



### Welcome to your FY

AS the New Year is now well underway, I'm delighted to be stepping into the role of editor of FYi. Having worked as a locum FY1 at Crosshouse Hospital, Kilmarnock last year, I am taking time out to pursue a career in medical writing, including contributing to a new website, HealthFriends (http:// healthfriends.cloudapp.net). It offers health-related news and features and allows people to share their healthcare experiences.

An important issue for trainee doctors is lack of sleep and on page 4 I look at the potentially damaging effects of sleep deprivation. While trainee doctors are probably not as tired as they used to be in days gone by, one thing that has changed is what we wear on the wards. More casual dress codes have sparked complaints but does it really matter how doctors look? Joanne Curran investigates on page 6.

All doctors will soon have to get used to regular performance checks thanks to the recent launch of revalidation. On page 10, MDDUS editor Jim Killgore looks at two key events in the development of this major new system of checks. Meanwhile, our article on page 5 discusses how failing to raise concerns about patient safety could land YOU in trouble.

Blazing a trail for fellow trainees is FY2 doctor Hannah McLean who has worked to bring much-needed healthcare to prisoners in the grim surroundings of Ugandan jails. On page 12 she tells Adam Campbell how she balances her charity work with the demands of medical training.

International work is just one of many options available to doctors who pursue a career in occupational medicine. Find out more on page 8. And our case study on page 14 looks at the delayed diagnosis of a brain haemorrhage.

**Dr Anne Parfitt-Rogers** Editor

### **GMC FEES CUT** FOR TRAINEE DOCTORS

THE fees paid by trainee doctors to register with the General Medical Council in 2013 have been cut for the second year running.

The move is part of a package of cost-cutting measures being introduced by the regulator to save doctors money.

From April 2013, newly qualified doctors will pay £185, down from £195 this year, while the provisional registration fee for foundation trainees will fall from £95 to £90. The Annual Retention Fee has been frozen at £390 for all registered and licensed doctors and at £140 for registered doctors without a licence to practise. More doctors will benefit from a 50 per cent reduction in annual retention fees as the salary threshold to qualify is being increased from £30,000 to £31,000.

### END TO PENSION TALKS



NEGOTIATIONS over changes to the Scottish NHS pension scheme between BMA Scotland and the Scottish Government have ended.

The BMA said there was "little scope for negotiating alternatives to the reforms" which will see NHS staff working longer and paying more towards their pensions. It means changes proposed by the UK government to reform NHS pensions are "highly likely" to also apply in Scotland.



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### DOCTORS TO HELP PROTECT **VULNERABLE CHILDREN**



HOSPITAL doctors are to have access to a new system to help them identify victims of child abuse, the government has announced.

The Child Protection - Information System, which is being developed with help from the Royal College of Paediatrics, is expected to be introduced in NHS hospitals by 2015.

Once it is up and running, doctors and nurses in emergency departments or urgent care centres will be notified if a child they are treating is subject to a child protection plan or is being looked after. The system will also flag up if the child has frequently attended emergency departments/urgent care centres over a certain period of time, which can be an indicator of abuse or neglect.

Announcing the move, health minister Dan Poulter said: "Up until now, it has been hard for frontline healthcare professionals to know if a child is already listed as being at risk or if children have been repeatedly seen in different emergency departments or urgent care centres with suspicious injuries or complaints, which may indicate abuse. Providing instant access to that information means vulnerable and abused children will be identified much more quickly - which will save lives."

### 2012

Ready for revalidation >> starts 3 December

# Information for doctors in training

# REVALIDATION LAUNCH FOR DOCTORS IN TRAINING

THE GMC has launched its long-delayed programme for revalidation of all licensed doctors in the UK – including those in FY2 and specialty training.

All trainees will have a "designated body" with a "responsible officer" (RO) to support revalidation. The RO will base their recommendation to revalidate on participation in the Annual Review of Competence Progression (ARCP) process or the equivalent Record of In-Training Assessment (RITA). This means that trainees need to be engaged in and meeting the assessments and curriculum requirements of their training programmes. In general the timing of revalidation will depend on your period of training. If your training lasts less than five years, your first revalidation will be at the point of eligibility for CCT. If longer than five years, you will be revalidated five years after full registration with a licence to practise, and again at the point of eligibility for CCT.

Responsible officers are either your postgraduate dean or in Scotland the medical director for NHS Education Scotland (NES). More information can be found on the GMC website (www.tinyurl. com/895yuo9), including a leaflet that you can download.

# MEDICAL STUDENT NUMBERS

THE number of students accepted to medical school should be reduced by two per cent in England, according to a governmentcommissioned report.

The cut should start with the 2013 intake with the aim of balancing workforce supply and domand from 2025. This i



demand from 2025. This will ensure money is not wasted training more doctors than the NHS needs, said health minister Dan Poulter.

Forecasts predict demand for GPs will outstrip supply but that hospital doctors supply would exceed demand, unless "rebalancing" from other specialties to general practice occurred.

### TRAINEE SUCCESS VARIES BY MEDICAL SCHOOL



TRAINEE doctors who qualified from certain medical schools were more likely than others to be appointed to UK specialty training posts, according to a new survey. Most Foundation

Most Foundation Year 2 doctors who

had graduated from Cambridge University (86.4 per cent) were appointed to UK specialty training (including general practice), followed by Keele University graduates (85.9 per cent) and Oxford University (83.7 per cent).

Universities where the fewest number of F2s were appointed to UK ST include Brighton and Sussex Medical School (44.9 per cent), Bristol (48.6 per cent) and Southampton (55 per cent). Some of the doctors who were not appointed to UK ST chose other UK posts, took a career break or decided to work abroad.

The figures were revealed in a report from the UK Foundation Programme Office (UKFPO) who surveyed F2 doctors at all 25 UK foundation schools. Nearly all 7,346 F2s who successfully completed training in August 2012 responded, including 6,658 on the Foundation Programme and 433 on the Academic Foundation Programme.

