

PRIME TIME

Adam Campbell
chats with children's
favourite TV doctor
Ranjit Singh - better
known as Dr Ranj

ALSO INSIDE

07 SMARTPHONES
RISKS AT WORK

08 CAREER
MEDICAL ONCOLOGY

AN MDDUS
PUBLICATION





Welcome to your FYi

FOUNDATION years can be a bit of a whirlwind, but what happens next? On [page 4](#) I discuss the pros and cons of taking a break from training, whether to explore different specialties, hone your CV for that perfect post or spend time abroad or with your family. As our news item on [page 2](#) reports, this is becoming increasingly common as almost double the number of foundation year 2 doctors are taking years out compared with a couple of years ago.

There is something of a career theme to this issue as Dr Liz Berkin offers some practical advice on [page 10](#) on how to make sure you choose the right specialty. Children's favourite media doctor Ranjit Singh – better known as Dr Ranj – talks about the demands of TV work, his specialty training in paediatric emergency medicine and being asked for autographs by patients. Find out more on [page 12](#).

Meanwhile, our regular careers feature looks at the opportunities for working in oncology on [page 8](#).

How many times have you used your smartphone at work to photograph patients or check an app? An increasing number of trainees are using their devices for clinical reasons – but are you aware of the risks? Find out on [page 7](#). Dr Jekyll famously tried it and countless comic book villains have dabbled. But is it ever ethical to experiment on yourself? Allan Gaw investigates on [page 5](#).

Foundation trainees are now expected to master 15 core procedures. On [page 6](#), F2 doctor Anli Zhou offers some tips for tackling the first three on the list. Our case study on [page 14](#), meanwhile, looks at the case of retained surgical patties in a patient with a slipped disc.

• **Dr Anne Parfitt-Rogers**
 Editor

RISE IN OUT-OF-WORK F2 DOCTORS

THE number of doctors who finished foundation training but could not find a job has increased, a new report shows.

The proportion of trainees still seeking employment as a doctor in the UK in August 2013 was 7.6 per cent, up from 7.4 per cent in 2012 and 6.3 per cent in 2011.

The number of F2s who moved directly into specialty training also fell. Just over 7,000 doctors finished foundation training in August 2013 and, of those, 64 per cent found a UK specialty post compared to 67 per cent in 2012 and 71 per cent in 2011.

The figures were published by the UK Foundation Programme Office (UKFPO) which surveyed all 7,299 F2 doctors who successfully completed the programme in August. Of those, 6,961 (95.4 per cent) responded.

Half of the doctors who couldn't find a specialty training job said they were still looking for employment in the UK. Of the doctors who did achieve a specialty training post, almost 30 per cent were appointed to a run-through programme with the same amount heading to a core training programme.

The report also showed 9.4 per cent of F2s took a career break – more than double the 2011 total of 4.6 per cent – and five per cent were appointed to positions outside the UK. A further 0.3 per cent left the medical profession permanently.



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SCALE OF TRAINEE JOBS SHORTAGE CONFIRMED

THE foundation training programme is oversubscribed by almost 300 places, the UKFPO has confirmed.

There are currently 293 more eligible applicants than places available for the programme which starts in August. That is only slightly lower than last year's record-high oversubscription of 295. This is the fourth year in a row there has been a shortfall in places.

Despite the high number, the UK Foundation Programme Office has moved to reassure trainees. They predict a number of applicants will drop out of the programme between now and March when the primary list allocations will be announced.

Over the coming weeks, all eligible applicants will be ranked in score order and the top 7,589 will be allocated to a foundation school on March 10. Those left over will be put on a reserve list and given jobs in batches over the following months.

UKFPO national director Professor Derek Gallen said: "Despite the programme being oversubscribed again, I would like to reassure applicants that we are in a better position at this stage in the process than last year."

"I am confident that as has been the case since the programme was first oversubscribed, all eligible applicants will be placed in jobs by the start of the programme in August."

For more information visit www.foundationprogramme.nhs.uk

BULLYING A SIGNIFICANT CONCERN AMONG TRAINEES

MORE than one in 10 trainee doctors report being bullied in the workplace according to the 2013 annual national training survey conducted by the GMC.

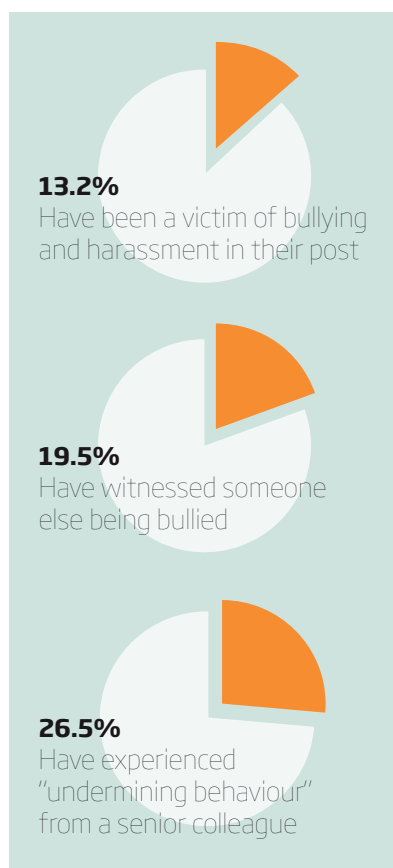
In the survey of 54,000 doctors in training in the UK, 13.2 per cent of respondents said they had been victims of bullying and harassment in their posts and 19.5 per cent had witnessed someone else being bullied.

Over a quarter (26.5 per cent) also experienced "undermining behaviour" from a senior colleague, with doctors in obstetrics and gynaecology most affected. Doctors in years four to seven of specialty training were more likely to report undermining than those in foundation or core training.

In its report on the findings, the GMC reiterates that undermining or bullying behaviour is in total contradiction with its values regarding respect for colleagues as set out in *Good Medical Practice*. "It is more than a simple failure to comply. Serious or persistent failure to follow our guidance puts a doctor's registration at risk."

The National training survey 2013 also found that 2,746 survey respondents (5.2 per cent) raised a concern about patient safety. More than half of patient safety concerns raised by doctors in training relate to a lack of staffing or resources (61.4 per cent), with a significant number related to problems with patient management (29.9 per cent) or processes of care (26.4 per cent).

Doctors near the start of their training are much more likely to raise concerns than those in the later stages of training - 8.7 per cent in the first year of foundation training (F1) versus 2.8 per cent in year eight of specialty training (ST8). This was also true of GPs at the start of training compared to those near the end of their programmes.



ATTENTION JUNIOR OR TRAINING GRADE DOCTORS

JUNIOR or training grade doctors will be aware that your MDDUS membership includes up to £10,000 cover from work that is not otherwise indemnified by your NHS post.

With effect from your renewal date in 2014, this threshold will **not** include cover for the following:

- Primary care services, such as work as a GP, GP locum or GP out-of-hours sessions, with the exception of work done as part of a formal GP training programme.
- Obstetrics
- Spinal surgery
- Cosmetic surgery
- Botox and other non-permanent fillers
- Gynaecology
- Orthopaedic surgery
- Neurosurgery
- Forensic/police physician work (FME)
- Occupational health
- Non-NHS palliative/hospice work
- Pharmaceutical physician work
- Expert medico-legal report writing.

