FYi

ISSUE 21

GET REAL

Think before you get in front of the camera

ALSO INSIDE

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A CAREER IN GASTRO

10 COMMUNICATION
GOOGLE TRANSLATE RISKS

AN MDDUS PUBLICATION

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UK INDEMNITY, ADVICE & SUPPORT

Welcome to your FYi

ONE of the many rewarding aspects of practising medicine is the ability to engage with people from a range of socio-economic and cultural backgrounds. However, communication difficulties can arise that can negatively impact care. But before you reach for Google Translate, read my advice article on page 10.

Sticking with the communication theme, how easy to understand are your outpatient clinic letters? Find out more about the latest guidance on getting these vital letters right on page 4. From Alzheimer to Zenker, medicine is full of eponyms. On page 7 Dr Allan Gaw explores the fascinating history behind this naming convention.

Many junior doctors may think that NHS indemnity provides all the help and support you need should you run into professional difficulties. But what about all the things it won't help you with? Find out why you need an MDO on page 5.

Increasing numbers of doctors are being asked to take part in media broadcasts and various online channels. Find out how to manage the risks on page 6. Opening up a world of career opportunities for fellow doctors is NHS entrepreneur Dr Abeyna Jones. She talks about starting a business and finding happiness on page 12.

Gastroenterologist Dr Helen Fidler offers an insight into her "marvellous" specialty and offers practical career advice in our article on page 8.

Finally, our case study on page 14 focuses on an accusation of rudeness and poor communication in the care of a patient who attends A&E with severe back pain.

• **Dr Naeem Nazem**
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NHS FAX MACHINE BAN

FAX machines are being banned from the NHS in England in a bid to move to more secure hi-tech systems.

Health and social care secretary Matt Hancock has blocked NHS trusts from buying new machines from January 2019 and has pledged to phase them out entirely by 31 March, 2020.

A freedom of information request revealed in July 2018 that more than 8,000 fax machines are still being used across the NHS in England.

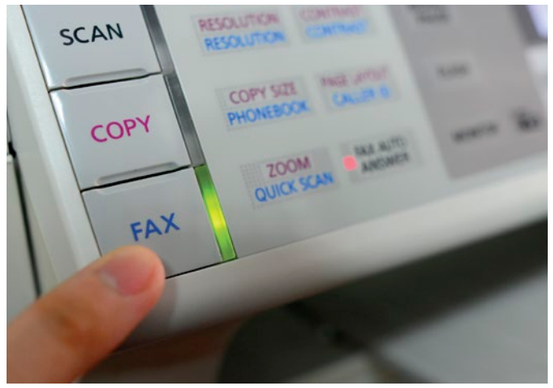
But from April, NHS organisations will have to use more modern, secure systems to comply with new standards. Any system that does not meet these standards will be phased out and the government has said it will end contracts with providers who do not fall in line.

Mr Hancock said: "Email is much more secure and miles more effective than fax machines. The NHS can be the best in the world – and we can start with getting rid of fax machines."

Richard Kerr, Chair of the Royal College of Surgeons Commission on the Future of Surgery, said it was "absurd" that so many NHS hospital trusts were still relying on faxes.

However, RCGP Chair Professor Helen Stokes-Lampard expressed concerns. She said: "While fax machines may be terribly old-fashioned, they do work and remain a highly valued and reliable form of communication between many GP surgeries and their local hospitals, nursing homes and pharmacies.

"A wholesale switchover to electronic communication seems like a brilliant idea but for some practices it would require significant financial investment in robust systems to ensure their reliability was at least as good as the trusty fax machine, as well as having the time to embed – neither of which we have at present as GP teams are already beyond capacity trying to cope with unprecedented patient demand."



CLINICAL TRIAL FOR CANCER BREATH TEST

A CLINICAL trial has begun on a breath test to detect certain cancers at an early stage.

It's being run by Cancer Research UK in collaboration with Owlstone Medical to test the new "breath biopsy" technology.

The researchers believe the technology has "huge potential to provide a non-invasive look into what's happening in the body and could help to find cancer early, when treatment is more likely to be effective".

In the trial, breath samples will be collected from 1,500 people to see if odorous molecules called volatile organic compounds (VOCs) can be detected. Cells produce a range of VOCs when carrying out biochemical reactions as part of their metabolism. When that metabolism becomes altered, such as in cancer and various other conditions, cells can release a different pattern of VOCs. The researchers aim to identify these patterns.

Should the technology prove effective in accurately identifying cancers, the team hope that breath biopsies could in future be used in GP practices to determine whether patients should be referred for further diagnostic tests.

GMC CALLS FOR ACTION ON IMPENDING WORKFORCE CRISIS

A SURVEY by the GMC has revealed that 21 per cent of 45 to 54-year-old doctors and two-thirds of those aged 55 to 64 intend to take early retirement by 2021, presaging a workforce crisis that could be compounded by Brexit.

These findings emerged from research commissioned by the regulator for its 2018 *The state of medical education and practice in the UK* report, which it says "paints a stark picture of unabated pressure on health services".

The survey of around 2,600 doctors indicates that many are considering career changes to escape the heavy workload in primary and secondary care. Around a third are considering reducing hours in the next three years, a fifth plan to go part time and a further fifth plan to leave the UK to work abroad. These findings are further supported by research from the RCGP which found that 31 per cent of GPs said they are unlikely to be working in general practice in the next five years - many citing stress and plans for early retirement.

The GMC report has also revealed that some doctors are employing measures to cope with patient demand that may be piling more pressure on other parts of the system. These include making unnecessary referrals, ordering excessive blood tests or bypassing clinical checklists in order to get through workload.

The possibility of a "no deal" Brexit is adding to uncertainty, with worries about how EEA qualified doctors, who make up nine per cent of licensed doctors in the UK, will be able to join the UK medical register after the UK leaves Europe. The status of EEA qualified doctors already registered in the UK is guaranteed but the GMC has warned that it is crucial that the "tap is not turned off" after March 2019, enabling EEA doctors to come and work in the UK in future.

The GMC is proposing the development of a UK database to record which doctors have what skills and in which locations. It also wants more flexibility in processes for joining the GP and specialist registers.

The GMC also proposes increasing capacity at its testing centre to accommodate the rise in international doctors wishing to sit the two-part skills and language test needed to work in the UK.

