as I would like to, but the challenges of putting together and using all the accrued information at the ward round or MDT is satisfying.

• What is your most memorable experience so far?

So many! Usually they revolve around patients' characters, whether they're stroking consultants' beards whilst giving the rest of the team a cheeky wink, playing the mouth organ for us or getting all the patients around a dining table rather than eating at their bedsides.

• What advice would you give to a final year or FY trainee considering geriatric medicine?

If you like taking the time to talk to people, and enjoy detective work and sometimes complex general medicine, do it! Get as much general medical experience as possible. It's now pretty much compulsory to do audits from an early stage, so talk to a geriatrician to get some good ideas and guidance. And then ask if they can help you submit it to a geriatrics-related conference.

A WELCOME EAR

Defusing patient complaints is far preferable to answering them later in court or before the GMC – so says MDDUS medical adviser **Des Watson**

NO ONE likes negative feedback – undeserved or otherwise. But it's an inevitable part of being a doctor, unless of course you can claim perfection and even that offers no guarantee.

The NHS defines a complaint as "an expression of dissatisfaction that requires a response." Not only is this usefully concise it also incorporates two important elements in the overall management of complaints: dissatisfaction and response.

Patient dissatisfaction

Two questions arise once you accept the inevitability of some patient dissatisfaction:

- What can you do to minimise the dissatisfaction?
- How can you frame a response that is most likely to satisfy the patient who has complained after an adverse outcome?

But first it is important to note that an adverse outcome is one seen from the perspective of the patient and often there is no suggestion of error, negligence or threat to patient safety. Evidence from the Harvard Medical Practice Study has shown that about one third of complaints or lawsuits will arise from passages of care that were entirely straightforward.

Secondly, the two questions above are not exclusive to handling patient complaints. In the UK, the dissatisfied patient has a number of ways of escalating that dissatisfaction besides making a complaint. Some people will report the doctor to the GMC directly and for others the strictly legal route of a claim for compensation is preferred. Doctors often grumble about ambulance-chasing lawyers and the complaints culture but these are preferable to leaving the patient with no alternative but more direct action. My chief attending surgeon in the USA was murdered by a dissatisfied patient about nine months after my overseas training period ended.

How do you minimise dissatisfaction?

The short answer is to manage patient expectations or more succinctly – under-promise and over-deliver. Think for a moment about what a patient expects from the doctor. This is probably almost the same list as you yourself would expect from your dentist or accountant or even the garage servicing your car. You expect the following:

- competence (and for airlines and doctors among others, safety)
- respect
- to be listened to
- to be kept informed and given timetables.

Let's look briefly at these apparently simple suggestions and think about how different ways of handling them can contribute to dissatisfaction.

How do people assess the competence of their clinicians? How do you assess the competence of your garage mechanic? Do you check his qualifications and track record at fixing cars? Do you check that your GP is on the GP register? We all use surrogates for competence and in most cases, these are to do with communication style. So, in a way,

competence is the least important of the four elements listed above. The patient will judge your competence based on the other three communication issues: respect, being listened to and being kept informed.

Imagine that a middle-aged woman has just come back from the dry-cleaners with an expensive blue dress that still has a visible stain on it after the cleaners have laundered it. Which of the following two scenarios is likely to generate more dissatisfaction with the cleaners when the stain is still visible after collection?

Scenario 1: "When I took the dress in last week, they did not seem at all interested; they just took it and offered me a receipt. I am not even sure that they attached the stub of the receipt to the dress or just hoped for the best when I came back in to collect it. I was not at all surprised when the stain was as bad as ever. They did not have a clue what they were doing."

Scenario 2: "When I took the dress in, the cleaners asked to look at the stain. They asked what it was. When I could not tell them, they said: 'It is a nasty stain which spoils a beautiful dress and we can see why you want to get it out. Because we don't know what it is,

"The patient will judge your competence based on your communication style"

it may be difficult even with our best efforts. Although we offer a 24-hour turnaround, this may take a bit longer if it's a very stubborn stain so please let us have an extra day'. Well, I knew it would be difficult for them but they have obviously tried really hard and you can hardly see the stain now."

So both cleaners tried equally and failed equally to remove the stain. In the first scenario, this was the fault of the – obviously incompetent – cleaners. In the other it was just a particularly stubborn stain.

How do you respond to dissatisfaction?

Say you find yourself dealing with a patient who has survived his emergency repair of an abdominal aortic aneurysm with his kidneys, cerebrum and myocardium still more or less intact and who is complaining bitterly about a minor stitch abscess. You are on your last of seven night shifts and it's 4 am. The temptation is to tell the patient not to be so pathetic and he should be grateful he is still alive. While you might feel better, the patient will almost inevitably escalate his grumbles.

