FYi

ISSUE 09

DYING FOR A DRINK

AS THE ANNUAL COST TO THE NHS OF ALCOHOL ABUSE SOARS TO £3.5BILLION, WHAT ROLE CAN DOCTORS PLAY IN TACKLING THIS WORRYING TREND?

ALSO INSIDE

AN **MDDUS** PUBLICATION

MDDUS

Welcome to your *FYi*

MAKING the transition from medical school to foundation training can be a daunting one, but good relationships with nurses and other healthcare staff can make the job a lot easier. FY1 doctor Anne Parfitt-Rogers looks at the importance of learning to work in a team in her article on page 4.

As the annual cost to the NHS of alcohol abuse soars to £3.5billion, it's clear that more needs to be done to tackle the problem. But what role can junior doctors play? *FYi* associate editor Joanne Curran investigates on page 10.

Intimate exams can be distressing for patients and can also leave doctors vulnerable to complaints of inappropriate behaviour. In her article on page 5, MDDUS medical adviser Dr Anthea Martin discusses the value of having a chaperone present, for both doctor and patient. A recent survey found medical students believe doctors should have the right to refuse to perform treatments that conflict with their personal beliefs – but what about their professional duty of care? MDDUS medical adviser Mr Des Watson offers some guidance on page 12.

Technology is playing an increasingly prominent role in patient care and on page 7 Dr Benjamin Visser looks at the pros and cons of medical apps. All doctors should treat patients equally, regardless of their sexuality, but a recent survey found that isn't always the case. Our article on page 6 takes a closer look at this area of discrimination in care.

The specialty of orthopaedics offers a complex balance between mechanics and biology – so is it right for you? Find out more in our careers article on page 8. And on page 14, our case study highlights a delayed referral in a patient with a painful swelling.

• **Rebekah Skeldon**
Editor

PHOTOS: WALTER NEILSON

NEW CPD GUIDANCE FOR DOCTORS

GUIDANCE for doctors on how to plan, carry out and evaluate their CPD has been published by the General Medical Council ahead of the launch of revalidation.

Continuing professional development: guidance for all doctors advises doctors to "reflect on their learning needs" based on the GMC's core guidance *Good Medical Practice*. It also encourages practitioners to use information from their CPD within their appraisal as this will be the basis upon which they revalidate.

Read the guidance at **www.tinyurl.com/cmmflfj**

NEW TRIBUNAL SERVICE LAUNCHED BY GMC

A NEW impartial adjudication function for doctors has been launched by the GMC as part of key fitness to practise reforms.

The Medical Practitioners Tribunal Service (MPTS) has been heralded by the GMC as the biggest shake-up of fitness to practise hearings since being first established in 1858.

The new service, based in Manchester, is part of the GMC but operationally separate from the regulator's complaint handling, investigation and case presentation and is accountable to Parliament. His Honour David Pearl has been appointed Chair of the MPTS, having held a range of senior judicial roles including the President of the Care Standards Tribunal and Commissioner of the Judicial Appointments Commission.

He will be responsible for appointing, training, appraising and mentoring MPTS panellists and legal assessors.

MPTS panels will have the power, in the most serious cases, to remove or suspend a doctor from the medical register or place restrictions on their practice. The service can also take early action to ensure patient safety by considering cases in advance of a full fitness to practise hearing, if it is judged appropriate to place restrictions on a doctor's practice immediately or suspend their practice while investigations proceed.

Niall Dickson, GMC Chief Executive, said of the MPTS: "It represents a key part of our reforms and delivers a clear separation between investigations and the decisions made about a doctor's fitness to practise.

"Although panels already make their decisions independently, it is important that their autonomy is clear and that the oversight of their work is quite separate from our investigatory activity. We hope that the MPTS will strengthen professional and public confidence that our hearings are impartial, fair and transparent – the fact that the service is led by a judicial figure who has a direct line to Parliament should provide that assurance."

For more information on the MPTS, all current fitness to practise cases and recent decisions visit **www.mpts-uk.org**

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AUGUST CHANGE-OVER "PUTS PATIENTS AT RISK"

A SENIOR NHS executive has admitted that the August change-over – when junior doctors start their new jobs – puts patients at risk.

NHS medical director Sir Bruce Keogh has admitted publicly, for what is believed to be the first time, that the so-called "killing season" does exist and that measures are being put in place to tackle the problem.

Research has suggested that death rates increase by as much as eight per cent at the start of August when trainees take on their new roles and repeated calls have been made to address the problem.

One of the main measures being introduced includes four days of paid work shadowing for juniors. Sir Bruce said he expects 7,000 trainees to shadow senior colleagues voluntarily before starting their posts in August 2012. From next year the work shadowing will be compulsory for all foundation year doctors.

Sir Bruce said he hopes the scheme will halve the number of errors. He said: "The intention is to end the so-called killing season. This is good news for patients – we recognise the change-over period in August puts patients at risk.

"Junior doctors are under stress as they change from being a student to a professional and they need help to adapt to a working environment when they've never done a job before."

The scheme follows a successful pilot in Bristol where the number of mistakes made by juniors halved in their first four months. The number of patients left permanently damaged by their errors also fell from five cases to just one.

The shadowing scheme has been broadly welcomed. Joyce Robins of Patient Concern said: "This is an excellent idea and will be of great relief to patients."

Junior doctors change jobs every six months, in August and February, and Sir Bruce accepted that the new scheme would tackle only part of the problem, adding: "We will audit the shadowing and see how different trusts manage it and their results."

FP CURRICULUM GUIDE PUBLISHED

A GUIDE to the 2012 Foundation Programme curriculum is available online.

The UK Foundation Programme Office has launched a resource that will help trainees improve their knowledge and understanding of the topics set out in the curriculum.

It lists many of the freely available evidence-based resources which will help consolidate and develop the knowledge and skills to deliver safe and effective patient care.

Read the resource at **www.tinyurl.com/cxexke2**

GMC ISSUES CHILD PROTECTION GUIDANCE

NEW guidance to help doctors protect children from abuse has been issued by the GMC.

Protecting children and young people: the responsibilities of all doctors is aimed at supporting doctors dealing with a wide range of complex child protection issues. The guidance makes clear the responsibilities of doctors in this area and advises where they can turn for support.

GMC Chief Executive Niall Dickson said: "Doctors must raise their concerns if they believe a child or young person may be at risk of abuse or neglect – and this applies whether or not the child is their patient. They also need to know who to contact for advice if they do have any concerns."

The guidance has been developed following concerns that some recent high-profile cases were deterring doctors both from working in this area and from raising child protection concerns.

It states: "Taking action will be justified, even if it turns out that the child or young person is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable, and the doctor takes action through appropriate channels."

MDDUS senior medical adviser Dr John Holden added: "The guidance reminds doctors to work in partnership with colleagues to keep children safe. MDDUS recommends that doctors seek advice from a senior colleague, a lead child protection liaison contact or medical defence organisation if in any doubt."