NHS STAFF STRUGGLE WITH VOLUME OF SAFETY GUIDANCE

A REPORT looking at 'never events' in 18 hospital trusts in England found that staff struggle to cope with large volumes of safety guidance, with little time and space to implement it effectively.

This is a key conclusion from the Care Quality Commission's (CQC) report, *Opening the door to change*, which examines the issues that contribute to the occurrence of never events and wider patient safety incidents in NHS trusts in England.

It found that, while staff try to implement guidance, this is often on top of demanding and busy roles which make it difficult to give such measures the required priority.

The report also concluded that within the wider healthcare system, different parts at national, regional and local level do not always work together in the most supportive way, with confusion over the roles of different bodies and where trusts can find the most appropriate support.

Education and training for patient safety also could be significantly improved with more appropriate training at undergraduate level and after staff have embarked on clinical careers.

CQC's chief inspector of hospitals Professor Ted Baker praised the work of NHS staff but said: "[T]here is a wider challenge for us all to effect the cultural change that we need, to have the humility to accept that we all can make errors – so we must plan everything we do with this in mind."

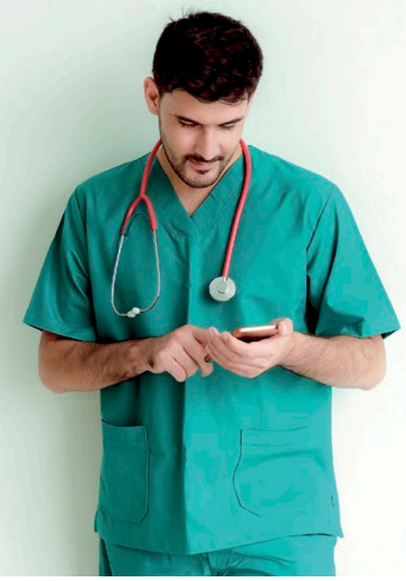
GUIDANCE ON USING INSTANT MESSAGING IN A CRISIS

NEW guidance has been released to help doctors, nurses and other NHS staff safely use instant messaging and other digital technology to co-ordinate patient care during emergencies.

It is in response to the use by medics of communication channels such as WhatsApp to deal with emergency situations like the Croydon tram crash, Grenfell Tower fire and terrorist attacks at the London Bridge and Manchester Arena.

The aim is to help NHS organisations and staff make sound judgements on how and when to use such technologies safely in acute clinical settings, taking into account data sharing and privacy rules.

Among other precautionary steps it advises that staff should only use apps and other messaging tools that meet the NHS encryption standard. Message notifications on device lock-screens should be disabled to protect patient confidentiality and devices used for work should not be accessible to other users. Original messaging notes should be deleted once any advice has been transcribed and attributed in the medical record.



The guidance (**tinyurl.com/yads2zh3**) is provided for staff using instant messaging, videoconferencing, mobile devices including cameras, smartphones and tablets, and also personal devices (BYOD).

Dr Simon Eccles, Chief Clinical Information Officer for Health and Care, said: "Helping people during a crisis like the Grenfell fire demands a quick response and instant messaging services can be a vital part of the NHS toolkit. Health service staff are always responsible about how they use patients' personal details and these new guidelines will help our doctors and nurses to make safe and effective use of technology under the most intense pressure."

PLAIN ENGLISH FOR PATIENTS

Clear and comprehensible outpatient letters are of vital importance for safe healthcare – and they should be addressed to the patient

SAFE care requires clear and prompt communication between primary and secondary care. Failures in communication between sectors underlie many complaints and claims for negligence. Writing outpatient clinic letters is a topic that has generated a recent spate of guidance and this has prompted MDDUS to consider the risks that members face, both in a hospital setting and in primary care.

Generating outpatient letters undoubtedly requires skill, time and care. It is essential that they provide accurate and unambiguous information to the patient and GP. Poor quality clinic letters can lead to failures to clearly address specific clinical questions or set out the necessary action required regarding onward referral, follow-up, additional investigations or changes to medication. This can then lead to delays/failure to investigate or amend treatment, resulting in patient harm.

Following on there may be complaints, GMC investigations, negligence claims and fatal accident inquiries or coroner's inquests. Significant or repeated failures by hospital doctors to produce appropriate quality letters in a timely fashion can also lead to hospital disciplinary action.

As these letters are so important, they have been the focus of particular attention and recently the Academy of Medical Royal Colleges (AoMRC) published guidance: *Please, write to me: Writing outpatient clinic letters to patients*. In it the AoMRC advises doctors to write most of their outpatient letters directly to patients and to copy in their GP. This provides information in a way that complies with GMC guidance, wider professional guidelines and legal requirements. It has also been shown to improve communication with patients and clinical colleagues.

The AoMRC says: "GPs find the letters easier to understand and spend less time interpreting the contents for the patient". Such an approach also avoids the awkwardness of writing about patients in the third person and can help avoid errors: for example if there is a mistake in a letter the patient can take steps to have it corrected.

The new guidance advocates using simplified language and avoiding complex medical terms: for example, writing 'kidney' instead of 'renal' and clearly explaining the meaning of technical terms or acronyms such as 'atrial fibrillation' or 'CRT-D'. Latin phrases such as 'bd' should be avoided in favour of their plain English equivalent ('twice daily'), and any medication changes should be highlighted in bold.

A clearer writing style will also mean that patients can more easily share information with relatives and carers. While doctors may initially spend more time writing letters in the new style, the Academy says they will quickly adjust and may find improvements to the way they communicate with patients during consultations as a result.

The AoMRC document also provides useful examples of patient feedback, letter structure and the appropriate use of plain English. From an MDDUS perspective, anything that improves communication in this area is to be welcomed.

The guidance from AoMRC is in line with that from the Professional Records Standards Body, which must be followed in accordance with NHS contractual requirements in England: "The provider must send the Clinic Letter as soon as reasonably practicable and in any event within 10 days (with effect from April 2018, within seven days)".

These standards are necessary for safe and effective clinical care and to fulfil professional responsibilities. Whilst the contractual obligation refers to England, this is nonetheless a useful guide for any practitioner.

Whilst the GMC does not comment specifically on outpatient letters, there is abundant guidance about appropriate standards for communication with patients and colleagues. *Good Medical Practice* states: "You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must… promptly provide or arrange suitable advice, investigations or treatment where necessary". It adds: "You must give patients the information they want or need to know in a way they can understand".

