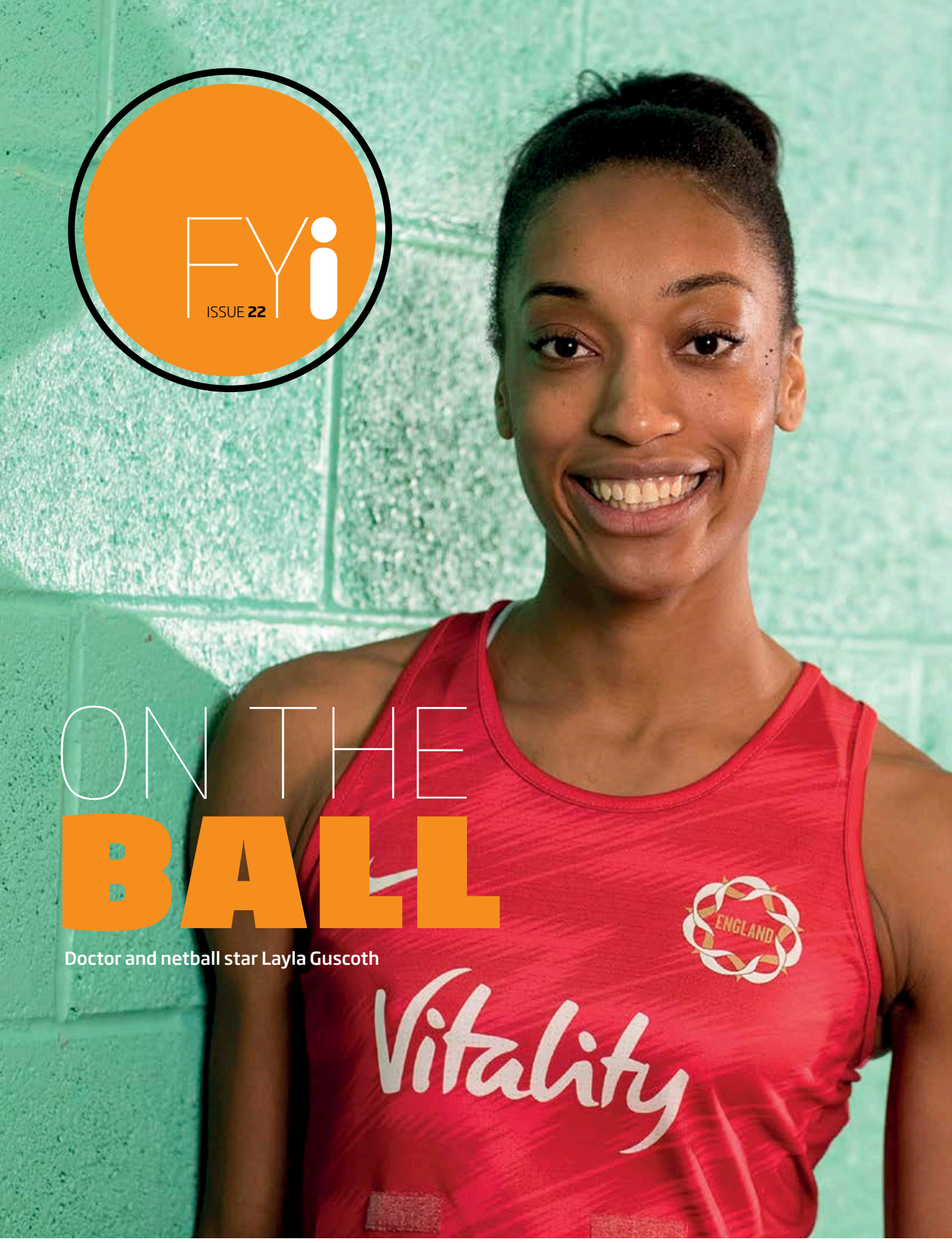
FYi
ISSUE 22



ON THE BALL

Doctor and netball star Layla Guscoth

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS
UK INDEMNITY, ADVICE & SUPPORT

Welcome to your FYi

NO ONE likes to give or receive criticism. But while it is tempting to keep quiet, failing to speak out can threaten patient safety. On page 10, senior risk adviser Liz Price offers practical advice, including on the tricky issue of giving feedback to a senior colleague.

If you've ever felt out of your depth at work or that everyone else knows more than you, then you may be affected by "imposter syndrome". This mindset is remarkably common and has affected greats including Albert Einstein and Meryl Streep. Dr Allan Gaw takes a closer look at this phenomenon on page 4.

Stress can be an unavoidabe part of medical training, but there are ways to make it work for you. Dr Aman Arora talks meditation and goal-setting on page 5. Helping new medical graduates in Scotland on their way is a book of specially-selected poems. Sponsored by MDDUS, *Tools of the Trade* speaks to the experience of being a junior doctor (page 6).

It can be tricky remaining detached from patients on a personal basis, particularly for doctors who have longstanding clinical relationships with individuals and families. Read advice on staying professional in Liz Price's article on page 7.

A career in medicine is demanding enough, but Dr Layla Guscoth has also blazed a trail as a star player in the England Netball squad. She talks about her twin passions on page 12.

In our career article on page 8, Dr Elizabeth Reilly offers an insight into the rapidly evolving field of rheumatology. Meanwhile, our case study on page 14 looks at the treatment of a patient presenting with a paraumbilical hernia.

• **Dr Naeem Nazem**
Editor

COVER PHOTOGRAPH: HEATHCLIFF O'MALLEY

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CAMPAIGN TO SUPPORT REFLECTIVE PRACTICE

NEW guidance and resources have been published in a bid to encourage doctors and other clinicians to take part in reflective practice.

A joint statement signed by the General Medical Council (GMC) and eight other UK healthcare regulators emphasised the importance of reflective practice in improving services and patient care.

Being a reflective practitioner, it said, benefits people using health and care services by:

- Supporting individual professionals in multi-disciplinary work
- Fostering improvements in practice and services
- Assuring the public that health and care professionals are continuously learning and seeking to improve.

It endorsed the value of reflecting in groups, teams and multi-professional settings "to develop ideas that can bring about positive change" in practice. Employers are urged to encourage teams to make time for reflection as a way of "aiding development, improving wellbeing and deepening professional commitment".

The statement also reassured clinicians that personal written reflections will not be used to investigate concerns about them. Registrants will be given the choice of offering them as evidence of insight into their practice. Patient confidentiality, it said, is vital. "Where reflections are recorded, they should be anonymised and focus on learning gain and development rather than the identifiable details of people, the experience, activity or event."

The GMC has added new resources, case studies and learning materials to its online resource *The reflective practitioner* (**tinyurl.com/y6lshe8r**)

NEW APPROACH NEEDED TO IMPROVE TRANS PATIENT CARE

NHS care for trans patients must involve a whole-system approach to improve services, including education and training for healthcare professionals, improved IT systems and access to gender identity services, according to a new position paper by the Royal College of GPs.

The paper on the role of the GP in caring for gender-questioning and transgender patients recommends that the GP curriculum covers gender dysphoria and broader trans health issues – and that more training programmes should be developed to support GPs and their teams to appropriately engage with and advise trans patients.

It also calls for updated IT systems to enable GPs to treat trans patients in a safe and respectful manner, and that record codes are established for gender identity and trans status as well as biological sex.

INPATIENT SATISFACTION HIGH BUT IMPROVEMENT HAS STALLED

MOST inpatients in hospitals in England have confidence and trust in the doctors and nurses treating them but overall improvement has stalled, according to a CQC survey.

The 2018 inpatient survey involved 144 NHS acute trusts in England and over 75,000 adults who had stayed in hospital for at least one night during July last year. Less than half of people surveyed (48 per cent) rated their overall hospital inpatient experience as 'nine or above' out of 10. This is down from 50 per cent in 2017 and marks an end of year-on-year improvement previously seen for this question.

