FYi

ISSUE 08

CLIMATE CHALLENGE

THE NHS AND GLOBAL WARMING

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

Welcome to your FYi

THE NHS has a carbon footprint that is roughly the same as Croatia. It's a startling figure that throws into perspective the health service's considerable environmental impact. And while climate change might not seem like a priority in these tough financial times, it's an issue that won't go away. On page 10, Joanne Curran looks at the role UK doctors can play in the fight to save the planet.

Doctors are renowned for making poor patients but failing to look after your health can impact patient care, as our article on page 6 explains.

FY doctors have to contend with a variety of assessments during their training and on page 4 Dr Emma Peagam focuses on Case Based Discussions, offering some helpful tips. Consent is a fundamental principle of medicine and on page 5 MDDUS medical adviser Dr Barry Parker takes us through the three key factors that all doctors must understand in order to obtain informed consent from patients. Meanwhile on page 7 we offer advice on the tricky area of mental capacity in adult patients.

The tragic story of Dr Karen Woo, who was killed while working as an aid worker in Afghanistan in 2010, has been an inspiration for many medics across the world. On page 12, Jim Killgore highlights some of her many achievements and talks to some of the people whose lives she touched.

On page 8 we examine what it takes to start a career in dermatology, while on page 14 we analyse the case of an apparently drunk patient who was brought to A&E by police only to be allegedly "turned away" by a doctor.

• **Dr Rebekah Skeldon**
Editor

PHOTOS: WALTER NEILSON

'LIKE' US ON FACEBOOK

CALLING all medical students – have you 'liked' the new MDDUS Student Facebook page? Keep up-to-date with the latest news and events by logging on to **www.facebook.com/mddus.student** or search Facebook for 'mddus student'.

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RISE IN TRAINEE GMC REPORTS

NEW figures have shown a rise in the number of medical graduates declaring health issues, alcohol offences or medical school disciplinary action to the General Medical Council.

Applications from trainees for provisional GMC registration have also shown a small increase in the number of "serious" issues compared to the previous year. The proportion of graduates declaring issues overall, however, remained the same at 9.6 per cent of applications.

An article in *BMA News* reported that 691 graduates declared fitness to practise issues this year, ranging from minor parking offences to more serious issues such as violence, theft and criminal damage. Of these, 381 were deemed to need further investigation, and there was a small rise of 0.3 per cent – to 196 – in the number of cases declared serious and handled by the GMC's complex casework team.

Of the 7,205 applicants this year, 35 confessed to alcohol-related offences, compared with 22 of the 7,103 applicants in 2010. The number reporting being found drunk and disorderly rose to 16 from nine the previous year, and those guilty of drink driving increased to 19 from 13.

Seventy-five students said this year that they had been disciplined by their medical schools, compared with 57 the previous year. The greatest increase in this category was in warnings, which jumped to 29 from 11.

Health issues were reported by 85 students this year, compared with 51 the previous year; the number of graduates with mental health issues increased to 39 from 26, and those with physical health issues rose to 40 from 22.

BMA medical students committee joint deputy chair Jenny Ross said: "This small amount of change is likely to be the result of normal fluctuation from year to year, although we note the relative increase in the reporting of more serious issues."

GMC CUTS FEES FOR JUNIOR DOCTORS

THE cost of training qualifications has been cut as part of a package of GMC fee reductions for doctors.

Junior doctors will now pay less for a CCT (certificate of completion of training) which has been cut from £500 to £390. The Certificate of Eligibility for Specialist Registration or GP Registration (CESR or CEGPR) has also dropped from £1,600 to £1,500. All other certification-related fees have been frozen at 2010/2011 levels.

From April 2012, practising doctors will pay £390 a year instead of £420 – a saving of £2.50 per month. Registered doctors who don't have a licence to practise will pay £140 instead of £145 – a saving of 42p per month. Doctors in foundation years one and two will make a similar saving, paying £95 instead of £100.

MDDUS

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ENTRIES OPEN FOR BMJ GROUP AWARDS 2012

ENTRIES have opened for the 2012 BMJ Group Improving Health Awards.

Nominations are open for a total of 12 awards which are designed to recognise excellence in medical practice. For the third year running, MDDUS will be the headline sponsor.

Categories from previous years include Junior Doctor of the Year and Research Paper of the Year. Seven new categories have been created for 2012 including the Karen Woo Award, in memory of the doctor killed in Afghanistan in 2010, which honours an individual who has gone beyond the call of duty to care for patients (see p12 of this issue).

Winners will be announced at a ceremony at the London Hilton on Park Lane on May 23, 2012. Nominations for awards can be made online at **groupawards.bmj.com** until February 28.

NEW DOCTORS "POORLY PREPARED" IN ACUTE CARE

NEWLY qualified doctors don't feel prepared to look after acutely ill patients or prescribe drugs, a study has found.

Senior colleagues tended to share the trainees' concerns, according to the study in the *Postgraduate Medical Journal*. It suggests recent changes in medical undergraduate training could be to blame.

Trends in the ratings given by professional colleagues suggest that preparedness may have declined since the medical students' guidance document *Tomorrow's Doctors* was first published by the GMC in 1993.

The report concludes: "The results of this study suggest that recent changes to UK undergraduate training, while improving preparedness in some areas, may have neglected acute care skills."

MEDICAL TRAINING SHOULD BE MORE FLEXIBLE

MEDICAL training should be more flexible to allow junior doctors to switch specialties and develop skills in other disciplines.

That's the view of the NHS Future Forum in its report on education and training. It says greater flexibility would also allow trainees to take up academic fellowships or international posts.

Properly constructed jobs with educational opportunities should be made available to doctors who don't want to become consultants or GPs once they have their certificate of completion of training, the Forum adds. It also supports the RCGP's calls to extend GP training and says generalism should be fostered as a career choice for doctors.

The recommendations were made as part of the government's "listening exercise" on its plans to modernise the NHS as set out in the white paper, *Liberating the NHS: Developing the Healthcare Workforce*.

The forum's proposals, and plans to keep the deanery set-up, have been largely welcomed by the BMA. But Tom Dolphin, chair of the BMA's Junior Doctors Committee, expressed concern at plans to encourage trainees to take time out of training to bolster their experience, adding: "If trainees are in a training programme, then that programme should deliver the experiences they need without them having to take time out."

FREE WHISTLEBLOWING HELPLINE LAUNCHED

NHS staff in England can now raise concerns about patient care using a new whistleblowing helpline.

Health secretary Andrew Lansley launched the free, government-funded service to encourage staff and employers in both the social care sector and the NHS to speak out about poor practice. The helpline is in addition to a new contractual duty to raise concerns which will be enshrined in the new NHS Constitution. A web-based whistleblowing service is also being developed.

The new helpline number is **08000 724 725** and operates weekdays from 8am to 6pm with an out-of-hours answering service.