The full guidance comes into effect on September 3, 2012 and can be accessed at **www.tinyurl.com/86e3b5z**

MEDICAL STUDENT HARDSHIP FUND LAUNCHED

A HARDSHIP fund has been launched to help medical students in financial difficulties.

A pilot scheme has been set up by the Royal Medical Benevolent Fund which says a small but important number of students are facing real financial hardship due to unexpected and often distressing circumstances.

Traditionally the RMBF has helped doctors and their families in need, but they are now extending this help to trainees.

Applicants to the Medical Student Financial Hardship Fund will have to meet eligibility criteria and go on to qualify and practise as doctors.

The charity reported a higher number of enquiries in January and February 2012 with an increasing trend for younger, recent graduates asking for help, as well as those in their early thirties with young families.

Student applications cannot be made directly to the RMBF. Students should approach their university student welfare officer or the head of their medical school for more information.

SAFETY IN NUMBERS

FY1 **Dr Anne Parfitt-Rogers** looks at the importance of teamwork

BY now, most of you will be easing your way into foundation training and embracing the beginning of your medical careers. Part of that challenge involves working in a busy ward environment for the first time. With pressure to keep pace with current medical developments and meet patient expectations, it is important not to overlook the key role of the multidisciplinary team in ensuring things run smoothly.

During medical school, it is easy to get caught up in the process of acquiring knowledge and passing exams, and students can forget the other members of the healthcare team. However, good relationships with nurses and other healthcare staff can make the job significantly easier, especially at the start of the first foundation year.

Studies have also shown that good teamwork correlates positively with patient satisfaction and plays a crucial role in patient safety.

An editorial published in the *BMJ* in 2010 by Rhona Flin, professor of applied psychology at the University of Aberdeen, noted that rudeness and a lack of mutual respect among clinical teams can compromise patient safety. She described how "a series of studies has shown that being the victim of rudeness can impair cognitive skills". This was illustrated in the 2009 case of two airline pilots who started arguing, lost concentration and ended up overshooting the airport by 150 miles. The example can also be applied to medical teams where rudeness or an emotionally charged atmosphere risks distracting healthcare professionals from crucial tasks.

On the ward...

The importance of teamwork is something I have become increasingly aware of during my training. I am currently based on a cardiology ward where I have to work alongside a wide range of healthcare professionals in order to deliver effective, safe patient care. A typical day starts with a safety brief from the sister or ward receptionist which provides a quick orientation of patients at particular risk, including frequent fallers, wandering patients and those with infections. During the day, senior colleagues delegate tasks such as reviewing patients, chasing bloods and ordering investigations. In the afternoon, daily team meetings with the FY1, advanced nurse practitioner (ANP) and senior house officer (SHO) provide an opportunity to discuss patient care.

It's vital to learn how to work well with everyone, from the ward sister to the senior doctors and also the pharmacist. Good team relations will also make your job easier when it comes to important tasks such as completing discharge summaries which rely on your ability to gather information from different members of the team. And remember, most of these people will have been working in the hospital a lot longer than you and there is a lot to learn from them. Always listen and consider their input – never assume you know best.

Asking for help

Starting work on the wards can be daunting as a trainee, so having someone to turn to for advice or support makes all the difference. This is especially true for on-call work. The hospital at night team varies from hospital to hospital, but most include ANPs, senior doctors and clinical support workers (CSWs). CSWs can be invaluable in the middle of the night when you're struggling to get a cannula in, as can ANPs in the patient with sepsis or the on-call SHO for less straightforward scenarios. (Don't forget to note all the relevant pager numbers before starting your shift.)

In acute receiving wards, good relations are also vital to ensure things run smoothly. At busy periods, the nurses will be far more understanding if you've previously taken time to consider their input. Also, remember to ask questions on the consultant ward rounds – as well as being a learning opportunity, it makes the phone call to the duty radiologist or consultant microbiologist much easier later in the day.

The General Medical Council, in its core guidance *Good Medical Practice*, highlights the importance of teamwork. When working in a team, it says doctors must respect the skills and contributions of colleagues, learn to communicate effectively with them and ensure both patients and colleagues understand your role and responsibilities within the team and know who is responsible for each aspect of patient care. Importantly, working in teams "does not change your personal accountability for your professional conduct and the care you provide."

It goes on to advise doctors to take part in regular reviews and audits of the standards and performance of the team so that any deficiencies can be remedied. So next time you're thinking about skipping the afternoon meeting on morbidity and mortality in favour of a coffee in the canteen, remember they can be a useful learning opportunity and your input will be valued.

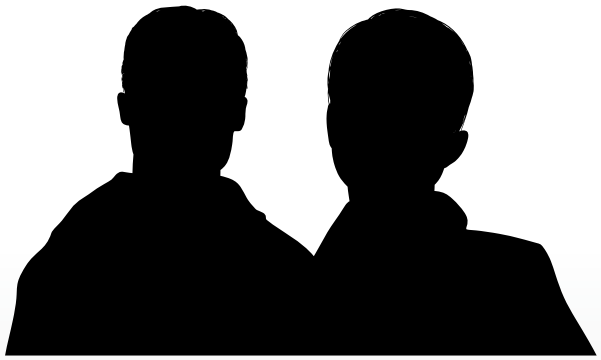
The GMC adds that effective teamwork also involves being willing to offer support to any team members who have problems with performance, conduct or health. If you have concerns about a colleague then don't ignore them. Depending on the situation it may be appropriate to raise concerns with the person directly or alternatively seek advice from a senior colleague.

Like any skill, teamwork is something that can improve with practice and the best approach is to acknowledge and respect the role played by all members of the team.

Dr Anne Parfitt-Rogers is an FY1 at Crosshouse Hospital, Kilmarnock

CHAPERONES – FOR DOCTOR AND PATIENT

MDDUS adviser **Dr Anthea Martin** on the value of an "impartial observer" in intimate examinations



ONE of the most serious complaints a doctor can receive is that they inappropriately touched or examined a patient. Worse still is an allegation of sexual assault.

These types of complaints are not uncommon and if examinations of an intimate nature are not approached in the right way, a patient may complain to the GMC, or even the police, with potentially catastrophic consequences for a doctor's career.

There are a number of measures doctors can take to help avoid such accusations. It is crucial to follow GMC guidance *Maintaining boundaries – guidance for doctors*, with one key element of this being to "offer the patient the security of having an impartial observer (a 'chaperone') present during an intimate examination."

So just what is an "intimate examination"? Generally this would include examination of the breast, genitalia and rectum but may also extend to the chest, groin or abdomen. For some patients, just touching or close physical proximity could be perceived as intimate.

The role of the chaperone is to reassure patients and offer emotional support as intimate examinations can be embarrassing or uncomfortable for patients. Also, by having a chaperone present, a doctor can reduce the risk of complaints or allegations during intimate examinations. It is recommended that even where the doctor and patient are of the same gender, the offer of a chaperone is still made.