The survey also found that 80 per cent of respondents felt they had "always" been treated with dignity and respect during their hospital stay (82 per cent in 2017) and only two per cent said they were not given enough privacy when being examined (unchanged since 2017).

Of those who had an operation while in hospital, 80 per cent said that staff answered their questions in a way they could understand "completely" and 69 per cent said they "always" had confidence in the decisions made about their condition or treatment, a decrease from 71 per cent in 2017.

Over a third (40 per cent) of patients surveyed left hospital without written information telling them how to look after themselves after discharge (up from 38 per cent in 2017), and of those who were given medication to take home, 44 per cent were not told about the possible side-effects.

Fewer people said they had discussions with staff about the need for further health and social care services after being discharged (80 per cent in 2018, compared to 81 per cent in 2017) and 24 per cent reported not enough support from health and social care professionals to manage their condition when discharged home.

Responses were also less positive across many question areas for younger patients (under 50-years old) and for those with a mental health condition.

Professor Ted Baker, chief inspector of hospitals, said: "The need for greater collaboration between local health and care services has never been more apparent."

MHA CODE OF PRACTICE NOT BEING USED AS INTENDED

HEALTHCARE providers and staff are not using the Mental Health Act (MHA) code of practice as intended due to a lack of awareness and understanding of the statutory guidance, according to a new report by the Care Quality Commission (CQC).

The report found variation in how the code has been used across mental health services since last updated in 2015. The code is intended to help professionals interpret and apply the legislation in their day-to-day practice and to provide patient safeguards, particularly in regards to detaining people under the MHA.

The CQC recommends that the Department of Health and Social Care develop standardised resources, support and training for patients, carers and staff so that they understand how the code should be applied and promote use of the guiding principles to improve practice and enable meaningful engagement with families and carers.

It also calls for improved usability and access to the code in "practical situations", including how to make it digitally accessible, with links to other relevant guidance for quick support.

CQC deputy chief inspector of hospitals Dr Paul Lelliott said: "Use of the MHA to detain people in mental health services is more common than when the code of practice was first created 26 years ago.

"That makes it even more important that the code is clear, accessible and supports the legal safeguards that protect people's human rights and autonomy."

GMC UNCOVERS FACTORS IN HIGH BAME REFERRALS

INADEQUATE job induction and support along with isolating work patterns and poor feedback are all factors in higher GMC referrals for black, Asian and minority ethnic (BAME) doctors, new research suggests.

The GMC commissioned the research in response to data showing that employers and healthcare providers refer BAME doctors to the GMC at more than double the rate of their white counterparts. This means they have more chance of being investigated and, in turn, receiving a warning or sanction.

The report *Fair to Refer?* concluded that some BAME doctors do not receive adequate induction or support in transitioning to new social, cultural and professional environments. It also found that doctors from diverse groups do not always receive effective, honest or timely feedback which could prevent problems later. This is attributed to some clinical and non-clinical managers avoiding "difficult conversations", particularly when they are with individuals from a different ethnic group.

Working patterns also mean that some BAME doctors in isolated roles lack exposure to learning experiences, mentors and resources. The report found that BAME doctors may be treated as "outsiders", creating barriers to opportunities and making them less favoured than "insiders" who experience greater workplace privileges and support.

The report also cites organisational leadership cultures with a "knock-on effect" where leadership teams are remote and inaccessible, and doctors struggle to approach them for advice and support and may not be listened to.

The report made a number of recommendations around improved support and systems.

MDDUS medical adviser Dr Susan Gibson-Smith commented: "We welcome the measures contained within this report and fully support the research recommendations that focus on the four key areas of support, working environments, inclusive leadership and delivery of these recommendations."

LETTERS FOR RAINY DAYS

A reflection on the imposter phenomenon and how to deal with it

FOR years, I've kept a file. It's in the bottom drawer and labelled 'letters for rainy days'. In it I keep all the nice ones. The thank you notes, the letters of recommendation, all the ones that start, 'I am pleased to…'. I don't look at it very often but I know it's there. It's the tangible evidence that helps counter all those niggling doubts, the lack of confidence and the feeling that I'm a fraud.

Despite the name it often goes by, the so-called 'imposter syndrome' is not a medical condition. It's not a form of mental illness nor something that needs to be cured. Really, it's just a way of thinking about how we measure up in the world, and it's extremely common.

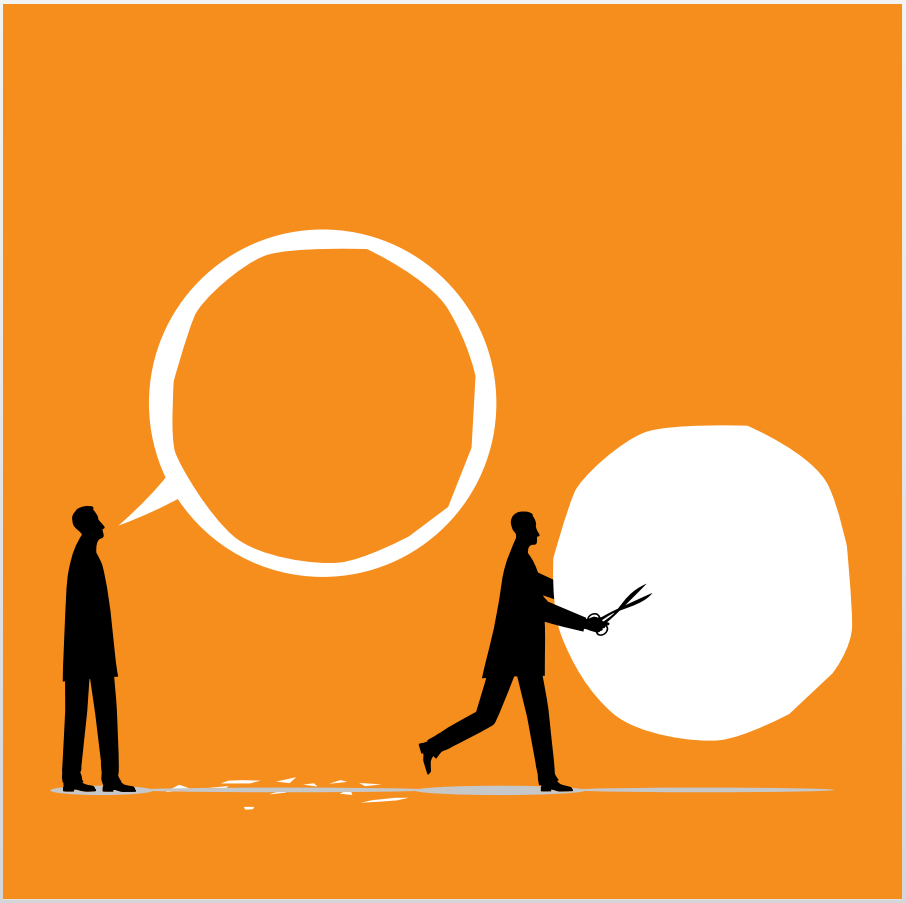
Ever sat in a meeting, looked around and heard an inner voice say, what are you doing here? You know they're going to find you out, don't you? Ever given a presentation after a poor night's sleep, unable to settle because of the anxiety that they'll all know more than you? Ever got the job and told yourself, they must have been desperate, there must have been a mistake?

If you recognise any of these scenarios, welcome to the club. And it's a very big club. Well over two-thirds of everyone who has ever achieved anything has thought like this at some point. As a phenomenon, it was formally described in the late 1970s by American clinical psychologists, but of course it's been around a lot longer than that and crops up in unlikely places.

For example, Academy Award-winning actress Meryl Streep is quoted as saying: "You think, 'why would anyone want to see me again in a movie? And I don't know how to act anyway, so why am I doing this?'"