Only a minority of dissatisfied people are looking for compensation or retribution; the vast majority will settle for something called "empathetic validation". This means having a good old grumble while someone mops your fevered brow, listens to your woes and agrees with you how awful it has all been.

Imagine you have come home after the train journey from hell: no seats, no air conditioning, no information, missed connections and a 45 minute walk home from the station in the rain. How do you feel if your partner greets you with: "I'm glad you are back at last. I'm just off to badminton. Oh, by the way, the cat has been sick and I've not had time to clear it up."

What you wanted to hear was more along the lines of: "You poor thing! What a dreadful journey! Sit down here and I'll bring you a drink – something long and cool with tinkling ice-cubes – and you can tell me all about it."

Perhaps a Singapore Gin Sling is not necessary for the patient with the aneurysm but you do need to acknowledge the problem, which is very real to him. Empathise with the patient by showing how sorry you are that he is upset and let him tell his story while you (actively) listen. The fundamental structure is something like:

"I can see that this is a very serious issue for you Mr Smith. I am very sorry that this has not worked out as we both hoped. Please take your time and tell me what the problems are and then we can talk about how we can set them right."

Next you should reassure the patient that his concerns have been heard and understood. Do this by active listening and feeding back short summarising sentences along the lines of: "Let me check I have understood you correctly; you are worried that the stitch abscess might be an indicator that your graft is infected. I can understand that this would be very worrying."

A welcome ear

It's not difficult to find people who are very good indeed at empathetic validation. They often have a sign on the door that says something like: "Have you been injured in a medical accident? Come in and talk to a solicitor today. We guarantee that all your damages will be paid to you!" The attraction of a free half-hour with a solicitor is understandable. Out comes the patient saying how competent and respectful the solicitor is having also explained how it is well worth trying to obtain some compensation. Reinforcing the view that the doctor is a complete monster is for a solicitor time well spent.

So if there is one single secret to dealing with complaints and preventing lawsuits, it is to be at least as good at empathetic validation as the lawyers and to deliver it first.

Of course, some complaints will not be resolved by empathetic validation but it's always a good start. Remember that 80 per cent of complaints are made by 20 per cent of patients and you will always encounter people who will remain unhappy no matter how you answer their dissatisfaction.

But the "take-home" message here is that managing expectations beforehand and dealing promptly and empathetically with complaints when they happen will resolve the majority of problems before they can progress any further.

Mr Des Watson is a medico-legal adviser at MDDUS

NAMING THE DEAD

Professor Sue Black's work in the field of forensic anthropology has helped convict killers and find justice for victims of war crimes. She talks to *FYi* about her work

PHOTOS: BBC/SHINE TV LTD/ALAN PEEBLES

THE RECENT BBC2 series *History Cold Case* may have made Dundee Professor Sue Black something of a household name but she is no stranger to high-profile forensic investigation.

In 1999, Sue acted as the lead forensic anthropologist to a British team sent to identify victims of genocide in Kosovo. Her work helping to exhume and identify more than 1,000 bodies led to Slobodan Milosevic becoming the first head of state to stand trial for crimes against humanity. It also earned her an OBE.

In 2004, Sue travelled to Thailand in the wake of the Boxing Day tsunami and helped identify the British victims who were among the 200,000 dead. Her investigations in Iraq helped convict Saddam Hussein, while her work in the UK has also been instrumental in securing the convictions of serial killers such as Fred and Rosemary West as well as in child sex abuse cases.

She is currently director of the Centre for Anatomy and Human Identification at the University of Dundee and is a founder and director of the Centre for International Forensic Assistance. She is founder and past president of the British Association for Human Identification and adviser to the Home Office and Interpol on issues pertaining to forensic anthropology in disaster victim identification (DVI).

Apart from appearing in *History Cold Case* Sue has also worked in radio. She lives with her family near Aberdeen.

How did you get started in forensic anthropology and the field of human identification?

I went to university not knowing what I wanted to study other than something 'biological'. I found human anatomy utterly absorbing in terms of study and my fate was sealed in the discipline. However when it comes to research I have a morbid fear of rodents and so any exploration in that realm was completely off limits. The only other thing available to me was the study of human bones - perfect! My first forensic case came during my PhD studies and at that point, I knew that was what I wanted to do.

What advice would you give to trainee doctors who are interested in your field of work?