SAFEST SURGEONS ARE AGED 35 TO 50

SURGEONS aged between 35 and 50 provide the safest care compared with their younger or older colleagues, according to a new study.

Research published on bmj.com looked at operative complications at five hospitals in France. It focused on patients undergoing a thyroidectomy and found complications were more likely amongst inexperienced surgeons and those who had been in the job for more than 20 years.

The results appear to support previous studies which have shown experts tend to reach their peak performance after about 10 years in their specialty. Older doctors who have been practising for a long time may have less factual knowledge and may be less likely to adhere to evidence-based medicine which risks safety of care, studies have also shown.

Data for the bmj.com study was collected from more than 3,500 operations carried out by 28 surgeons. The results found that surgeons with 20 years or more of experience had three times the risk of a patient suffering recurrent laryngeal nerve palsy and more than seven times the risk of hypoparathyroidism. The researchers also found that younger surgeons performed less well.

The link between a surgeon's age and complication rates was irrespective of how complex the surgical case list was, which suggests it wasn't because the older, more experienced surgeons were seeing the "harder-to-treat" patients.

The findings raise concerns about ongoing training and motivation of surgeons throughout their careers, although experts stress they are not conclusive and further research is needed.

A CASE IN POINT

Coping with Case Based Discussions

EIGHT weeks into my FY1 respiratory job it dawns on me I need to complete not one, but two, Case Based Discussions (CbD) before the end of this placement. Cue mild panic and a frantic search for an appropriate patient to discuss with a consultant who is willing to listen (and complete the assessment form!).

This was my first encounter with CbD and a useful learning experience. I cast my mind back eight weeks to Trust induction and the wise words issued by our Foundation Programme Director who explained CbD to us while we all gave convincing impressions of rabbits in headlights at the prospect of tackling the e-portfolio.

CbD is a structured discussion of clinical cases managed by the foundation doctor, providing an opportunity for assessment and discussion of clinical reasoning. Assessors must be consultants, GPs, doctors in higher specialist training (ST3 or above/SpRs), associate specialists/staff grade or specialty doctors, and must have training in how to conduct assessments and how to give feedback. FY2, ST1-ST2 doctors, nurses or pharmacists cannot be assessors.

It is best to use a different assessor for each CbD, ideally one being your clinical supervisor. During FY1 and FY2 you have to complete at least six CbDs in each year. Each should focus on a different clinical problem with the aim of presenting a balance of cases including those involving children, mental health, cancer/palliative care and older adults across varying contexts, i.e. surgery, home visits or out-of-hour contacts.

So here I am on a busy respiratory ward, trying to find the time to complete a CbD. Finding an interesting case that I have been involved with is not difficult. If there's a learning opportunity, there's a CbD waiting. I chose to discuss a lady who was admitted with shortness of breath and recently investigated for a pleural effusion. Awareness of the Foundation Programme Curriculum is important as trainees need to show evidence of competence in each clinical area represented in the curriculum.

Next: find a suitable assessor. Every case presented to a senior colleague is an opportunity for a CbD – so don't be afraid to ask. For me, the consultant of the week seemed keen and we agreed a suitable day with no clinics and good ward staffing levels to cover me for the 20-ish minutes I would be away. I scribble on my jobs list to do background reading but sadly, I return home exhausted, fall asleep and forget. I wake at 6am, realise it is CbD day and consult Wikipedia and patient.co.uk instead. An important lesson here: prepare where possible as you will get more out of the discussion from an education point of view. Remember you are a trainee and while this process is for the portfolio, it's primarily to benefit your learning.

The format of the CbD was quite informal, with me leading the discussion based on my entries in the clinical notes. It covered seven rated question areas including record keeping, clinical assessment, investigation and referral, treatment, follow-up and future planning, and professionalism. There was opportunity for me to ask questions, "why did we do this and not that?", "what would happen if…?", and expand my understanding of overall clinical management.

Lastly, the CbD form should be completed at the time of assessment. Massive error on my part here: my consultant got called away and, you guessed it, the form never got completed as there wasn't enough time afterwards. Subsequently I had to do two more assessments but at least I was better prepared and ensured I completed the electronic form during the discussion.

My main pointers for CbD:

- Understand you are not doing it just 'because you have to' - it benefits your learning and experience too.
- Prepare – be aware of the many distractions on the wards, identify an assessor and set aside time where you will not be interrupted (give your bleep to a colleague if possible).
- Complete the form at the time of assessment - timely feedback is more relevant and action plans can be targeted to your individual learning needs. You do not get much time for focused feedback as a junior doctor so make the most of it.
- A "low score" in the early days is not necessarily a bad thing. It provides an ideal opportunity to demonstrate progression in your training when scores improve in future assessments.

Done well, the CbD can be a valuable opportunity for all those isolated facts you learn as a student to come together and help build your understanding of how to manage the whole patient. Just make sure you give it some thought before the end of the placement.

Further information

The Foundation Programme: Case-based Discussion (CBD): Guidance for Assessors.
www.tinyurl.com/7pbaqlg

By Dr Emma Peagam, F1 doctor at Bolton Hospital with contribution from Dr Mayen Egbe, consultant physician and Foundation Programme Director at Bolton Hospital

INFORMED CONSENT

How much detail is "sufficient" for a patient?

OBTAINING proper consent from patients for any planned investigation or treatment is a fundamental principle of medicine, recognising the importance of patient autonomy. Valid consent must of course be voluntary and "competent" – that is patients must have the maturity and mental capacity to freely make a decision. It must also be informed and this is perhaps the one aspect of consent that leads most to discussion and debate.

Clearly a patient needs to be given sufficient information to make a decision, but what constitutes "sufficient" in this respect? The diagnosis, prognosis, need for the procedure, the potential risks and benefits and the alternatives, including doing nothing, should all be covered, but it can be difficult to know how much detail to include. All major complications, common or rare, and common minor complications would normally be included, but in complex procedures with a large number of potential risks, how do doctors decide what to discuss?

"Reasonable" standard

Past court judgments in the UK have tended to rely on a "professional standard" when judging such issues, ruling that doctors should include the amount and type of information that would be provided by a doctor of that particular specialty if exercising ordinary skill or reasonable care. In essence, doctors have been judged according to norms existing amongst their peers. Thus if the amount of information given is in accordance with normal practice, any claim for negligence was likely to fail.

More recently, however, there has been a move by some judges to adopt a "reasonable patient standard", in other words the amount of information that a reasonable patient would wish to be told in that situation. In other jurisdictions, this patient-centred approach has been extended to a "particular patient standard" – that is the information a particular patient would have wanted to know about a procedure.

One example of this comes from a case in Australia *(Chappel v Hart)* in which a patient underwent a pharyngeal pouch operation. During the consent process, she asked specifically about possible effects on her voice. She was reassured there would be no problem but subsequently developed the rare complication of mediastinitis following perforation in which her voice was damaged. The patient worked in broadcasting and the court found that the doctor was negligent in not explaining this particular risk, however rare. Such a risk may not have required specific disclosure in all cases but the patient had indicated its particular importance to her.