And look at what one scientist had to say about his achievements: "The exaggerated esteem in which my lifework is held makes me very ill at ease. I feel compelled to think of myself as an involuntary swindler." And that was Albert Einstein, the most celebrated physicist of the last 500 years.

So what do these people have in common? They're all talented, all hard working, but most importantly they are all successful. Real frauds and true incompetents rarely, if ever, feel like imposters. The former don't care enough and the latter achieve nothing to make them feel undeserving.



Why do we do this to ourselves? It stems from the fact that the only mind we can access is our own. We have an internal life – thoughts, feelings and insecurities – that only we can glimpse. Of course, everyone else has exactly the same, but we can only see the surface and often that looks completely at ease with the world. As such, we naturally start to think that it's just us who feel like this, that we are the only ones in the room, or on the ward round or on the shortlist who really shouldn't be there. Everyone else is smart and assured, confident and deserving, but not us.

Although you cannot share other people's insecurities first-hand, what you can do is realise, quite objectively, that they all have them and that they are no different from you. And you can even let some of that awareness temper the self-doubt. You know you're not the best or most talented person in the room but just how good are the rest?

Former First Lady Michelle Obama has admitted to feeling like an imposter. But her concerns were softened when she reflected on her own experiences. "Here is the secret," she said. "I have been at probably every powerful table that you can think of, I have worked at non-profits, I have been at foundations, I have worked in corporations, served on corporate boards, I have been at G-summits, I have sat in at the UN; they are not that smart." The emperors, as it turns out, really aren't wearing any clothes.

Realising you're not alone in this feeling is a first step, but next time you feel like an imposter, catch yourself and change the narrative. Ask yourself what you did to earn it, whatever the 'it' is. Don't dismiss the hard work that got you there, acknowledge it. And don't put it all down to luck. We all benefit from luck and equally we all suffer because of it, but we probably give it too much credit. It wasn't luck that got you into medical school, or got you that degree. It wasn't luck that helped you get that job or build that reputation or receive that prize. It was a little bit of talent and a lot of hard work.

But there will still be rainy days, and on those you might need to be reminded that you're smarter, more accomplished, more deserving than you allow yourself to imagine. And that's why I have a file. Maybe you should have one too.

Allan Gaw is a writer and educator in Scotland

Doctor and educator **Aman Arora** offers practical tips for preventing burnout

MAKE STRESS WORK FOR YOU

STRESS can be a challenging but sometimes unavoidable part of medical training. If left unattended it can lead to immense difficulty and burnout, but if recognised early and appropriately managed it can be a positive driver for excelling in all aspects of life.

Having worked with thousands of doctors in training, I have all too often seen the challenges that balancing stress in life can bring. Below are four techniques that can help reduce the potential negative impact of stress and enhance its beneficial effects.

Recognition

Accepting that there will inevitably be stressful times – and that it is perfectly okay for this to happen – means it can be targeted early and therefore adequately countered.

The first step to managing stress effectively is learning to recognise it. What manifests as stress in one person can be very different in another – being aware of your own signs is crucial. Whether that is increased snappiness, an overwhelmed feeling or simply a sense of apathy, try to observe these in yourself (if you are feeling brave perhaps ask someone else for your signs!)

Failing to recognise your own signs of stress limits your ability to effectively manage it, eventually leading to the stress managing you.
Action: *Consider three signs that you know occur when you are stressed. Make a plan to do something about it as early as possible the next time you notice one.*

Three mini-goals a day

Keeping things small and manageable in your mind allows for a more productive and stress-free day. If your mind is continuously bombarded with 10 or 15 things to get done in a day, it can feel overwhelmed and become counter-productive.

Focus on three things that you must achieve each day. Set aside a few minutes before you sleep, or a few minutes in the morning to focus on what you want to achieve that day – and commit to it. Write it down on paper or make a note in your phone. Whether that is to ring the patient that you've been meaning to contact for over a week, finally arrange a date for your educational supervisor's report or pick up that anniversary card on the way home from work.

Highlighting three, very achievable 'goals of the day' gives them high importance in your mind and you will automatically focus on ways to get them done. Once these are achieved, anything that you do beyond these seems a bonus. At the end of the day you'll feel highly productive, something that can automatically reduce stress.
Action: *Write down three mini-goals for today or tomorrow. Start acting on them right away.*

Pre-set catch-up action slots

Despite our best intentions there are inevitably busy periods in life. However busy training is, your non-work life will always be running alongside. Weddings, birthdays, parenting etc – all can lead to falling behind in aspects of training such as exam preparation or e-portfolio completion.

Consider scheduling predefined 'action' or 'catch-up' days in the diary – perhaps one Saturday a month or two evenings a month. Nothing else can go in these slots – they are purely for those (often mundane) tasks that usually get put behind everything else. All too often these small tasks creep up on us, leading to increased stress levels. Keep a note of things that will slot into those days and add to the list as you go along.

Adequate planning is a huge component of stress reduction. Knowing that tasks are accounted for (even if a few weeks away) allows your mind to be less cluttered, and consequently more effective.
Action: *Schedule your first 'catch-up' slot and start a list of what you will do in it.*

Meditation

This one is not for everyone but don't dismiss it out of hand – you will never know if it is for you until you try.

Forget the stereotype about sitting cross-legged for hours in a trance. For me, meditation simply means refocusing the mind away from the daily hustle and bustle. This refocus can be to your breathing, a memory, a colour, a word – anything that gives your mind a break from the stresses and 'business' of daily life. This does not have to be for extended time periods (I meditate for six minutes in the morning and three minutes in the evening) but the shift in focus to something that you chose can be liberating as well as extremely calming.

As a certified meditation trainer I have introduced simple meditation techniques to many doctors and have seen first-hand how it can help reduce stress, both with exam preparation as well as with daily life. Consider giving it a go... it may make all the difference.

Action: *At some point today, close your eyes for 60 seconds and focus completely on something of your choice.*

There are many other methods to counter stress and what works for one person may not work for another. Medical training is long and eventful, with many ups and downs. Having a good grasp of your own stress management needs is crucial in order to make it as enjoyable and rewarding as possible. Always remember there are many sources of support – from educational supervisors and programme directors to the BMA's wellbeing service – never fear approaching someone for advice or guidance.

Dr Aman Arora is a portfolio GP who runs Arora Medical Education (www.aroraMedicalEducation.co.uk). He has previously been a GP VTS programme director, GP appraiser and GMC PLAB examiner

TOOLS OF THE TRADE

A new edition of a pocket-sized poetry book that speaks to the experience of being a junior doctor

WHAT are your essential tools of the trade? People might assume a stethoscope but if you ask most young doctors today they would probably reply their smartphone. It's doubtful anyone would say a book of poetry.

And yet this is what was presented to all doctors graduating from medicine this year in Scotland.

Tools of the Trade is a pocket-sized volume of medically themed poetry first published in 2014 and offered "simply as a compassionate friend" to Scottish medical graduates that year and in 2015. Now a new edition of the book has been published for doctors graduating in Scotland in 2019, 2020 and 2021 – thanks to the support of both MDDUS and the Royal College of General Practitioners (Scotland).

All the poems speak in some way to the experience of being a junior doctor, say the editors. Some of the poets featured in the book are or were doctors themselves, including Dannie Abse, Rafael Campo, Glenn Colquhoun, and Martin MacIntyre. Different poems suit different situations and readers but all are intended simply "as tools to help connect with your patients, your colleagues, yourself."

MDDUS CEO Chris Kenny said: "MDDUS are delighted to provide support for a new edition of *Tools of the Trade*, a resource for doctors to draw on in both the quiet and thoughtful moments of your career and perhaps at its most challenging times as well."

Adam, There Are Animals

Chloe Morrish

There is a small fox
slipping through the fabric of morning,
still coated in a layer of grey dusk

and carefully placing his paws
between what's left of night
in the garden.