The chaperone does not have to be medically qualified but should have received appropriate training and must be sensitive and respectful of the patient's dignity and confidentiality. He or she should be prepared to reassure the patient if they show signs of distress or discomfort and be familiar with the procedures involved in a routine intimate examination.

The chaperone must be prepared to raise concerns about a doctor's behaviour where necessary. Any discussion about a chaperone should be noted in the medical record, including the chaperone's name. If the patient does not want a chaperone and the doctor is happy to proceed, then it should be noted that a chaperone was offered and declined.

Should no chaperone be available and the doctor or patient is unwilling to proceed without one, the patient should be given the option of delaying the examination to a later date. If either party is uncomfortable with the choice of chaperone then the examination can be delayed until a suitable replacement is found.

The GMC offers clear guidance on conducting intimate examinations even with a chaperone present. You should always explain to the patient why the examination is necessary and give them plenty opportunity to ask questions. Explain just what will be involved in clear language that the patient can understand, including any potential pain or discomfort. Obtain clear consent from the patient before the examination and record that consent in the notes.

Patients should be given privacy to undress and you should ensure they are covered as much as possible during the examination to maintain their dignity. Do not help the patient undress unless you have clarified with them that some assistance is required.

Should the examination differ in any way from the procedure you have already described to the patient, explain why this is necessary and seek further permission to go ahead. Always be prepared to discontinue the examination if asked by the patient. Keep any comment to the patient relevant and do not make unnecessary personal observations.

Remember that any decision you make should take into account the patient's best interest. Use of a chaperone can prevent unfounded allegations of inappropriate behaviour during intimate examinations. Therefore, chaperones not only benefit the patient, but the doctor too.

Key points

- Chaperones should be offered to all patients during intimate examinations.
- Chaperones need not be medically qualified but should be appropriately trained.
- Complaints and serious allegations can be avoided by having a chaperone present.
- Keep a record of use of chaperones (including their name) – even if they are offered and declined.
- Chaperones are for the doctor's benefit as well as the patient.

Dr Anthea Martin is a senior medical adviser at MDDUS

WITHOUT PREJUDICE

Do you discriminate by sexuality?

DO all patients deserve to be treated equally, regardless of their sexuality?

All doctors should answer "yes" to this question, but a recent survey suggests lesbian, gay and bisexual (LGB) patients are still subject to discrimination and poor care. Whether it involves making assumptions about a patient's lifestyle or denying access to care, any form of discrimination is wrong and could spark patient complaints that may lead to charges of professional misconduct.

Charity Stonewall recently produced its *Gay and Bisexual Men's Health Survey* in which 34 per cent of gay and bisexual men who accessed healthcare services in the previous year reported having a "negative experience" related to their sexuality.

One 24-year-old who responded to the survey said: "My GP assumes I sleep around just because I'm gay", while a 40-year-old said: "I came out to my new local GP and when I informed her she physically moved back in her chair."

Another respondent described being unable to "be myself" with health professionals, explaining: "If I thought that they were trained and sensitive to lesbian, gay and bisexual issues then perhaps I would be able to. My main concern is coming out and having to talk about my sexual health rather than my real health issues."

Other examples raised in the survey include one man who was given medical advice that "assumed I was HIV positive" and another who overheard a receptionist say: "The poof is here for his appointment." Another commented: "There was no visible commitment to equality. I saw lots of posters about services for disabled people and the elderly, but nothing for lesbian, gay and bisexual people."

Confidentiality was a major issue for many who responded to the survey, as one said: "My doctors had written on a letter I took to the hospital after breaking my wrist HOMOSEXUAL in big letters for the A&E staff to see. Also, every time I saw a different doctor and they would pull my details up on the computer it would say HOMOSEXUAL in big letters."

The General Medical Council makes it clear that doctors "must never discriminate unfairly against patients. Nor must they allow their personal views about their patient's sexual orientation to prejudice their assessment of their clinical needs or delay or restrict their access to care."

The regulator, in conjunction with Stonewall, has produced an information leaflet (**www.tinyurl.com/cbyrlqs**) for this patient group informing them what they should expect from the doctors treating them and what to do if they experience poor care. It highlights elements of *Good Medical Practice* which tells doctors "you must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress." This applies to doctors' personal beliefs about sexual orientation. It adds that it is unlawful under the Equality Act 2010 for doctors to discriminate against LGB patients.

The leaflet goes on to highlight issues raised by Stonewall such as an incident where a doctor refused to offer a smear test to lesbians or another case where the doctor told others a patient is gay when this had nothing to do with their treatment.

A major factor in overcoming discriminatory practice is ensuring healthcare professionals are suitably informed and receive appropriate training in how to treat LGB patients. It's equally important not to make assumptions about a patient's lifestyle, while practices and hospitals should ensure they have relevant information posters and leaflets available for LGB patients.

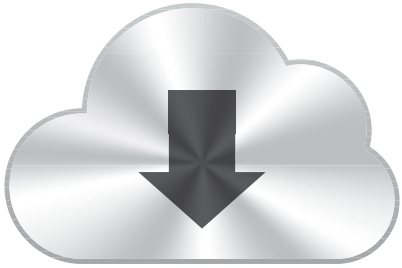
Stonewall also make a number of other recommendations for healthcare professionals. The first is the importance of understanding the specific health needs of LGB patients which relate to much more than just sexual health. Figures show they are more likely to attempt suicide, self-harm, take drugs, experience domestic abuse and have depression than straight peers.

The recommendations also encourage practices and hospitals to have a clear, visible policy that states discrimination will not be tolerated against people due to their sexuality. They also advise healthcare professionals have a clear policy on confidentiality to reassure LGB patients who may be considering disclosing their sexuality. It's recommended also that a sexual orientation field should be made available on all confidential electronic patient record systems.

Doctors are also encouraged to undergo training to better equip them to treat LGB patients. The Stonewall survey found only a quarter of gay and bisexual men said their healthcare professional acknowledged their sexuality after they had come out and only one in eight said they were told their partner was welcome to be present during a consultation.

So remember, don't make assumptions or judgements about a patient's sexuality or lifestyle, acknowledge their sexual orientation if they do discuss it with you, always treat them with respect and dignity and make sure you understand the specific health needs of LGB patients.

Joanne Curran is an associate editor of FYi



AN APP FOR THAT?

More than 17,000 medical apps are now in circulation. How do you sift the good from the bad? Dr Benjamin Visser offers some tips

INCREASING numbers of doctors and medical students are using smartphones and associated "apps" in clinical practice. A recent survey conducted by the General Medical Council found that currently 30 per cent of doctors use a smartphone for medical apps. A number of studies predict this will rise to 90 per cent this year.