Read the full AoMRC guidance at **tinyurl.com/y8cucgxd**

ACTION

- Clear/comprehensible outpatient letters are vital for safe care.
- Stay up-to-date with good practice guidelines.
- Take steps to check that your letters meet these standards and continue to do so.

Dr Gail Gilmartin is a medical and risk adviser at MDDUS

WHY YOU NEED AN **MDO**

As a junior doctor, you may believe that NHS indemnity provides all the help and support you need should you run into professional difficulties. But what about all the things it won't help you with?

HOSPITAL doctors often assume that NHS indemnity provides all they will ever need in terms of professional advice and support, with many not giving a second thought to the idea of joining a medical defence organisation (MDO).

It can come as a shock to discover that there are a number of key exclusions to NHS cover, leaving some unsuspecting clinicians having to pay hefty legal bills out of their own pocket.

Hospital doctors must ask themselves how they would cope without advice, support or legal representation in the event of a General Medical Council (GMC) referral, disciplinary hearing, coroner's inquest or fatal accident inquiry. And would they be in a position to fund such assistance personally?

It's true that you will be indemnified by the NHS for the work you do within your NHS contract, but there are a number of key areas where your NHS cover will not assist you.

These are issues for which a medical defence organisation can provide unlimited assistance:

- 24/7 medico-legal advice.
- General Medical Council referrals – without access to assistance, you will have to pay for your own advice and representation.
- Disciplinary hearings – NHS indemnity does not provide advice or support in relation to any disciplinary issues.
- Coroner's inquests/fatal accident inquiries – NHS indemnity offers no guidance or representation on how to conduct yourself at these hearings.
- Private work – it is a GMC requirement that you secure access to indemnity for work not included within your NHS contract.
- Good Samaritan cover – membership of a medical defence organisation will provide you with access to worldwide indemnity for Good Samaritan acts.

As a member of a medical defence organisation, hospital doctors have access to a number of key benefits which are further explained in these commonly asked questions.

I work for the NHS. Why do I require MDO membership when I already have NHS indemnity?

As a hospital doctor you will be indemnified by NHS indemnity for work undertaken within your NHS contract. If, however, you are involved in disciplinary issues, GMC referrals, fatal accident inquiries or coroner's inquests you would not receive any assistance unless you have secured membership with an MDO. Such situations can seriously impact upon your career and could ultimately result in you being struck off. It is therefore crucial that you have access to support and guidance from experienced medico-legal advisers.

I undertake private work, will the NHS cover me for that?

The GMC requires you to secure adequate and appropriate indemnity for any private practice undertaken beyond your NHS contract. As a result you must ensure that you have the necessary cover in place.

If I am referred to the GMC will the NHS offer me assistance?

No. The NHS will not assist you if you are involved in a GMC matter. Remember that the GMC has the power to suspend, place restrictions on your practice, issue you with a warning and ultimately erase you from the register. With such potentially severe consequences there are a range of advantages of having representation and assistance from an MDO whose focus will be to ensure that your case is dealt with fairly and efficiently and that you are properly represented.

What are the advantages of having assistance from an MDO at a fatal accident inquiry or coroner's inquest?

Any criticisms made at an inquest/inquiry can lead to a GMC or a criminal matter being raised against you. With such high stakes it is important to have the support and guidance of a medico-legal adviser with the experience and insight to advise you on how to conduct yourself at such a formal and daunting process. MDOs which employ and retain some of the UK's leading medico-legal solicitors can instruct the best legal representation, which will be made available to members free of charge.

Does my membership provide me with assistance regardless of where I work in the UK?

This is an important point to check with your MDO. Assistance should be offered regardless of where you work in the UK (there may be some exceptions such as the Channel Islands, the Isle of Man, Gibraltar and the Falkland Islands). Even if an MDO does not normally operate membership outside the UK, it is likely it will indemnify members for Good Samaritan acts anywhere in the world which are not covered by any other indemnity or insurance arrangement.

What is the difference between occurrence-based and claims-made products?

Before joining an MDO it is important to clarify the type of product they offer. With an occurrence-based product, members can apply for assistance with claims or complaints arising from incidents that occurred from the period while you were a member, even if you have left membership when the claim/complaint arises. In contrast, claims-made products only guarantee protection if you are insured, both when the incident occurred and when the claim/complaint is made. The crucial importance of this lies in the fact that acts of medical malpractice often do not occur and then materialise in a claim/complaint within a short period of time. There can be several months or even years between the events that give rise to a claim/complaint and the claim/complaint being made.

• For more information visit www.mddus.com

IS **REALITY TV** TOO RISKY?

FEW would argue that electronic media – be it broadcast or online, via websites or apps – is not now an integral part of everyday life: some would say essential. It offers a seemingly unlimited source of engaging material on a vast range of subjects. Growth in this area has been enormous over the last few decades, reaching into every aspect of our lives, both personal and professional.

Popular medical websites and TV programmes have always proved gripping to the public and there doesn't appear to be any decline in appetite.

MDDUS regularly receives calls from members seeking advice about engaging with media producers and these types of calls are on the rise.

Common scenarios which raise questions from members include:

- Requests to participate in online channels with real-time comments on popular TV programmes. Producers often are just looking for a personal view but in the context of being a medical/dental professional.

- Contributing to online blogs or publications which are not directly related to professional practice but in which professional qualifications are stated (which are no doubt seen as a good selling point).

- Patients with complex histories who agree to be 'followed' for a documentary. They want the doctors involved in their care (both primary and secondary care) to speak to the producers about participating in the programme, including being filmed whilst consulting and later interviewed about the patient's condition.

- Requests from friends to add some clinical content to their blog or social media post about a particular medical condition.

MDDUS often hears from members seeking advice about engaging with media producers. What are the risks involved?

- A TV company asking a medical practice if they would be agreeable to participating in a 'fly-on-the-wall' documentary.

Medical professionals are not forbidden from taking part in any of these activities but it is essential to remember that anything you do is judged against professional standards. For medical professionals, the relevant standards set out in *Good Medical Practice* must be applied.

Remember that the General Medical Council (GMC) places great emphasis on maintaining public confidence in the profession and takes seriously any doctor's activities which could bring the profession into disrepute.

In this regard the GMC, in its guidance *Maintaining a professional boundary between you and your patient*, advises: "You must consider the potential risks involved in using social media and the impact that inappropriate use could have on your patients' trust in you and society's trust in the medical profession.

"Social media can blur the boundaries between a doctor's personal and professional lives and may change the nature of the relationship between a doctor and a patient. You must follow our guidance on the use of social media."