There is a monkey,
a stained toy, in your hand
when you arrive at the hospital,

which none of the fussing people
had noticed
and you had clung to.

There are wild-eyed soldiers' horses,
charging at us from the jigsaw pieces
in the waiting room

where we try to sleep
on the table and chairs
and pretend we're not waiting.

There are several pigeons
on the window ledge, shuffling about
before the steel chimneys and pinking sky

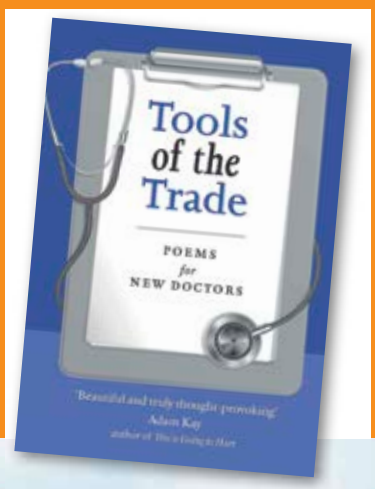
and a seagull's bark
in the deflated quiet
just after you die.

There is an overfed cat
in the arms of a nurse who smokes
by the automatic doors.

and there are baby rabbits
eating the grass verges
of the hospital car park.

There is our dog
at the door, confused
when we get home without you.

From Tools of the Trade: Poems for New Doctors which is available for sale from the Scottish Poetry Library's online shop at www.scottishpoetrylibrary.org.uk/shop



BLURRED BOUNDARIES

It can be tricky remaining detached from patients on a personal basis, particularly for doctors who have longstanding clinical relationships with individuals and families. Senior risk adviser **Liz Price** offers advice

MDDUS advisers often hear from members concerned that the professional boundary with a patient has become blurred. It can be tricky to remain detached from patients, particularly in the early stages of your career. You may share a hobby in common or may have treated someone through a very traumatic illness or distressing period. You may also know a patient well as a member of a small local community. These and other circumstances can be the starting point of a potentially "unprofessional" relationship and, without realising, you may find yourself in difficulty in regard to regulatory guidance.

Consider these examples:

1. A doctor accepts a small gift from a patient who is grateful to him for treating her elderly parent. He then finds that she starts to bring more gifts which, over time, start to increase in value. The GP doesn't want to offend the patient but feels that the nature of their relationship is changing and that by continuing to accept the gifts he is perhaps encouraging something unintended.

2. A colleague has disclosed that she has started seeing someone who is a registered patient. She has treated the patient previously and recognises that the relationship could be seen as inappropriate. To mitigate any problems that might arise, she suggests that in future she will ask the patient to consult with other doctors in the practice.

3. A trainee has shared his mobile phone number with a patient experiencing symptoms of depression, as at their last consultation she had become very distressed. She feels she cannot talk to her family and he didn't want her to leave without support. She is now calling frequently to talk to him and appears to be becoming dependent.

It can be difficult to identify the point at which a doctor-patient relationship starts to blur, particularly for those who have longstanding relationships with patients, or other clinicians treating vulnerable people with mental health issues.

GMC guidance *Maintaining a professional boundary between you and your patient* states: "If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary. If trust has broken down and you find it necessary to end the professional relationship, you must follow the GMC guidance *Ending your professional relationship with a patient*".

In Scenario 1 above, the GP should have considered whether accepting the gifts was in line with current guidance and, if so, he would most likely have politely declined at an earlier point in time. At this point, he could have explained his concerns to the patient. Whilst having this conversation might be embarrassing, it ensures that, whether or not such concerns are founded, there is now the opportunity to reinforce professional obligations to the patient and restate the boundaries of the relationship. Dependent on the outcome of such a discussion, it may be appropriate to suggest that the patient see another GP in future.

GMC guidance also states that: "You must not pursue a sexual or improper emotional relationship with a current patient".

In Scenario 2, the doctor entering into a relationship with her patient is very vulnerable to criticism. GMC guidance is clear that doctors "must not end a professional relationship with a patient solely to pursue a personal relationship with them". Even after a patient has left your care, you should think carefully before engaging in a personal relationship. With regard to such a scenario, the GMC advises doctors to consider the length of time since they treated the patient, how long their patient-clinician relationship lasted, the nature of the treatment, whether the patient could be considered vulnerable (then or now) and whether the doctor is still treating members of their family.

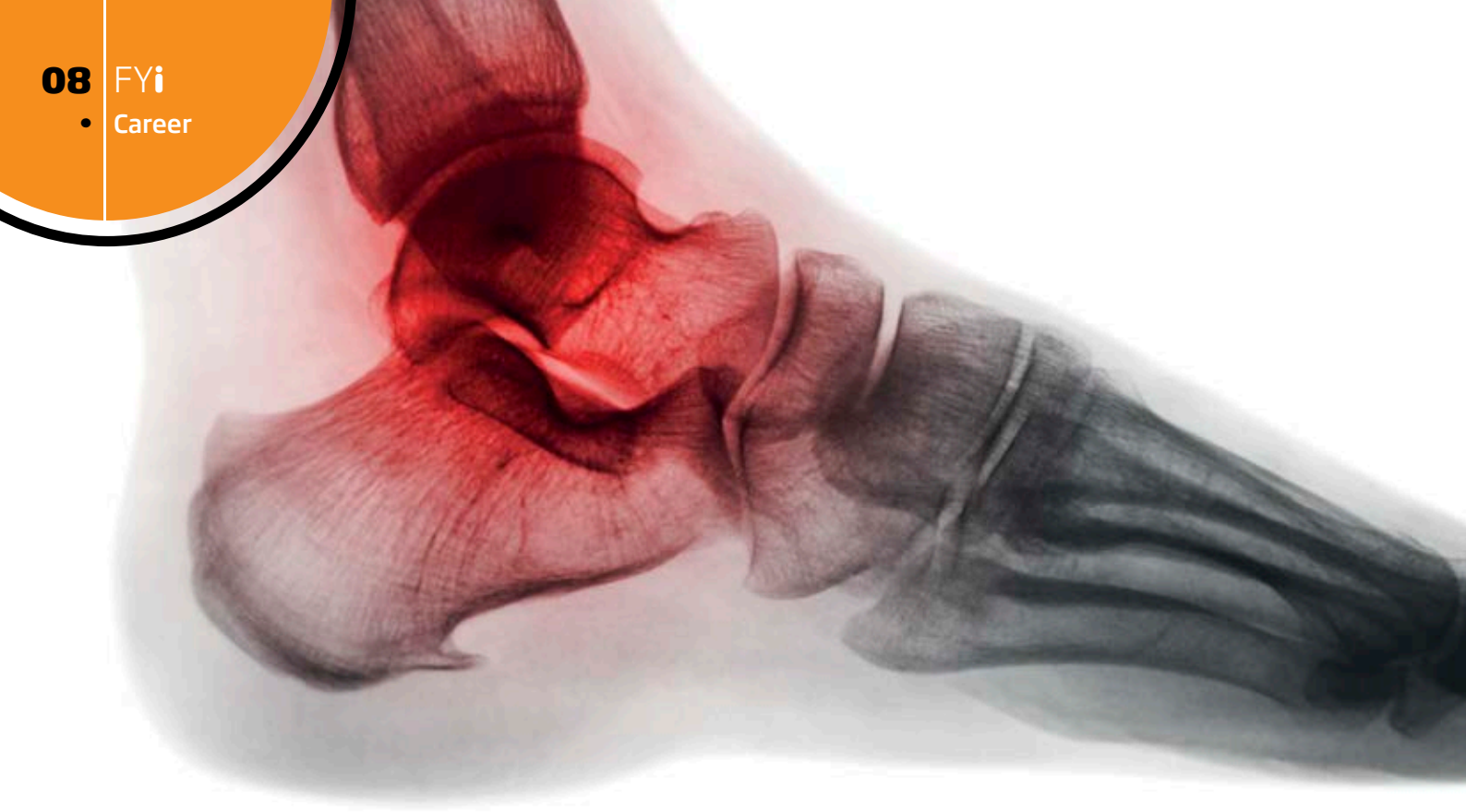
Considering Scenario 3, there may be circumstances (although not advisable) where a doctor determines it is appropriate to disclose personal contact information to a patient – and patients may see this as good service. In this type of situation, it could possibly have been foreseen that the patient may become dependent. The doctor should seek advice from his trainer, who may decide to intervene – ensuring that the patient is aware of alternative mechanisms of accessing support and the boundaries of the doctor-patient relationship.