In addition, where a junior/training grade doctor (non-consultant) performs private practice treatment, we would normally expect such practice, for example a resident medical officer, to be performed under the direction of a senior colleague (such as a consultant) with overall responsibility for the patient's clinical care.

The £10,000 limit will continue to provide cover for all other aspects of work outside your NHS contract, including attendance at music and sporting events.

These changes will take effect from your next renewal date, but should you have any questions regarding this matter, please contact our membership team on **0845 270 2038** or membership@mddus.com



DOCTORS IN DIFFICULTY

A SMALL number of trainees needed support from their foundation school's "doctors in difficulty" programme, according to the UKFPO's August 2013 survey.

A total of 193 (2.6 per cent) F1 and 185 (2.4 per cent) F2 doctors were monitored across the 25 foundation schools. The main area of

concern for both F1 and F2 related to the doctor's knowledge, skills and performance, which included personal health issues.

The outcome for foundation doctors in difficulty was typically favourable, with over a third (34.2 per cent) of F1s and 37.3 per cent of F2s being signed off by the original end date of their foundation year. A further 50.3 per cent of F1s and 48.6 per cent of F2s are expected to be signed off by an agreed, extended end date.

A small number of doctors were referred to the GMC for fitness to practise issues - 18 (0.3 per cent) F1 and three (0.2 per cent) F2 doctors.



A CHANGE OF PACE

Medical training can be an intense and challenging experience. *FYi* editor **Dr Anne Parfitt-Rogers** considers the merits of taking some time out

AFTER five or six years at medical school and six busy foundation year rotations, many doctors consider taking a break. Time away from a busy schedule provides an opportunity to consider your future career, build your CV or do something a bit different before committing to specialist programmes.

But is pressing pause a good idea? Like anything, there are pros and cons but the key is to carefully consider what you want to achieve to make the best use of your time.

Some people worry that taking time out will make them less desirable when applying to specialty posts. In fact, while the conventional route may be more common, opting for charity work, taking part in research or gaining experience as a locum can show flexibility and help you offer something extra to prospective employers. The notion of an "F3" year is becoming increasingly popular as people look to undertake audits or complete membership exams whilst applying for competitive posts.

Locum work

If you are getting itchy feet being stuck in one deanery, or considering a future career abroad, you may want to test the waters by working or volunteering in the UK or further afield. Locum positions can be great for this. You can find Locum Appointment for Service (LAS) posts and there are also plenty of agencies who can provide work at short notice once you have full GMC registration. As well as deciding on a place to spend your training years, they can also help to firm up your choice of specialty. It's worth saving up some money before diving into this as it may take a while to find a steady source of work.

Another possibility is Locum Appointment for Training (LAT) posts, which are attached to a deanery and count towards your training. They allow you to change location in your FY2 year if you are unhappy or need to move. Competition is tough and they may only be advertised for a short time. Check NHS jobs websites (www.jobs.nhs.uk, www.scot.jobs.nhs.uk) and publications like the *BMJ*.

Charity work

Many doctors are keen to pursue an interest in charity work, either abroad or in a specialised area such as prison or wilderness medicine. Although the learning opportunities provided by work in the so-called "third sector" can be scarcer and more costly, it can provide valuable experience in areas like business management. It can often give insight for future career planning, as well as greater job security than the private sector.

If you are thinking of going abroad, link up with a charity such as Médecins Sans Frontières or Mercy Ships, or ask your hospital

the *Improving Working Lives* initiative. If you have a child under six or a disabled child under 18, you have a right to request part-time working. This will likely involve a discussion with your employer about continuous professional development and ensuring you remain up-to-date with current practice.

Academic work

If you are academically minded or enjoy passing on your knowledge, you may enjoy clinical teaching fellowships. These combine ward jobs with weekly slots teaching medical students, ranging from anatomy classes to ward-based

teaching or tutorial sessions. It's said that you've only understood a subject once you've explained it to someone else, so these jobs are great for anyone wanting to increase their knowledge and contribute to the education of future doctors.

Some doctors may wish to take a break from medicine altogether to spend time

travelling or pursuing other interests. Activities can vary wildly from banking or medical writing to music and portfolio investments. If you are really lucky, your next interviewers will share the same interests.

Preparing for re-entry

A well-planned year out can be a great experience and make you a more versatile doctor. When you do return, be ready to show that you've retained your knowledge and skills. As with riding a bike, this should return once you are back on the wards, but it is prudent to dip into your textbooks and *BNF* or complete some online modules. Keep in touch with your colleagues, read journals, and have a look for weekend or day courses to hone your skills in areas such as suturing or plastering. Above all, enjoy it – you may never get the chance again!

Anne Parfitt-Rogers is an FY1 doctor and editor of *FYi*

"Well planned time out can help you offer something extra to employers"

registrars and consultants if they have any trips planned. Conferences are also a great way to meet people from around the globe. Check out www.medicstravel.co.uk for hospital information and www.avicenna.ku.dk to search international medical schools. Certain organisations can provide vaccines and health checks, as well as discussing your motivations for travelling further afield to plan for the longer term.

Before carrying out any charity work at home or abroad, be sure to contact your medical defence organisation to discuss your professional indemnity cover.

Flexible working

Flexible and part-time training are also options. Traditionally they are taken for family reasons such as caring for a child/relative. However, these posts are becoming more common and have been encouraged by the Department of Health and British Medical Association under

DIY RESEARCH

Allan Gaw asks is it ever ethical to experiment on yourself?

A LABORATORY, bubbling chemicals, glassware and, most probably, gaslight – the scene is set for the physician-scientist to drink his transforming potion. This is our stock image of self-experimentation in clinical research, and apart from the bubbling and the gaslight it is probably not too far from the truth. Researchers have always self-experimented, both in fact and fiction. In the latter, these experiments have usually resulted in mayhem, while in the former they have, on occasion, earned their scientists the Nobel Prize, while leading others to their death.

Dr Jekyll sipped his concoction to discover the beast of Mr Hyde within, while Dr Brundle's dabbling with teleportation in *The Fly* led to a self-experiment with distinctly unfortunate consequences when he inadvertently shared his pod with a housefly. Comic-books abound with villains – such as The Lizard, Spider-Man's arch enemy – who are often the product of self-experimentation by mad-geniuses or initially well-meaning, but ultimately evil, scientists. But what of the reality of self-experimentation? Does it happen and if so why? Here are two examples from the 20th century.

In 1984, Barry Marshall and Robin Warren postulated that *Helicobacter pylori* was the causative agent of peptic ulcer disease. The implications of this for medicine and surgery would be enormous, as Marshall thought the disease might be treated using antibiotics rather than surgery, which had been the only treatment for decades. However, his proposals were laughable to many and he needed to gather some convincing proof quickly.

Increasingly frustrated by the negative criticism of his work and his failed attempts to produce an animal model for *Helicobacter* infection, Marshall decided to self-experiment. He successfully infected himself without discussing his plans with an ethics committee or, "more significantly" he noted later, with his wife. "This was one of those occasions," he added, "when it would be easier to get forgiveness than permission."

One of his colleagues mentioned the self-experiment to a journalist and the story was instantly sensationalised under the headline: "Guinea-pig doctor discovers new cure for ulcers ... and the cause". It would, however, take 10 years before his evidence was finally accepted, and another 10 before he and Warren would be awarded the Nobel Prize.