"Consent should be considered an ongoing process, not a single event"

Interestingly, GMC guidance on consent states: "The amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and risk to them." This clearly points to a patient-orientated rather than doctor-orientated standard.

What you don't know....

Very occasionally, patients may wish a procedure to go ahead without any detailed information – the "just do what needs to be done doctor" approach. The GMC advises attempting to give basic information about what the procedure aims to achieve, what is involved and any serious risks. But where the patient adamantly refuses, the advice is as follows: "If a patient insists that they do not want even this basic information, you must explain the potential consequences of them not having it, particularly if it might mean that their consent is not valid. You must record the fact that the patient has declined this information. You must also make it clear that they can change their mind and have more information at any time."

Consent can be verbal but for procedures associated with any significant risk – including surgical procedures – it is more commonly written. Consent is best obtained by the doctor responsible for carrying out the procedure, or if delegated, then another professional with the knowledge and skills to accurately inform the patient. Although a consent form may be signed at a particular time, consent should be considered an ongoing process rather than a single event, with opportunity for questioning and clarification up until the time of the procedure.

Failure to obtain informed consent leaves doctors open to allegations of clinical negligence. In order to prove this, patients must establish that they were not properly informed about the possible consequences of an intervention, that the intervention brought about that risk even though the risk was not increased by the failure to warn, and even though the patient had not shown necessarily that they would never have had the operation knowing of that risk. It is therefore of medico-legal as well as clinical importance that proper informed consent is obtained and documented.

Dr Barry Parker is a medical adviser at MDDUS

REACHING BREAKING POINT

Doctors who fail to seek help for health problems risk burnout

THE job of a healthcare professional is a demanding one and some under-pressure doctors may find that while they are trying to care for their patients they are neglecting to care for themselves.

Doctors may think they are only hurting themselves by suffering in silence, but studies have shown that ill health can lead to poor performance which in turn could jeopardise patient safety.

MDDUS has dealt with a number of cases involving clinicians who have been subject to a complaint or fitness to practise proceedings relating to mistakes brought about by health problems. Often, such mistakes could have been avoided had the medic sought help sooner.

The role of a trainee doctor can be a very stressful one and it's crucial to start as you mean to go on by being aware of your own wellbeing and not being afraid to ask for help. Doctors are renowned for not making the best patients and may sometimes deny health problems, but looking after your own health is vital.

"Pay attention to warning signs of illness and take them seriously"

The General Medical Council has just launched a new advice website called *Your Health Matters* which encourages doctors who may be concerned about their health to seek help early, before the problem spirals out of control.

It acknowledges that "the very qualities that make a good doctor, such as empathy and attention to detail, can also make them vulnerable to stresses and burnout or to turning to drugs or alcohol."

They urge doctors to register with a GP and to trust them to treat you in confidence rather than conducting unofficial "corridor consultations" with colleagues. The guidance warns doctors not to self-diagnose or self-medicate for anything more than minor ailments.

Doctors should also pay attention to warning signs of illness and take them seriously. For example, feeling low or irritable or having poor concentration or low energy may be signs of burnout. Doctors are encouraged to try to maintain a healthy work/life balance and consider discussing concerns with family, friends and colleagues.

Similarly, the website advises that if you are worried about your drinking or someone close to you has raised concerns, then chances are you are drinking too much and you should seek help.

The GMC explains that while it aims to protect patients it is also there to support healthcare professionals. It encourages doctors to inform the regulator if they have a health condition or a drug/alcohol problem that may put patients at risk. The GMC will then be able to assess the doctor and make recommendations on how to support them and help them back to safe practice. But before contemplating making any contact with the GMC in regards to their health, a doctor should contact MDDUS as soon as possible.

The guidance emphasises that only a small number of sick doctors are referred to the GMC each year, adding: "It is difficult to provide a list of health conditions which we need to know about because our involvement relates, not so much to the health problem itself, as to the effect that the health problem may be having on your ability to care for your patients.".

Usually, there is no need for the regulator to be involved in cases where doctors have insight into the extent of their condition, are seeking appropriate treatment, following the advice of their treating physicians and/or occupational health departments in relation to their work, and are restricting their practice appropriately.

MDDUS is very experienced in helping doctors with health problems that impact upon their fitness to practise. Whilst the GMC's guidance does not, as yet, expressly advise doctors to consult their medical defence organisation, MDDUS strongly advises members to seek our advice **before** contacting the GMC.

Doctors who are concerned about a colleague's wellbeing are advised to be sensitive and encourage them to seek help. More detailed advice is available in the GMC's revised guidance ***Raising and acting on concerns about patient safety***, which comes into effect on March 12, 2012 and states:

"You must protect patients from risk of harm posed by another colleague's conduct, performance or health by taking appropriate steps immediately so that the concerns are investigated and patients are protected where necessary". It adds: "If you believe that patient safety is or may be seriously compromised…you should put the matter right if that is possible. In all other cases you should raise your concern with the organisation you have a contract with or which employs you."

So remember: register with a GP and seek help early for health problems. And always seek advice from MDDUS before contacting the GMC.

Joanne Curran is associate editor of FYi

WHO DECIDES?

Assessing whether an adult patient has the capacity to decide about their medical treatment can be daunting

THE TREATMENT of adults with incapacity generates a large number of calls to MDDUS. The legislation designed to protect incapacitated adults can appear daunting, but its aim is simple – to ensure patients who cannot make or communicate decisions for themselves about medical treatment have those decisions made on their behalf in their best interests.

In Scotland, the relevant legislation is the Adults with Incapacity (Scotland) Act 2000, while in England and Wales the Mental Capacity Act 2005 applies. In Northern Ireland, decision-making is governed by common law. Both Acts have a number of common themes: decisions must be made on the basis of most benefit to/best interests of the patient, the least restrictive option should be preferred, account should be taken of the patient's previous expressed wishes if known, and the views of relatives and carers should be taken into consideration.

Both Acts have provision for a legally recognised proxy decision-maker to be identified by the patient before capacity is lost (welfare attorney in Scotland, lasting power of attorney in England) and for court appointed decision-makers once capacity is lost (welfare guardians in Scotland, court appointed deputies in England).

Key differences include the requirement in Scotland only to complete a prescribed certificate of incapacity form for treatments under the Act, which can be signed by doctors, but also by appropriately trained dentists, nurses and opticians. In England, specific provision is made for independent mental capacity advocates to be appointed to support an incapable adult who has no family or friends, and advance directives refusing treatment are recognised as legally binding in the English Act only. A special Court of Protection exists in England to oversee the workings of the Act.