Anatomy is a core subject for all medical and paramedical disciplines but the 'forensic' element gives you an added dimension of investigative skills, attention to detail, importance of accurate recording and of course never going beyond your sphere of experience. Any element of forensic medicine is good for trainee doctors as it develops a very useful set of skills that will serve them well in whatever aspect of medicine they may choose to specialise.

What are the best and worst things about your work?

The best is that you play your part in securing justice for victims. The worst is that you have to bear witness to the inhumanity that man bestows on his fellow man. It can be very sobering especially when working on genocide cases such as Kosovo or in much of the current work in which we are involved which is identification of perpetrators of child sexual abuse.

Which of your professional experiences is the most memorable?

Kosovo was unquestionably a turning point for me in my career. It was memorable for so many different reasons. We were still technically working in a war zone so security and co-operation with the military was a new dimension to my working environment. The heat and the lack of amenities that we take for granted - sanitation, electricity, running water - really tested ingenuity. The humanity of the survivors was an abiding memory.

How do you cope with witnessing what must be some very harrowing scenes of mass graves and murder?

You cope by arming yourself with clinical detachment. You focus on the work that you have to do, retrieval of evidence for courtroom

From left: Prof Sue Black, Dr Xanthe Mallett and Prof Caroline Wilkinson

purposes, and you do not deviate from that goal. If you take on the enormity of the suffering and inhumanity that you witness, then you cannot remain objective and in so doing you do not serve justice, you do not serve the victims and you do not serve the survivors.

What do you find most rewarding about your job?
The most rewarding element is in being able to identify a deceased person and return them to their families.

Describe a typical working week.
There is no such thing as a typical week - fortunately. I have a short attention span and get bored very easily. So part of a day might be taken up with teaching undergraduate or postgraduate students, I might be talking with Interpol about DVI training, I might be liaising with a police force about the remains of a dead body that has been found, I might be working on some research with my PhD students - and of course there is always administration and paperwork.

How did you get involved in TV work?
I don't know how I got involved but as anyone who knows me will tell you, it is not something that I enjoy. I don't enjoy the process and I certainly don't watch the end product.

Was it a challenge performing in front of the cameras for *History Cold Case*?
It isn't really a challenge but as I said, I have a short attention span and so get bored very quickly. I don't do well at being directed to say or do something and certainly not more than once. The *History Cold Case* production crew were very patient with me. Conversely, I love doing radio and especially live radio. There is no retake and you get the opportunity to tell a story in words. I am much happier there.

How has the current popular interest in forensics – with the spate of TV dramas – affected what you do?
Forensic awareness from the public affects us in a number of ways. A lot of students have unrealistic expectations of what studying will be like and some find it very challenging. Also our juries consider themselves to be more

"The best part of the job is securing justice for victims"

forensically aware than in the past and at times managing their expectations is also difficult.

How has the field of forensics changed in recent decades?
The field has changed quite dramatically from an amateur approach to more professional requirements. For many years, forensic anthropology was seen as the back door into forensic work but that is no longer the case. Regulation and legislation are ensuring, quite rightly, that formal training is much more rigorous and being able to 'break into' the field is no longer a matter of chance but requires formal processes.

What is the secret to your success?
You have to work hard and you have to work long hours and there must be no job that you are not prepared to do yourself. There is no room for an academic ego. There is no easy fix.

What do you do in your spare time?
Quite seriously, I don't have any spare time. When our daughter was nine years old she asked us if we had ever been on holiday. Bit of a wake up call. We did go on holiday, but I got so bored that I wrote the guts of a text book. I have known my husband since we were in school together and he is also a qualified anatomist - although he changed career path to become a finance director. We have three daughters 27, 16 and 14 and two grandchildren aged two and 10 months. We live in the north east of Scotland and are ridiculously old fashioned parents.

Interview by Joanne Curran

A FATAL ERROR?

Associate publications editor **Joanne Curran** attends a mock fatal accident inquiry run by the MDDUS legal team

THE STAGE is set and the lawyers, solemn in their black gowns, prepare to question the first witness at a fatal accident inquiry (FAI). It is a troubling case – a young man said to be on methadone was brought to A&E with a head injury. He was in police custody, it was late at night and it fell to junior doctor Dr Wilson to treat him. She examined the patient and prescribed a large dose of methadone and he appeared to settle. But just a few hours later he was dead.

Questions were asked about her treatment of the patient, known as John Doe, and now – almost two years later – she has been called to give evidence at the FAI. But with only her memory and limited clinical notes to rely on, her appearance before the sheriff– and before the deceased's family – looks set to be a stressful experience.