Unravelling another infection was the task given in 1900 to Major Walter Reed, a US Army doctor who led a team to investigate the transmission of yellow fever in Cuba. They tested a number of theories, the most crackpot of which had been proposed 20 years earlier: that the disease was spread by mosquitoes.

Concerned about the ethics of such investigations Reed and his team decided that

before they sought volunteers they should experiment on themselves. First, they "loaded" mosquitoes by allowing them to feed on yellow fever patients. The mosquitoes were then allowed to feed on a pair of junior doctors, Carroll and Lazear, all while Reed was safely in Washington DC. Both doctors developed the disease and while Carroll recovered, Lazear died aged 34.

This self-experimentation in Cuba became famous and, for many, one of the hallmarks of ethical research. Indeed, when the 10 principles of bioethical research were pronounced at the conclusion of the Nuremberg Doctors' Trial in 1947, article 5 stated:

No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

This caveat may have been included to counter one line of defence put forward by the counsel for the Nazi defendants, i.e. that previous US military research had knowingly put the lives of research subjects at risk. In particular, the lawyers cited the example of Reed and the yellow fever experiments. The fact that Reed himself was never a subject of the experiments was conveniently overlooked.

Thus, self-experimentation is used partly as an expedient as in the case of Marshall, and partly as a justification as in the case of Reed. Expediency, however, may lead to a loss of objectivity that is so vital to good research, and justification may be challenged. Even if an investigator is willing to be the first subject in a potentially life-threatening experiment does this really make it ethical to put others at risk?

Self-experimentation, it has been argued, is not research at all but simply "self indulgence" or even "self abuse". However, one eminent researcher, Thomas Chalmers, summed up his view as, "...you shouldn't be involved in a trial unless you would be willing to be randomised yourself".

Today, self-experimentation continues but is increasingly controversial, raising uncomfortable ethical and scientific questions. The quality of the work, the safety and the motivations are all debatable but, for the self-experimenter, perhaps no more debatable than the same work done on volunteers. We certainly need rules of clinical research but whether we need different rules for researchers who wish to take that first step themselves is far from clear.

Dr Allan Gaw is a writer and educator in Glasgow

CORE SKILLS

Foundation training now requires doctors to perform 15 core procedures. F2 **Dr Anli Zhou** looks at the first three on the list

TWO months into my FY1 haematology placement and I had taken blood and inserted cannulas into patients many times. Yet my core procedures form was empty. I knew I had these skills, but to prove I was competent I needed someone to assess me.

One of the benefits of being on a haematology placement meant I could prepare and administer IV fluids for patients undergoing venesection. But I had never been formally assessed for this either. Trying to find someone to assess me was the difficult part. With my consultants and registrars busy in clinic, I was usually the first port of call for ward patients. Leaving the task for my next placements, a busy surgical rotation and a hectic respiratory firm, was not ideal either. Eventually, I plucked up the courage to ask someone to help me complete these first three core procedures: venepuncture, IV cannulation, and the preparation and administration of IV medications, injections and fluids.

I soon realised things do not always go right the first time round.

The haematology registrar agreed to assess me for venepuncture for a patient admitted with haemolytic anaemia. The patient had excellent veins, bulging and obvious. I introduced myself, confirmed the patient's identity and confirmed that he needed a full blood count. I explained the procedure and gained consent. I prepared the equipment using aseptic non-touch technique and took a sharps bin with me. Things were going very smoothly. The problem was, I could not bleed the patient. The patient was kind and allowed me to try again. Unfortunately, it failed again. This was embarrassing and I asked my registrar to take over. I disposed of my equipment appropriately and documented the procedure in the notes. I also checked the patient was okay afterwards.

Afterwards, I sat down with my registrar who gave me feedback and encouragement. Although I didn't get my core procedures signed

off first time, this opportunity taught me the importance of seeking advice and help where appropriate and to learn from my failures. By keeping this in mind and using the same structured approach as I previously did, I was able to complete all three core procedures within my haematology placement, despite the rocky start.

What are core procedures?

F1 doctors must demonstrate competence in 15 procedures mandated by the General Medical Council (GMC). In order to become eligible for full GMC registration, all 15 procedures need to be completed within the year along with supporting evidence of competence. Once we can competently perform these, we will likely then be able to teach undergraduates the same skills to that standard.

Assessors can be anyone who is qualified to do the core procedure. This can involve GPs, consultants, specialist registrars, staff grade and associate doctors, trainee doctors more senior than F1, fully qualified nurses and allied healthcare professionals. It is best to use a different assessor for each encounter. The GMC also understands that it may not always be possible to actually do the core procedure itself, so it provides two other options for F1s to choose from – simulated and shadowed. Simulation involves talking through and demonstrating the procedure, but not on a real patient. Shadowing someone who is trained in the core procedure allows you to discuss the procedure first and then to reconsolidate your knowledge by watching someone else demonstrate. This provides a learning opportunity to competently perform on a patient in the near future (with adequate supervision).

My main pointers for core procedures:

- Complete the form at the time of your assessment.

- Understand that doing core procedures is to benefit your learning and experiences, not just a tick box.
- Prepare beforehand – identify an assessor when the opportunity crops up and organise a time to do the procedure together. Trying to find an assessor last minute may not always be possible, neither is it the best thing to do.
- Failing to complete the procedure or missing certain components does not mean you are not competent. Instead, it will provide an opportunity to learn from your mistakes and do better next time. You may have to repeat the assessment of the procedure, but experience will help reconsolidate your skills. This highlights the central theme of formative assessments, which is to demonstrate the progression of competence.
- The take-home message is that you do not necessarily have to start your F1 year competent in all core procedures. The whole idea is to learn a little more everyday so that by the end of the placement you are better off than when you started, and can carry out the procedures safely and competently.

Whichever career path you follow, core procedures are a set of skills that you will most likely need to perform again. Performing them as a foundation year 1 doctor will provide us with valuable opportunities to receive objective and personalised feedback so that we can learn from this experience. Try to complete as many core procedures as you can in your first placement as this will allow you to further build on your skills in later rotations.

Dr Anli Zhou is an F2 in acute medicine based in Bolton

GET SMART

As trainees increasingly make use of smartphones at work, it's vital that patient confidentiality is not compromised

WHEN was the last time you used your smartphone to make a call or send a text/picture message regarding a patient's care? Or perhaps you use an app to assist in diagnosis or dosage calculations?

Chances are you are among the growing number of trainee doctors who make regular use of their phones at work.

A recent survey in the *Postgraduate Medical Journal* questioned 108 F1 trainees, and 102 of them said they owned a smartphone. Of those, on at least a daily basis for the purposes of work, 83 per cent said they made/received phone calls, 87 per cent sent/received text and 41 per cent sent/received emails on their phone. What's more, 53 per cent had used their smartphone to take a work-related picture, in most cases to get advice about a wound or for research purposes.

Apps are also commonly used by trainees, with popular ones provided by the British National Formulary, MIMS, SIGN and NICE.

But do you think about the security of patient data and issues of confidentiality when using your phone?

The *PMJ* research concluded: "There is a need for guidance on how patient information can be safely secured and transmitted using smartphones, their appropriate use, and any restrictions on the use of these devices in certain clinical settings."