Assessing capacity can cause anxiety for doctors who do not specialise in this field, but the principles are straightforward – on questioning the patient, a view must be taken on whether there is understanding of the treatment offered, the reasons for the treatment and the potential side-effects or consequences. There must be an ability to retain this information long enough to make a decision, and the patient must be capable of communicating the decision clearly, with support where necessary. In those with memory impairment, consistency of response on repeated interview is important. It is also important to remember that capacity is task specific – for example, a patient may have difficulty with the *Times* crossword but still be able to decide on an amputation.

Patients with fluctuating capacity can be a particular challenge, and in difficult or borderline cases it is useful to seek a second opinion from a specialist in this area.

FAQs

If a patient's relative says they have power of attorney, can they discuss the patient's care and decide on treatment?

Firstly, confirm whether the patient concerned has lost capacity – the proxy decision-making powers only come into force when the patient is incapable of decision-making. If capacity is retained, treatment should be the same as for any other individual in terms of consent. Secondly, clarify which type of attorney power is held – these can be for financial or welfare decisions or both. Only powers covering welfare would be relevant for medical treatment decisions.

What happens if there is disagreement between a power of attorney and medical staff over the patient's best interests?

Every attempt should be made to reach a consensus when possible. The GMC advice on resolving disagreements includes involving an independent advocate, consulting a more experienced colleague, holding a case conference or using local mediation services. The Mental Welfare Commission (Scotland) may also assist. Otherwise, seek legal advice on applying to the appropriate court/statutory body for review or an independent ruling.

Which doctor should complete a certificate of incapacity for treatment in Scotland?

The doctor providing or authorising the treatment is responsible for this as he would normally be responsible for obtaining informed consent from the patient. If the patient is not well known to the doctor and there is uncertainty over capacity, seek further information from the doctor who knows the patient best.

What happens in an emergency, when there is no time to seek information from relatives/carers and no advance directive by the patient?

The normal certification process specified in the Adults with Incapacity (Scotland) Act is not required where treatment is needed in an emergency to preserve life or prevent serious deterioration in health. In England, similar direction is contained in the Mental Capacity Act, with treatment allowed in these circumstances on a 'best interest' basis. GMC guidance on consent reinforces this advice, and reminds doctors that the 'least restrictive option' in terms of treatment should be preferred.

What do I do if I believe a power of attorney is abusing his authority?

In Scotland, either the local authority or the Mental Welfare Commission can be contacted with concerns. The Office of the Public Guardian oversees financial powers of attorney only. In England, the Office of the Public Guardian oversees lasting powers of attorney for both welfare and financial matters.

Dr Barry Parker is a medico-legal adviser at MDDUS

SKIN DEEP

Is dermatology the specialty for you?

IT HAS been predicted that by the year 2024 skin cancer rates among 60 to 79-year-olds will rise by a third in the UK – this on top of statistics suggesting that people in the same age group are today five times more likely to be diagnosed with malignant melanoma than their parents were, thanks to an increase in sunny foreign holidays and the use of sunbeds.

Just these figures alone attest to the growing profile of dermatology as a medical specialty and the need for competent practitioners in the coming decades. But that's not to say that competition for dermatology NTNs (National Training Numbers) isn't stiff and the training demanding.

Overview

Dermatologists manage diseases of the skin, hair and nails. These are extremely common and account for around 15 per cent of GP consultations. The number of possible dermatological diagnoses has been estimated at 3,000 and includes inflammatory, inherited, environmental, occupational or malignant skin disorders.

The specialty requires an in-depth knowledge of skin physiology and pharmacology, internal medicine and other specialties including immunology, pathology and genetics. It is mainly an out-patient specialty although some patients need hospital admission and dermatologists are often on the wards seeing patients in other departments.

Some skin conditions are chronic and intractable but many are curable and most are at least treatable. Dermatology is said to have the largest formulary in the hospital ranging from ancient tar preparations to the latest immunomodulatory drugs.

Most dermatologists are also skin surgeons and responsible for treating approximately three-quarters of all skin cancers, identifying lesions that require excision for histological confirmation and providing further treatment. A growing number of other subspecialties are also emerging in dermatology including dermatopathology, hair and nail disorders, paediatric dermatology, cutaneous allergy, immunodermatology, photodermatology, cosmetic dermatology and genetic skin disease.

Personal qualities required in dermatology include reliability, self-motivation, punctuality, flexibility and an ability to work well in a team. Dermatologists must also possess good communication and interpersonal skills because of the considerable psychological impact of some skin conditions.

A typical day for a dermatologist might involve an outpatient clinic, followed by ward visits and a surgical list. Dermatologists work with other consultant dermatologists and nurse consultants and due to a high volume of skin cancer work there may be close liaisons with histopathology, plastic, ENT and maxillofacial surgery colleagues and clinical and medical oncology. Weekend on-call duties are generally less demanding than in other medical specialties.

Training

Entry into specialty training for dermatology requires two years of foundation training and then a further two years in core medical training or the acute care common stem (ACCS). Trainees must have passed the full MRCP (UK) for entry to ST3.

The programme is highly competitive and some experience in dermatology at ST1 or ST2 level or as a locum specialty registrar is certainly beneficial. Most trainees will also try to get involved in some research or audits to improve their chances. Specialist training takes four years (specialty registrar) with the award of a certificate of completion of training (CCT), after which a doctor can apply for a job as a consultant dermatologist.

Because dermatology is a well-structured outpatient based specialty with a relatively low

Q&A
Dr Alastair Kerr, SpR in dermatology, just attained CCT

• What attracted you to dermatology?
I was interested in the skin as a medical student but didn't get as much teaching as I had hoped for. After obtaining my MRCP, I was lucky enough to get an SHO job in dermatology and found it was even more interesting than I had imagined. The low acute workload out of hours is also appealing, and lends itself to flexible training for family and for research.

• What do you find most challenging about the job?
There are a lot of diagnoses (about 3,000) so you're always reading to try to keep up-to-date. There are also a lot of patients referred to out-patients, so you are very busy between 9-5 and have to be good at time management.

• Has anything surprised you about the role?
When I first started, I didn't know that dermatologists did any surgery. Even in the time I've been in training, the amount of surgery dermatologists do has increased a lot. There is always going to be a great demand for dermatological surgeons in any department, with the current epidemic of skin cancer. I was also surprised about the amount of blood tests and other investigations that dermatologists did, as I thought it was all just recognising patterns and prescribing creams. Dermatologists are physicians, and doing my MRCP stood me in good stead.

• What do you consider the most important personal characteristic in a good dermatologist?
You have to be empathic towards those with skin disease, as there is a lot of morbidity and psychological upset that goes with having some skin conditions. Although rarely life-threatening, many are chronic in nature, which requires patience. Some of your patients will be with you for your whole career.

• What is your most memorable experience so far?
Being given the opportunity to work in a friendly unit which is very research-active, and to publish several papers which have clinical relevance. I have also travelled to several international meetings to disseminate my work.