Foundation schools showing the highest percentage of trainees appointed to UK ST include Coventry and Warwick (83.5 per cent), Birmingham (83.2 per cent) and LNR (82.8 per cent). The lowest include Severn (48.3 per cent), Wales (57.4 per cent) and Wessex (59.1 per cent).

The survey showed that, on the whole, fewer trainee doctors found UK ST posts in 2012 compared to the previous year. Only 67 per cent of F2s were appointed to a post in 2012, a slight fall on the previous year's figure of 71.3 per cent. A further 6.6 per cent said they had found jobs outside the UK.

Of the 4,753 doctors appointed to a UK specialty training post, more than half (2,773) were female and just over a third (1,826) were male. The remaining 154 (3.2 per cent) were unknown or did not specify.

The most popular specialty training was general practice, chosen by around one third of F2s (1,717), while less than five per cent (222) chose core psychiatric training. The most common examination sat by doctors during F2 was the MRCP (Royal College of Physicians) followed by MRCS (Royal College of Surgeons), MRCPCH (Royal College of Paediatrics and Child Health) and the MRCOG (Royal College of Obstetrics and Gynaecology).

Read the report at www.tinyurl.com/b6h99vw

### PATIENTS TO RATE DOCTORS ON SERVICE

PATIENTS are to be given the power to rate the service provided by their doctor under new plans announced by the prime minister.

David Cameron said a new "friends and family" test would be introduced in every hospital in England from April with a view to later extending it to GP practices and community hospitals.

Under the test, patients and staff would be asked whether they would recommend the service to a friend or relative, in a bid to expose unacceptable standards of care. Mr Cameron said it should be applied to all NHS services.

The test is part of a broad range of measures aimed at raising standards of patient care. More support is to be offered to nurses, healthcare assistants and wider NHS staff including better training and career development opportunities.

# ESS THAN 40 WINKS

Trainee doctors often don't get enough rest. New *FYi* editor **Dr Anne Parfitt-Rogers** looks at the impact of sleep deprivation

HETHER we're trying to stay awake in lectures the morning after a night out, studying into the early hours for an exam, or driving home from a long shift, most of us will be familiar with the effects of sleep deprivation.

The 2009 European Working Time Directive (EWTD) was brought in to limit the average working week for doctors to 48 hours, but reports suggest rotas in some hospitals are still non-compliant, with a number of doctors regularly exceeding the legal weekly limit. And although long shifts and tiredness have largely become an accepted part of being a junior doctor, the physical and mental demands of the work should not be underestimated.

Extreme tiredness poses a risk both to patient care and to the doctor's own wellbeing. This was highlighted in the case of 23-year-old Lauren Connelly, an FY1 doctor who crashed her car and died while driving home from a nightshift in 2011. The tragedy sparked calls for improved access to overnight rest facilities for trainees amid reports that a number of Trusts had been removing on-call rooms on the grounds that staff on full shift rotas should not be sleeping while on duty. Other trainees have reported having to pay to access on-call rooms.

According to a 2006 survey of more than 1,000 specialist registrars by the Royal College of Physicians, road accidents among trainee doctors are not uncommon. Of those questioned, 16 per cent had been involved in motor vehicle collisions during their commute, with approximately half of those occurring on the drive to work and half on the drive home.

Some studies have also highlighted links between lack of sleep and medical errors. One report in the *New England Journal of Medicine* in 2004 analysed intensive care workers and found that serious medical errors were significantly more common among staff working long shifts as well as longer working weeks.

Despite the risks of extreme tiredness, the EWTD has not been universally popular. Many trainees feel they no longer receive sufficient clinical exposure and senior staff have remarked on the lack of patient continuity associated with the new rotas. Some also prefer a seven-night shift rota across all areas to adjust properly to nocturnal working hours. While a return to the old system is not on the cards, it is hoped the new system can be adjusted to address these concerns.

With all this in mind, it's useful to consider exactly why we need a good night's sleep. Simply put, it allows us to store a certain amount of metabolic energy for later periods when increased activity is needed. Certain forms of repair increase during sleep, including parts of the nervous system. In a sleep cycle, the first four stages are non-rapid eye movement (REM) sleep, followed by REM, the deeper form of sleep. People who sleep for fewer hours per night may miss out on this latter, crucial form of sleep. REM sleep is also instrumental in the formation of memories so when we are sleep-deprived, we may find it harder to remember facts on the ward round the following morning.

Many studies analysing the effects of sleep debt have compared it to the effects of consuming alcohol. In a 2005 study in the *Journal of the American Medical Association*, researchers found it can lead to delayed reaction times and poorer memory and concentration. Another study found that after we have been awake for just 17 hours, our alertness falls to below the point it would be at if our blood alcohol level were at the designated driving limit.

Longer term, immunity may be compromised and cortisol levels can be

increased, while those on irregular shift patterns may also develop insomnia. Mood has also been found to be significantly affected by sleep deprivation - in one study by an even greater amount than cognitive or motor performance.

Although there is no official Guinness world record for the longest period without sleep, many have attempted this feat. In 1964, Toimi Soini stayed awake for 11½ days, although this was later removed from the records as it was thought to encourage unhealthy behaviour. Randy Gardner managed 11 days in 1965, experiencing hallucinations after four, but managing to beat the researcher at pinball at the end of the study. More recently, Tony Wright kept himself awake for 266 hours - two hours longer than Gardner's record.

There are a number of ways doctors can reduce the effects of disrupted sleep. A field study on NASA astronauts found short naps to be effective in improving alertness and performance. Some doctors also find regular snacks and breaks during nightshifts boost concentration and one FY1 recommends using an eye mask to sleep during the day. Creating a quiet environment and avoiding alcohol and caffeine before sleeping may also help. If you find you are nodding off during work then ask for assistance and whenever it's available, take a break.