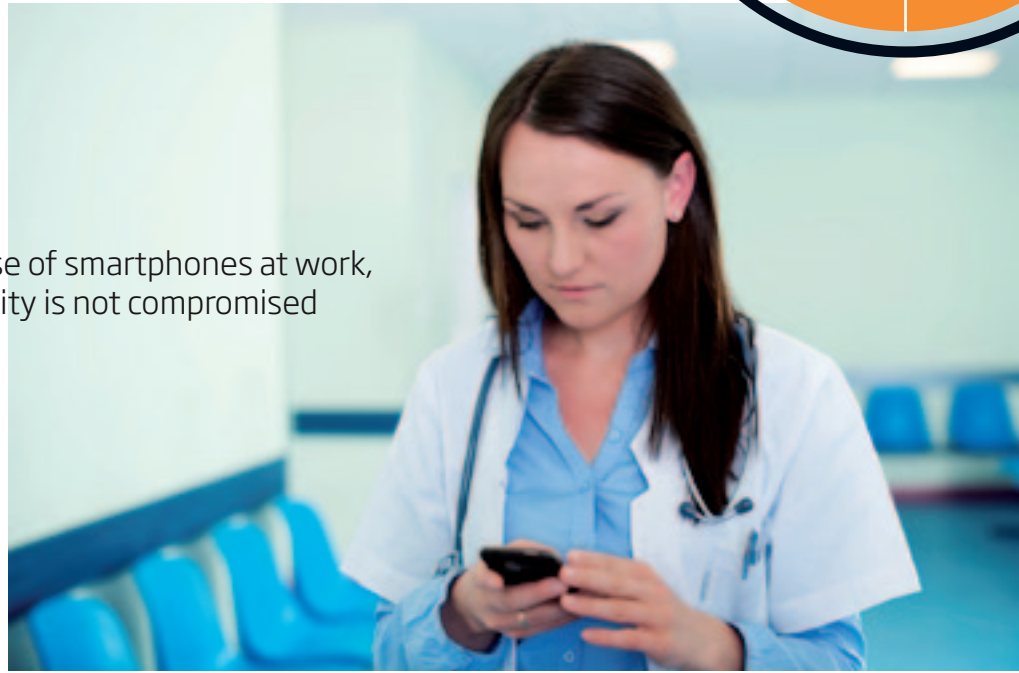
It called for improved hospital policies on mobile and smartphone usage to avoid confidentiality breaches.

There are a number of key points to keep in mind when using your phone at work.

Before considering whether to take a photograph of a patient on a mobile phone, you should be aware of your local organisation's policy and seek approval to do so from your employing or contracting body, a Caldicott Guardian (the person responsible for ensuring data security) or equivalent. Robust arrangements must be in place to transfer the image to the medical records and to ensure that the image is kept securely and protected from unauthorised viewing.

The General Medical Council has investigated a number of doctors in recent years relating to patient photographs, often where the doctor's intentions have been wholly appropriate.

Be sure to comply with GMC guidance *Making and using visual and audio recordings of patients* which states: "You must get the patient's consent to make a recording that forms part of the investigation or treatment of a condition, or contributes to the patient's



care... You should explain to the patient why a recording would assist their care, what form the recording will take, and that it will be stored securely."

The guidance goes on to explain that doctors should, where practicable, explain any possible secondary uses of the recording in an anonymised or coded form and that key elements of the discussion should be recorded in the patient's notes.

In situations where an adult patient lacks capacity, you must get consent from someone who has legal authority to make a decision on their behalf. Where no one with authority is available or immediate treatment is required, photographs may still be taken where they

leave patient records (on paper or on a screen) unattended or where they can be seen by others. Other basic precautions are advised, such as ensuring your device has its passcode lock activated with a limit set on the number of failed attempts allowed.

Many NHS policies on mobile phone use by doctors relate more to practical aspects of phone maintenance and fair usage rather than issues of confidentiality, but some do go into more detail.

Rotherham CCG, for example, has a smartphone and tablet policy which states: "Where the processing of NHS patient information is proposed on smartphone or tablet devices, additional authorisation must be obtained from the organisation's Caldicott Guardian and the device must use encryption software."

"Sensitive data, including that relating to patients, should not routinely be stored on an NHS device and where necessary should be kept to the minimum required for its effective business use in order to minimise the risks and

impacts should a breach occur."

If you use your smartphone for personal messages or emails, then take extra care to ensure any patient-related correspondence is kept separate and that patient details or images are not stored on the device.

While smartphone use by doctors is becoming increasingly common, you should always first seek advice from your employing/contracting body and be sure to comply with GMC guidance. Even doctors with the best of intentions can find themselves in professional difficulties if they do not take a cautious, informed approach to using their device at work.

"Before you think about photographing a patient, you must get approval from your employer"

form an integral part of an investigation or treatment.

The GMC's *Confidentiality* guidance makes it clear that any personal patient information that you hold or control must be "effectively protected at all times against improper disclosure".

It adds: "You must make sure that anyone you disclose personal information to understands that you are giving it to them in confidence, which they must respect."

The GMC acknowledges that many breaches of confidentiality are unintentional and advises against discussing identifiable patient information where you can be overheard, whether in a public place or in an internet chat forum.

Doctors should not share passwords or

Joanne Curran is an associate editor of FYI

FACING THE BIG C

Medical oncology is a dynamic and evolving specialty, ever responsive to a changing evidence base

ANCER RESEARCH UK reports that nearly 331,000 people were diagnosed with cancer in 2011, an average of around 910 new cases a day. More than one in three people in the UK will develop some form of cancer in their lifetime with more than a third diagnosed in patients aged 75 and over.

A growing elderly population leads to one obvious conclusion – the burden of disease represented by cancer poses a major challenge to the NHS in the future. And this has, in turn, led to high levels of government funding for clinical and research posts in medical oncology.

Medical oncology deals with the diagnosis, assessment, treatment and management of cancer patients. It is a dynamic and rapidly evolving specialty focused on systemic therapies such as chemotherapy, endocrine therapy, biological therapy, immunotherapy, hormonal therapy and other novel approaches designed specifically to target “dysregulated” pathways in the cancer cell.

The specialty is distinct from clinical oncology which also covers the therapeutic administration of ionising radiation (radiotherapy) and whose practitioners are members of the Royal College of Radiologists. Medical oncologists are members of the Royal College of Physicians (RCP) and the specialty arose originally at academic centres where

medical oncologists were often involved with translating advances in the laboratory to the clinic. Latterly, the two specialties have moved closer together and there are academic clinical oncologists and medical oncologists at district general hospitals.

Treatment aims in medical oncology may be curative but can also involve palliation and prolongation of good quality life. Medical oncologists will discuss treatment options with patients, supervise therapy and manage any complications of both the disease and treatment. Often patients will have undergone surgical treatment but require further therapy to improve their prognosis. The job involves close team working with surgeons, specialist physicians, clinical oncologists, radiologists, pathologists, clinical nurse specialists, research practitioners and palliative care physicians.

Medical oncology as a specialty encourages development in both clinical and academic medicine and because it is such an active area of research there is the necessity to regularly assimilate a changing evidence base.