• Is there any advice you could give to a final year or FY trainee considering dermatology?
I think there is a perception that it can be an easy option and the phrase "derma-holiday" is well known. However, the reality of it is like any other hospital specialty. It's competitive at entry level and busy on a day-to-day basis. There are relatively few FY jobs which have dermatology placements, but you may be lucky to find one. If you really are interested, it can be a very rewarding specialty, with many subspecialties to choose from.

on-call commitment it is well suited to flexible training. In 2006, 13 per cent of specialty registrars were training flexibly.

Making the choice

A recent article in *BMJ Careers* offered a list of the advantages and disadvantages of dermatology as a profession*.

Advantages

- Variety of patients; all ages and genders
- Clinical variety
- Reliance on clinical diagnostic skills
- Rewarding work – curable or controllable diseases
- Patients rarely life-threateningly unwell
- Less demanding out-of-hours workload
- Medical and surgical options
- Can link clinical findings to pathological findings
- Great opportunities for clinical or lab-based research – skin is visible and accessible
- Flexible specialist training

Disadvantages

- Very large and increasing tumour workload

"Some patients will be with you for your whole career"

- Busy working week, requiring good time management skills
- Competition for jobs is tough at specialty trainee year 3 level
- Less acute work than some other specialties

Further information

Getting involved in societies is a good way of exploring an early interest in dermatology and this can also provide a network to meet clinicians and academics and to increase clinical knowledge, along with gaining an appreciation of the possibilities a career in dermatology can offer. Relevant societies include:

- British Association of Dermatologists – **www.bad.org.uk**. The BAD website has a whole section devoted to medical students and how to attend dermatology meetings through their DermSchool initiative.
- British Society for Dermatological Surgery – **www.bsds.org.uk**
- British Society for Medical Dermatology – **www.medderm.org.uk**
- The British Skin Foundation – **www.britishskinfoundation.org.uk**

* Yusuf I, Turner R, Burge S. *A career in dermatology. BMJ Careers* 26 May 2010

A GLOBAL THREAT

Experts believe climate change poses a major global health threat. But what role can UK doctors play in the fight to save the planet?

THE price of ignoring the issue of climate change was spelled out in dramatic detail at a recent UK meeting of healthcare professionals. If the problem is not tackled then it will not only bring a "global health catastrophe" but has the potential to "threaten global stability and security".

That is the view of some of the most prominent names in healthcare, including former president of the Royal College of Physicians Professor Sir Ian Gilmore, Professor Anthony Costello (Director of the UCL Institute for Global Health), *BMJ* editor-in-chief Dr Fiona Godlee and Lord Michael Jay, chair of international health charity Merlin.

The group signed a statement at the high-level London meeting in October 2011 calling for action. It stated in no uncertain terms that complacency "will be paid in human lives" and that tackling climate change could "significantly cut rates of premature death and disability for hundreds of millions of people around the world."

The statement makes some tough demands, including calling on the EU to reduce greenhouse gases by 30 per cent by 2020 and for an end to the building of new coal-fired power stations.

At first glance, climate change may not seem like an urgent health issue but the statement outlines how rising temperatures and weather instability will lead to more frequent and extreme weather events, loss of habitat and habitation, water and food shortages, spread of diseases, ecosystem collapse and threats to livelihood, potentially triggering mass migration and conflict within and between countries.

This is echoed by a report published in *The New Scientist* in 2003 that says more than 1,500 people died prematurely during the heatwave in England that year.

NHS impact

In the UK, one look at the scale of NHS emissions shows its considerable environmental impact. NHS England's carbon footprint is estimated at 21 million tonnes of CO^2 equivalent (roughly the same as that of Croatia), while the figure for NHS Scotland (estimated in 2004) is around 2.6 million tonnes – about the same as the small Caribbean island of Martinique. By comparison, greenhouse gas emissions for the UK as a whole are 520 million tonnes.

In January 2009, the NHS in England pledged to become one of the country's leading sustainable and low carbon organisations. It set itself the ambitious goal of meeting the government target of an 80 per cent reduction in carbon emissions by 2050.

The pledge coincided with the launch of a new carbon reduction strategy, ***Saving carbon, Improving health*** which calls on the NHS to "set an example" for the rest of the UK. Dr David Pencheon, Director of the NHS Sustainable Development Unit, said: "Carbon reduction is something that needs to extend to every part of the organisation. Everyone who works for the NHS should be thinking about reducing their carbon footprint as part of their day job."

Taking action

The 2011 report acknowledged that meeting carbon targets would be a "huge challenge" for the NHS in England but goes on to identify how organisations can make changes in three main areas of energy, travel and procurement.

Action points include encouraging every NHS staff member to take responsibility for carbon reduction; asking NHS organisations to create a strategic plan to develop more renewable energy sources; minimising waste through efficient procurement; and minimising staff, patient and visitor travel.

Similarly, in October 2009 Scottish health secretary Nicola Sturgeon launched the report *Carbon Footprint of NHS Scotland (1990-2004)*, just two months after the Climate Change Act (Scotland) 2009 came into force

with the aim of cutting emissions by 80 per cent by 2050.

The report recommends researching ways of identifying and tackling key "carbon hotspots" such as patient travel and pharmaceuticals and improving ways of measuring carbon emissions within the NHS and its suppliers.

In 2008, NHS Lothian was among the first Scottish health boards to sign up to the Carbon Management programme and receive a £700,000 grant from the Central Energy Efficiency Fund. The programme provides tools for analysing energy consumption and workshops to show staff and managers how to effectively use carbon management in their day-to-day work.

"Everyone in the NHS should think about reducing their carbon footprint"

The board was subsequently awarded the Carbon Trust Standard in March 2011 for having cut its emissions by 5.3 per cent in the previous two years. New energy-saving measures included using recycled rainwater in the laundry at one hospital and installing solar panels to preheat domestic hot water at a new health centre. The board also started an energy saving drive in 2011 to encourage staff to be more energy efficient. The board hopes to reduce its carbon footprint by four per cent in each of the next five years which would unlock funding of more than £600,000 that could be reinvested in clinical services.

Practical steps

Practical guidance is available for NHS decision-makers in the 2009 guide *Sustaining a Healthy Future – Taking action on climate change [Special Focus on the NHS]* which offers "action checklists" on how they can reduce their organisation's carbon footprint. It offers tips on how to become a "Good Corporate Citizen organisation" through measures such as "increasing green spaces and plants within the care environment"; encouraging health visitors to promote the benefits of walking and cycling; "redesigning patient care and treatment pathways" to make them more environmentally friendly; and holding a "carbon audit" to involve friends and family in the fight against climate change.