However this is not a court room but a lecture theatre with an audience of almost 250 final year Glasgow University medical students. They have come to watch this fictional scenario played out with actors and real lawyers in order to experience first-hand exactly how an FAI works and the type of questioning they might face should they ever find themselves called to give evidence.

Mock FAIs are scripted proceedings designed to give students valuable insights into the workings of the court. In this case MDDUS solicitors David Holmes and Lindsey McGregor take the roles of sheriff and procurator fiscal while Duncan Mawby, a solicitor from Edinburgh firm Shepherd and Wedderburn, assumes the role of Dr Wilson's defence agent. Professional actors take the roles of John Doe's brother and Dr Wilson.

Proceedings open with a general introduction to fatal accident inquiries before John Doe's brother takes the stand. Clearly angry, he contradicts claims apparently made by Dr Wilson surrounding John Doe's treatment. He is adamant his brother was not on methadone and should never have been given such a large dose without confirmation from his GP.

A nervous looking Dr Wilson then takes the stand to face a grilling from the fiscal who asks tough questions about her poor note-keeping, vague clinical instructions and her decision to prescribe methadone in the absence of more detailed medical information from John Doe's GP. Her defence appears to focus on being too busy to write full notes and being unable to confirm the methadone prescription because it was late at night. She made several phone calls to try to confirm his methadone prescription, she says, but was too busy to note these efforts in the patient's records.

It is a scenario that has no doubt played out in court rooms across the UK and there are useful lessons for the gathered audience to learn from the team of MDDUS experts. Each audience member has been given an information pack to guide them through the FAI. It contains copies of the 'clinical notes' relating to John Doe's care and one trainee doctor comments that he would not like to be in Dr Wilson's shoes, giving evidence based only on these sparse notes.

Questions at the end of the FAI raise concerns about giving evidence. There are fears that evidence given by doctors at an FAI (or coroner's inquest in England and Wales) could incriminate them, or that any criticism of a doctor's actions could spark GMC disciplinary proceedings. While this prospect cannot be entirely ruled out, it's made clear that in a real case MDDUS advisory and legal teams would be on hand to offer support, advice and, where necessary, legal representation to members.

For most newly qualified doctors starting out on their careers, the idea of facing difficult questions about their professional conduct in an FAI or CI may seem a distant prospect.

But involvement in such proceedings is one of the most common reasons that junior doctors contact MDDUS for advice and support. Being called to appear in a sheriff or crown court to be questioned about your involvement in the care of a patient who died is something few doctors relish. Crown indemnity will not provide individual legal support in an FAI or CI where the interests of a particular doctor and their employer may diverge – that's why it is so important for junior doctors (and doctors in general) to have appropriate indemnity cover.

MDDUS provides its members with access to expert medico-legal advice and legal representation where appropriate to help them cope with these stressful situations.

MDDUS has organised and run mock FAIs as educational events for Scottish trainee doctors for several years and is now looking to expand the service by organising mock FAIs and coroner's inquests for the benefit of medical students across the UK.

To find out about MDDUS hosting a mock FAI or CI in your medical school, contact Karen Walsh on **kwalsh@mddus.com**

Joanne Curran is associate editor of FYi

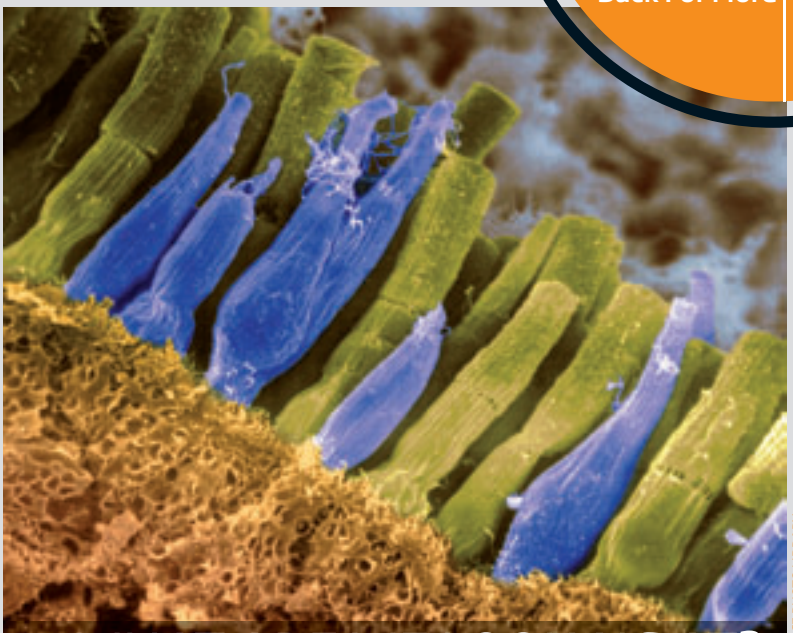
OUT THERE

VINTAGE SURGERY Nose jobs in the 19th century were brutal, according to a new book by surgeon John Stevenson. Scissors, quills, pins and needles were used to correct misshapen noses - and there's no mention of anaesthesia. Patients seeking cosmetic help include a baron who lost the tip of his nose in a duelling accident. *Source: The Guardian*