There are many different kinds of medical apps, and up to now most have been informative only. However, increasingly medical apps are being developed and marketed that operate in conjunction with a medical device. For example, medical apps are available to analyse an electrocardiogram, interpret an arterial blood gas analysis and there are even apps that can be used to perform an ultrasound or measure blood glucose and share the results with the health professional. Other medical apps make it possible to interpret and access imaging studies on the smartphone at the point of care.

These new medical apps have great potential for improving our practice by providing a quick, comprehensive and up-to-date overview of current clinical guidelines, which could aid decision-making and change the way healthcare is delivered by the next generation of doctors. Apps that are used in clinical care, or apps that can be classified as a medical device, have to meet certain standards and rules but if something goes wrong, the doctor could be held responsible.

The potential of medical apps has not gone unnoticed by developers – more than 17,000 are now available for several platforms. But how can you sift the good from the bad? Their sheer number makes it difficult for healthcare professionals to locate reliable apps. How can you know if an app is reliable, evidence-based or developed without a conflict of interest?

Some recent studies have addressed the lack of evidence and professional medical involvement in the design and development of medical apps. This raises concerns over the reliability and accuracy of the medical content and the potential consequences for patient safety. Certainly, many apps in the medical sector suffer from being totally trivial and useless to downright dangerous. The use of medical apps in clinical practice can pose several potential risks to patient care due to the unique characteristics of the medium, the potential breach of patient confidentiality, conflicts of interests and erroneous clinical decision-making.*

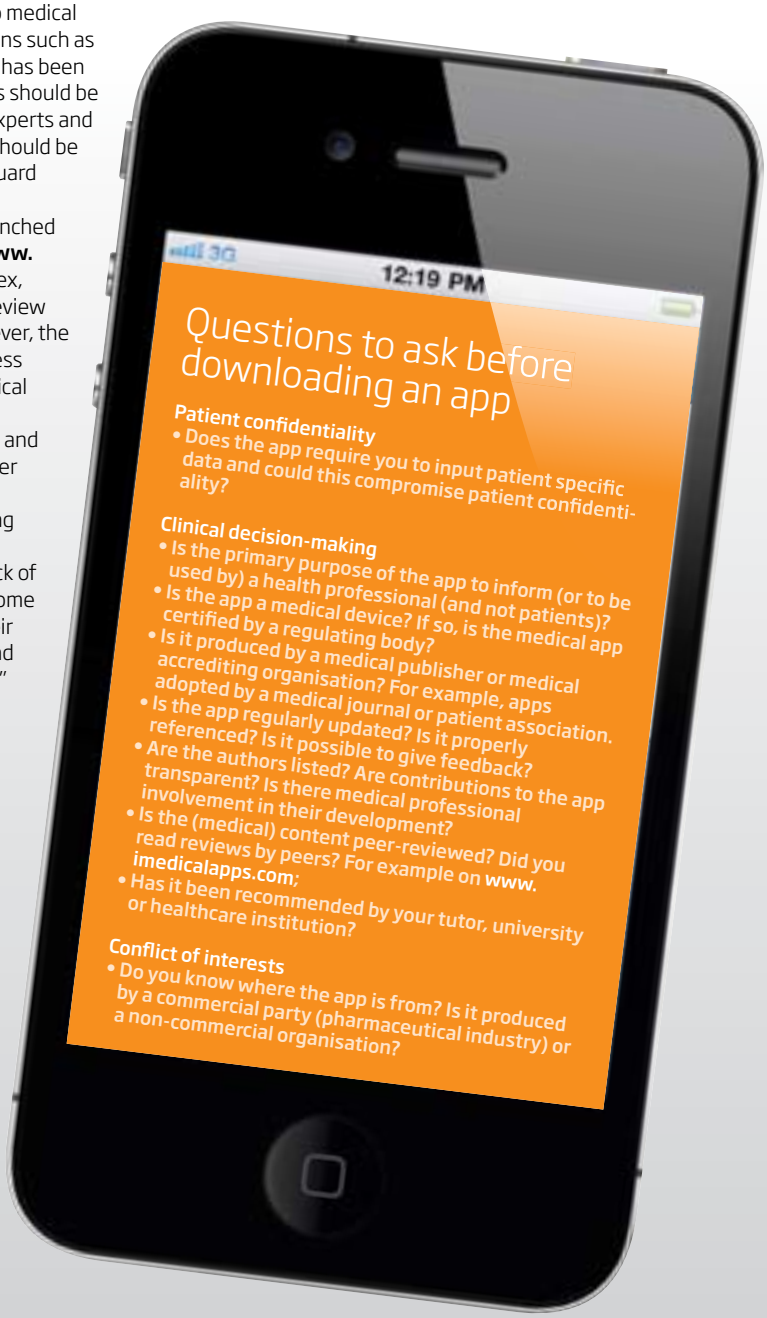
To date, there is no regulation governing the use of medical apps in the UK. In the US, the Food and Drug Administration released draft guidelines on medical apps in 2011. The FDA plans to regulate apps that work as accessories to FDA-regulated devices or that turn smartphones into medical devices to monitor conditions such as abnormal heart rhythms. It has been proposed that medical apps should be peer-reviewed by clinical experts and that regulatory measures should be increased in order to safeguard quality of care.

Websites have been launched (such as iMedicalApps - **www.imedicalapps.com**) to index, provide commentary and review medical applications. However, the review criteria do not address scientific evidence for medical content, but solely concern matters of usability, design and content control. On the other hand, no better alternative exists and for the time being they can provide valuable reviews. Because of this lack of proper quality indicators, some companies are creating their own medical app market and "app certification programs" (for example, Happtique– **www.happtique.com**) However, app markets regulated by commercial concerns could have conflicts of interest about which apps get published.

Medical app development is one of the most dynamic fields in medicine with big potential to change how healthcare is delivered in the future. It can be difficult to decide which app to buy and use. A few key questions (see panel) can help you critically appraise medical apps rather than simply taking them at face value.

Dr Benjamin J. Visser is a trainee in the intensive/critical care unit at the Onze Lieve Vrouwe Gasthuis in Amsterdam

*Further reading: Visser BJ, Bouman J. There's a medical app for that. *Student BMJ* 2012;20e2162



MENDING WHAT'S BROKEN

Are you considering a career in trauma and orthopaedic surgery?

A FRENCH physician named Nicolas Andry published a book in the year 1741 entitled *Orthopédie*, principally about correcting spinal and limb deformities in children. Though popular in its day, the book's most enduring attribute is its title, from which the term orthopaedics is derived.

Orthopaedics refers to the specialty of trauma and orthopaedic surgery. It is one of the largest of the surgical specialties and deals with the treatment of musculoskeletal conditions – either traumatic injury or diseases and infection. Over 20 per cent of GP attendances are for musculoskeletal problems and this represents a massive cost to the NHS – over £3 billion per year.