The Royal College of Physicians has produced a guide for junior doctors working nights, available at **www.tinyurl. com/6v67cog** 

If you are curious about your sleep patterns, you can also take a quiz at www. tinyurl.com/yye9k3f

Dr Anne Parfitt-Rogers is editor of FYi and a medical writer at HealthFriends, a patient website

Wellbeing

Raising concerns

# DON'T TURN

### Failure to raise concerns about patient safety could land YOU in trouble

EPORTING a colleague who you believe poses a threat to patient safety is never easy for any healthcare professional and it can be a particularly challenging area for trainee doctors. However, you must resist the temptation to simply overlook, or "turn a blind eye" to, issues of concern. By doing so, not only could patient safety be jeopardised, but you yourself could end up in professional difficulty for not having acted to put those issues right.

All doctors, whatever their role, are required to speak up if they believe patient safety or care is being compromised by the practice of colleagues – being a trainee does not excuse you from this responsibility. The General Medical Council recognises there may be reluctance among some medical professionals to do so, perhaps for fear that nothing may be done or that raising your concern may cause problems for colleagues or for your own career prospects.

But that is no excuse for inaction.

In its guidance *Raising and acting on concerns about patient safety,* the GMC says: "You have a duty to put patients' interests first and act to protect them, which overrides personal and professional loyalties."

If you have concerns about a colleague and you do not raise them with the health board/PCT or the GMC and the failing clinician's fitness to practise is later called into question, then you could also find yourself in professional difficulties.

In recent months there has been an increasing emphasis on the value of "whistleblowing" and a growing number of support structures have been put in place. In early 2012, a free government-funded whistleblowing hotline was launched (08000 culture where staff will be able to raise genuine concerns in good faith, without fear of reprisal." A web-based whistleblowing service is also being developed.

The GMC recently launched a confidential helpline for doctors to raise concerns about patient safety on 0161 923 6399. The regulator also advises doctors against signing contracts that contain so-called "gagging clauses", stating: "You must not enter into contracts or agreements with your employing or contracting body that seek to prevent you from or restrict you in raising concerns about patient safety. Contracts or agreements are void if they intend to stop an employee from making a protected disclosure."

If you have concerns but are unsure of how to proceed then it is advisable to discuss the issue with a senior colleague or call your medical defence organisation where an adviser can offer guidance and support.

Some legal protection is offered to whistleblowers against victimisation or dismissal in cases where they have revealed information to raise genuine concerns.

The GMC reassures doctors in *Raising concerns...* that: "You do not need to wait for proof – you will be able to justify raising a concern if you do so honestly, on the basis of reasonable belief and through appropriate channels, even if you are mistaken."

The regulator adds that doctors must be "clear, honest and objective about the reason for your concern. You should acknowledge any personal grievance that may arise from the situation, but focus on the issue of patient safety." It is advisable also to keep a record of your concern and any steps that you have taken to deal with it.

The Public Interest Disclosure Act (1998) (PIDA) was introduced to provide protection for those who honestly raise concerns about wrongdoing or malpractice in the workplace and

are victimised and/or dismissed for doing so. Where possible, you should follow your health board/Trust's whistleblowing policy and drastic measures, such as alerting the media, should only be taken as a last resort.

The British Medical Association has also pledged to support any doctor who raises concerns and has previously called for a "culture change" in the NHS to encourage more doctors to speak out.

If you do have concerns then it is important to act swiftly and not delay raising them by trying to investigate them yourself

or because you feel you are not in a position to put the matter right. Ultimately, the decision on whether to speak out will be a matter of individual professional judgement but GMC guidance should be at the forefront of your mind.

"All doctors, whatever their role, are required to speak up if they believe patient safety is being compromised"

724 725) and a national charter, *Speaking Up*, was published to protect NHS staff who raise concerns. This is in addition to a contractual duty to raise concerns that is being enshrined in the new NHS Constitution.

Announcing the helpline launch, former health secretary Andrew Lansley said it will "play an important role in creating a

Joanne Curran is an associate editor of FYi

Professionalism

# WHAT ARE YOU WEARING?

# Is it a positive thing that doctors now dress less formally or were the days of white coats and smart suits the era of true medical professionalism?

T was the ancient Greek physician Hippocrates who said that doctors should "be clean in person, well-dressed, and anointed with sweet-smelling unguents."

And at the turn of the 20th century, as the medical profession established its reputation for professionalism and expertise, its practitioners were indeed well-dressed. They subscribed to a strict dress code that, for men, consisted of a formal jacket, shirt, tie and waistcoat, with white coats emerging in the late 1800s. Images of women doctors from this era are harder to come by but dress codes seem to be equally formal, with high-collared blouses and long skirts featuring.

It's a far cry from today's less formal approach where jackets, ties, long-sleeved shirts, watches and white coats were all abandoned in 2007 in the name of crossinfection control. But has the relaxation of dress codes gone too far and would patients prefer to see their doctor looking smart and therefore more "professional"?

One snapshot of opinion emerged in a recent article in the *Clacton Gazette*. It reported how the chief executive of Colchester's two NHS hospitals called for an investigation into the clothing worn by junior doctors following concerns from members of the hospitals' Patient Environment Action Team (PEAT). In a report to senior hospital executives, PEAT detailed issues about what was deemed to be "inappropriate attire", with one trainee spotted wearing ripped jeans.

Andy Patrick, a lead governor who wrote the report, reportedly said it was feared the junior doctors' casual clothing would make elderly patients "anxious". Chief executive Gordon Coutts promised to look into the matter, saying: "Some appear very smart and some look less smart than we would like them to. Without a specific dress code it has allowed it to become a bit fluid. One of the benefits of uniform is to have a standard appearance and people are immediately recognised as to what their role is."

#### **Past formality**

Historical images held by the Wellcome Library in London show how doctors' clothing choices have changed. One shows a very dapper looking Dr Basil Hood, 28, of the St Marylebone Infirmary in 1904 in full formal attire, including long jacket and waistcoat. This was the uniform of choice for trainee doctors too as an image taken in London in the 1920s shows a group of medical students, in their best threepiece suits, getting to grips with a multiple stethoscope.