The job

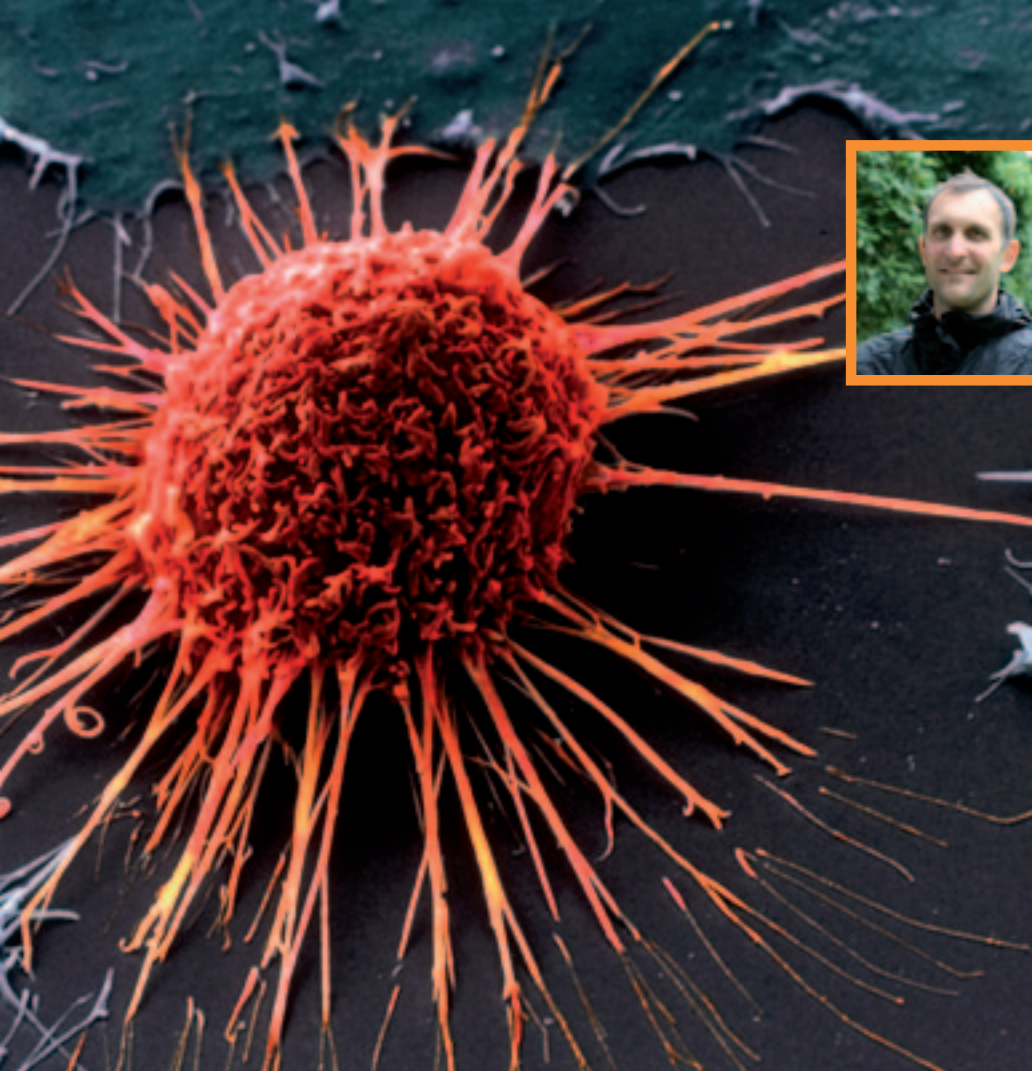
Most medical oncologists will be based in a cancer centre where patients commonly receive care in outpatient settings, such as clinics and day care wards. They will see new and follow-up patients for the organisation

and prescription of treatment and will also participate in inpatient ward rounds. Medical oncology consultants often specialise in the management of patients with specific tumour types and work in close liaison with site-specific medical and surgical teams.

Medical oncologists are found primarily in secondary care settings but there will likely be more direct liaison with primary care services in future if increasing numbers of patients are treated in the community. Acute oncology has recently emerged as a facet of some posts where oncologists get involved early in the management of patients recently admitted and diagnosed with cancer. This has led to an expansion of jobs in smaller hospitals and district general hospitals, previously only visited by oncologists from larger centres.

Dealing with patients who have potentially terminal illnesses can be challenging. A combination of empathy and sensitivity, coupled with a certain psychological “robustness” (which can be developed with experience) is necessary but helping such patients and their families can be extremely rewarding. An enquiring interest into the developments in the field is also essential to advance and optimise outcomes for patients.

The RCP on its ST3 recruitment web page states that medical oncology particularly suits trainees who:



Q&A

Dr Adam Dangoor,
medical oncologist at
University Hospitals Bristol
NHS Foundation Trust

• What first attracted you to medical oncology?

I took rather a long time to make a career decision compared with current junior doctors. However, as early as house jobs, I found aspects of palliative care interesting and rewarding. Then I did an SHO job which included oncology outpatient clinics so gained an insight into what oncologists do, and enjoyed it. My subsequent experience as an SHO in oncology was not entirely satisfactory as the post was far too busy and disorganised; also on the ward you often see the patients who are doing less well. Fortunately it didn't put me off!

• What do you enjoy most about the job?

You get to know your patients well, as there is more continuity of care than in some specialties. They have a serious diagnosis but you can help to ease their symptoms and hopefully support them. You can sometimes cure, or at least prolong life, and really make a difference to patients and their families, which is very satisfying. Academically it is interesting with new advances that you can help bring to the clinic.

• What do you find most challenging?

Obviously you are often dealing with patients with terminal illness and that can be tough but to a certain extent you get used to it. Unlike more sessional specialties, you have more irregular calls on your time - maybe review of patients on the ward, organising treatments and answering queries from patients, families and other doctors, outside your timetabled clinics. In addition of course you have to stay up to date in your field, which can be fairly fast moving. There are new treatments being developed all the time.

• Has anything surprised you about the specialty?

I had quite a lot of exposure as a junior so knew basically what to expect. My period in lab research took me out of my comfort zone, and although I had a mixed experience, there are a variety of opportunities and many find it adds another facet to their career.

• What do you consider the most important attributes of a good medical oncologist?

An interest in people, empathy, good communication skills, organisation and conscientiousness, an enquiring mind and positive attitude.

• What advice could you offer to a final year or FY trainee considering medical oncology?

I always think people need to find a specialty that suits their personality. You should certainly try and get along to an oncology outpatient clinic or do a relevant post so you get an insight into the job. If you want to apply you need to try and make aspects of your portfolio relevant and show a genuine interest, as well as aptitude.

- have good communication skills
- enjoy practising evidence-based medicine by analysing and adapting the results of research to optimise patient outcomes
- are interested in a broad spectrum of academic research, including basic and translational science and clinical trials
- can work as part of a multidisciplinary team.

Entry and training

Entry into training follows successful completion of both a foundation and core training programme. The two core training programmes for medical oncology are: core medical training (CMT) or acute care common stem (medicine; ACCS). Both lead to the attainment of MRCP(UK). This is followed by specialist medical oncology training leading to CCT. The minimum training period from ST1 is six years. Trainees must register for specialist training with the Joint Royal Colleges of Physicians' Training Board (JRCPTB) at ST3.

Medical oncology is seen as an academic specialty and a significant proportion of trainees will take time out during training to do an MD or PhD, but this is not mandatory.