Orthopaedists work mostly in hospital settings, usually with accident and emergency facilities and the role involves team working with surgical and medical colleagues (e.g. paediatricians, rheumatologists, geriatricians) as well as outpatient staff, theatre staff and hospital managers. UK consultants in orthopaedics operate around 40 per cent of the time, with the rest of their day divided between clinics, ward work and on-call commitments.

An orthopaedic surgeon writing in the *British Orthopaedic Association Undergraduate Guide 2011* comments: "One of the main attractions of Orthopaedics as a career is the fact that our interventions can rapidly and dramatically improve quality of life for patients. It combines theoretical knowledge with practical skills but also involves an interface with technology, industry and the multidisciplinary team unmatched by any other specialty."

A long road

Both "uncoupled" and "run-through" training posts in trauma and orthopaedic surgery are available upon completion of Foundation year 2. "Uncoupled" posts involve two years of core surgical training (CT1/2), followed by another competitive application system for higher specialist training (ST3+). "Run-through" training involves a commitment to orthopaedics in ST1 with automatic progression to ST3+, as long as a candidate satisfies the competency requirements.

The trauma and orthopaedic curriculum is governed by the Intercollegiate Surgical Curriculum Programme (ISCP) and it breaks down into stages: intermediate (ST3-6) and final (ST6-8) years.

The intermediate years offer focused orthopaedic training, concentrating on trauma management and the generality of elective practice. Time will be spent in theatre both assisting the consultant and performing operations under supervision. In addition there are ward rounds and orthopaedic and fracture clinics dealing with referrals and follow-ups. The culmination of this phase of training is attainment of the FRCS (T&O) exam.

In the final years of training, orthopaedic surgeons usually develop an interest in one particular sub-specialty. These include:

- foot and ankle surgery
- knee surgery
- hip surgery
- upper limb surgery
- paediatric surgery
- spinal surgery
- sports injuries surgery
- trauma surgery.

Candidates at the end of a successful training programme are awarded a Certificate of Completion of Training (CCT) and become eligible to join the specialist register and apply for consultant posts.

Getting in

Competition for orthopaedic specialty training posts is fierce.

Applications open within the first half of Foundation year 2 and all core surgery interviews follow the same structure nationally. Interviews are comprised of three 10 minute stations – a clinical scenario, management station and portfolio station. All interviews will require you to provide evidence of your achievements such as elogbook records, an eportfolio, an educational supervisor's report and certificates.

Students or foundation trainees keen on orthopaedics should start early to enhance their chances of attaining a post. Arrange surgical placements in T&O and find a mentor to help guide you through the process. Getting involved in audit or research at an early stage is critical for improving your CV and demonstrating your commitment and work ethic.

Many hospitals offer foundation doctors taster weeks in chosen specialties and this is another great opportunity to show an interest in orthopaedics and to get into theatre. Attaining certificates of achievement for Basic Surgical Skills, ALS, ATLS and other surgical courses also shows your commitment to surgery while providing you with ways to bolster your practical skills.

Attending orthopaedic events will also demonstrate your commitment to the specialty. The British Orthopaedic Trainees Association (BOTA) has recently extended its membership to junior trainees from Foundation year 1 upwards to provide support and opportunities for juniors interested in orthopaedics.

For more information on a career in trauma and orthopaedic surgery check out:

- British Orthopaedic Association
  www.boa.ac.uk
- British Orthopaedic Trainees Association
  www.bota.org.uk
- Future Orthopaedic Surgeons
  www.futureorthopaedicsurgeons.com

Q&A
Mr Sam Molyneux
orthopaedic surgeon

• What attracted you to trauma and orthopaedic surgery?
I trained on a three year basic surgical rotation and experienced several different surgical specialties. I liked the massive variety in orthopaedics, ranging from infant hip surgery to the young athlete struggling to maximise performance to the severely injured patient struggling to survive. I loved the logical nature of the surgery with its complex balance between mechanics and biology. I loved the range of surgical techniques from nerve repair under a microscope to hitting things (very accurately!) with a large hammer. I had, and still have, an almost childish delight at all the shiny hi-tech toys we get to play with in orthopaedics. I liked the fact that most patients get vast improvements in their quality of life very quickly. Finally, the senior trainees and consultants seemed to really enjoy their day-to-day work.

• What do you find most challenging about the job?
There is an incredible amount to know and learning it takes time. Keeping up with developments in the literature is a lifelong task. Managing to do this while learning a whole new set of manual and technical skills, doing your day-to-day job and having a life is a difficult balance. You have to learn early on in your career how to be efficient but thorough.

• Has anything surprised you about the specialty?
Patient interaction and counselling is incredibly important in orthopaedics. Many operations are not lifesaving but life-altering (for instance a knee replacement) and making a joint decision with patients about their best treatment options is one of the biggest determinants of satisfaction. All those months I spent at medical school learning about the importance of social history, ideas, concerns and expectations have proved invaluable.

• What do you consider the most important personal characteristic in a good orthopaedic surgeon?
I think most of the important characteristics for orthopaedics are shared with all the surgical specialties – enthusiasm, perseverance, perfectionism, a good work ethic, the ability to work in a team, the ability to cope in a crisis. In orthopaedics, however, I think the ability to get on with your colleagues is especially important. The job is extremely busy and lots of patients end up being handed on between and within subspecialties. It's important to be able to discuss challenging patients with each other and help each other as needed. Also, most post-op X-rays in orthopaedics end up being reviewed in daily or weekly meetings – the banter that ensues is an important way of maximising quality and sharing ideas for improvement. You have to be able to take both criticism and compliments well and give them both judiciously.

What is your most memorable experience so far?
I think what I'm doing at the moment – I'm on a trauma fellowship in Vancouver, Canada and in the last week seem to have seen every variant of major open fracture in the book. There is something special about finishing major pelvic fracture surgery and then heading off to the beach for a barbecue.

Is there any advice you could give to a final year or FY trainee considering trauma and orthopaedics?
Get some experience and get some research published or presented. If you're not working in orthopaedics go and collar your nearest orthopaedic consultant and confess your love of the specialty to them. Most will have some project or other you can join in with or complete and most will be happy to have you along to theatre or clinic for a few sessions. Let's face it, telling someone that you think what they do is fantastic and you desperately want to be like them is never going to go down badly. Most of all, though, go for it. I love my job and have never once regretted my choice of career.

DYING FOR A DRINK

THE number of people being admitted to hospital each year in England for alcohol-related problems has more than doubled in the last 10 years, and now tops one million.

According to official figures from the NHS Information Centre, there were 1,057,000 alcohol-related admissions recorded in England in 2009-2010 compared to 945,500 the previous year. And that's excluding A&E treatment. In 2002-2003 the figure stood at 510,800. Of the 1,057,000 hospital admissions, one in four was wholly attributable to alcohol while the remainder was partly attributable to drinking. The report also showed alcohol dependency cost the NHS £2.4million in prescription items in 2010, up 1.4 per cent on the previous year.