This dress code varied little for surgeons. An image from an operation circa 1900 shows the surgeons still wearing shirts and waistcoats but with rolled-up sleeves and full body-length aprons. Before the advent of aseptic surgery these aprons would often be encrusted with blood from previous surgeries – the greater the staining the more experienced the surgeon was seen to be. By the 1950s and 60s, styles had changed slightly with doctors still wearing



'A patient action group was concerned that the junior doctors' casual clothing would make elderly patients anxious''

a shirt and tie but with a white coat instead of formal jacket. This was the norm until very recently.

#### Attitude change

The Department of Health's 2007 dress code guidelines – referred to as the "bare below the elbows" guidance – have played a decisive role in ending the wearing of formal attire in a bid to reduce hospital infection rates, opening the door for a more casual look.

The guidelines were based largely on the findings of two literature reviews conducted by Thames Valley University, one of which looked at how uniforms affect the image of individuals and the importance people attach to this. Amongst its findings were that "patients prefer to be treated by staff who have short or tidy hair and are smartly presented." The DoH defined good practice for doctors, advising them to "dress in a manner which inspires confidence" because "people may use appearance as a proxy measure of professional competence."

Many health boards/trusts now have their own dress code policy in line with the DoH's guidelines, which must balance the need for infection control with the need to maintain a professional image. These generally require tattoos to be covered, jewellery and make-up to be kept to a minimum and the "excessive exposure of flesh" to be avoided. Nail varnish and false nails are banned as are items such as transparent blouses and t-shirts bearing potentially offensive slogans. However, judging by some media reports, dress codes may be enforced by hospital management to varying levels of strictness.

In a recent *BMA News* article, BMA junior doctors committee vice-chair Andrew Collier said doctors should be able to express themselves in a place where they spend many of their working hours, but that a line needs to be drawn where this affects their clinical work.

He said: "People should be encouraged to be individuals at work but at the same time we have to ensure that clinical standards and professional standards are maintained at all times."

The BMA's dress code guidance falls largely in line with the DoH, supporting the ban on white coats and long sleeves and advising doctors to tie back hair and cover tattoos. Guidance from the BMA Consultants Committee adds: "LNCs should ensure that whatever local policies are implemented, assist in maintaining a professional appearance."

Such dress codes have their critics and not all are convinced of the need for such a strict regime. But while a conclusive evidence base may not be present, it is true that public perception plays an important part in influencing what doctors wear. Perhaps a happy medium can be found, somewhere between a formal three-piece suit and ripped jeans?

Joanne Curran is an associate editor of FYi





Clockwise from left: Dashing Dr Basil Hood tends to a patient in full formal attire: A group of surgeons roll up their shirt sleeves and don full-length aprons to operate c.1900; A doctor wearing a white coat examines a pregnant patient; A group of formally dressed medical students test a multiple stethoscope. Below: Doctors nowadays must abide by the "bare below the elbows" policy.







Careers

### DCCUPATIONAL

Occupational medicine promises a varied career with many opportunities both within the NHS and beyond

EW medical specialties offer the promise of an international career covering such varied interests as aviation and space, travel, radiation and diving.

Occupational physicians can work all over the world, in both the public and private sectors, in a specialty that covers the multi-faceted relationship between health and work. Occupational medicine (OM) specialises in the diagnosis, management and prevention of disease that is due to - or exacerbated by workplace factors. It is concerned with all aspects of the effects of work on health and health on work.

It has an important part to play in rehabilitating employees back into work after sickness or injury. Specialists will be called upon to provide high quality, objective, professional advice, sometimes in difficult situations, and with an awareness of the various agendas of government, employers, employees, trades unions and pensions trusts.

And as issues of employment and fitness to work become increasingly important in these economically straightened times, occupational medicine is moving up the political agenda and is likely to play a larger role in future government policy.

#### **Entry and training**

Doctors interested in pursuing a career in this field can enter via a variety of routes. You can

complete either core medical training or the acute care common stem in acute medicine (ACCS) and enter OM training at ST3 levels.

But there are other routes. Instead of undertaking core training in acute medicine, doctors may choose to start specialist training in a number of other disciplines, namely: general practice, psychiatry, public health and surgery. Post-foundation level training generally lasts six years: e.g. two years of core medical training (ST1, ST2) followed by four years of specialist OM training (ST3 to ST6). All specialist trainees must register with the Faculty of Occupational Medicine (FOM) and pass exams in the first (ST3) and final years of specialist training. More detailed information on the training pathway can be found on the faculty's website at **www.fom.ac.uk**.

The desirable personal qualities for OM trainees include an ability to build rapport/ listen/persuade/negotiate, a capacity to take in the perspectives of others and to "see patients as people". Doctors must also be able to work in multi-professional teams, supervise junior medical staff and show leadership. The Faculty also recommends doctors applying for specialist training demonstrate an interest in OM as well as showing evidence of achievement outside medicine including "altruistic behaviour" such as voluntary work.

In addition, physicians must have knowledge of employment and anti-discrimination legislation, as well as of environmental and health and safety law. They must also have an understanding of epidemiology, disease prevention and toxicology.

#### In practice

A typical day in occupational health practice can vary enormously depending on the role and setting. The FOM says specialists could find themselves working in settings such as an international company or in the NHS as a private provider. You could be advising on the health of oil rig workers or call centre staff or ambulance drivers. You will come across a huge range of physical and mental health problems and could, for example, be the first to identify the link between a hazard in a factory with an industrial disease.

Often the work will involve a clinical element: assessing individuals for capability, eligibility for ill-health retirement or other specific purpose. It will also likely involve monitoring people's health in relation to the statutory duties to control risk at work. Occupational physicians assess the workplace and work activities, advising on control measures in liaison with other related specialists such as safety officers, occupational hygienists or ergonomists.

There will almost always be a team to either manage or work with. In most organisations occupational physicians work with others to formulate policy and procedure in line with relevant health and safety legislation.