It should also be recognised that contact via social media can add to the blurring of doctor-patient relationships.

MDDUS has all too often seen these types of cases result in complaints against the doctor, particularly if a patient perceives that the doctor is withdrawing support, or if they feel embarrassed about their part in the situation.

Recognising early warning signs and seeking the views of partners/senior colleagues and/or MDDUS is advised. Approaching situations as soon as concerns are highlighted, with great care and sensitivity, can prevent a breakdown of the doctor-patient relationship and ensure that boundaries remain clear.

Liz Price is senior risk adviser at MDDUS



GETTING PATIENTS BACK ON THEIR

RHEUMATOLOGISTS are doctors who investigate, diagnose, manage and rehabilitate patients with disorders of the musculoskeletal system.

This diverse range of more than 200 conditions includes arthritis, inflammatory spinal disorders such as ankylosing spondylitis, and multisystem autoimmune rheumatic disorders such as lupus, myositis, and systemic vasculitis. Rheumatologists are also trained in recognition and management of the breadth of regional musculoskeletal conditions including tendinopathies and osteoarthritis, as well as metabolic bone disease.

Rheumatology requires interdisciplinary knowledge and awareness of new developments in internal medicine, immunology, orthopaedics, neurology/pain management, rehabilitation, psychiatry, nursing and professions allied to medicine. Rheumatologists practising in adult medicine must also have knowledge of childhood and adolescent rheumatological disease to facilitate an effective transition to adult care.

Many rheumatologists practise the specialty exclusively but there are opportunities to subspecialise in a variety of areas such as rehabilitation or sports medicine.

A career in the rapidly evolving specialty of rheumatology offers doctors many exciting opportunities

Rheumatology is a very research-active specialty, and in recent years a great many novel treatments have been developed, trialled and introduced across the range of rheumatic disorders.

Entry and training

Following successful completion of foundation training, doctors must undertake two or three years of core training before sitting the membership exam of the Royal College of Physicians (MRCP UK). This is then followed by a further four years of specialty training, as well as completion of the specialty certificate examination (SCE) in rheumatology.

Increasingly, rheumatology training is being offered in conjunction with the opportunity to train for a dual certificate of completion of training (CCT) with general internal medicine.

The job

Most patients are treated in an outpatient department, but many also need to attend day treatment units to be administered novel biologic treatments by infusion. "Shared care" arrangements are increasingly common, where specialists and GPs, and homecare nursing teams jointly look after people with conditions such as inflammatory arthritis. Practical skills, including a range of joint and soft-tissue injections and increasingly ultrasound assessment, are invaluable to the rheumatologist.

As this specialty looks after patients with long-term conditions, there is a considerable amount of administration and liaison with the multidisciplinary team and other agencies. In most areas, there is active participation in continuing medical education, audit and research.

As a consultant, on-call and shift work in rheumatology is usually relatively light, although rheumatologists may contribute to the general medical on-call rota.

The British Society for Rheumatology (BSR) is the UK's leading specialist medical society for rheumatology and musculoskeletal professionals. Membership provides access to a range of courses, eLearning and conferences as well as other advice and support.

FEET

Q&A – Dr Elizabeth Reilly, (pictured), clinical research fellow in rheumatology and chair of the BSR Trainees Committee, based in Bath

What attracted you to a career in rheumatology?

During my foundation years, I spent some time within rheumatology clinics and quickly realised that this specialty had what I was looking for – to develop a specialist interest whilst also maintaining my general medical skills given the multi-system nature of many rheumatological conditions. I also knew that I wanted to spend time in research, and the opportunities for this are plentiful.

What do you enjoy most about the job?

It has shown me what being part of a true multidisciplinary team (MDT) can achieve. Each team member has a clear and vital role within a patient's care pathway. I also really enjoy the dynamic that is built up with long-term care patients, when you see their disease and quality of life optimised.

Are there any downsides?

Biological medications have become central to the management of some rheumatological diseases but funding can sometimes be tricky

to secure, particularly in unusual or atypical cases. This may require an individual funding request to the CCG. When these requests are not approved, it can be a frustrating time for patients, families and clinicians.

What do you find most challenging?

Balancing the time spent in general medical on-call commitments with sufficient exposure to specialist learning opportunities or procedures can feel a challenge during training. It is important to be organised in knowing when specialist events such as clinics are occurring so that your time is used effectively.

What is your most memorable experience so far?

Last autumn I was asked to present at a large European specialist ankylosing spondylitis conference. The meeting was held in the opera house in the beautiful city of Ghent, Belgium. Stepping out onto that stage was really quite a daunting experience. However, the satisfaction of having succeeded in presenting without any nightmare complications really boosts confidence for future speaking events.

What are the most common misconceptions about the specialty?

Of all of the medical specialties, I think rheumatology is probably one of the least well understood. The vast array of clinical conditions which we look after does surprise some people. The potential for true medical emergencies in our patients can also be a bit of a shock.

Describe a typical working week.

I'm predominantly research-based, but during my training a standard week would comprise five outpatient clinics. These would be a mixture of clinics including general rheumatology, ankylosing spondylitis, connective tissue disease and SLE, early inflammatory arthritis, osteoporosis and joint injection clinic. I would also undertake a musculoskeletal ultrasound clinic every two weeks, report on DEXA bone density scans, and cover ward referrals as part of the rotation.

"I enjoy the dynamic built up with long-term care patients, when you see their disease and quality of life optimised"

Each week would also comprise a radiology MDT, followed by the postgraduate meeting offering regular opportunities to present clinical cases or as part of a journal club, and hear visiting lecturers.

What are the tools that you can't live without in your day-to-day work?

There are multiple apps available to help calculate outcome measures for many rheumatological conditions. In my area of interest, axial spondyloarthritis, it is essential to have a tape measure and goniometer in clinic to accurately measure patients' range of spinal movement (the BASMI score). Electronic devices such as iWatches or FitBits are also helping us to track patients' levels of physical activity, pain, fatigue or sleep.

What opportunities are there for working in rheumatology?

Each hospital trust will have a rheumatology team who can explain how the service runs in your local hospital. They may have opportunities to get involved in audit, quality improvement projects or grand rounds. Taster days, particularly during FY1/2, can also be really useful. Rheumatology is a research-rich specialty, so if you are interested in pursuing this do speak to your local team or the British Society for Rheumatology (BSR), who have a mentoring scheme for young researchers.

Is there any advice you could give to a trainee doctor considering a career in rheumatology?

I would suggest exposing yourself to the specialty as early as you can and speaking to as many rheumatologists as possible because career paths can be hugely varied. The BSR events such as the new *21st Century Rheumatologist* course, offer an introduction to the specialty for those at any stage of their medical career. The BSR website is also being updated with more information and we plan to have a greater presence at careers events across the country to answer questions. The annual BSR conference is also a great source of information and resources.