Meanwhile, a 2012 Department of Health (DoH) report, submitted to a Commons health select committee inquiry, put the annual cost to the NHS of alcohol misuse at £3.5billion. That's up 30 per cent in just three years.

Combine these statistics with the perpetual onslaught of media reports of drink-fuelled violent crime and anti-social behaviour and alcohol quickly begins to look like public enemy number one.

And while alcohol abuse may be seen by some as a problem for the police and criminal justice system to solve, the impact on the NHS cannot be ignored. The 2012 DoH report warns more than 60 diseases and conditions, including heart disease, stroke, liver disease and cancer, can be directly linked to alcohol.

Preventive role

So is it time doctors played a more active role in the prevention of alcohol abuse, rather than focusing on repairing the damage it causes?

Senior lecturer and consultant oral surgeon Dr Christine Goodall believes so. She is based at the Glasgow University Dental School and has witnessed first-hand the horrifying consequences of violent crime, much of which is alcohol-related.

She is also one of the founders of the charity Medics Against Violence (MAV) in which medical professionals visit schools across Scotland to speak to pupils about the consequences of violence. To date, the charity has spoken to more than 10,000 young people with plans to further expand the programme.

As the annual cost to the NHS of alcohol abuse soars to £3.5billion, what role can doctors play in tackling this worrying trend?

Dr Goodall says: "I have worked in the maxillo-facial field for a number of years and the majority of facial trauma coming in – such as lacerations and fractured cheek bones – is in some way linked to alcohol use. Most facial trauma is the result of interpersonal violence amongst people – often young people – drinking to excess."

The surgeon has often seen the same patients return with facial trauma time and again, a trend which she says can be "soul destroying". It was this trend that prompted her and a group of fellow maxillo-facial surgeons to set up MAV in 2008 in a bid to influence attitudes to violence among young people.

She believes doctors – and particularly junior doctors – can play a key preventive role in the wider campaign against violence.

She says: "I think it is important for doctors not just to see their role as one that focuses solely on repairing the damage caused by violence. It's about making a leap from thinking 'that's not my job' to believing this is something in which they can make a positive change. It is important not to be put off by the scale of the task, but to do what you can.

"Young doctors are key to this as they will have the opportunity to adopt this approach early in their careers. One thing is for sure, if things don't change then the medical profession will be mopping up the fall-out from alcohol abuse for many years to come."

Dr Goodall believes even small changes can help to tackle the problem. One example is the practice of nurse-delivered brief interventions for problem drinkers who are suffering facial trauma. Dr Goodall led a study in 2007 that found the practice of nurses offering advice and support to this group of patients helped many reduce their drinking, even after 12 months.

Dr Goodall says: "There's a tendency within the medical profession not to think so much about prevention of violence or alcohol abuse in the way there is with smoking. But there would be huge benefits to both the health service and to people's health if more doctors engaged with this approach.

"It is now standard treatment in the maxillo-facial unit at the Southern General for nurse intervention amongst trauma patients who are problem drinkers. It doesn't take up a lot of time and it is making a difference."

Political plans

While medical professionals can play a part in tackling the rising problem of alcohol abuse, their efforts need support from official bodies such as PCTs, Trusts and health boards as well as government.

In their 2011 report *Making alcohol a health priority – Opportunities to reduce alcohol harms and rising costs* the charity Alcohol Concern found services for alcohol misuse in England "have remained shamefully under-invested in" with specialist treatment only available for fewer than six per cent of dependent drinkers. It calls on GP consortia to engage with the issue of alcohol misuse and for the government to "double our current investment, leading to improved public health savings of £1.7billion a year for the NHS." The charity also calls for comprehensive strategies to be drawn up at both local and national levels to tackle the problem.

Political moves are already underway in some parts of the UK and have been widely supported by the medical profession. Under the Alcohol Act 2011, the Scottish Government banned discount deals on alcohol sold in shops and tightened restrictions on alcohol advertising. It now plans to reduce the drink driving limit (from 80mg per 100ml of blood to 50mg) and set a minimum alcohol price of 50p per unit.

A study from Sheffield University suggests a 50p unit price would cut drinking by 5.5 per cent and save 60 lives in the first year, rising to 300 per year after 10 years. The study suggests there would be 1,600 fewer hospital admissions in the first year, rising to 6,500 fewer admissions after 10 years.

A number of organisations have backed the moves including Alcohol Concern, drinks producer Tennent's, Scotland's Chief Medical Officer Dr Harry Burns and BMA Scotland.

BMA Scotland chairman Dr Brian Keighley says: "A minimum price, as part of a wider strategy, could end Scotland's heavy drinking culture" and "will also reduce the toll of alcohol on the health service."

There are plans to introduce a similar raft of measures in England and Wales, including a 40p minimum alcohol price, under the government's new *Alcohol Strategy*. An inquiry into the proposals is being carried out by the Commons Health Committee.

Joanne Curran is an associate editor of FYi

KEEPING A CLEAR CONSCIENCE

What should doctors do when their personal beliefs conflict with their professional duty to provide care? MDDUS medical adviser **Mr Des Watson** offers some guidance

ALL doctors should know that their prime duty is to make the care of patients their first concern, regardless of any personal beliefs. But what if a doctor strongly objects to performing certain procedures because it conflicts with these beliefs? Should they be allowed to refuse to be involved?

That was the question put to a group of medical students in a recent survey for the *Journal of Medical Ethics*. As part of the survey, researchers also asked trainees if they had objections to carrying out intimate examinations of patients of the opposite sex or to learning about and managing alcohol-related illness.

Nearly half of the 733 students surveyed felt that doctors had a right to object to performing any procedure that conflicted with their religious, moral or ethical beliefs. In some ways, the surprise is that this figure is not 100 per cent. Surely every doctor has a right to refuse to be involved in a procedure that he or she finds morally, ethically or religiously abhorrent? It would then become a matter for each individual to make a judgement as to where the bar is set. A doctor who was comfortable with performing a late termination of pregnancy, for example, might well have an objection to administering a lethal but legally sanctioned injection to a condemned prisoner on Death Row.

The Journal's study does not go to such extremes as lethal injection but keeps largely to common clinical presentations. It groups possible reasons for "conscientious objection" or refusal to be involved in the management of a patient into two types.

The first relates to specific procedures or prescribing and can be defined broadly as objection to the task. The usual example here is termination of pregnancy but it could just as easily be provision of contraceptive advice to under 16s or sex determination of a foetus where there is no clinical reason to provide parents with this information.

Here the advice from the General Medical Council's (GMC) guidance *Personal beliefs and medical practice* states: "Where, for personal, moral or religious reasons, you are not prepared to discuss or carry out a procedure that the patient requests and which is not illegal or against the best interests of the patient, you must be prepared to refer the patient to another practitioner who can manage the patient."