Occupational physicians are often based in the workplace, working normal office hours. Sometimes they can be based at a local centre where individuals will attend for assessment and there is often a certain amount of





#### **Q&A** Dr Rae Chang, specialty registrar in occupational medicine

#### What attracted you to occupational medicine?

For many registrars, occupational medicine is a secondary career. It was only as a medical officer in the Royal Australian Air Force and then an airline doctor that I learned about the specialty. This included carrying out workplace risk assessments, making decisions on fitness to fly and for overseas deployment, giving advice to commanders and workforces as well as individuals. There is overlap with public health - looking after a deployed population requires a working knowledge of exercise physiology, heat and cold injury, food hygiene, injury prevention and rehabilitation. Ten years as a GP gave a good grounding in clinical medicine which is helpful for giving authoritative and credible advice. And I've found myself recruited from Australia to Dubai and now the UK working in occupational and aviation medicine.

• What do you find most challenging about the job?

The legal aspects. This is the specialty most likely to interact with tribunals and courts; if you are giving advice to a company about employment law and disability discrimination cases, you need to make sure it's accurate and defensible. Fortunately there are senior colleagues and CPD courses to learn from, and a number of occupational physicians also complete a law degree. Ethics is another tricky area - because we have a dual duty of care to the worker and employer, and not a typical therapeutic relationship, we need to be scrupulously objective and fair when liaising with medical colleagues and translating medical jargon into practical advice without giving unnecessary detail.

#### • Has anything surprised you about the role?

I think the sheer variety of medical jobs you can aspire to. There are occupational physicians working in the oil and gas industry, NHS hospitals, military, aerospace, transport, mining, fire and ambulance, automotive and so on. As the health adviser usually in a senior position, strong leadership and teamwork skills are essential to develop. You may work in a multidisclipinary environment with nurses, physiotherapists, occupational hygienists, safety engineers, human factors scientists and health and safety reps.

Just learning about what people do for work in all walks of life is fascinating. Timely advice can possibly save someone's job even if not their life. For example, when you see Joe Bloggs on the hospital ward, do you think about how his hand injury is going to affect his work long-term if he is a self-employed plumber? And when you see a professional pilot with a suspected TIA in A&E, do you consider that she needs to inform the regulatory authority that she has a significant condition with a high risk of recurrence and public safety implications?

• What do you consider the most important personal characteristic in a good occupational physician?

Common sense. We need good plain-speaking skills when explaining to workers and employers what a condition means in terms of effects on daily function and work, what workers are capable of doing as opposed to 'unfit for'. Being practical and not afraid to get your hands dirty visiting worksites and trying out some of the tasks - if you understand the role, you can give relevant advice.

- What is your most memorable experience so far? There aren't many medical jobs where you can fly first class regularly in the private suite of an A380 / B777 - bonus of working for an international airline!
- Is there any advice you could give to a final year or FY trainee considering occupational medicine?

occupational medicine? There is a world beyond hospital medicine. If you are a people person and enjoy adventure through a road less travelled, having flexibility to look after your family and pursuits whilst working reasonable hours - it is worth considering. Some medical schools offer a taster in occupational medicine in FY 1/2 years and the Faculty of Occupational Medicine offers funding for student electives in occupational medicine through the Mobbs Corporate Health Fellowship. Ask the FOM to put you in contact with your medical school teaching lead or a practising physician in a specific industry.

travelling required. They will also work closely with both medical and non-medical colleagues such as occupational hygienists, union and safety representatives, disability employment advisers and managers. The specialty is almost invariably provided by a multidisciplinary team with occupational physicians and nurses playing key roles.

Patients tend to be of working age – generally between 20 and 65. Sometimes doctors will consult with retired workers although these are usually workers who have retired early through ill-health. The time taken to assess patients would typically be around 45 to 60 minutes for new patients and around 15 to 30 minutes for a review.

"Learning about what people do for work in all walks of life is fascinating"

#### **Pros and cons**

The work of an occupational physician is varied and can depend on the industry sector in which they work. There are opportunities to move around within the specialty and for career development as well as the enjoyment of working with non-medical managers as a technical expert within an organisation. One challenge the role presents for doctors in this field is to remain independent when providing opinions and to avoid being partial to either workers or management.

The opportunities for flexible training are many as it can be carried out within the NHS, in industry and the defence medical services. Training posts must, of course, be GMC approved with deanery approval for all appointments. More than half of OM training posts are outside the NHS, making this specialty distinct from many of the others.

Sources: www.fom.ac.uk www.medicalcareers.nhs.uk



looks back at two key events in its development

T'S unlikely that any medical student, trainee or doctor in the UK will be unaware of the fact that after many years of development revalidation has finally been launched. An estimated 13,000 doctors will take part in the first wave of revalidation with the majority of the UK's 230,000 licensed doctors expected to have undergone the process by 2016.

Any doctor who is fully registered with a licence to practise will be required to revalidate and this applies to doctors in foundation year 2 and specialty training (see page 3). Not everyone is happy with the added bureaucracy this will bring but the Government has long favoured a process by which licensed doctors demonstrate on a regular basis that they are up-to-date and fit to practise. This is intended to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC.

Two major events within the last 25 years

have shaped development of revalidation as we know it today – and it's useful to look back at the genesis of what is being called one of the greatest shake-ups of medical regulation in the last 150 years.

#### **Heart scandal in Bristol**

Revalidation as an idea has been around for at least 40 years. Back in the 1970s a government committee set up to modernise medical regulation first suggested doctors might undertake some form of periodic "relicensure". But the issue remained mostly dormant until 1998 when a high-profile GMC hearing found three doctors guilty of serious professional misconduct in connection with the deaths of 29 babies undergoing operations in the paediatric cardiac unit of the Bristol Royal Infirmary. The Bristol heart scandal dominated headlines at the time and a later Government inquiry into the matter yielded a damning 461-page report calling for a major change of culture in the NHS.

Problems at the Bristol unit first emerged over 10 years before when a hospital report indicated that the death rate in operations carried out on babies under age one was twice the British average. A young anaesthetist named Stephen Bolsin joined the staff at Bristol in 1988 and noticed that operations conducted by one senior cardiac surgeon James Wisheart (also director of cardiac services) lasted much longer than average, leading to an increased rate of complications and mortality.