Public media includes social networking sites, blogs and other social media. In particular, doctors must take care not to make personal, inaccurate or derogatory comments about patients or colleagues.

Where patients are directly involved, their informed, documented consent is essential. If anonymised data is used or filming occurs in a medical setting, remember that inadvertent breaches of confidentiality can and do occur.

We all remember the high-profile blunder when Jeremy Hunt was photographed standing in front of a board of named patients while visiting a maternity unit. MDDUS shares this responsibility when creating our own drama series, *Bleak Practice*, which is filmed in an actual medical practice and hospital premises.

Also remember to check with your employers or contracting body to ensure that you comply with their requirements. The GMC provides specific guidance on *Making and using visual and audio recordings of patients*, which covers areas such as checking the agreement of your contracting or employing body, informed consent in line with the Ofcom Broadcasting Code and special considerations for vulnerable patients.

ACTION POINTS

- Think carefully before agreeing to take part in programmes or publications on broadcast/social media.

- Check the details of any proposal carefully and ensure that the activity complies with guidance from your regulator.

- Ensure you also check with your employer before agreeing to participate.

- Never discuss confidential details of a patient's case without their express consent.

- Seek advice from MDDUS if in doubt, particularly with regard to indemnity.

Dr Gail Gilmartin is a medical and risk adviser at MDDUS

TAKING **POSSESSION**

From Alzheimer to Zenker, **Dr Allan Gaw** explores the world of medical eponyms

THERE is a comet stitched into the heavens of the 11th century Bayeux tapestry. It is now known to be a regular visitor to our skies, but while the comet had been observed many times by the ancients, it was the Astronomer Royal, Edmund Halley, who is first believed to have predicted its periodic return to our skies. He did not live to see the comet reappear and to have his calculations vindicated, but when it arrived on cue it was named after him in 1759. An apostrophe secured the deal, and what goes around comes around; in Halley's case, roughly every 76 years.

It is all too easy to be possessive. Discovery often implies ownership and those who first describe a disease, a phenomenon or, in Halley's case, a comet, have in the past been honoured with not just their name being applied, but they have also been granted the deeds of ownership that come with an apostrophe S. In the world of medicine, those such as Asperger, Duchenne, Burkitt, Grave and Addison, as well as many others, took possession of diseases from which they never suffered, but which they are credited as first describing.

Cushing, Crohn and Alzheimer are just three examples of very well-known medical eponyms. Harvey Cushing was an American neurosurgeon who described what would become his eponymous disease of the pituitary in 1912. Burrill Crohn was an American gastroenterologist who published details of patients with his inflammatory bowel disease in 1932. And, Alois Alzheimer was a German psychiatrist and neuropathologist who first described an 'unusual disease of the cerebral cortex' that led to the premature death of a patient in her mid-50s in 1906. Meanwhile, some physicians' names were given to more than one condition, including German pathologist Friedrich Albert von Zenker (Zenker paralysis and Zenker diverticulum) and his fellow countryman and paediatric pathologist Wolf W Zuelzer (Zuelzer syndrome, Zuelzer-Ogden syndrome and Zuelzer-Kaplan syndrome).

Of course, in medicine it isn't just diseases that bear the names of the famous. When it comes to examination we have a whole medical dictionary of clinical signs named after their exponents, from an Adie's pupil to Beau's Lines and Osler's Nodes. And then, there are tests. I am sure I am not alone in long-believing that the Apgar Score for assessing neonatal wellbeing was a clever acronym, only to discover we owe that particular one to Virginia Apgar, the American obstetric anaesthetist who devised the scoring system in the 1950s.

Apostrophes, however, do have a habit of disappearing over time and taking the ownership they signify with them. Mr Charles Henry Harrod's department store in Knightsbridge has lost its apostrophe, as has Mr John Boot's chemist shop and, much more recently, Mr Tim Waterstone's bookshop. Possession evaporates with rebranding and the same is happening in medicine. Today, we are as likely to see eponymous disease names written either with or without the apostrophe, or even without the additional letter S altogether. For example, Crohn's, Crohns and Crohn Disease have all become synonymous in the literature.

The main argument against the use of eponyms is that they are unhelpful for both clinician and student, telling us nothing of any clinical import about the disease/test/sign in question. For example, unless you are a 1930s baseball fan, amyotrophic lateral sclerosis tells you much more about the underlying pathology than its eponym, Lou Gehrig's disease. That one, however, at least bears the name of a patient rather than a physician.

Indeed, a common criticism is that merely describing a disease that you have never suffered does not constitute ownership. The corollary, however, seems equally quaint: just because you contract a disease, one that many others before you have also suffered, you can hardly take possession of it. But perhaps we are being unfair to the physicians and scientists in question for they rarely, if ever, called their diseases after themselves, and the conferring of the eponym was usually left to others.

"For some, the use of eponyms adds a sense of history to medicine"

Particularly in medicine, this issue of eponyms has been debated for many years. A generation ago one conference of the Canadian National Institutes of Health proposed: "The possessive use of an eponym should be discontinued, since the author neither had nor owned the disorder." More recently, both the WHO and the American Medical Association have argued for the elimination of possessive eponyms.

For some, however, the use of eponyms does add colour and perhaps a sense of history to medicine. Perhaps we should honour those who have laid the foundations of our subject. But, if we are going to go to the bother of memorialising those who first described a disease, perhaps the least we can do is offer them the nicety of some punctuation to go with it.

Sources

- The Lancet 1975 March 1; 1(7905): 513.

- WHO Style Guide, 2004.

- AMA Manual of Style, 2007.

Allan Gaw is an educator and writer based in Scotland

GO WITH YOUR GUT

A career in gastroenterology promises to be diverse, exciting and satisfying

GASTROENTEROLOGISTS investigate, diagnose, treat and prevent all gastrointestinal and hepatological diseases. The role is varied and offers clinicians the opportunity to look after acutely ill and chronically unwell patients, as well as carrying out technical and often demanding procedures. One of the fastest-growing UK medical specialties, it has seen considerable scientific and technological developments in recent years, meaning specialists are always acquiring new skills and extending their knowledge.