This seems a workable and appropriate way of balancing the doctor's overriding duty to make the care of the patient his or her first priority with the acceptance that doctors' firmly held personal ethical frameworks may mean that some procedures are abhorrent. It builds in a clear safety net for the patient by requiring the doctor to refer the patient to another appropriate practitioner.

It is worth noting that in England, Wales and Scotland, the right to refuse to participate in terminations of pregnancy is protected under section 4(1) of the Abortion Act 1967 (the Act does not apply in Northern Ireland). It states that "no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in the treatment authorised in this Act to which he has a conscientious objection". However, doctors have no legal or ethical right to refuse to provide care for patients pre- and post-termination of pregnancy.

The second type of conscientious objection relates to patients rather than procedures and can be defined as objection to the person and their background, beliefs and lifestyle choices. Refusal to see, treat or even learn about disease resulting from alcohol misuse is clearly in this category. It could be argued that objection to performing intimate examinations is refusal to carry out a procedure but the qualification, "... examining a person of the opposite sex", clearly defines it as an objection to the person (based on their gender).

The GMC's guidance *Good Medical Practice* has something to say on this subject and makes it pretty clear (in paragraph 7) that: "You must not unfairly discriminate against [your patients] by allowing your personal views to affect adversely your professional relationship with them or the treatment you provide or arrange." This is further underlined later in GMP where it states that: "All patients are entitled to care and treatment to meet their clinical needs" and goes on to emphasise that doctors have an obligation to treat a patient even where this might put the doctor's own health at risk.

Worryingly, five per cent of students in the ethical study objected to intimate examination of patients of the opposite sex and 8.5 per cent would object to treating patients who are suffering from acute alcohol intoxication. (Smaller proportions would go further than objecting and would firmly refuse the intimate examination or to manage alcohol intoxication.)

Medicine will always need highly principled individuals but these medical students and doctors are not permitted by the GMC to pick and choose whom they will treat. There is also the question of how practical the stance actually is in the complex world of clinical medicine. The doctor cannot choose to treat only part of a male patient's HIV complex where that patient is both a haemophiliac and bisexual. What if they were then required to manage the risk to this man's (heterosexual) wife?

It is very worrying that there are medical students already well along the path of their medical studies whose personal ethical and religious framework means that they will not treat particular patients who have made lifestyle choices that those students find objectionable. Even with the most careful choice of jobs after qualification, it is impossible to be sure that the doctor will not have to manage such a patient, often in an on-call role where it may be very difficult to find someone else to take over.

Medical schools have a duty to consider applicants equally regardless of their moral or religious beliefs or of their lifestyle choices. Surely they also have a duty to remind applicants that the GMC may well sanction doctors who unfairly pick and choose which patients they will examine or treat? It should then be up to those applicants to decide for themselves if medicine is really the correct career choice. Perhaps a follow-up study could be arranged to ask the conscientious objectors if they were made aware, when they applied to study medicine, that they would inevitably face such difficult choices.

SCENARIO:

A 16-year-old patient, Miss B, presents at A&E on a Sunday morning seeking emergency contraception. She is seen by Dr E and tells him that she had unprotected sex the previous night following a drink and drugs binge. She reassures him that the sex was consensual but she is concerned she might be pregnant and is worried her parents will find out.

However, Dr E is a practising Catholic and disapproves of Miss B's drinking and drug-taking. He also has a conscientious objection to prescribing contraception and explains to her that he is not prepared to treat her because of his personal beliefs. Miss B is unhappy and challenges the doctor's refusal. He tells her another doctor will treat her but does not submit a request until later that morning, due to Miss B's behaviour. Miss B is finally seen by another doctor three hours later.

The following week, she submits a complaint to the hospital about the way Dr E handled her case and this is eventually resolved by way of an apology from Dr E.

Key Points

- **Never refuse or delay treatment because you believe a patient's actions have contributed to their condition.**
- **If you have a conscientious objection to treating a patient, you must explain their right to see another doctor and ensure they have enough information to exercise that right.**
- **If the patient can't make their own arrangements, you must ensure arrangements are made, without delay, for another doctor to take over their care.**

Mr Des Watson is a senior medical adviser with MDDUS

A PAINFUL SWELLING

Day 1
A 40-year-old man – Mr G – attends accident and emergency with a painfully swollen testis. He is seen by a specialist registrar – Dr A – who makes a diagnosis of epididymo-orchitis. Mr G is given a seven-day course of the antibiotic co-amoxiclav and advised to see his GP for follow-up.

Day 7
Mr G attends for an appointment at his local general practice surgery. He is seen by Dr B who notes the A&E attendance and antibiotic prescription. The patient reports improvement in his condition but there is still some slight swelling. Dr B prescribes a further seven-day course of antibiotics but this time with ofloxacin.

Day 16
Just before the surgery opens Mr G phones requesting an urgent appointment. He is concerned that the swelling has not cleared with the second course of antibiotics. Dr B examines the patient again and identifies a small non-tender cyst in the left epididymis but the testis is "normal". Dr B reassures the patient and instructs him to return in two weeks if the symptoms have not settled.

Day 37
Mr G attends the practice again complaining of a persistent and painful swelling. He sees Dr B and expresses his worry that he might have testicular cancer. Dr B notes "Left testicular pain persists, lump adherent to upper pole" and he refers the patient for an ultrasound investigation of the testicle and issues a further prescription of the antibiotic ciprofloxacin.

Day 51
An ultrasound investigation is conducted and Mr G is referred to a urologist the next day. The urologist finds several focal lesions consistent with tumour on the scan. On examination he detects a hard tender mass at the upper pole of the left testis. He notes that the pain and position are not entirely typical of testicular tumour but decides it is necessary to explore the testis and probably carry out an orchidectomy. Two days later the procedure is undertaken and histological analysis confirms a diagnosis of seminoma. A CT scan shows enlargement of the peri-aortic lymph nodes on the left side so Mr G undergoes both chemotherapy and radiotherapy. He later reports prostatitis and neuropathic pain as a result but his prognosis is good.

FOUR MONTHS later a letter of claim is received at the practice from solicitors acting on behalf of Mr G. It alleges that Dr B was negligent in not making an urgent referral before involvement of the lymph nodes necessitated the need for chemotherapy and radiotherapy.

Dr B contacts MDDUS and expert reports are commissioned. A urologist comments on the case stating that the tumour could have been present in the testicle up to six months before the patient attended Dr B but it is not possible to determine if it caused the epididymo-orchitis. He writes: "Epididymo-orchitis is a relatively common condition, which causes swelling of the testicle. It would therefore camouflage any intra-testicular lumps and made diagnosis of the tumour much more difficult."

The expert concludes that Dr B at the initial presentation would have had no reason to suspect anything more serious than epididymo-orchitis and later made the referral to ultrasound at a "prudent stage" when the symptoms had not been resolved by antibiotics. The fact it was not an urgent referral would have led to a delay of no more than about a week and this would have made no difference to the staging of the tumour, the enlargement of the peri-aortic lymph nodes and thus the treatment options and long-term prognosis.