Various committees, schemes and strategies have been devised by the NHS in recent years to cut carbon emissions. The NHS Sustainable Development Unit, established in 2008, was one of the first official bodies set up to monitor the health service's carbon footprint and contributed to the creation of the NHS Carbon Reduction Strategy. The 2008 Carbon Reduction Commitment is a mandatory energy efficiency scheme that will affect the majority of NHS hospitals. Compliance is rewarded with a top spot in annual performance league tables while penalties may be handed out for failure to comply.

Elsewhere, the NHS Reuse Programme was set up by University College London Hospitals NHS FT to reuse old office furniture and equipment across the NHS instead of it being thrown away or put into storage.

Technology also has a role to play in reducing carbon emissions. Over the next five years, the Department of Health (DoH) in England says it will work to bring telehealth and telecare to millions of people with long-term conditions. The telehealth initiative involves patients using electronic equipment at home to monitor vital health signs such as pulse, weight and blood oxygen levels which can be read remotely by health professionals. Telecare involves installing electronic equipment in patients' homes to support independent living. Examples include personal pendant alarms worn around the neck, door alarms and bed sensors to detect unexpected movements.

Both programmes can help minimise travel to and from practices and hospitals as well as easing pressure on other resources. The DoH admits take-up so far has been slow in England with only around 5,000 telehealth users signed up and 1.5million pieces of telecare in use. But hi-tech healthcare is also increasingly being used in other parts of the UK and it's hoped it will bring financial, environmental and patient care benefits for the NHS.

Joanne Curran is associate editor of FYi

In the weeks and months after Karen Woo's death a picture emerged of a tireless and charismatic young doctor determined to improve healthcare in one of the most dangerous and chaotic places on Earth. Her legacy recently inspired the BMJ Group to inaugurate a new Karen Woo Award to be presented at its annual Improving Health Awards ceremony in May 2012 to a medic who has gone well beyond the call of duty to care for patients and "exemplifies medicine's traditional values of altruism, service, and courage". So who exactly was Karen Woo?

Powerhouse of enthusiasm

One person who knew her well was Dr Andrew Vallance-Owen, medical director of BUPA. Karen worked for BUPA as assistant medical director before moving to Kabul to take up full-time aid work. She came to BUPA with a less-than-usual background having first studied dance at the London Contemporary Dance School. Later at the age of 24 she decided to do medicine at The University College London Medical School before specialising in surgery.

THE LEGACY O

A British doctor killed in Afghanistan inspires a new award and offers a role model for medical altruism. **Jim Killgore** tells only part of her story

PHOTOS: COURTESY OF MARK SMITH

IN EARLY August of 2010 a team of 10 aid workers on a three-week expedition to the Nuristan region of Afghanistan were making their way back to the capital city of Kabul. The expedition had been organised by a Christian charity called the International Assistance Mission (IAM) and included medics from the USA, Germany and the UK who were providing medical assistance and supplies to remote mountain communities.

The team had been delayed getting their three 4-by-4 vehicles across a swollen river and had stopped for a rest when they were attacked by an armed gang. Everyone was killed apart from one driver. Among them was a 36-year-old British doctor named Karen Woo.

Karen was on her third trip to Afghanistan and had been living in Kabul since October providing medical treatment in a variety of settings including maternal and neo-natal care. Afghanistan has some of the highest maternal and child mortality rates in the world with one woman dying in childbirth every 28 minutes and one in five children dying before the age of five. She was determined to improve the situation not only in the city but in rural areas of the country. A later inquest into her death heard that the team had helped some 1,000 people over the three-week trek to Nuristan including saving the life of a young boy.

"It was clear from my first interview with Karen that she was a powerhouse of ideas and enthusiasm – and so it turned out," says Dr Vallance-Owen. "She was full of life and quite exciting to work with really."

During her medical training Karen had undertaken electives in Trinidad and Tobago, parts of Australia and Papua New Guinea so she knew about providing care in deprived regions. It was while she was working at BUPA that she made her first trip to Afghanistan.

"She came back very affected by the difficulties that the Afghan people were facing, the poverty there, especially the conditions that children were living in," says Dr Vallance-Owen.

"So she decided to start collecting stuff to take out to Afghanistan – medical-related kit. It was a typical Karen sort of thing really. She got a cause and went for it, contacting hospitals, our own included and some of our businesses."

Karen collected a lorry-load of surplus medical equipment and materials for airlift to Afghanistan to distribute among hospitals. She also began working with Bridge Afghanistan, a not-for-profit collective of medics, filmmakers and journalists attracting aid to the country.

"Everyone was very proud of her for doing this," says Dr Vallance-Owen. "And it was not long after that she decided that this is what she wanted to do."

F KAREN WOO

Consequences of conflict

Karen left her job at BUPA and moved to Kabul. Here she worked as a general physician and public health consultant, as well as in emergency medicine. She also began filming a documentary to highlight the desperate suffering in the country and to show the human side of Afghanistan. An insight "through the lens of birth and death, of loss and disability," she wrote, and one that "reflects every aspect of the consequences of conflict on individuals and on their community. The loss of nearly all elements of the infrastructure of a country, security, governance, education, transport, clean water, sanitation and power, are all visible in the health of the people."

Proceeds from the film were intended to raise funds for a charity she had started to help improve health and education programmes, particularly those focusing on neonatal, paediatric and maternal health.

In Kabul she also met Paddy Smith, a security consultant based in Afghanistan, to whom she became engaged. In a blog written in the months before her death she described both the dangers of life in Kabul and her difficulty in buying a silk ball gown for a "special occasion".

She writes: "Me being me, I've left everything to the last minute and just to add extra pressure, I've decided to run the gauntlet of the Afghan dressmaker."

Karen joined the Nuristan trek with IAM to run mother and child clinics in the remote mountain villages the team visited. Later after the attack the Taliban claimed that the group had been "preaching Christianity". IAM is a Christian organisation and has operated in Afghanistan for over 40 years but Karen's family have denied that her work had anything do with religion, saying her motivation was purely humanitarian. Even now it remains unclear who was responsible for the attack and the reasons behind it.

Going above and beyond

In the year and a half since her death Karen's family have set up a grant-giving charity to carry on the work started by Karen. The Karen Woo Foundation (**www.karenwoofoundation.org**) supports healthcare projects in Afghanistan providing medical supplies and healthcare education, particularly to remote and rural communities with little or no access to even basic medical provision. A key figure in the work of the Foundation is Karen's mother Lynn.

"What can I say about my daughter," she says. "I described her to the *New York Times* as my Renaissance woman, reflecting on her multi-faceted skills and interests over the years. She was an energetic and driven soul, bright and intelligent. She wanted to be valued and valuable, wanted to express both her artistic skills and her scientific bent. In Afghanistan she seemed to have brought those different passions together."

Karen's legacy also lives on with the Karen Woo Award. The genesis of the prize began when Dr Vallance-Owen was approached by the BMJ Group awards last year to ask if BUPA would sponsor The Medical Team in a Crisis Zone Award.