Entry and training

Upon successful completion of the two-year foundation training programme, specialty training in gastroenterology generally lasts seven years. This begins with either two years core medical training (CMT) or three years in acute care common stem (ACCS). At this stage, trainees are expected to gain full membership of the Royal College of Physicians (MRCP UK) before progressing to specialty training (beginning at ST3). Most gastroenterologists also train in general internal medicine, which takes a minimum of five years (ST3-ST7). Sub-specialty training in hepatology can be taken in ST5. Trainees are expected to have six months each of core liver and nutrition training.

The job

Gastroenterology is known for its diversity. While some specialists deal with a single organ, gastroenterologists manage patients with disorders of the liver, intestines, stomach, oesophagus, pancreas and gallbladder. That said, there is opportunity to become highly specialised in fields including hepatology, inflammatory bowel disease, inherited cancer syndromes and tropical diseases.

All gastroenterology specialists are competent at upper gastrointestinal (GI) endoscopy and most will be trained in lower GI endoscopy. Some will have had additional training in hepatobiliary endoscopy or small bowel endoscopy. Most will participate in acute gastroenterology admissions and manage a broad range of GI disease, either in outpatients or following admissions.

They treat a wide range of conditions including: GI bleeding; GI cancer; anaemia; inflammatory bowel disease, e.g. Crohn's; gastroenteritis; hepatitis; short bowel syndrome; jaundice; and management of the wide range of causes of hepatitis. This broad range makes multidisciplinary team working a key feature of the specialty. In addition to liaison with nurse specialists, gastroenterologists will work closely with surgeons, diagnostic and interventional radiologists, pathologists and oncologists.

Sources:

- British Society of Gastroenterology: **www.bsg.org.uk**
- Royal College of Physicians – **www.rcplondon.ac.uk**
- GMC gastroenterology training curriculum - **tinyurl.com/yb6lego5**
- NHS Health Careers - **www.healthcareers.nhs.uk**

Q&A

Dr Helen Fidler, consultant gastroenterologist, Lewisham and Greenwich NHS Trust

What first attracted you to gastroenterology?
As a trainee, it seemed to me that the cleverest and most engaging physicians I met were gastroenterologists or chest physicians. I planned to train in chest medicine but a freeze was placed on training numbers, so I switched half way through my MD research from sarcoidosis to Crohn's disease. And I haven't regretted it for one day.

What do you enjoy most about the job?
Gastroenterology is a marvellous specialty. There is huge flexibility in the discipline. I love practical skills – violin, gardening, knitting – so endoscopy is a joy for me. Being paid to play computer games whilst chatting with an amazing group of endoscopy staff and interesting patients is a privilege.

What do you find most challenging?
I really hate multitasking. I like life to be predictable and to feel in control. So overbooked clinics and interruptions during endoscopy lists would be in my Room 101. Add to that, patients having difficulty getting back to clinic due to waiting times or our endoscopy and IBD nurses not being valued. I rarely find patients challenging, except the ones who take only one glass of Moviprep and think that one episode of diarrhoea will be enough for their colonoscopy prep.

Has anything surprised you about the specialty?
It has been remarkably straightforward to fit this specialty around family life, and to vary my job plan with my caring commitments over the years. This is partly due to the sessional nature of endoscopy and outpatient work. I'm still surprised by Twitter posts showing an entire male 'top table' at gastroenterology conferences.

What do you consider the most important attributes of a good gastroenterologist?
Well, all the things that make a good consultant plus some others. So patience, professionalism, diligence, kindness and fabulous communication skills are a start. Plus manual dexterity and, for women, the ability to hold your own amongst a majority of male colleagues, and not apologise for working less than full time. The Supporting Women in Gastroenterology group (SWiG) of the British Society of Gastroenterology (BSG) is really helpful here.

What are the most common misconceptions about the job and the specialty?
My children call me a 'bum doctor' and ask how I can spend all day looking at bottoms. I try to explain but it hasn't worked so far.

Describe a typical working week
I'm now 56, and I think it's important at this stage of a consultant's career to reassess your career goals. I've taken on medical politics in the last five years to try to improve things for our future colleagues, and now work with the BMA as deputy chair for the UK Consultants Committee, and on the BMA Council and Board of Directors. I still do clinical gastroenterology every week but each one varies, which is hugely enjoyable. And working with SWiG and setting up our first ever conference at the Royal College of Physicians was marvellous.

What are the tools you couldn't live without?
My phone, for responding to urgent clinical and medico-political crises. It drives my family mad - the children are always telling me to put it down which is true role reversal. I also love Microsoft One drive for enabling me to carry work with me, and our family labradoodle for de-stressing without gin.

Any advice for FY1s on securing a training post?
First decide exactly what you want and then go for it. Talk yourself up, everyone else does, and get the best possible CV you can by aiming to publish a case report or abstract in each job you do. Remember you will meet your colleagues again repeatedly throughout your career so don't fall out with anyone.

Tell us more about your work with SWiG
Only 30 per cent of gastroenterology consultants are female, and we are under-represented on BSG Council. This needs to change, and is changing, as diversity is essential to our specialty's future. SWiG aims to make the specialty attractive to women and those with caring commitments and improve flexible working practices. The BSG is a very friendly society, and small enough to be able to make real differences fairly quickly. Our website features blogs and advice on topics from working less than full time to maintaining an academic career. Our SWiG day at the RCP was very well attended and, with so many talented women training and working in the specialty, the future looks bright.

LOST IN TRANSLATION

Overcoming communication barriers with patients can be challenging. **Dr Naeem Nazem** looks at the pitfalls of Google Translate and other solutions

ONE of the many rewarding aspects of practising medicine is the ability to engage with people from a wide range of socio-economic and cultural backgrounds.

But communication difficulties can arise and these have the potential to negatively impact patient care. In dealing with limited English proficiency to motor speech disorders, there are a number of pitfalls to avoid.

Language barriers

An obvious, and increasingly common, risk area is treating patients who speak little or no English. This can cause significant difficulties.

When faced with a language barrier between you and your patient, the ideal solution is to have a certified interpreter present. If so, be sure to record the interpreter's details within your contemporaneous medical entry. However, logistical difficulties often mean that a professional is not readily available. In these circumstances, first check if your hospital has a policy on interpreter and translation services and be sure to follow it. If an interpreter is not readily available, consider whether it is possible to defer your interaction with the patient until one can be arranged. You may want to discuss your decision to postpone with senior colleagues to ensure they are also content it does not compromise patient care.

