GET REAL

Think before you get in front of the camera

ALSO INSIDE

08 GUT FEELING  A CAREER IN GASTRO
10 COMMUNICATION  GOOGLE TRANSLATE RISKS
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 is it to manage the risks of confidential and personally identifiable information? The PowerPoint presentation on page 3 shows up a world of career opportunities for fellow doctors is an online course Dr Abeyna Jane. She tells us starting a business and finding happiness on page 12.

Gastroenterologist Dr Helen Siddon offers an insight into her “marvellous” specialty and offers practical career advice in our article on page 3.

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

• Dr Naeem Nazem Editor

NHG FAX MACHINE BAN

FAX machines are being banned from the NHS in England in a bid to move to more secure fhi-technology. 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 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 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 contract 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 Knup, 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, RCPG Chair Professor Helen Stokes-Lampard expressed concerns. She said: “Fax machines may be traditionally old-fashioned, they do work and remain a highly valued and reliable form of communication between many GP surgeries and their hospital based on getting these vital letters out. Authorities are being asked to take measures to cope with patient demand that may be piling more pressure on other parts of the system. These include making unnecessary referrals, ordering excess blood tests or bypassing clinical guidelines in order to get through workloads.

The possibility of a “no deal” Brexit is adding to uncertainty, with worries about new ERA qualified doctors, who make up seven per cent of the EU workforce, will be able to join the UK medical register if 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.

However, the GMC is progressing 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.

NHS FAX MACHINE BAN

NHG FAX MACHINE BAN

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 or leave the workforce by 2024. The GMC has said this could be compounded by Brexit.

These findings emerged from research commissioned by the regulator for its 2018 State of medical education and practice in the UK report, which it says “paints a stark picture of unbalanced pressure on healthcare 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. Doctors are being asked to work for hours in the next three years, a fifth plan to go part time and a further fifth plan to leave the UK. However, new findings are further supported by research from the RCGP which found that 35 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 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 excess blood tests or bypassing clinical guidelines in order to get through workloads.

The possibility of a “no deal” Brexit is adding to uncertainty, with worries about new ERA qualified doctors, who make up seven per cent of the EU workforce, will be able to join the UK medical register if 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.

However, the GMC is progressing 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.

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 the things it won’t help you with? Find out why you need an FPD on page 3.

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 an online course Dr Abeyna Jane. She tells us starting a business and finding happiness on page 12.

Gastroenterologist Dr Helen Siddon offers an insight into her “marvellous” specialty and offers practical career advice in our article on page 3.

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

• Dr Naeem Nazem Editor

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 Owlscone Medical to test the new “breath biopsy” technology.

The researchers believe the technology has “huge potential to provide a non-invasive route 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 3,500 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 but 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 capable of 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. In practice, however, the ability to engage with people, as aspects of practising medicine is 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 is it to manage the risks of confidential and personally identifiable information? The PowerPoint presentation on page 3 shows up a world of career opportunities for fellow doctors is an online course Dr Abeyna Jane. She tells us starting a business and finding happiness on page 12.

Gastroenterologist Dr Helen Siddon offers an insight into her “marvellous” specialty and offers practical career advice in our article on page 3.

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

• Dr Naeem Nazem Editor
PLAIN ENGLISH FOR PATIENTS

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

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 MDO’s 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 Board, 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 obligations. 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/1c6ygscd

Dr Gill Gilchrist is a medical and risk adviser at MDDUS

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

- 24/7 medical-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.
- Coroners’ 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 member ship 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 present yourself at such a formal and daunting process. MDOs which employ and retain some of the UK’s leading medico-legal solictors 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 restrictions on what the Channel Islands, the Isle of Man, Gibraltar and the Falkland Islands). Even if an MDO does not normally operate medical indemnity 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 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?

EW 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 media and TV programmes have always proved gripping to the public and there don't appear to be any decline in appetite.

MDDUS regularly receives calls 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 participate 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 erode that confidence.

In this regard the GMC, in its guidance ‘Making and using visual and audio recordings of patients’, 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.

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

Here 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 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 he arrived on our planet it was named after him in 1705.

An apostrophe secured the deal, and what goes around comes around: in Halley’s case, roughly every 76 years.

If 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 not just with their name being applied, but they have also been granted the deeds of ownership that come with an apostrophe. So in the world of medicine, those such as Asperger, Duchenne, Burditt, 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 any with a medical eponym. Harvey Cushing was an American neurosurgeon who described what would become his eponymous disease of the pituitary in 1912. Burditt-Crohn was an American bacteriologist who published details of patients with his inflammatory bowel disease in 1932. And, Alan 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 paralyses and Zenker diverticulus) and his fellow countryman and paediatric pathologist Wolff W. Zuelzer (Zuelzer syndrome: Ogden syndrome and Zuelzer-Kaplan syndrome). Of course, in medicine it isn’t just diseases that bear the marks of the famous. When it comes to examination we have just a whole medical dictionary of clinical signs named after their exponents, from an Adie’s pupil to Beau’s lines and Oiler’s Nodes. And then, there are tests. I am sure I am not alone in long believing that the 3Arterg Score for assessing neonatal wellbeing was a clever acronym; only to discover we owe that particular one to Virginia Aggar, 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 Harrison’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 with or without the apostrophe, or even without the additional i’s altogether. For example, Crohn’s, Crohns and Crohn’s 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; instead, it is the symptoms, for example, with 1930s baseball fan, amytropic lateral sclerosis. So much more to 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 unjust.