Entry into medical oncology is competitive

and candidates should be able to demonstrate some specific interest in oncology. F1 and F2 and CT1 and CT2 posts are available in hospitals with oncology departments, and rotation through one of these posts during training gives an excellent insight into the specialty. It would also be useful to undertake a project pertinent to medical oncology, either an audit, publication or presentation at a local or national meeting. It is also helpful to speak with current medical oncology trainees and be aware of some of the research that underpins practice.

Sources/Further reading

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CHOOSING A MEDICAL SPECIALTY

Charting your career path can be daunting. **Dr Liz Berkin** offers some advice to help ensure you make the right decision



ONE of the hardest decisions in your career begins at foundation level, which is when you have to start thinking about which specialty to pursue. Anecdotally, about half of foundation doctors have a good idea early on; the other half are very much influenced by their experience.

There are over 60 specialties and over 30 subspecialties to consider after foundation training. If you know which specialties you prefer, you may be able to opt for particular foundation or core programmes which will assist your career decision. Other trainees are more influenced by geography, i.e. they want to stay in a particular region and will consider a range of specialties in order to fulfil that aim.

Factors in making a decision

When choosing a specialty it is important to take into consideration who you are: your personality, likes and dislikes, abilities, interests, ambitions, aptitudes, cognitive processes, limitations and task-management skills. What makes you unique? You need to consider the specialty's requirements, conditions of success, advantages and disadvantages, financial and personal compensations, prospects and opportunities for further career and educational development. You should be realistic about the relative strength of your application; some specialties are very oversubscribed.

All specialties require completion of an application form. Domains are usually (but not always) marked at the shortlisting stage, and if you don't get many marks at this stage you may not get an interview no matter how good a clinician you are. Most doctors cannot gauge the relative strength of their application, but if you look at the national application form (see <http://specialtytraining.hee.nhs.uk>) you should be able to work out whether you can gain marks in any or all of the domains. Additional degrees, postgraduate exams, presentations, publications and teaching or audit experience can provide the basis for enough marks at the shortlisting stage to get an interview for a very popular specialty. You should investigate the competition ratios, but bear in mind that this data isn't historical and does not necessarily reflect future competition – indeed the mere act of making this information available can change applicant behaviour!

If you have decided on a career as a physician, the first step is relatively simple because there are only two main training routes. You should apply for either core medical training or acute care common stem (acute medicine) training. Entry is at core training level 1 (CT1) and the training lasts for two to three years. Both routes open up access to about 30 medical specialties which commence training at specialty training 3 (ST3). This ST3 training lasts four to five years and can sometimes lead to subspecialty training (for example, as a gastroenterologist you could specialise further in hepatology). Visit www.rcplondon.ac.uk/medical-careers to find out more about the different physician specialties.

You may not know that there are a handful

of ST3 specialties which accept trainees from other core training programmes. For example, palliative medicine can take trainees from general practice, and dermatology from paediatric core training. There are also opportunities for trainees from surgery, anaesthetics, emergency medicine and psychiatry to enter some ST3 specialties. Additionally, some non-physician training programmes, such as intensive care medicine, are available to physician trainees.

What are your aspirations?

You need to decide where you want to be in five or 10 years' time, professionally and personally. Do you want to have time with your children, family and friends or time to travel? Where do you place your ideas of contentment or fulfilment? Is this through an ultimate career success or peak, or in achieving a work-life balance?

Many factors can alter your aspirations at any stage of your career. Personal factors include relationships and your sense of self. But there are also organisational/governmental factors (such as new laws coming into effect that may change how certain work is done) and economic issues (financial security and career progression).

Get experience

During clinical placements at student and foundation levels, you will experience a number of specialties, and the real-life medical situations you encounter can influence your view. These placements are vital in providing a taste of life in a certain specialty; you should make the most of these and try to experience as many as you can. As a student, you can consider volunteering or undertaking elective work at a hospital to gain more experience. As a foundation or core doctor you can arrange 'taster' sessions in a specialty which is not already part of your rotation. Do ensure that your decision is objective and not solely based on how much you like the consultant and their team; objectively consider how you felt about that specialty.

Personality

Something else to take into consideration is your personality. Although this should not be the only factor, you need to have an understanding of yourself and how you behave in situations. How you process and communicate information, focus attention, in what environments you like to work and how you solve problems are all crucial when weighing up what specialty would suit you. Are you a hands-on practical person, or do you like to think about detail and solve complex problems? Can you deal with uncertainty and complex/busy situations or do you prefer a more ordered approach with time to think?

Many of the medical specialties require a mixture of attributes because of the varied and variable nature of work as a physician. Deaneries and foundation schools often provide personality and learning styles testing through their careers department, as well as detailed specialty descriptions.

Having second thoughts

If you find yourself in the position where you doubt whether you are in the right specialty, there are still opportunities for change. Quite a few specialties recognise that trainees who move from one training path to another bring with them useful skills – for example undertaking core medical training before moving into radiology or general practice, or undertaking general practice before entering physician training. However, the more changes you make, the longer your overall training pathway becomes. Your decision-making capabilities may be also questioned by selectors.

You could consider a fixed-term post, either in the UK or abroad, to gain experience in particular specialties. This will help you validate your decision about the specialty you want to pursue next. This is also relevant if you are having trouble choosing your first specialty. Quite a few foundation doctors step off the career ladder before entering specialty training in order to experience different specialties and different healthcare systems, and the experience gained is usually very useful.

Liz Berkin is a consultant cardiologist and clinical lead for specialty recruitment at RCP London

Article adapted from How to choose a specialty – originally published as an RCP Insight on the Royal College of Physicians website (www.rcplondon.ac.uk)

Points to consider in choosing a specialty

- Patient contact – will you have time to develop patient relationships or would you prefer to see many patients in a day? What kind of patients do you want to treat, i.e. do demographics play a role in your decision?
- Training schedule and time taken to reach consultant level – how long do you want to train for, how many hours are required and once you are a consultant what hours do you want to work?
- How competitive is the specialty selection process? Do you have the knowledge and skill base to get selected? (See <http://specialtytraining.hee.nhs.uk> for details of specialty entry)
- Career progression – how far can you go in each specialty and how far do you want to career-climb?
- Stress management – how do you cope with haste/stress? Would you prefer time to think things over? For example could you work in the high-pressure environment of acute or emergency medicine?
- Do you like to work by yourself or in a team?
- Do you like research? Data and analysis?
- Do you like problem solving or straightforward care practices – structured work?
- Do you like to teach others, speak to groups?

MEDI



Adam Campbell chats with children's favourite TV doctor Ranjit Singh – better known as Dr Ranj

BEING asked for his autograph during a patient consultation is not something Ranjit Singh would have considered at all likely when he began studying medicine back in the 1990s. But for Dr Ranj – as he is now almost universally known – being recognised in this way has become something of an occupational hazard.

Well, fronting your own BBC children's show and having a regular slot on ITV's *This Morning* programme will have that effect on your life. Not to mention the many public appearances – on TV, radio and in person – that Dr Ranj makes in his hectic schedule, whether he's talking about self-harm on Radio 1, raising

money for Children in Need, presenting a BMJ Award, or even appearing in a Christmas panto.

"It's a really surreal experience, because it's not something that I had ever been used to," says the 34-year-old, whose "day job" – he still calls it that – is at a central London A&E where he is a sub-specialty trainee in paediatric emergency medicine. "I'm at work, so I can't really be spending time giving out autographs and taking pictures. But I appreciate why they ask, and I use it as a sort of bravery award now, just to say, awww, here you go."