Help from friends or family

In a busy hospital setting it is often tempting just to "make do" with whatever resources are available. Doctors often encounter relatives or friends who are keen to be helpful and translate for patients. This may seem like the most convenient (not to mention cost-free) solution but there are pitfalls. The first and fundamental issue to consider is your patient's right to confidentiality and your obligation not to disclose their personal information to a third party without consent.

Another relevant consideration is the lack of any training or accreditation for such an ad hoc interpreter. Do they understand the important points you are making? Even if they do, can you be sure they are relaying the information accurately? Although this is important in all aspects of medical care, it is essential when you are seeking your patient's informed consent. MDDUS has encountered several cases of complaints and accusations of clinical negligence in which patients have stated they were not aware of all the risks because they had not been communicated by the interpreter.

It is also important to keep in mind that friends or relatives of a patient are not impartial and may have their own agenda which may not align with your patient's. As a consequence, they may filter the information they communicate to the patient, or amend responses to suit their own motivation.

That said, there is no specific rule preventing you from seeking their assistance. A patient may be adamant that they want a particular person to translate for them, or circumstances may justify seeking their assistance. In these cases it is important to make a comprehensive note explaining that a friend/relative is acting as interpreter. Include their name and a brief record of why you believe it is appropriate or necessary, and bear in mind the pitfalls mentioned above.

Smart apps

Who needs a human interpreter when you've got technology, right? Given the difficulties in securing a trained professional, clinicians are increasingly turning to online translating tools. Perhaps the most recognised is Google Translate, which has been gaining in popularity over recent years. Although it can be useful in social settings, Google Translate has not been validated for use in the medical setting and is not endorsed by the NHS. As a result, there is a significant risk of error in using it to facilitate medical consultations. Online translating tools often use a literal approach and direct translation of words can fail to take into account the broader context and may alter meaning. Similarly the English translation of a patient's response may not accurately reflect their intention.

"In the absence of any validated online translating tool it is perhaps best to avoid relying on them"

In the absence of any validated online translating tool it is perhaps best to avoid relying on them. Not only is there a significant risk of a potentially serious error, but there's a good chance using such online tools will breach your hospital's interpreter/translation policy. Instead, focus on liaising proactively with your hospital's interpreter service to find out about their availability and any practical help they may be able to offer in more urgent cases. Your hospital may have a list of multi-lingual staff members who are able to assist in urgent situations. Finally, if you find yourself in difficulty don't forget the immense skills and experience of your colleagues – seek guidance from other doctors, nurses and ancillary staff.

Capacity

At the beginning of any patient interaction it is essential to establish whether they have capacity to engage in their medical care and provide consent if required. If a patient lacks capacity for the specific decision required, you should establish whether they have made a valid advance decision or appointed a power of attorney for healthcare decisions. Also check whether the court has appointed an individual to make decisions on their behalf. If in doubt, seek assistance from senior colleagues, your hospital legal department or medical defence organisation, being sure to carefully document any decision making.

If there is no advance decision, power of attorney or court-appointed decision-maker, you should act in the best interests of your patient. The relevant legislation is the Mental Capacity Act 2005 (England and Wales), the Adults with Incapacity Act 2000 (Scotland) and the Mental Capacity Act (Northern Ireland) 2016. You should be familiar with GMC guidance, *Consent: patients and doctors making decisions together*, and their website features a very helpful interactive online tool for when you are unsure if a patient has capacity.

Motor speech disorders

A patient's ability to communicate may be affected by a motor speech disorder. A common one is dysarthria which can be caused by factors such as stroke, head injury and facial nerve damage.

In isolation, dysarthria does not affect a patient's ability to understand. If the level of dysarthria affects your ability to communicate with your patient, consider any means by which you could overcome the difficulties. This may include seeking assistance from the speech and language team, trying to remove background noise, deferring non-urgent decisions if the dysarthria is likely to resolve shortly, or using additional means of communication such as writing.

*For more specific guidance, contact the MDDUS advice line on **0333 043 4444**.*

Dr Naeem Nazem is a medical adviser at MDDUS and editor of FYi

A BLUEPRINT for HAPPINESS

NHS Entrepreneur **Dr Abeyna Jones** explains how her quest for a satisfying career inspired her to launch her own business

STARTING life as a newly-qualified doctor was not quite how Dr Abeyna Jones imagined it would be. Having successfully completed her medical degree, she felt "disenchanted" by the prospect of years more of exams, qualifications, certificates and gruelling work.

But far from giving up, Abeyna decided to make positive changes by launching her own business. And her new venture, Medic Footprints, didn't just take her career in a completely new direction, it has done the same for thousands of other clinicians too. The social enterprise, which aims to help doctors diversify their careers and improve their wellbeing, has gone from strength to strength and earned praise from NHS England who have named her as one of their "clinical entrepreneurs".

Speaking to *FYi* while on honeymoon in rural Vietnam, the doctor talks about how the decision to diversify in her own medical career has brought flexibility and life experience, but above all, happiness.

She says: "As a junior doctor the experience was quite different from what I expected. There was still a lot to learn after five years of medical school, with perpetual exams, qualifications, certificates and more. I wondered whether the time and cost investment of medicine as a career was worth it."

Learning curve

During her core surgical training, an opportunity arose to work in general and trauma surgery in South Africa and the London-based doctor jumped at it. The 18-month trip would become a life-changing experience and help carve out her then-uncertain future.

Taking a sabbatical from her UK post, she went to work in a semi-rural public healthcare setting where resources weren't as readily available compared to the major cities.

"The learning curve was huge," she says. "I had to perform trauma laparotomies, amputations and bowel resection within a few weeks of arriving when all I could really do after my two years of core surgical training [back in the UK] was basic appendicectomies and circumcisions."

Being a UK doctor working overseas does pose its challenges, and Dr Jones experienced a few. The language barrier was a particular challenge in the Zulu-speaking community in which she was based. However, the entire experience helped her grow professionally as a doctor.

She says: "It reminded me why I went into medicine in the first place and clarified that I was previously frustrated with the UK healthcare system – not medicine as a whole."

Diversifying

The experience prompted Abeyna to make some big professional changes. Not only did she set up Medic Footprints in 2014, she then took the difficult decision to leave surgery and to retrain as a specialist in occupational medicine where she could spend more time with patients and work more regular hours.

There are similarities across her roles as a businesswoman and as an occupational health (OH) physician. In both, her mission is to ensure doctors are happy in what they do, offering advice and support to clinicians who may be suffering from physical or mental health problems, stress or other issues affecting their work. Both roles also allow her to apply her entrepreneurial skills such as tendering contracts, bidding, and developing relationships.