Based on the expert reports MDDUS was able to make a firm rebuttal of the claim and it was subsequently abandoned.

Key points

- Beware of infections or other conditions possibly causing or masking other more serious conditions.
- Consider carefully the need for an urgent referral in persistent unresolved infections.
- Keep clear notes justifying clinical decisions.

OUT THERE

RANCID REMEDIES Eating body parts, the sweat of a dying man, ground-up remains of embalmed bodies and distilled brain pulp are just some of the treatments dreamed up by proponents of 'corpse medicine'. Australian academic Louise Noble has researched a range of stomach-churning remedies on the practice which was popular from the 12th to 17th century. Source: *Daily Mail*

GRAPHIC CONTENT Doctors at Memorial Hermann Northwest Hospital, Texas, made history when they tweeted more than 100 updates, pictures and video clips during a four-hour open heart surgery on an unnamed 57-year-old patient. Non-medics may have been alarmed to know that "Dr Macris opened patient's chest with knife, bovie, then saw", but all went well and the patient is now recovering.

CROSSING GENDERS Shock new figures reveal that, between 2009 and 2010, over 17,000 men attended NHS obstetric services, more than 8,000 to gynaecology and nearly 20,000 to midwifery. The phenomenon isn't a way to increase social inclusion, but a symptom of erroneous capturing and coding of patient episodes. In a letter on bmj.com, clinicians are asked to take care as this data will inform NHS commissioning decision-making.

E-PIDERMIS US scientists have invented "electronic skin" patches that monitor patients' vital signs and will ultimately be able to wirelessly transmit the data to a doctor. It could mean the end of patients being attached to machines for hours of treatment or monitoring. The patches can track brain, heart or muscle activity.

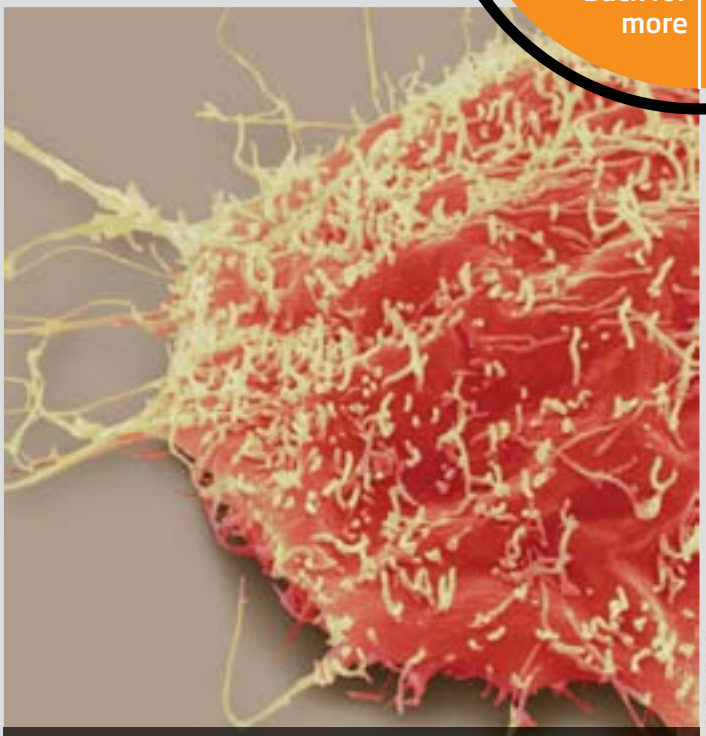


PHOTO: SCIENCE PHOTO LIBRARY

WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

Pick: DVD - House (Season 1)

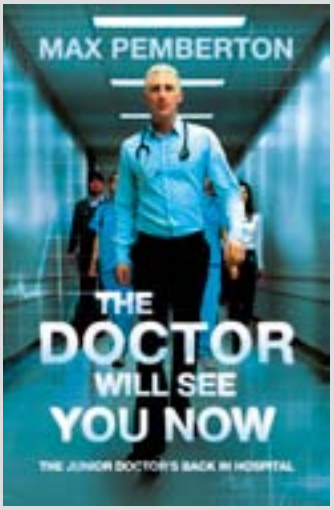
Directed by Bryan Singer and others; starring Hugh Laurie, Robert Sean Leonard; 2006

This hugely popular American medical drama saw the last episode of its eighth and final season broadcast in May 2012. So what better time to go back to where it all started and meet the pill-popping medical maverick and damaged diagnostic genius, Dr Gregory House MD? Hugh Laurie's cranky, misanthropic healer and his long-suffering team devote their time to diagnosing mysterious medical complaints that stem from increasingly exotic and unexpected causes. Who can forget the young boy whose simple rash turns out to be leprosy or the homeless woman who suffers a seizure and turns out to have rabies.

Working on the assumption that "everybody lies" and routinely ordering his doctors to break into patients' homes in search of clues, House's blunt assertions provoke outrage and tears in equal measure. If he were a real doctor, it's fair to say House would have been struck off long ago. But despite the main character's mind-boggling rudeness and severe lack of redeeming qualities, *House* is a compelling drama that lays bare the complexity of motives in both medicine and in life.

Book Review:
The Doctor Will See You Now by Max Pemberton

Hodder & Stoughton; ***£12.99***
Review by Joanne Curran, associate editor of FYi



THE junior doctor is back and he's facing a host of new challenges as he gets to grips with life as a hospital doctor.

The Doctor Will See You Now takes us behind the scenes of NHS hospital care and offers a candid account of Max Pemberton's experiences dealing with dementia patients and the elderly with some added drama of A&E. Woven into the mix are personal tales involving unpredictable flat-mates and difficult bosses, while Pemberton also offers up some poignant observations and criticisms of health service failings.

His previous two books charted his progression from his days fresh out of medical school to working as an FY2 with homeless and drug-addicted patients. Now he is back on the wards and having a typically frenzied time. Pemberton gives us a doctor's-eye-view of life working on the NHS frontline, from the embarrassment of the patient whose erection won't go away to the injustice of the dementia patients locked in their rooms to give care staff an easier shift.

The book is readable, funny and engaging and Pemberton does his best to offer something that both medics and members of the public will find interesting and easy to understand. It is sometimes a difficult gap to bridge, particularly in moments where he is discussing more doctor-specific topics such as the impact of the European Working Time Directive or the difficulty he has in breaking bad news to a patient's family.

There are many genuinely important points made throughout the book (albeit in a somewhat earnest fashion) about the frustration of trying to do your best for patients in a system that is under-funded and often poorly managed. Knowing the story is based on real events adds to its credibility and impact.

So, while it's unlikely to earn Pemberton any awards for literary merit, *The Doctor Will See You Now* is an entertaining read and offers an interesting insight into the trials and tribulations of a young doctor trying to make sense of NHS medical practice.

WHAT ARE WE LOOKING AT? *SEM of a brain cancer cell*