Bolsin expressed his concerns to hospital officials, among them Dr John Roylance, chief executive of the United Bristol Healthcare NHS Trust. But Bolsin's whistleblowing did little good and led to him being rebuked and isolated from many of his colleagues.

Wisheart continued to operate on babies and between 1990 and 1994 he carried out 15 operations to correct atrioventricular septal defects (AVSD) in which nine children died (60 per cent mortality rate). There were also concerns over another consultant surgeon working in the unit. Janardan Dhasmana conducted 38 arterial switch operations in babies with transposition of the great vessels between 1988 and 1995 in which 20 patients died (53 per cent mortality rate). The average success rate for this operation nationally was 80 to 90 per cent.

A decision was made to stop arterial switch operations at the BRI in 1994 but in 1995 an exception was made by Wisheart and the clinical team in the case of 18-month-old Joshua Loveday. The boy's parents were not told of the BRI's high mortality record nor of the earlier decision to stop the operations on neonates. Mr Dhasmana conducted the procedure in which Joshua died.

#### **GMC** takes action

In March 1996 a Channel 4 *Dispatches* programme exposed the high mortality rate in cardiac surgery on infants and young children at the BRI and the failure to address the issue. Over the next few months Bolsin and the parents of some of the dead children sent formal letters of complaint to the GMC. Wisheart, Roylance and Dhasmana were all charged with serious professional misconduct.

The GMC panel found that Wisheart and Dhasmana had continued to operate on children despite poor success rates and without sufficient regard to the safety and best interests of their patients. It determined that Dr Roylance should have stopped them operating when colleagues made clear their concerns. Wisheart and Roylance were both struck off the medical register and Dhasmana banned from operating on children for three years.

Amidst the fallout of the Bristol scandal the notion of revalidation again became a topic of discussion at the GMC. The then GMC President Sir Donald Irvine later wrote: "I was now quite clear that a response to Bristol from the GMC and the profession would have to address head-on – and promptly – this issue of the ongoing competence of doctors. That meant re-certification."

Over a series of meetings the plans were further developed and at a special conference in February 1999 the GMC decided to introduce revalidation for all doctors. A steering group was formed to devise plans for the implementation with two main objectives: the weeding out of poorly performing doctors so as to protect patients and the enhancement of performance in others. The target date for implementation was 2002. Six months earlier, though, another event transpired that would have a major impact on these plans: the arrest of a Manchester GP named Harold Shipman on the suspicion of murder.

#### Just a pinprick

Harold Shipman ran a single-handed GP practice in Hyde and in March 1998 a doctor at a neighbouring practice expressed her concern to the local coroner about the death rate among Shipman's elderly patients. In particular it seemed unusual that Shipman was present at many of these deaths.

Suspicions were further aroused over the death of a Kathleen Grundy at her home. Shipman was the last person to see her alive and signed her death certificate citing "old age" as the cause of death. It later transpired that in her will Mrs Grundy left £386,000 to Shipman, gathered around 2,500 witness statements and analysed approximately 270,000 pages of evidence resulting in six reports running to 5,000 pages.

Among the many areas considered was the GMC's then current proposals for revalidation. In a section entitled 'Whither Revalidation?', Dame Janet concluded the proposals did not satisfy the statutory definition of revalidation, which is an "evaluation of a medical practitioner's fitness to practise". In particular she was concerned with the implication that a doctor would only fail to be revalidated if practising at a very low standard.

Dame Janet also expressed reservations about a five-year process based primarily on yearly employment appraisals designed for a very different purpose. In her view, revalidation should be based on the preparation of a folder of evidence demonstrating competence over the last five years and including data derived

### The objectives of revalidation were to weed out poorly performing doctors and to enhance performance in others"

having excluded her own children. Police investigated and Grundy's body was exhumed and found to contain traces of diamorphine. Shipman was arrested and police later determined that the disputed will had been written on Shipman's own typewriter.

Fourteen other suspicious deaths were investigated and a pattern established of overdosing patients with morphine and signing death certificates before forging medical records to indicate the patients had been in poor health. Shipman was convicted of murder in the 15 cases in January 2000 but was suspected of 235 other murders making him possibly the most prolific serial killer in British history. Four years later he hung himself in a cell at Wakefield Prison.

#### Shipman's lasting impact

In the wake of Shipman's trial and conviction the Government announced the launch of an independent inquiry into the case with the aim of deciding what "changes to current systems should be made in order to safeguard patients in the future". Dame Janet Smith was appointed to head the inquiry which over five years from clinical governance. She also favoured the inclusion of a certificate showing successful completion of a knowledge test.

One thing Dame Janet did **not** suggest was that catching another Shipman should be the "litmus test" of whether revalidation was worthwhile. She doubted even if revalidation would uncover such crimes. "Shipman knew what he was doing. He was quite capable of giving a good standard of care and very adept indeed at concealing the fact that he was killing his patients."

In response, the Government undertook a broad review of medical regulation with a subsequent report and white paper addressing some of her concerns and this led to the passage of legislation in 2008 granting the powers to establish revalidation. Four years later proposals are still evolving even as the first doctors undergo the process.

No doubt few of the many lawyers, politicians, doctors and administrators involved in revalidation today would disagree that it is still very much a work in progress.

Jim Killgore is an associate editor of FYi



VER since she was a young girl, Hannah McLean dreamed of working in Africa. Her grandparents were medical missionaries in Nigeria for over 20 years and her mother was brought up there. She grew up hearing stories of their experiences and something about them lit a desire inside her that was overwhelming.

"It was one of my main motivations for going into medicine," says the 27-year-old F2 doctor. "I felt I really wanted to have a tool that I could share."

That early dream has long since come to fruition – and as a direct consequence saw her nominated last year in two categories of the BMJ Group Improving Health Awards, the Junior Doctor of the Year and the Karen Woo Award, mainly for her work bringing much-needed healthcare to prisoners in Ugandan jails. The latter, named after a relief charity doctor killed in Afghanistan in 2010, recognises an individual who has gone well beyond the call of duty to deliver care for patients in difficult environments.