UNDER YOUR SKIN A hand-held gadget designed to help patients understand the healing process projects X-ray images of bone structure, muscle tissue, tendons and nerves onto their skin. The AnatOnMe consists of a projector, camera and laser pointer and can display stock images of six injury types. *Source: Daily Mail*

OH HAPPY DAY The Royal Wedding brought about a 7 per cent mood lift in women, according to online tool Moodscope. Men, however, enjoyed a peak in good mood on Good Friday, 3 per cent higher than on the wedding day. *Source: BMJ*

HANDY HINTS The key to spotting future top doctors lies in the length of their second and fourth fingers. Italian researchers found med students with a lower finger length ratio (known as 2D:4D) in their right hands were more likely to be successful. *Source: The Guardian*



WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: SCIENCE PHOTO LIBRARY

PHOTO: THE KOBAL COLLECTION

Pick: DVD - Gattaca

Directed by Andrew Niccol, starring Ethan Hawke, Uma Thurman, Jude Law; 1997

IT is the not-too-distant future and a time when children are selected through preimplantation genetic diagnosis in a bid to create a race of superior human specimens. People are classified as either genetically preferred "valids" or less desirable, naturally conceived "in-valids" - a label that dictates their future role in society.

Genetic screening is commonplace, meaning professional roles are reserved for hand-picked valids while in-valids - who are more prone to health problems - are relegated to menial jobs. Ethan Hawke plays in-valid Vincent who struggles against society's prejudices in the hope of proving he can achieve more than his genetic profile suggests.

He assumes the identity of valid Jerome (Jude Law) to hide his genetic weaknesses and pursue his dream of becoming an astronaut for Gattaca Corp, but Vincent's deceit means he must stay one step ahead of the constant genetic tests if he is to make it into space.

Gattaca is a smart, thought-provoking sci-fi thriller that raises serious questions about the practice of eugenics and the potential consequences of employing sophisticated reproductive technologies.

Product Review:

MIMS app
SIGN Guidelines app

MIMS; ***£5.99*** *SIGN;* ***Free***

Review by Jim Killgore, contributing editor

Many medical smartphone applications suffer from being either totally over the top and inappropriate for the format or less than useless. I mean do you really need an app to check a patient's BMI? But there are some notable exceptions including two new apps that have been attracting attention.

For over 50 years MIMS (Monthly Index of Medical Specialties) has been providing healthcare professionals with information on medicines licensed in the UK, including drug dosages, warnings, contraindications and adverse events. The resource is updated in monthly editions and in recent years has been available online. It is said to be accessed over 450,000 times every month by UK general practitioners.

Doctors can now download a MIMS app from Android Market or iTunes, providing handy pocket-access to the resource with a predictive search to quickly find concise information on over 2,000 products. You can also search or browse by brand or generic name, or find products by manufacturer or therapeutic area. The one-off download also allows you to access free updates instantly.

Another useful app was launched in April of this year by the Scottish Intercollegiate Guidelines Network or SIGN for iPhone, iPad and Android phones and tablets. It features Quick Reference Guides (QRGs) on a selection of SIGN guidelines, including those for the management of atopic eczema, rheumatoid arthritis, venous thromboembolism, psoriasis and psoriatic arthritis in adults, chronic venous leg ulcers, stroke, sore throat and indications for tonsillectomy, diabetes, obesity, depression, Parkinson's disease and asthma. The QRG content is enhanced with material from the main guideline and online resources, linked to the SIGN website.

Each new SIGN QRG will be added as an update as it is published, building into a complete library. The app also features keyword search, bookmarking and in-app access to the SIGN website. Best of all, the app is free and has already proven surprisingly popular being downloaded over 8,000 times since being launched in April. The application has earned 24 four-star ratings on iTunes with the main suggestion among users being that it should be updated with the inclusion of all the guidelines available on the SIGN website.

So delete that disgusting iBoak app and download something useful for a change.

WHAT ARE WE LOOKING AT? *Rods and cones in the retina*