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

Please feel free to contact the author with comments or questions.
A career in gastroenterology promises to be diverse, exciting and satisfying.

ASTROENTEROLOGISTS 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 (ACS). 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 (ST5-7). 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 gall bladder. That said, there is opportunity to become highly specialist in fields including hepatology, inflammatory bowel disease, inherited cancer syndromes and tropical diseases. All gastroenterologists 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; gastrointestinal/ hepatic, short bowel syndrome; jaundice; and will be trained in the management of the wide range of causes of hepatitis. This broad range makes a gastroenterologist a highly skilled clinician.

They deal with patients of varying ages and sometimes patients can be very ill. The work can be demanding, but gastroenterologists are well rehearsed in managing patients in crisis.

What first attracted you to gastroenterology?

It was the thrill of finding out what is going on inside a patient that first attracted me to gastroenterology. It was the first specialty where I could be directly involved in life-saving work and interventions, something that was very appealing.

What do you enjoy most about the job?

What really makes the job is the patients. It’s their stories that make it very special. It’s not every day you see a patient with a life-threatening illness and then see them well and happy at follow-up.

What do you find most challenging?

It’s a daily challenge to keep up to date with the latest in research and technology.

What are the most common misconceptions about the job and the specialty?

People often believe that gastroenterology is all about treatment of ulcers and inflammatory bowel disease. In reality, it’s a much broader specialty that encompasses the whole of the digestive tract, from the mouth to the anus.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.

What are the most common misconceptions about the job and the specialty?

People often think that gastroenterologists just deal with digestive problems, but they also treat a wide range of other conditions, such as liver disease, inflammatory bowel disease, and pancreatic and bile duct disorders.

What do you consider the most important attributes of a good gastroenterologist?

Communication skills are essential. Gastroenterologists need to be able to explain complex medical information in a way that patients can understand.

What are the tools you couldn’t live without?

A laptop and a mobile phone are essential to keep in touch with colleagues and patients.
Overcoming communication barriers with patients can be challenging. **Dr Naeem Nazem** looks at the pitfalls of Google Translate and other solutions.

### 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 record. 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 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 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 with regard to what they communicate to the patient, or amend their 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 recount 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. 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. 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.
NHS Entrepreneur
Dr Abeyna Jones
explains how her quest for a satisfying career inspired her to launch her own business.

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 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 NHS healthcare system – not medicine as a whole.”

Diversifying
This 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, project 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 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, 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.”

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 complments 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 dreamt 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.”

“Young doctors are keen to highlight the exciting NHS career opportunities that doctors may not know about.

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, undertaking 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 it is also having problems urinating. Dr P examines her and confirms weakened plantar flexion and sensory impairment in both limbs. Sclerotic line 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 the theatre for decompression surgery and makes a good recovery.

Six months later the GMC writes back to say that the case is to be concluded with no further action. The GMC seeks to case examiner states that “in applying a ‘realistic perception 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 were conducted’.

There can be a range of possible reasons why a patient might not have reported pain. It may be that the patient was preoccupied with other aspects of their life, or simply did not want to discuss it. It may also be that the patient did not understand the nature of their condition or did not feel it was serious enough to warrant reporting. It is important to consider all these factors before drawing any conclusions.

Clear/comprehensive records are the best defence in any presentation of a complaint, or the manner in which it were conducted”. Dr P fully understood this, and is confident that he had fulfilled his obligations to the patient.

Book Review: Blueprint: How DNA makes us who we are

The psychologist Robert Plomin argues in his new book Blueprint that “genes are the most important factor shaping who we are”. A recent 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 summates 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 part 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 of ‘nature vs nurture’, and thinks it is important to establish from the records.

Pick: Netflix - The Bleeding Edge

Directed by Kirby Dick, starring Robert Bridges, Angela Firlmalino.

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 profiles 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 his implant being removed.

Book Review: Blueprint: How DNA makes us who we are

By Robert Plomin

Review by Dr Greg Dollman

The psychologist Robert Plomin argues in his new book Blueprint that “genes is the most important factor shaping who we are”. A recent 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 summates 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 part 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 of ‘nature vs nurture’, and thinks it is important to establish from the records.

Pick: Netflix - The Bleeding Edge

Directed by Kirby Dick, starring Robert Bridges, Angela Firlmalino.

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 profiles 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 his implant being removed.

Book Review: Blueprint: How DNA makes us who we are

By Robert Plomin

Review by Dr Greg Dollman

The psychologist Robert Plomin argues in his new book Blueprint that “genes is the most important factor shaping who we are”. A recent 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 summates 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 part 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 of ‘nature vs nurture’, and thinks it is important to establish from the records.
CALLING ALL STUDENTS!

‘Like’ our MDDUS Facebook page for all the latest news for medical and dental students.

You can find our page at www.facebook.com/mddus1 or search Facebook for ‘mddus’.

We are also on Twitter, so follow us at twitter.com/MDDUS_News or search Twitter for @MDDUS_News