But Hannah's road to medical recognition has been anything but typical: a mere 18 months after starting her medical degree at Nottingham, she put her studies on hold indefinitely. Ironically, though it was Africa that had got her into medicine, she had begun to feel that medicine was keeping her away from Africa. She still hadn't ever set foot on the continent.

"I started questioning why I wanted to do medicine. I went straight from doing my A levels to medical school. It was very academic. I like the more practical things and I felt like I was re-sitting my A levels and I really started doubting if it was for me," she says.

#### In the deep end

Through a friend of a friend, she managed to arrange a two-month stint as a volunteer at the Children of the Nile hospice in Soroti, in north-east Uganda, a local charity funded by an American agency. The charity looks after widows in an area that has seen a lot of rebel activity. Seventy per cent of the women were HIV-positive. Though it was quickly clear to her the hospice was struggling in terms of its leadership, she "shut up for eight weeks and got on with serving them".

At the end of that period, however, she outlined her vision for what the hospice could be, and her ideas for how to achieve that, including outreach into the community. An American director who was visiting offered her the job of running the hospice then and there. She was 22.



Above and right: The grim surroundings of a prison sick bay and one that has been renovated by the African Prisons Project. Below and opposite: Dr Hannah McLean helps women who are being cared for at the Children of the Nile hospice in north-east Uganda.









Her main input was to increase the efficiency of care delivery and staff motivation. "The care that was being given was excellent – it was how they were being led. A lot of the problems were to do with finance, staff, wastage. So I kind of tipped it all round – when I got there there were 15 widows using this 100-bed hospice and when I left nine months later, 70 widows were able to use it for pretty much the same money."

#### **African Prisons Project**

She still wasn't ready to go back to medicine and during a trip to the capital, Kampala – her reputation evidently preceding her – she was offered a job by another charity, the African Prisons Project (APP), as its administrative director.

Coincidentally, the APP had been set up by a fellow student at Nottingham, Alexander McLean, at the breathtakingly young age of 18, after coming face-to-face with awful scenes of deprivation, brutality and ill health in Kampala's Luzira Prison during his gap year. Hannah and Alexander have since married but they barely knew each other at the time. "I had met him once at Nottingham. I knew he was in Uganda and he knew I was in Uganda but we hadn't met during the year."

The scenes that had driven Alexander, now a barrister, to set up APP in the first place were truly shocking, she says. "I had spent a year in Uganda and I'd seen a lot of horrendous things and I didn't think I could see anything worse. I then happened upon this project working in prisons and I found worse."

The overcrowding was grave and people were dying, she says, from "the most ridiculous conditions", including dysentery, malaria, diabetes and high blood pressure, which simply weren't being treated. "Hygiene is a massive thing. Many of the diseases are passed around by not washing hands and the most simple things – in fact, there's faeces everywhere, as they still have the bucket system."

AIDS was rife, as was tuberculosis, cholera and typhoid, and terminally ill prisoners faced a largely unsupervised and painful slide towards death. "My interest at that point was end-of-life care and I've seen people with cancer and end-stage diseases die in prison the most awful deaths."

She spent around six months in Kampala on that occasion, helping to advance the charity's immediate aims of improving the welfare of prisoners and its longer-term aims of putting in place an infrastructure offering better access to healthcare, education and legal representation. By the end of that period, APP had built a health centre and a welfare centre and developed a library in Kampala's remand prison. They were also making plans to build a health centre in Gulu, one of the country's poorest areas, to benefit not just prisoners, but also prison staff and the wider community.

#### **Back to the books**

Hannah had also come to a realisation. To do the best she could for the organisation, she would have to return to the UK to finish her degree. "I recognised that I could stay in Uganda and I could be a leader and a manager, but I wouldn't be able to go and train and spend more time really helping, hands-on, on the more medical issues without completing my medical training."

There was also a question of credibility and authority, not least because she was a woman – and a young one at that. "A medical degree affords you a status in that environment, which I struggled to get. You have to work and work and work to prove that you're on the level to have a conversation at the table."

Back at medical school, her outlook had changed completely. "The faff and the stress just went away, because I had so much more perspective. After I came back, I think I did about a tenth of the work but in a far more focused way and my results went up significantly."

She continued to work with APP, becoming less hands-on and more strategic - though she admits: "I spent a lot more time than I should have in Africa when I was doing my exams. I wasn't the most popular medical student. I'd work very hard for a couple of weeks and then head off for a bit."

That was two years ago, and since then she's continued in her role as APP's strategy and healthcare adviser while completing her F1 year at the Royal Derby Hospital – including running a GP clinic in a British prison – and embarking on her F2 training in Mansfield. And if life could not be any more busy she and Alexander have just had their first child. She is currently on maternity leave and planning another trip to Africa. "We're going to take our son to Uganda in April and spend a couple of months there before I go back to work in August."

Hannah has been working two jobs for so long that the busy-ness doesn't seem to ruffle her feathers one bit. It is a sign of the drive and dedication that brought her the *BMJ* nominations in the first place and, though she didn't win either, she's more than happy for the publicity they have brought to the charity.

"I'm very passionate about the work we've been doing in Africa and it's nice for the project, and what it's achieved, to be acknowledged."

For more information on the African Prisons Project, visit **www.africanprisons.org** 

Adam Campbell is a freelance writer and regular contributor to MDDUS publications



#### Day 1

Dr B, a recently qualified GP, is working as a locum at a large urban practice. A request for a home visit has been made by Mrs L on behalf of her husband John. He had been mowing the lawn and felt a sudden sharp pain in the back of the head followed by a severe frontal headache and vomiting.

Dr B attends the patient two hours after the call has been made and finds John sitting up in bed still suffering with headache. On examination there is no evident rash and the patient's pulse, blood pressure and temperature are normal. Examination of the eyes discloses no aversion to bright light, no abnormality of the pupils and normal ocular fundi. John does complain of tenderness in his neck but examination reveals no obvious stiffness. The patient suggests he may have "pulled something" playing tennis the day before.