Sources:

- GMC rheumatology curriculum – **tinyurl.com/y47hkfvr**
- NHS careers – **www.healthcareers.nhs.uk**
- BSR – **www.rheumatology.org.uk**

LET'S BE

No one likes to give or receive criticism, but failing to speak up can threaten patient safety. Senior risk adviser **Liz Price** offers advice

MOST of us don't like to be criticised or challenged about our performance or behaviours. Despite our best intentions, such encounters can quickly disintegrate into defensive and unhelpful interactions. While avoiding potentially awkward discussions with colleagues might seem like a good idea, failing to speak up can harm patient care.

Evidence suggests that in teams where regular positive and negative feedback is given across the group:

- difficult issues are addressed earlier
- individuals are more likely to disclose problems and receive swift help
- people are less afraid to challenge
- effective relationships are built up more quickly.

These are important factors in delivering safer patient care.

Doctors have a responsibility to raise concerns if patient safety is at risk. Whilst it can be difficult, most clinicians find the courage to challenge colleagues when there is an imminent clinical error. Behaviours that are most difficult to address are often those which are less immediate, but more pervasive in terms of their effect on you, the team, or patients. This article will explore how to plan your approach to maximise the chance of a successful outcome. It will also look at how best to deliver feedback as a junior doctor, including the tricky dynamic of raising issues with senior colleagues.

Assessing risk

As a junior doctor, you will have received feedback about your performance, and perhaps been challenged about your behaviours: "you were too abrupt with that patient" or "you didn't consent the patient properly and that wasted our time". Consider how the feedback was given – was it valid? Just? Constructive? What were your emotional and cognitive responses – did it make you feel uncomfortable, or even angry? Did you leave the encounter understanding what was expected of you? It's likely that not all of your feedback experiences will have been pleasant.

To decide on whether or how to address issues, ask yourself these questions:

- How much do you want to tell the person about your concerns? Is the issue making you unhappy or causing you/others to underperform? If it is not important in relation to patient care, is it your responsibility to raise the issue? If it's not, decide whether the risk of a negative response is worth taking.
- Is there a culture of providing feedback within the team or do individuals tend to avoid challenging each other, meaning your feedback is then more likely to cause surprise? Providing regular praise has been shown to make it easier to accept criticism.

HONEST...

- Has a senior colleague asked for feedback in the past? Ideally, clinical leads would give juniors a safe space or "permission" to offer feedback. If they have at least mentioned it, they are likely to understand the value of receiving feedback from a junior colleague – even if they find it hard to swallow in the moment.
- What is your level of trust with the individual? If high, it is more likely that feedback will be valued and responded to positively - even if only after they have time to reflect.
- Do they seem like the type of person who would retaliate if they don't like what you have to say? Maintaining a good working relationship is important. You may have observed that they are happy to receive feedback on some areas of work/ behaviour but not others. Concern about this is not a valid reason to avoid challenging your colleague but it's crucial to do it carefully.

Constructing feedback

What we might classify as "constructive feedback" can still be hurtful to someone who feels they are trying their best while working under pressure. It is essential to "construct" a feedback encounter with care. You should:

- Think about when and where you will have the conversation. As soon as possible after an incident or issue arises is good practice. Ensure it is done privately and when the person is less likely to be distracted or exhausted.
- Start by asking if it would be okay to share some thoughts or insights with them. Alternatively, you could say that you would like to have a chat about something, and ask if you can schedule a time to talk.
- Find a way to acknowledge the positive aspects of your relationship or normal behaviours.
- Avoid subjective feedback and generalisations. Do you have specific evidence or recent examples to back up your position?
- Resist spontaneity unless a positive feedback culture is already in place or there is a high level of trust between you. Choose your words carefully and focus on the specific evidence, aspect of the task, or behaviour that is causing the problem. Focus on the future, not the past. It can be useful to write down and rehearse in advance what you plan to say.
- Be selective in what you choose to raise and stick to the issue(s) that matter. If a feedback culture is in place there's more likely to be only one thing that is being raised. This can be less threatening - particularly against lots of positive feedback encounters.
- Focus on problem solving and actions. Use 'I' statements such as "I would appreciate more support in...." or "When you are telling me about X, could you also include Y details, as this would stop me having to bother you with minor questions".
- Encourage the person to articulate any points of disagreement with the feedback. It may not be obvious how much pressure or other issues they are experiencing.
- Highlight a potential personal benefit for the senior colleague in changing behaviour if you can. For example, a change by them might prompt a change in others' responses to them, or their ability to perform more effectively, which will make their own life easier.
- Stick to your script. Allow the other person to process what you're saying but try to politely bring them back round to the issue at hand before the encounter ends.

Learning to give feedback is an important aspect of developing your skills as a doctor. Carefully considering the nature of your feedback as well as how, where and when it is delivered using the suggestions above will help. You may not always get the response you would have liked in the moment, but you will perhaps get the person thinking and possibly open an ongoing dialogue. This will help the personal development of all parties, fostering a better working relationship, and potentially improving patient care.

Liz Price is senior risk adviser at MDDUS

HALF DOCTOR

Netball World Cup star Layla Guscoth tells *FYi* how she balances life as an elite athlete with her work as a doctor

PURSUING your life's passion is not something everyone has the chance to do. But Layla Guscoth is currently pursuing two.

Through sheer determination and force of will, the 27-year-old has successfully blazed a trail through the world of national and international netball while also qualifying as a doctor.

This remarkable feat would sometimes see the young medic play games straight after a nightshift or travel to far-flung corners of the UK to compete after a long working day. It also saw the 6ft tall defender play a key role in England's progression at the 2019 Vitality Netball World Cup in Liverpool in July.

Full schedule

Most people might balk at the thought of managing a schedule that is so physically and mentally demanding, but Layla is unfazed.

"It is challenging finding time to play netball and work as a doctor," she says, "but it is so worth it. I enjoy them both so much and see them for what they are. I know you can only play netball for a short time and I plan to make the most of it for as long as I can."

Born in Birmingham, Layla began playing the sport aged 11 before discovering an interest in medicine during a hospital work experience placement in sixth form. Not wanting to sacrifice either, she continued to play club netball – for Team Bath – throughout medical school.

"Team Bath were very understanding," she says. "They were really good at helping me balance it all, sometimes rescheduling games around my shifts."

Layla – who describes herself on Twitter as "half doctor, half netballer" – has been an England international player since 2011. She did her pre-clinical training at Oxford University before moving to University College London (UCL) to be closer to the England netball training camps.

"It wasn't without difficulties," she says. "I would sometimes finish nights then have a game that evening which wasn't ideal, but I got through it."

Knowing her long-term career would be in medicine, she took a break beginning in 2015 to complete her foundation training. In an unfortunate twist of fate, it was during this hiatus that her England team mates achieved their best result in a major tournament – taking gold at the 2018 Commonwealth Games in Australia.

Going pro

Despite missing out on the Roses' moment of glory, Layla has no regrets and describes the win as "amazing", adding: "It meant so much for everyone who has ever had anything to do with England netball, or played netball even."

Indeed, watching her team mates win gold inspired her to come back to the sport stronger than ever. Having finished her foundation training in 2018, she was offered a contract to play for the Adelaide Thunderbirds in Australia's Super Netball League – the only professional league in the world.

She took a year off medicine and moved Down Under in January 2019. While she won't be doing clinical work in Australia, Layla will be filling her time off-court by taking part in a research project studying metabolism and sleep at Adelaide University.

Her new life in the sun has been quite a change from the UK.

She says: "I've always dreamed of going to Australia to play because the standard is so high and it's so competitive. Playing netball there has been great. It's fully professional which makes it quite a different experience.

"I do miss clinical work but doing the research fellowship has given me the chance to learn new skills and try academia. And the beautiful weather is also a nice change from what I'm used to in the UK."

Positive impact

One key skill Layla has honed over the years is time management. Something she admits took a lot of practice.

"Balancing both roles has given me me really good organisational and time management skills, something I wasn't good at in the beginning. Being so busy all the time, you do need to take time to look after yourself and your health, including your mental health."