In fact, he says that when children recognise him, it often helps them to relax and promotes an informality that is a big part of his approach to patients. "For lots of people, Dr

Whatever sounds very formal. I always introduce myself as Ranj. My whole ethos is about being approachable."

Icky stuff and all

Taking the formality – and the fear factor – out of healthcare was one of the goals he sought when he took time out from his training to work on the concept of what was to become the CBeebies show *Get Well Soon*. Aimed at pre-school children, the show features puppets, games, a doctor's surgery run by Dr Ranj and songs about medical issues from verrucas to vaccinations – not forgetting the mucky subject of poo.

"Children like honesty and they like humour," says Dr Ranj. "For an adult, talking about wees and stuff, it's a bit icky, but a pre-school child loves it. It's about sneaking in education and take-home messages whilst children are having fun. That's the best way of

CINE

IS HIS "DAY JOB"

learning. It's the way I learned as a kid."

He had already started making the odd appearance in the media as a "couch doctor", talking about medical matters, and people were always asking him if he'd thought about screen-testing to be a presenter. This got him thinking and he came up with the idea of a medically based programme for children. He took it to his friend and fellow choir member, Simon Hickson, who had worked in children's TV for years as part of the comedy duo Trevor and Simon.

Hickson liked the idea, set up a meeting for Dr Ranj with a production company, Kindle Entertainment, and they agreed to help develop the show. This involved changing the original target audience, which Dr Ranj had foreseen as 6-12 year-olds, to pre-schoolers.

"I thought, this is probably too complicated for younger kids. But Kindle has a lot more experience in creating kids' shows and they said, actually, if we create this for a pre-school market, it will be richer."

It was at this time that the idea for songs was mooted. He laughs as he remembers it. "The people at Kindle said, 'Hang on, you know Simon through choir, right? How would you feel about singing on the show?' And I thought, you know what, I'll give it a go. And I think it's been one of the most popular parts actually."

The songs, based on modern and old-school classics, are indeed very catchy, and if you listen to them a few times do not be surprised to find yourself singing lyrics like "Where does your poo come from? Why does it stop? Stay in your bottom and not make a plop. Don't squeeze or strain or do it in a rush. Soon you'll be finished then you can fluuuush."

But there's always a serious intent, and Dr Ranj is extremely proud of the way they have managed to communicate some very complicated medical concepts, such as diabetes, to this age group. "Loads of families have contacted me, saying thank you, because now I can show this to my child and their friends and they can understand what's going on."

Finding time

As is the nature of these things, Dr Ranj's appearances on *Get Well Soon* did not go

unnoticed by other media executives. A meeting with ITV led to appearances on the *This Morning* programme, where as a 'couch doctor' he has dealt with a wide variety of issues, from constipation to meningitis to self-harm. After wowing audiences, ITV have now rewarded him with his own regular slot on the show, *Growing Pains*.

It all helps him to further his ambitions regarding health promotion, he says. "It's a family audience and we get to tackle some really, really serious issues."

Of course, having a dual career as a hospital doctor and a media doctor will pull a person in many directions at once. So after the career break that saw the birth of *Get Well Soon*, Dr Ranj took the decision to go part-time, so that he could cope with the competing demands on his time.

He was just starting his ST5 year and had to make a case for it to the Deanery and to his supervisors. "It wasn't a decision I'd taken lightly. But I thought that if an opportunity comes up that's too good to miss, I'd like to give it a shot."

It's quite an unusual step in medicine to go part-time for non-family/childcare reasons and he doesn't shrink from the difficult questions his status as both media personality and

from three to six years, it hasn't been detrimental at all. In fact I think it's been a very positive thing. You know, full-time medical training is a lot of pressure, there's a lot to do, and I would find that sometimes I barely had room to breathe, but now I can. I find that I have more time to consolidate what I've learned, to really make the most of my clinical experience."

Passion and possibility

For the future, Dr Ranj is looking to develop both parts of his career equally, eventually qualifying as paediatric emergency medicine consultant. He is also having meetings about taking *Get Well Soon* forward for another season, and hopes to get some other shows off the ground. "I'm constantly trying to think up new ideas, all medical, and pitching them to production companies."

He agrees that his has not been an orthodox way to pursue a medical career, but he's having fun, he says, and advises young people starting out not to forget the importance of that. "Don't lose your passions just because you're a doctor and it tends to take over your life. It's very easy in medicine and clinical training to just start at the beginning and go through the sausage factory and come out at the end."



"It's a family audience and we get to tackle some really, really serious issues"

part-time trainee has raised. As he explains: "I don't think that part-time trainees always get the level of respect that full-time trainees get, because people assume that you're lazy. And if you're a media doctor, I've heard people say that maybe you are not good enough to be a normal doctor."

Not surprisingly, this does not reflect Dr Ranj's view of his own situation. "Going part-time has allowed me not only to continue the clinical part of my job, but also to play this other immensely important role that I've carved out. And although my training has extended

"Don't just settle for the norm. You know, if you have a passion for something, push for it, and be open to possibility. I'm not saying that everyone's going to go out and try this media thing, because it isn't for everybody."

"But I hope I have managed to give people the impression that, you know, you can have a laugh and have a career at the same time."

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

NEVER EVENT

Day 1

A 52-year-old woman - Mrs K - attends her GP complaining of a very sore back with pain radiating to her left knee. The GP suspects a prolapsed disc and arranges a private referral to an orthopaedic surgeon - Mr P.

Day 8

Mr P examines Mrs K in an outpatient clinic and arranges for an MRI scan. A week later the surgeon speaks with Mrs K to say he has reviewed the scan and identified a slipped disc. They discuss options and he recommends surgery to remove the disc.

Week 3

Mrs K is admitted to a private hospital and Mr P performs an L5/S1 nerve root decompression *without* excision of the slipped disc. He writes to the GP informing her that Mrs K is no longer experiencing leg pain.

Month 20

The pain suffered by Mrs K intensifies to the degree that she is unable to work. Her employer arranges for Mrs K to see another orthopaedic surgeon. He examines the patient and reviews her MRI scans. Later phoning her GP he states that the most recent scan reveals two surgical patties present in the spinal canal - obviously left in place during the second surgical procedure. He believes that these are the cause of the patient's chronic pain. A decision is made to leave the surgical patties in place rather than risk another operation to remove them.

Month 11

Mr P removes the slipped disc but the patient complains that this has only made the pain worse and more especially in her right leg. A few days later the surgeon examines Mrs K and diagnoses a DVT in the right leg and discharges her for review. The patient is commenced on anticoagulant medication. Two weeks later another physician examines Mrs K and concludes that the pain is most likely related to her back and is not a DVT. Mrs K is again referred to Mr P who arranges for another MRI scan. This time he informs the patient that her pain is being caused by scar tissue and an operation to correct this would be far too dangerous. Nothing more can be done.

Month 9

The patient is referred again to Mr P. She reports increasing pain in both legs over the last three weeks. The surgeon arranges for another MRI and the scan shows that the previous L4/L5 prolapse has increased in size. A further operation is scheduled.