A provisional diagnosis of migraine headache aggravated by muscle strain is made and Dr B prescribes Migramax sachets. He tells John and his wife to call back if there is no improvement.

#### Day 2

The next afternoon Dr B phones the patient for follow-up. John sounds normal and bright on the phone and says that although he did not sleep well the night before the pain has eased and he is feeling better. Dr B advises him to phone if he has any further problems.

#### Day 3

John has another poor night's sleep and in the morning feels extremely unwell. Mrs L takes him to Accident and Emergency. On arrival his Glasgow Coma Score is recorded as 13, indicating some mild neurological impairment. A CT scan is organised and during the procedure John's level of consciousness deteriorates rapidly and he requires artificial ventilation.

The CT scan shows a haemorrhage in the fourth ventricle and hydrocephalus. A ventriculo-peritoneal shunt is performed to reduce pressure on the brain and John undergoes a tracheotomy to help his breathing. He is then transferred to intensive care where his condition gradually stabilises but he is left with significant neurological impairment.

#### Six months later

A letter is received by the practice from solicitors acting on behalf of John requesting copies of his medical records with a view to pursuing a medical negligence claim against Dr B. The request is forwarded to an MDDUS adviser along with the patient's records. Prior to his intracranial haemorrhage John ran his own travel business. The condition has left him physically disabled with speech and language difficulties. It is uncertain if he will ever work again which makes it potentially a high-value case for MDDUS. N MDDUS adviser contacts Dr B and asks for his account of the case and this is sent along with the patient records to an expert in primary care medicine.

In his report the expert finds nothing to indicate that Dr B departed from what would be expected of a "competent general practitioner acting with ordinary care and skill." The patient records indicate that Dr B performed a comprehensive physical examination and that he had considered possible serious diagnoses such as meningitis (checking for fever, rash and neck stiffness) and raised intracranial pressure (examining the pupils and ocular fundi).

Migraine was a reasonable diagnosis given the symptoms but Dr B also instructed the patient or his wife to call back if symptoms did not improve or grew worse. In the patient's notes Dr B had also written "??admit" indicating preparedness to seek specialist assessment if the situation changed.

Intracranial haemorrhage can be difficult to diagnose. Patients experiencing major haemorrhage will report "explosive" headache followed by dramatic collapse but small bleeds can cause premonitory headaches of lesser intensity and the diagnosis may be recognised only in retrospect.

The MDDUS adviser forwards a copy of the expert report to the patient's solicitors. Two months later another letter is received by the patient's solicitors indicating that the case will not be pursued further.

#### **Key points**

- Have a high index of suspicion in unremitting severe headaches with nausea and vomiting – although intracranial bleeding rarely presents in general practice.
- Ensure that the patient and/or family are clear about when to get back in contact should the condition fail to improve or worsen.
- Keep accurate notes of all clinical findings (positive and negative) and advice to patients in order to clearly justify clinical decisionmaking.

### **OUT** THERE

EAT YOUR HEART OUT Fungal toenail cookies, red blood cell cupcakes and polycystic kidney cakes were among the attractions at an exhibition in the Pathology Museum at St Bart's, London. Curated by freelance artist Emma Thomas, it aimed to raise awareness of disease. Her next project is an edible autopsy.

MEDICINAL CHOCOLATE An Australian study in the BMJ revealed dark chocolate has antihypertensive, antiinflammatory, antithrombotic and metabolic effects, thanks to its high polyphenol content. It suggests eating dark chocolate could even be cost-effective in the primary prevention of cardiovascular events.

CLINICAL CLOTHES "Smart clothing" could help patients with life threatening conditions such as diabetes and obesity. Tiny sensors and electronics embedded in fabric monitor temperature or blood sugar levels and could one day administer insulin to the wearer. Source: The Herald

**EGGSHELLENT IDEA** Slow boiled quails eggs are being used to train juniors in endoscopic nasal surgery. They're embedded in the orbit or attached to the lateral wall of the maxillary sinus in a model made of synthetic materials. Inaccurate drilling can crack the membrane, with protruding egg white mimicking extrusion of orbital fat from periorbital injury. Source: BMJ





### Pick: DVD - Call the Midwife (Series 1)

patients and regulators

over the efficacy of some

Goldacre writes:

people who manufacture

them, in poorly designed

trials, on hopelessly small

"Drugs are tested by

**Book Review:** Bad Pharma – How drug companies mislead doctors and harm patients, by **Ben** Goldacre Fourth Estate; **£13.99** 

#### Review by Jim Killgore, publications editor, MDDUS

BEN Goldacre makes a pointed if rather mischievous observation in the introduction to his most recent book - Bad Pharma. "Today, when an academic or doctor tells you that they are working for the pharmaceutical industry, they often do so with a look of quiet embarrassment."

Just what might engender this embarrassment is the subject of over 400 pages of compelling argument - how a £600 billion industry reaps vast profits by routinely misleading doctors,



such a way to exaggerate the benefits of treatments. Unsurprisingly, these trials tend to produce results that favour the manufacturer."

The book is unashamedly "pop science" but a much more demanding read than his previous bestseller Bad Science. Goldacre sets out in painstaking detail his case against the current system of drug development and evaluation. "Some of this stuff is hard," he admits. "That's precisely why these problems have been

ignored." But this is not to say Bad Pharma is a dull read. The book is enlivened by Goldacre's passion and, at points, raw anger over how doctors making prescribing decisions in good faith and on the available evidence can be cynically misled over the best treatment for their patients.

Much of the material is shocking - case after case of pharma companies knowingly suppressing data from negative clinical trials to ensure drugs are marketable, often with the unwitting connivance of regulators. He describes drug trials rigged to yield desired results, doctors paid to extol the virtues of a particular drug, journals publishing positive reviews on the promise of expensive advertising and reprints, ghost-written articles by industry insiders the rot is deep and many years in the making.

There are solutions such as well-policed registers to ensure negative clinical trials are not buried - and Goldacre does see encouraging signs. Certainly this is an important book that needed to be written.

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