While she admits it is tiring, Layla says playing netball has had a positive impact on her role as a doctor.

"Good time management is an important part of working as a doctor, so I've definitely benefited from that side of things.

"From the perspective of mental health and wellbeing, it's really good to have a hobby and something to invest your time in. It's important to have something else to think about and have a passion for. It's helped me substantially and taught me a lot of good life skills."

Layla is encouraging to other doctors thinking of taking time away from medicine to pursue their passion. "It's being done more and more now," she says, "and it doesn't have to hold you back in your career. After your F2 year is a perfect time to do it because once you start specialty training it's pretty intense. I was encouraged by senior clinicians to try something I was interested in and I'm so glad I did."

Bright future

Looking to the future, Layla plans to return to the UK once the Australian netball league ends in late 2019. She will then face the decision of which specialty to apply for, with renal or gastroenterology the frontrunners.

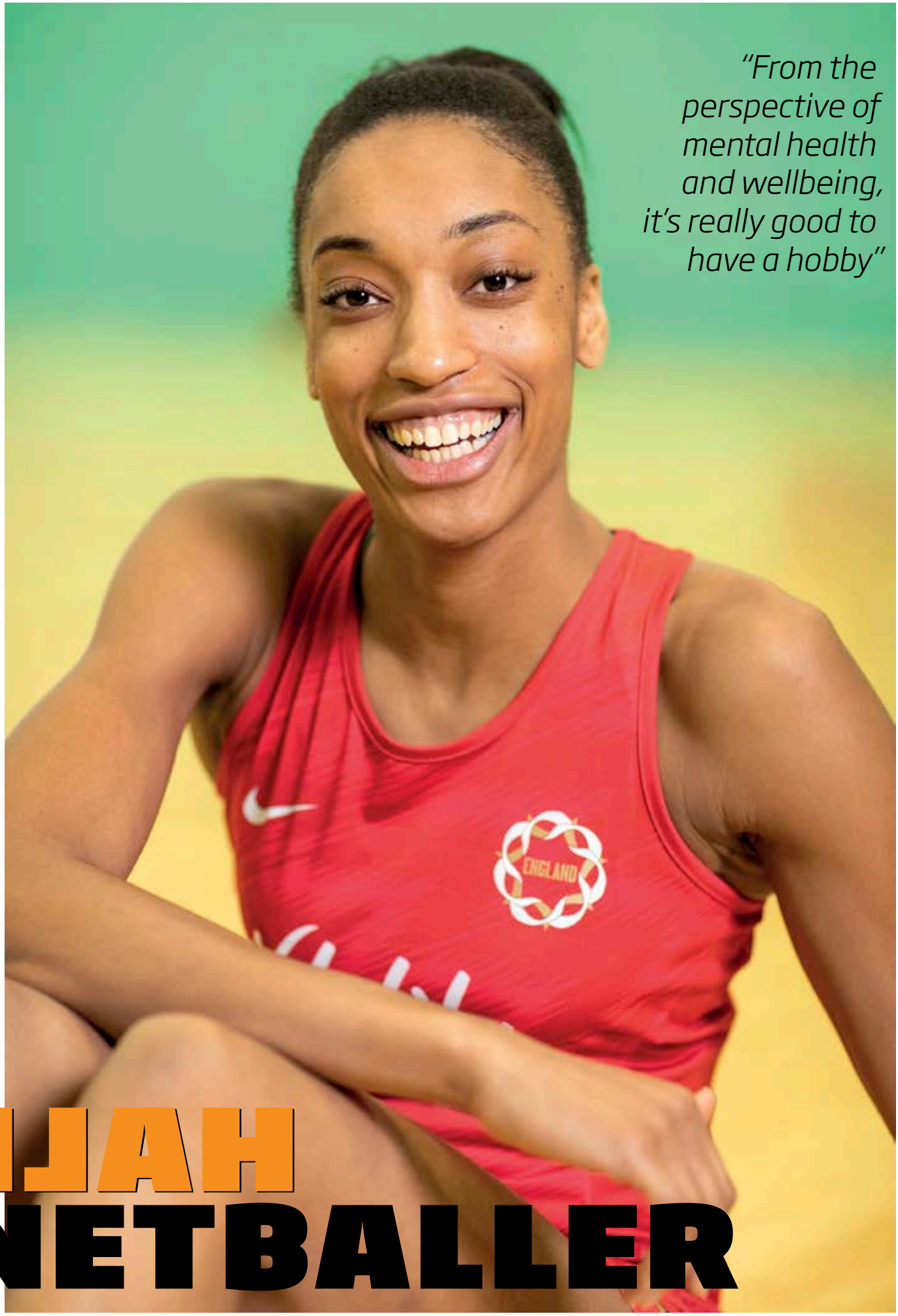
The Birmingham Commonwealth Games in 2022 are also in Layla's sights – but she faces a more immediate challenge. Having been named by BBC Sport as one of eight players to watch in the netball World Cup, she was forced to withdraw after only her second game when she ruptured her Achilles tendon in England's triumphant 36-goal victory against Scotland. Messages of support have flooded in from well-wishers as Layla prepares to undergo rehab.

Speaking before her World Cup appearance, Layla says: "I've learned to just take each year as it comes. If someone told me a year ago that I would be playing for my country in the World Cup I wouldn't have believed them."

England's manager Tracey Neville issued a statement confirming Layla's withdrawal, saying: "It is devastating that her journey in this World Cup is over but myself and all of the Roses are by her side supporting her through this time. We will do everything we can to ensure she is back playing again soon."

One thing is for sure – for someone as tenacious, versatile and tough as Layla, the future is bright.

Joanne Curran is managing editor of FYi



"From the perspective of mental health and wellbeing, it's really good to have a hobby"

HALF NETBALLER

PHOTOGRAPH: HEATHCLIFF O'MALLEY

SURGICAL MESH INFECTION

Day 1
Ms L, 48, attends her GP with a paraumbilical hernia present for two years. She is the mother of three young children and is mildly obese. Lately the hernia has become more painful and yesterday she suffered a severe painful episode. The GP refers Ms L to the surgical unit at a local private hospital.

Day 2
Ms L attends the surgical clinic and is seen by upper GI surgeon, Mr K. On examination she is found to have an obese abdomen with a small paraumbilical hernia which is easily reducible. She has had intense abdominal pain recently and Mr K suspects she has suffered an episode of incarceration. He advises surgical repair and discusses potential complications and recurrence rates.

Day 20
The patient is admitted to hospital and signs a consent form. The risks documented include infection, as well as bruising, bleeding and potential recurrence and damage to the underlying bowel. Mr K undertakes the hernia repair using a mesh in the preperitoneal space. She is reviewed the next morning and discharged home.

Day 22
Ms L returns to hospital complaining of bruising and discomfort at the surgery site. She is reviewed by an emergency physician who notes swelling, a haematoma and a discharge. A wound infection is diagnosed and the patient is commenced on Flucloxacillin. Two days later Mr K reviews the patient at the surgical clinic and confirms that Ms L has an ongoing post-operative wound infection. Cellulitis is noted and pus is expressed from the wound. Mr K considers the possibility of a mesh infection and arranges an ultrasound scan.

Day 26
Four days later Mr K receives the US scan report which shows no abscess cavity but considerable inflammation surrounding the mesh. A CT is arranged for the next day.

Day 29
Mr K receives the CT scan which confirms extensive deep inflammation but not affecting adjacent bowel loops. He reviews Ms L and advises urgent removal of the mesh and application of vacuum dressing (VAC). He offers to admit Ms L at short notice for the procedure but she has pressing work commitments and wants to seek a second opinion. She is prescribed further antibiotics and 10 days later has the mesh removed at a different hospital.