NHS England is hoping to encourage these types of entrepreneurial skills and much more with their clinical entrepreneur training programme. As one of the scheme's official "clinical entrepreneurs", Abeyna and her colleagues are offered opportunities to develop their entrepreneurial goals in the hope they will drive innovation and improve leadership in the NHS in the future. As NHS England says, the scheme is "designed to stimulate and encourage the most entrepreneurial clinicians to develop their own products and services to improve healthcare."

> *"There is huge scope for doctors to diversify their career without leaving clinical practice"*

Abeyna believes creativity and an ability to "think outside the box" are key to being an entrepreneur, but says doctors already have lots of relevant skills. "The breadth of skills that doctors learn are very easy to transfer," she says. "Teamwork, analytics, coping with exam pressure and the need to learn quickly, good communication skills, planning, policy – these are all very relevant."

She is pleased to see the positive impact of the NHS England scheme so far, but is eager for more changes.

She says: "With all the ongoing challenges in healthcare we need doctors to develop the tools to become better leaders which can only be gained through experiences beyond day-to-day clinical work. This includes learning about business, finance, management, working in different healthcare systems and beyond."

She says NHS doctors often do not have the opportunity to develop these skills because of the predominantly clinical focus of their training. "They're expected to magically have the knowledge required to be a healthcare leader when they reach consultant level which in my opinion is way too late."

Wellbeing boost

The goals of the clinical entrepreneur scheme dovetail nicely with Abeyna's work at Medic Footprints. The organisation has a firm focus on wellbeing and helping clinicians to pursue their entrepreneurial ambitions. It provides support through webinars on alternative careers, career coaching and mentorship. It also aims to give medics access to any career opportunities in any sector – pharmaceutical, management consultancy, health tech, media, overseas and more – almost like a niche version of LinkedIn.

As well as helping to drive progress in a modern NHS, Abeyna believes diversifying will also boost the health and wellbeing of under-pressure medical professionals.

The organisation has worked with doctors seeking a wide range of "non-traditional career paths". Some want to set up their own business or charity while others are looking to spend a period of time working abroad. A handful of more extreme cases want to quit the medical profession entirely but Abeyna and her team are keen to highlight the exciting NHS career opportunities that doctors may not know about.

"Alternative careers for doctors means many different things and doesn't mean having to leave clinical practice," she says. "There is huge scope to do other things on the side that doctors may not even have thought about."

Living the dream

Although her own medical career has transformed and diversified in recent years, she has certainly not turned her back on medicine and continues to work flexibly as a self-employed OH physician which complements the work she does as founder and director of Medic Footprints.

Compared to how unhappy and frustrated she used to feel as a hospital doctor, Abeyna is now living the dream. She says: "I'm living a professional lifestyle I could previously only have dreamed of – and arrived here by making very conscious choices about what I wanted in my life and pursuing them.

"The beauty of my life now is that I experience the rewards of what I put in – manifesting quite differently from when I was a hospital doctor. I feel much more content with my life and feel that I've made the right choices for me moving forward.

"I think I value myself much more than I used to which is perhaps the most important point of all."

- *Find out more about Medic Footprints at:* ***www.medicfootprints.org***

Kristin Ballantyne is a freelance writer based in Glasgow

FAILURE TO COMMUNICATE

Day one - 9am
A 51-year-old former primary school teacher – Ms W – attends A&E complaining of severe back pain with weakness/numbness in both legs. The pain is so severe she is provided with a wheelchair.

11:30am
Ms W is attended by an ST in emergency medicine – Dr P – who undertakes a history and examination. He notes Ms W sustained a lumbar spine injury two years ago after falling on ice. She had refused surgery and had been coping okay until a few weeks ago. The presenting symptoms include "pins and needles" in both legs, weakness and bilateral foot drop. She can walk but with difficulty and is also having problems urinating. Dr P examines her and confirms weakened plantar flexion and sensory impairment in both limbs. Sphincter tone on voluntary squeeze is also poor and Dr P notes the bladder is not full. A diagnosis of suspected spinal cord compression is recorded and Dr P requests a lumbar X-ray and referral to orthopaedics.

Later that day and beyond
An orthopaedic specialist examines Ms W and suspects a disc prolapse. An MRI reveals lumbar disc herniation with cauda equina syndrome. She is taken to theatre for decompression surgery and makes a good recovery.

THREE months later a Rule 4 letter from the GMC is received by Dr P stating that Ms W has made a complaint which will be investigated. It advises the doctor to contact his medical defence organisation and Dr P phones MDDUS.

The complaint alleges that Dr P undertook only a cursory inspection of Ms W and on testing plantar flexion accused the patient of "not pushing hard enough". It is also claimed the doctor asked why Ms W had attended A&E for a chronic back problem instead of first consulting her GP. Ms W also questions the need for a lumbar X-ray, having been told later that an MRI was the appropriate investigation.

Ms W claims that her symptoms clearly indicated an acute neurological deficit and she felt that Dr P was hinting that she was somehow "faking it".

MDDUS helps Dr P compose a letter of response to the complaint in which he disputes some of the assertions in the complaint but acknowledges that there was a communication breakdown. The records include a letter of apology to Ms W for this. The response also shows insight in that Dr P states he has subsequently attended a course on improved patient communication, in addition to a CPD session on the assessment and treatment of cauda equina.

Six months later the GMC writes back to say that the case is to be concluded with no further action. The letter sets out the reasons for the decision stating that the GMC sought advice from an independent expert consultant in emergency medicine who considered all the available documentary evidence including the letter of complaint and the medical records. The expert made some criticism of Dr P's actions but did not find that the care and treatment of Ms W fell seriously below an acceptable standard.

The expert opines that the patient presented with clear neurological sequelae from a prolapsed intervertebral disc. Symptoms included bilateral weakness and sensory deficit of the lower limbs which had been adequately recorded by Dr P.

The subsequent examination was also adequate in noting that the patient did not have a full bladder, had sensory and motor deficit in both lower limbs and some abnormality in anal sphincter testing. The conclusion that Ms W needed further assessment for spinal cord compression was appropriate although the lumbar spine X-ray was inappropriate and superfluous. An orthopaedic referral was the appropriate call as Ms W required urgent spinal surgery.