"I said we would sponsor it if I could connect the award to Karen's name – say a few words in her honour – because that is exactly what she had been doing. They were a bit nervous about it. It was not quite standard for an awards ceremony.

"In any case it went down very well and the audience very much linked to what I said – the sort of person Karen was. Someone who does something out of the ordinary. Who goes the extra mile in some way outside their normal comfort zone."

So this year the BMJ Group went one step further and devised a new award in her honour. Dr Vallance-Owen believes Karen's character is very much reflected in the award criteria – an individual who has addressed a significant health challenge and demonstrates a clear commitment to delivering high quality care in a challenging situation, going above and beyond normal professionalism, possibly involving a degree of self-sacrifice or personal risk.

"I learned a lot myself from Karen," he adds. "It's important to be reminded of our basic value set and what we're all here for."

Lynn Woo is proud to have her daughter remembered in this way.

"Karen was unable to make the difference she intended," she says. "The honour of the *BMJ* is that they saw the potential. She has inspired her family and friends to stand up and be counted."

Jim Killgore is an editor at MDDUS

Top: *Dr Karen Woo in an ambulance with a patient in Kabul.*
Above: *Karen at work in the operating theatre*
Left: *Karen ran mother-and-child clinics*

Improving Health Awards

MDDUS is proud to be principal sponsor of the 2012 BMJ Group Improving Health Awards. To find out more about the Karen Woo Award sponsored by BUPA and information and entry criteria for all the awards go to www.groupawards.bmj.com

THE MAN IN THE VAN

A SPECIALTY registrar in emergency medicine – Dr K – is working in A&E one Saturday night just before Christmas. Two policemen come into the department and approach a sister at the desk. They inform her that they have just arrested a man for domestic breach of the peace and assault. He is now out in the van and "full of drink" and the officers want someone to come and check if it is just the drink.

Dr K is sitting at a nearby computer and overhears the request. He tells the officers that it is not the department's responsibility to check for alcohol or drugs in such cases and certainly not in the back of a police van. One of the officers says "fine" and the two turn and leave A&E.

A short time later the department receives a phone call from the duty sergeant at the local police station complaining that a patient had been "turned away" without examination. He tells Dr K that the man in the van had been unable to stand and was unresponsive to questions and commands, and the officers had been concerned that he might not be fit to be detained due to some other condition or injury.

Dr K responds that the officers had not made him aware that the patient was unresponsive and possibly in need of medical attention. The duty sergeant asks why else would they have brought him to hospital and informs Dr K that the man will be seen by a police surgeon. Later that night the subject is brought back to A&E and examined by another doctor and discharged back to the police.

A few weeks later a complaint is sent to the hospital from the local police force. In it the duty sergeant sets out his version of events that night. He states that Dr K refused to assist in the medical assessment of an arrested male. In his account the two officers asked Dr K directly to determine if the man was drunk or possibly suffering from some other condition, and they offered to carry the man into A&E or allow for the check to be done in the van. Both suggestions were allegedly refused by Dr K. Only on the insistence of the police surgeon was the man returned to hospital and fully assessed and indeed found to be just intoxicated.

The complaint stated that despite the final outcome the police still found Dr K's attitude unhelpful and irresponsible. Had the man's condition been due to diabetes or a head injury this would have been missed and possibly with serious consequences. A copy of the document is also sent to the General Medical Council.

Analysis and outcome

Dr K contacts MDDUS and forwards the complaint to a medical adviser. He discusses the matter and with the help of the adviser writes a reply. In it he disputes the account provided by the two officers, stating that no concerns were expressed as to the medical condition of the patient and that no offer was made to bring the man into the department as is normal procedure. This can be corroborated by the sister at the desk.

He agrees that no doctor should assume that alcohol is the sole cause of a patient's condition but that a full physical examination is necessary to make such an assessment and this is not possible in the back of a police van.

A similar response is sent to the GMC and after an investigation the case is referred back for local resolution at the employing hospital. A meeting is convened to discuss the matter with the senior consultant A&E physician and management. No further action is taken against Dr K.

Key points

- Doctors should not be coerced into examining patients in circumstances which are unsuitable unless there is a very good reason, e.g. when it may be detrimental to move them prior to assessment.
- Doctors must be sure of all relevant facts before refusing to see any patient or potential patient.
- It would have been prudent to invite the police to formally bring the patient into the A&E department if they were concerned, as this would allow proper note keeping and recording.
- Always discuss any such matters or complaints with the responsible consultant and MDDUS.
- Remember that NHS indemnity will not provide you with advice and legal support in GMC/ disciplinary actions and thus maintaining private indemnity is recommended for all doctors.

OUT THERE

FROM BARD TO WARD Reading Shakespeare could give physicians a fresh insight into the links between emotion and illness, according to retired doctor Kenneth Heaton. He believes the Bard's many descriptions of psychological illnesses could help modern medics diagnose conditions linked to emotional disturbance. *Source: BBC*

ALIEN MYSTERY Remains recently found in Peru that were said to belong to a triangular-headed alien could be those of a child with hydrocephalus. Peruvian website RPP claims experts found something that "isn't human" but sceptics say the ancient practice of head-binding and a naturally-occurring craniofacial deformity could explain the over-sized skull. *Source: io9.com*

EMERGENCY DISCO Using a disco beat to guide you during CPR is no better than no music at all, an *Emergency Medicine Journal* study found. Bee Gees classic *Stayin' Alive* is the theme for the British Heart Foundation's latest CPR campaign but while such tunes help maintain a rate of 100 compressions a minute, they don't encourage the correct depth of 5 to 6cm.

FASTER, STRONGER Male orthopaedic surgeons have greater intelligence and grip strength than their male anaesthetic counterparts, a study in the *BMJ* has found. Researchers set out to test the popular saying that ortho surgeons are "as strong as an ox but half as bright".