SOLICITORS acting for Ms L submit a letter of claim alleging clinical negligence in the delayed diagnosis and treatment of her surgical wound infection. In particular the letter alleges that Mr K failed, within a reasonable period, to obtain the result of the ultrasound scan, arrange a CT scan and discuss the need for surgical management. Mr K is also accused of failing to provide Ms L with sufficient information to make an informed choice on the need for mesh removal surgery – or the potential complications of delaying surgery for a second opinion.

This allegedly resulted in an unacceptable delay of over 10 days – with associated pain and suffering – before the mesh was surgically removed and the infection fully treated.

MDDUS, acting on Mr K's behalf, commissions an expert opinion from a consultant colorectal surgeon. Based on his report, a letter of response is composed denying liability. In regard to the alleged delay in obtaining an ultrasound result and follow-up CT scan, the expert points out that Ms L was informed of the US report within three days and a CT scan was arranged for the next day. Ms L was then seen by the surgeon in his clinic a day later and options for further treatment discussed. The expert says such a time frame would not be considered unreasonable.

The expert also rejects the allegation that Ms L was not given sufficient treatment information. The patient notes show that Ms L was advised of the urgent need to remove the mesh but she chose to delay the procedure. A letter to Ms L's GP records the surgeon's willingness to admit the patient at short notice.

Breach of duty of care is denied, as is causation in that the treatment delay was an informed choice made by Ms L. No more is heard from the claimant and the case file is eventually closed.

KEY POINTS

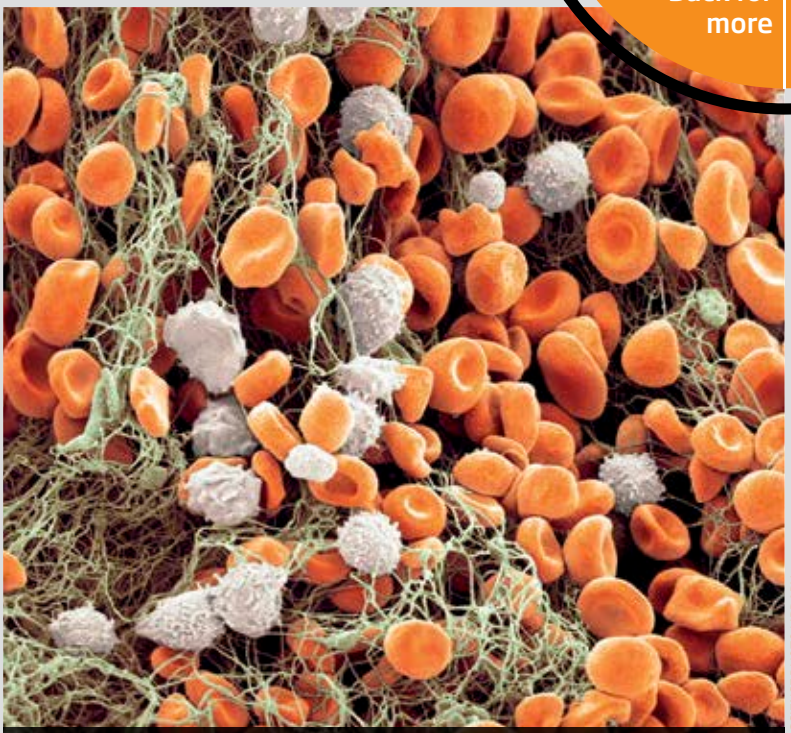
- Medical complications are a risk in any surgical procedure but are rarely a matter of clinical liability.
- Good record keeping justifying clinical decisions is the best defence in any legal action.

OUT THERE

POO-POO TO STOOLS It's out with the stool and in with the poo at the **nhs.uk** website. Content designers have revealed the words and phrases they say are easiest for users to understand. Peeing and pooing is favoured over urinating and bowel movements, while "water tablets" are now "tablets that make you pee more" and stools are something you sit on. Read the full list at **tinyurl.com/yyx9pzxs**

TAEKWONDOCS A group of junior doctors in India's NRS Hospital have earned taekwondo black belts following a rise in attacks by patients and relatives. While they have since reported a reduction in violent incidents, campaigners are calling for broader measures such as increased government healthcare spending.

IN GOOP HEALTH Actress/lifestyle guru Gwyneth Paltrow brought sound baths, liquid gold lattes and alkaline water to London for her inaugural UK-based wellness summit recently. For just £1,000 a ticket, guests mingled with celebs like Penelope Cruz and enjoyed the alleged health benefits of dance cardio, "visualisation toolkits" and other plant-based goodies.



WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTOGRAPH: SCIENCE PHOTO LIBRARY

PHOTOGRAPH: NETFLIX

Pick: Netflix - Mothers on the Edge

Directed by Mark Casebow. Written by Louis Theroux for the BBC.

AWARD-WINNING documentary maker Louis Theroux shines a spotlight on postpartum mental illness in women. In this one-hour standalone show he visits two specialist psychiatric units in England and speaks to women being treated for a range of conditions, from anxiety to psychosis, while living with their babies.

Among those is Barbara, who attempted suicide while in the grip of postpartum psychosis. She tells Theroux she fears her husband might be her baby's brother as well as father. Catherine, meanwhile, takes beautiful care of baby Jake yet feels no bond with him. She was sectioned after attempting suicide and tells Theroux she feels her son "deserves better than me".

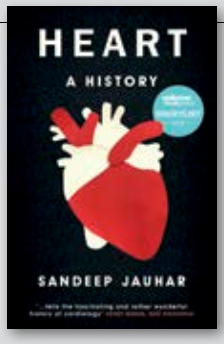
These are just two of the heartbreaking and profoundly affecting stories told in this fascinating, important programme.

Theroux certainly deserves credit for broaching a subject that has had little media attention.

Book Review:
Heart: A history

by Sandeep Jauhar
Oneworld Publications, £9.99, 2019

Review by Dr Greg Dollman



HEART is the story of what Sandeep Jauhar describes as the engine of life. The cardiologist chronicles medicine's quest to understand how the heart works (and how to fix it when it is 'broken') while considering how we "can most wisely live with – as well as by – our hearts".

Understandably, therefore, the book is a mix of science (including fascinating facts: heparin was discovered in the brains of salamanders, and "from birth until death, [the heart] beats nearly three billion times") and philosophy ("if the heart bestows life and death, it also instigates metaphor", which exist across cultures). And Jauhar considers the two against a backdrop of his personal stories 'of the heart'.

Heart will inevitably trigger memories of years spent in medical school laboratories and lecture theatres, as well as the patients you have met over the years. Jauhar gives the backstory to eponyms (like Osler and Billroth), and shares his own clinical experiences to complement the theory.

His chapters (named to describe the heart's function in lay terms, including 'dynamo', 'pipes' and 'wires') cleverly dissect the organ into its basic parts. These provide a helpful refresher on the heart's anatomy and physiology.

Jauhar also charts medics' understanding of the heart as a pump, noting that historically cultural fallacies limited progress. Those who dared to question the working of the heart risked their reputations and even their lives for disrespecting or challenging its sanctity. And some, like George Mines, paid the ultimate sacrifice as a result of self-experimentation. Historians believe that Mines, who discovered the electrophysiology phenomenon 're-entry', died while exploring the 'vulnerable period' for arrhythmias in a healthy heart.

Besides tracing the giant steps taken by clinicians and researchers to replicate the heart's function (the development of the heart-lung machine and the defibrillator), *Heart* also considers intertwined issues like medical paternalism, autonomy and consent.

Jauhar quotes pioneering cardiac surgeon C. Walton Lillehei as saying: "You don't venture into a wilderness expecting to find a paved road". Society is indebted to so many dedicated clinicians who had the courage (and audacity) to probe further and deeper to unlock the mysteries of the heart. And Jauhar's book is a neatly paved road that makes for an enjoyable journey through this wilderness.

WHAT ARE WE LOOKING AT? *Bone marrow SEM*