The expert also addresses the claim that Dr P initially questioned Ms W's decision not to first attend her GP and that the examination was cursory and conducted in an insensitive manner. He states that if this is accurate then Dr P's approach could be judged inappropriate and incorrect – but he also points out that the truth of the matter is in dispute and impossible to establish from the records.

GMC guidance to case examiners states that in applying a "realistic prospect test" to any allegation they should not normally seek to resolve substantial conflicts of evidence. They should instead rely on documentary information as "parties to a conversation may have very different perceptions of a discussion, or the manner in which it was conducted".

KEY POINTS

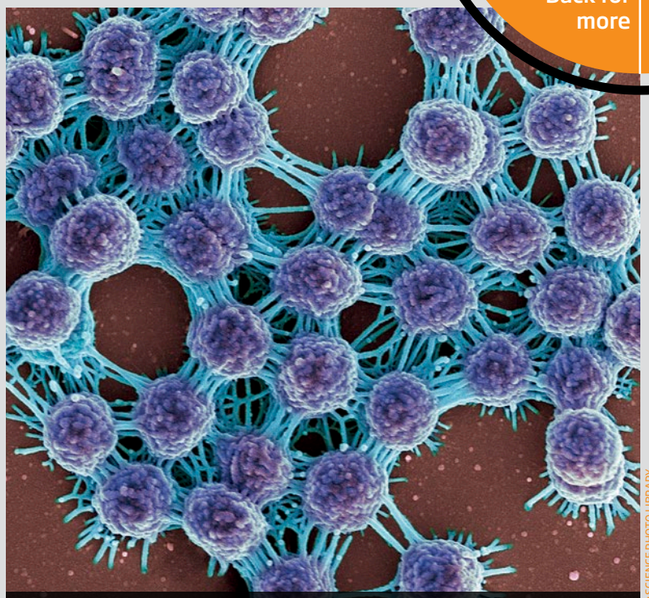
- Be mindful of patient perceptions in the manner in which you assess a presenting complaint.
- Clear/comprehensive records are the best defence in any complaint/claim.
- Remember that state-backed indemnity will not provide assistance for GMC proceedings – membership of a medical defence organisation is essential.

OUT THERE

E-HEALING A bandage that generates a gentle electrical current could help wounds heal four times faster, according to research from the University of Madison-Wisconsin. The electrical pulse caused skin-healing cells to flock to the injured area, which encouraged the production of collagen and new skin cells.

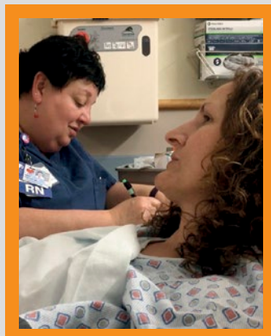
GOLDENEYE The world's oldest known artificial eye has been found in Iran in the remains of a woman who died almost 5,000 years ago. Made of tar and animal fat, it was still intact in her skull. She is likely to have been a wealthy woman in her late 20s and was buried with ornamental beads, a leather sack and bronze mirror.

KID CAR Transporting young children to surgery in a ride-on toy car can relieve preoperative anxiety to a comparable degree as midazolam. A study by academics in Shanghai and Cincinnati, USA, compared the method to using a trolley both with and without sedation and found the toy car eased anxiety without unwanted drug side effects.



WHAT ARE WE LOOKING AT?
Stumped? The answer is at the bottom of the page

PHOTOGRAPH: SCIENCE PHOTO LIBRARY



PHOTOGRAPH: NETFLIX

Pick: Netflix - The Bleeding Edge

Directed by Kirby Dick. Starring Robert Bridges, Angie Firmalino.

THIS Netflix documentary shines a light on the murky world of medical devices, a $400 million industry responsible for products such as hip and birth control implants. While prescription drugs are subject to rigorous safety checks, the same cannot be said for medical devices. One patient profiled in the film is orthopaedic doctor Stephen Tower whose tremor and alarming behavioural changes were found to have been caused by metal seeping into his body from a metal-on-metal hip replacement. His symptoms disappeared within a month of the implant being removed.

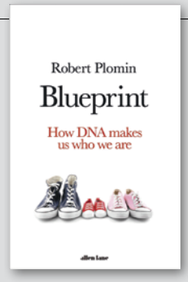
Director Kirby Dick told the *Guardian* that "right now medical device companies can get away with just about anything", and it's important to note the film's plea for urgent action is not limited to the US. A call for "drastic changes" to medical device regulation was made in November 2018 in the UK by the Royal College of Surgeons. This is an engrossing film that should not be ignored.

Book Review:

Blueprint: How DNA makes us who we are

By Robert Plomin
Allen Lane, £20 paperback, 2018

Review by Dr Greg Dollman



THE psychologist Robert Plomin argues in his new book *Blueprint* that "genetics is the most important factor shaping who we are". A keen advocate of 'nature' being the design of our individuality, Plomin does not seek to discard the influence of 'nurture', but holds that this is "mostly random". He argues that the findings of decades of DNA research will shape the way we predict mental illness, and also influence how we parent and teach.

Plomin summarises the substantial subject matter: "Inherited DNA differences are the major systematic cause of who we are. DNA differences account for half of the variance of psychological traits. The rest of the variance is environmental, but that portion of the variance is mostly random, which means we can't predict it or do much about it."

He clearly wants to start a discussion… Plomin considers heritability ("the one per cent of DNA that differs between us and contributes to our differences in behaviour") to understand the reason why we are different psychologically, even when environments are shared. He states that while our circumstances will direct outcomes, the genetic differences in personality increase this happening. So our genetic makeup will determine our response to external events.

'What about the impact of death, illness or divorce?', I hear you exclaim. Plomin argues that, genetics aside, any significant environmental factors boil down to chance. They involve random experiences over which we hold little control. As such, Plomin concludes that long term effects are insignificant. He writes: "Life experiences matter, but they don't make a difference". Even when looking at society's influence, he believes these factors have little impact on an individual's personality.

Plomin also explores the impact of this theory on individuals, society and psychology. He looks, for example, at predictor scores for mental illness, including schizophrenia and Alzheimer's, considering how we may use the findings to improve future detection and management. He does acknowledge, however, the dilemma in identifying genetic risk when we are (currently) unable to do anything about it.

Plomin acknowledges that the theory is complex, and that it will challenge our ideas of who we are and what makes us different. He writes elegantly, and explains carefully his specialty. The book is accessible and thought-provoking.

WHAT ARE WE LOOKING AT? *Saliva and bacteria, SEM*