Year 3

An action is served on Mr P on behalf of Mrs K alleging breach of duty both in performing unnecessary back surgery and in doing so leaving two surgical patties in her spinal canal. The action claims that due to Mr P's negligence Mrs K has suffered pain and some loss of sensation in

both legs and reduced mobility which has forced her to give up work. In the meantime Mrs K has been diagnosed with an unrelated cancer. She dies one year later and the case is continued by her husband as an executor on behalf of the estate.



XPERT reports are commissioned by MDDUS in regard to the case. In regard to breach of duty Mr P admits to having failed to remove the surgical patties but an expert report on nursing procedure also confirms that it is the duty of the scrub nurse to keep a count of surgical patties used in an operation and inform the surgeon if there is any discrepancy between items supplied and those recovered during the operation. In this matter MDDUS contacts the private hospital in regard to shared liability. Mr P also admits negligence in failing to identify (via MRI scan) and inform the patient of the retained surgical patties.

In regard to causation a number of experts report on their examination of Mrs K and the general opinion is that the surgical patties may have been a factor in the patient's symptoms but there was also evidence of lumbar degenerative disease. Concerning the charge that back surgery was unnecessary, the balance of opinion was that the decision to operate was not unreasonable though unlikely to have had any major impact on Mrs K's condition.

Considering all these factors it was agreed with the member to offer a small settlement to Mrs K's estate and without admission of liability. Some negotiation followed and the

settlement was accepted.

Key points

- Ensure operative protocols are strictly adhered to (see the WHO surgical safety checklist).
- Patients should have full understanding of treatment options and risks in order to make informed decisions.
- Causation (cause and effect of negligence) is a major factor in determining any potential settlement costs in a case.

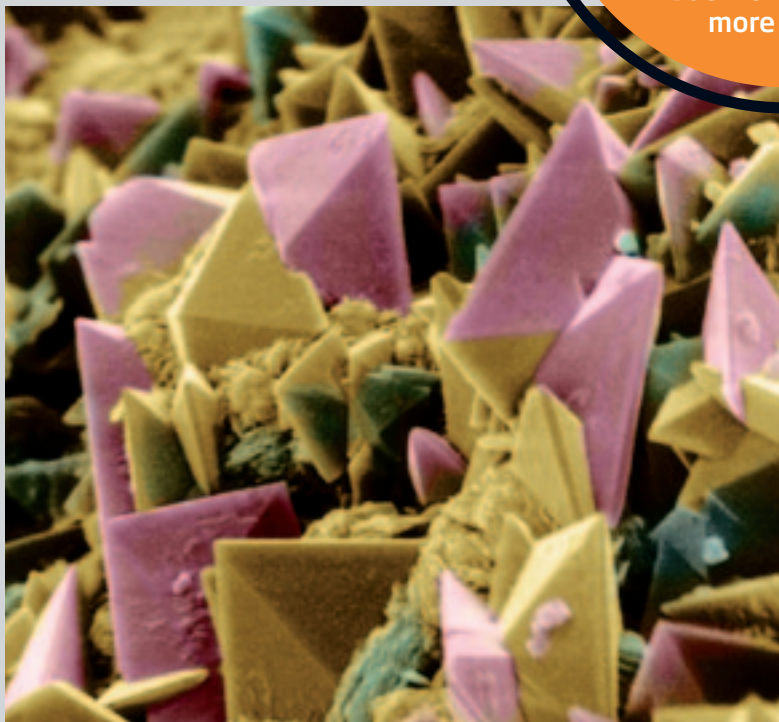
OUT THERE

BUMP OR SHAKE? A US surgeon is urging colleagues to fist bump as a more hygienic alternative to a handshake. Dr Tom McClellan found more bacteria was transmitted with a shake because more than three times as much skin surface is exposed, and for longer, compared to knuckle pounding.

SPIDER SEWING Medieval surgeons used spider webs to close wounds, thanks partly to its believed healing properties. Spider silks are also, weight-for-weight, six times stronger than steel. Research into arachnid spinning techniques is now inspiring pioneering new bio-compatible, biodegradable materials for use in surgery.

YE OLDE REMEDIES Stuffing bread in your ears eases earache while drinking potions of burnt birds and castor oil can tackle sickness. These bizarre remedies are contained in a recently discovered book from 1673 by Royal physician William Sermon.

OFFICE SUPPLIES Scientists at Massachusetts General Hospital have used a 3D printer and sheep cartilage to create an artificial ear that they then mould on a flexible wire frame. It's claimed realistic looking ears could eventually be produced for individual patients on a "rapid timescale".



WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: SCIMAT/SCIENCE PHOTO LIBRARY



Pick: DVD - Side Effects

Directed by Steven Soderbergh, starring Jude Law, Rooney Mara, Channing Tatum, Catherine Zeta-Jones; 2013

Ignore the blood-smeared floor in the opening sequence of this film and you might just think you're in for an earnest indictment of big pharma - greed and disregard for individual patient welfare. A suicidal young woman (Mara) is recruited onto a trial for a new antidepressant

with the lure of free meds. An unexpected side effect leads to tragedy and some uncomfortable questions for her psychiatrist (Law).

Here though the film veers into unexpected territory and the twists and turns never stop. In *Side Effects* Soderbergh offers a watchable thriller more Hitchcock than Goldacre but not without some interesting things to say about a society increas-

ingly dependent on Prozac and the like, generating billions in profits for drug companies.

Law is excellent as the at-first remorseful clinician who in trying to clear his name discovers things are not as they seem - and Mara (unrecognisable from *The Girl with the Dragon Tattoo*) is even more credible as the assumed victim in the affair. Turn off the phone and make the popcorn.

Book Review: Dirty Work

Jonathan Cape; £14.99 hardback

Review by Joanne Curran, associate editor of publications, MDDUS

THERE are few taboos left in modern medicine, or in society generally, but this bold new book from surgeon Gabriel Weston confronts one head-on.

Dirty Work plays out over four weeks in the life of gynaecologist Nancy, an "abortion provider" whose inability to complete a procedure leaves her patient in intensive care and her facing an investigatory panel of the General Medical Council.

As she is called to explain her actions, Nancy is forced to consider the brutality of the dirty work she must perform, as a doctor whose purpose is to end lives as much as save them.

Each of the four chapters covers one week in Nancy's life as she struggles to answer her investigators' questions. This is interspersed with flashbacks to her past, describing the events and experiences that have made her the person she is now.

What kind of person, or indeed doctor, is Nancy and is she guilty of some kind of wrongdoing? These questions are carefully and skilfully explored by Weston whose beautifully descriptive writing is both harsh and poignant.

Weston has talked of her

interest in exploring the idea of women's silence in this novel, of how they are often unable to describe their experiences as freely and brutally as men do.

It is partly Nancy's struggle to find her voice, to tell her story, that results in her potentially fatal surgical error. She remains virtually mute throughout the initial GMC interviews, afterwards explaining to her sister: "I had so much that I wanted to say. But I just... I just didn't say it. Or I didn't say it right. I didn't say enough of it right." A sentiment that any doctor who has ever been called to justify



their professional behaviour will no doubt understand.

The novel follows Weston's award-winning first book *Direct Red* which laid bare her experiences as a trainee surgeon and offered a fascinating insight into the closed world of surgery.

Dirty Work is a brave and complex work that examines the conflict between a doctor's belief in the right to abortion and the difficult reality of carrying out such procedures. It is a compelling read that never flinches from some of the less palatable issues that doctors must face.

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