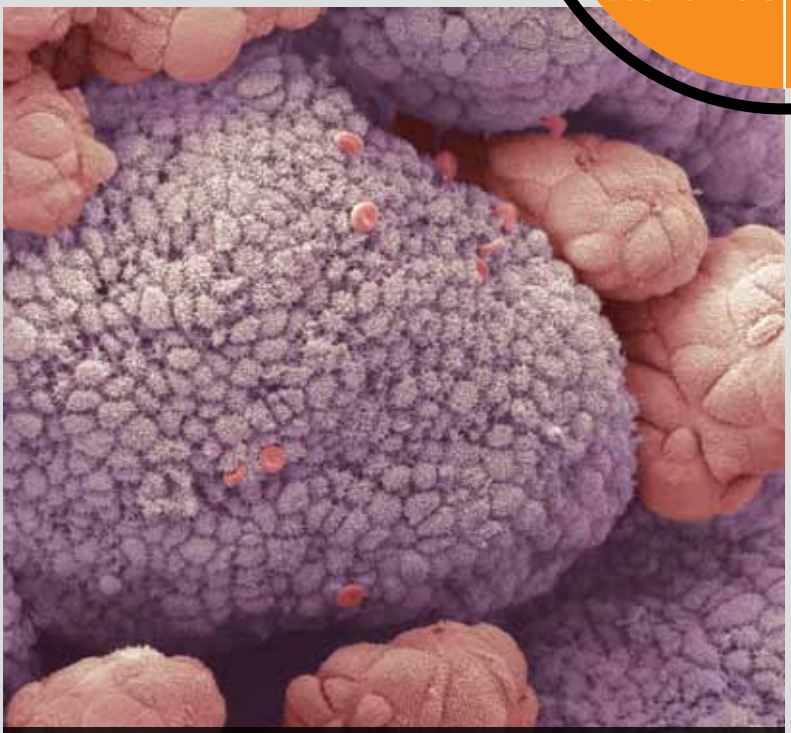


PHOTO: SCIENCE PHOTO LIBRARY

WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: THE KOBAL COLLECTION

Pick: DVD – The Skin I Live In

Directed by Pedro Almodóvar, starring Antonio Banderas, Elena Anaya, Marisa Paredes; 2011

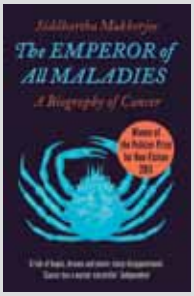
ROBERT Ledgard (Banderas) takes the stereotypical image of a plastic surgeon to extremes in this challenging film from one of Spain's finest directors. Suave, wealthy, with slicked-back hair, a BMW in the driveway and an unhealthy obsession with sculpting a woman in the image of his dead wife, Ledgard takes narcissism to new extremes.

Haunted by personal tragedies, the surgeon tosses bioethical concerns aside in his quest to develop a new form of artificial skin that doesn't burn or scar using transgenesis techniques involving animals.

The threat of violence is ever-present as Ledgard's surgical patient, Vera, reluctantly submits to his increasingly twisted demands and the film surges through themes of loss, passion, fantasy, escape and madness. It is Banderas' understated performance as the grief-stricken, obsessed surgeon that keeps this compelling film grounded, even through some of its more bizarre turns.

Almodóvar's disturbing film, with its shocking twist, will not be to all tastes but is surely one most surgeons would be intrigued to see.

Book Review:
The Emperor of All Maladies: A Biography of Cancer by Siddartha Mukherjee



Fourth Estate; ***£9.99***

Review by Dr Anne Parfitt-Rogers, FY1 doctor at Crosshouse Hospital, Kilmarnock

IN 2010, an estimated seven million people died of cancer worldwide, with countless more affected by the disease. As oncologist and professor Siddhartha Mukherjee writes, this is "a story that has to be told".

The book opens with Carla Reed, a Massachusetts kindergarten teacher who, aged 30, is struck by an aggressive form of leukaemia. The story of her gruelling treatment is interwoven with an account of the complex history of the disease itself. From the Persian Queen Atossa, who ordered a servant to excise her breast tumour with a knife, the book describes advances in the understanding and treatment of cancer over the past 4,000 years.

Central to this history is the pioneering work of Dr Sidney Farber, who developed antifolate chemotherapy in the 1950s, and his collaboration with Mary Lasker, a philanthropic American who was instrumental in the creation of the National Cancer Institute. It also describes advances such as Doll and Hill's landmark smoking study, the advent of mammography and the use of bone marrow transplantation to keep pace with an ever-evolving disease.

No book about cancer can dodge that big question – when will we find a cure? While no one can know for sure, Mukherjee is hopeful for the future, citing recent developments including gene therapy and vast improvements in multidisciplinary care.

An interview with the author gives a fascinating insight into the highs and lows of oncology, including the value of communication and the heartbreak of breaking bad news. Mukherjee describes the impact on his own life, from fitting the writing around evenings with family, to harvesting his daughter's umbilical cells as a resource for leukaemia research.

And what of Carla's story? In 1999, Mukherjee drove to her house with a bouquet of flowers to celebrate five years since her diagnosis – in oncology, almost tantamount to a cure – and asks how she survived the ordeal. "There was no choice," she explains. "For someone who is sick, this is their new normal".

This is a compelling, elegantly-written book which holds the reader's attention and leaves you better informed about a wide variety of aspects within oncology. Primarily aimed at patients, it is easily readable, while still providing a significant amount of depth. For doctors, it will enhance your treatment of patients and enrich your view of medicine.

WHAT ARE WE LOOKING AT? *SEM of intestinal papillomas*

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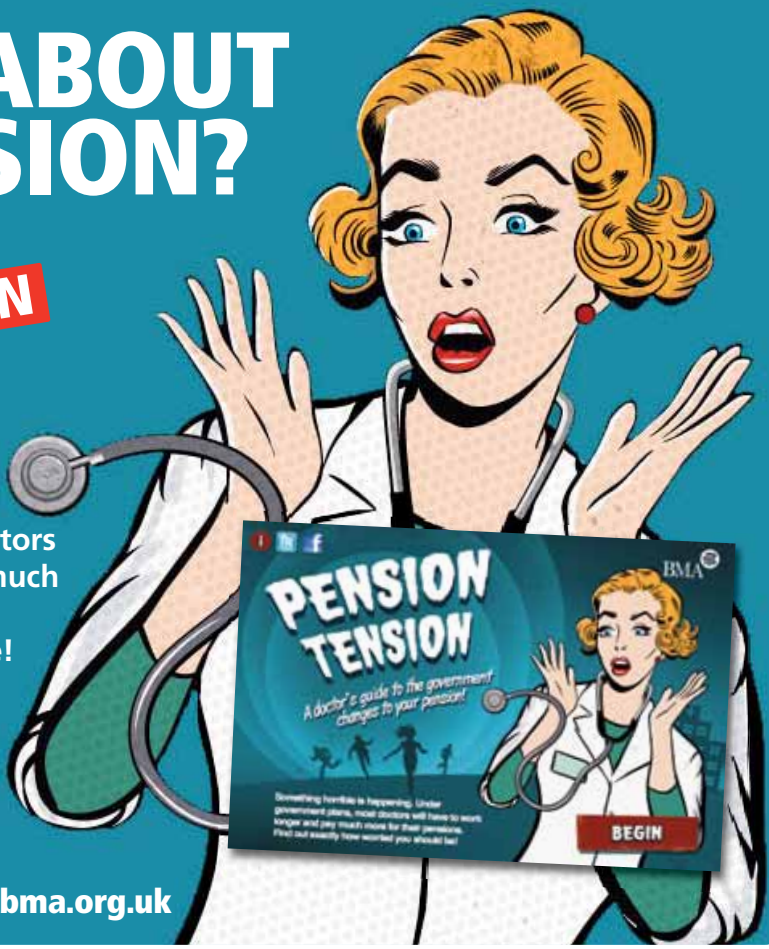

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