Think before you Tweet

Advice on using social media
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Every issue...

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We welcome contributions to New Doctor, so if you want to get involved, please contact us on 0113 241 0377 or email: sara.dawson@mps.org.uk
Welcome to your latest edition of New Doctor. I’d like to extend a particular welcome to those who have recently embarked on their first FY1 job. It’s a scary time, with lots to learn, but please remember there are places you can turn to for help – you are not alone!

At MPS we have long recognised the importance of gathering the views of doctors at the start of their career. We’ve collated your views about working as junior doctors and created some advice videos (page 6). Your opinions may change through your career, but try to keep in mind the way you feel now, as it will be invaluable as your career progresses.

In this edition we focus on claims – sometimes called litigation or being sued. The thought of being sued is one of the most frightening for doctors at any stage in their career. The thought of interacting with lawyers and having your involvement in a case reviewed by experts is particularly daunting. Although historically rare, and litigation is increasing dramatically.

For those not directly implicated in a medicolegal case, the process is shrouded in mystery. Ashley Dee, a solicitor and claims manager at MPS based in Edinburgh, has written an article on the claims process, which I hope will allay your anxieties. You are a member of a medical protection organisation, such as MPS, if something goes wrong.”

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Finally, any foundation doctor wishing to undertake such activities should contact MPS’s membership team before undertaking or agreeing to include indemnity for this work. Members wishing to work in this way should contact MPS’s membership team before undertaking or agreeing to undertake any medical practice in the UK unless they are connected to a designated body. The situation remains unchanged for provisionally registered F1s, who cannot work as a doctor outside an APS.

It should be noted that a foundation doctor (F1) included could volunteer at events as a first aider, providing they ensure their educational supervisor is aware of this and they comply with any reporting requirements set by their employer and training body.

The GMC stance has changed for F2 doctors, who will now meet the APS requirements as long as they hold and maintain their connection with a designated body. In practice this means that any F2 with a designated body can work outside their substantive post or training programme, providing they ensure their educational supervisor is aware of this and they comply with any reporting requirements set by their employer and training body.

The survey also revealed that whilst 60% of junior doctors chose a career in medicine because they enjoyed helping people, 71% of F1s felt they did not have enough time to give patients the care they required, and half found it hard to manage patients with unrealistic expectations.

Dr Pallavi Bradshaw, medicolegal adviser at MPS, said: “We must build an environment which allows junior members of the team to raise concerns about patient safety. It is encouraging to see that those in their second year of training feel confident to report such matters.

“Senior clinicians and clinical managers have a responsibility for creating an open culture and an environment where recognition and discussion of care quality issues is routine.”

Dr Bradshaw added: “It is important that junior doctors are supported in their first years on the wards, and with one in five respondents (22%) having been involved in a complaint or claim, it highlights the need to have support available from a medical protection organisation, such as MPS, if something goes wrong.”

© DR ANDREW MURRAY

Running up the UK’s highest mountains in 24 hours

Running 2,659 miles from Scotland to the Sahara, then running seven ultra-marathons on seven continents in a week, was not enough adventure for GP and Scottish distance runner Dr Andrew Murray, who recently ran up the ‘big ten’ in the UK in one day.

The aim was simple – run the ten highest mountains in the UK in a day with Donne Campbell from Team UVU. The challenge is different than my day job, but the principles are the same:

1) Have a clear focus
2) Involve the right people
3) Tackle difficult situations with a level head
4) Manage uncertainty

Scotland’s mountains are nothing if not unpredictable, the route could be altered by cloud, the rain could make the rock wet and slippery and the wind could blow you sideways.

So how do you prepare for an event like this? Run up hills morning and night and around surgeries. I can run average 80-110 miles per week.

The Big 10 are spread across three ranges, with Ben Lawers north of Loch Tay, the Nevis Range adjacent to Fort William, and the Cairngorms east of Aviemore. Ben Nevis, an apocalyptic weather forecast ensured at waterproofs were packed.

Ben Lawers at 1,214m was our first ascent. We were joined by BBC Scotland’s Adventurer Show, who filmed our trip. We reached the top in an hour, before heading to the Ben Nevis range. My back and hip were nagging, so I grabbed some paracetamol from the car; it actually made the pain worse. The clouds broke as we tackled the next
Everything you need to know about negligence claims

MPS Claims Manager Ashley Dee, who is based in our Edinburgh office, explains the claims process step-by-step and what it means for you.

Who pays?

Well, rest assured, it’s not you.

As an FY1/2 you are obliged to work in an approved practice setting. This will usually mean you will be covered by NHS indemnity. Put simply, it is the NHS organisation that is sued, as opposed to any individual/named practitioners, and the NHS that will be responsible for any compensation payment that may be awarded by the court or any out of court settlement that might be agreed.

The position is different for claims against GPs and private practitioners, who would be sued personally and would rely on support from MPS.

FY1/2s on placement in a GP practice will still be covered by NHS indemnity.

What is the law/legal test for negligence?

The patient has to prove:

a) That they are owed a duty of care: it is taken as read that a doctor owes his/her patient a duty of care; and

b) That there was a breach of that duty: in other words, that the standard of care fell below that to be expected from a responsible body of medical practitioners; and

c) Causation: that, on the balance of probabilities, the failings in the standard of care identified, directly caused or materially contributed to the patient’s injuries/outcome.

The onus is on the patient to establish breach and causation to the civil standard of proof, which is the balance of probabilities, and not to the criminal standard (beyond reasonable doubt). The test is subtly different in Scotland.

How is a claim started?

More often than not, a hospital or general practice is notified of a claim being investigated when the patient (usually through their solicitor) requests their medical records and advises it is in contemplation of a claim. There may also have been a complaint made before notice of a claim is received. Hospitals usually have a complaints department. General practice complaints tend to be dealt with by the practice manager or a nominated complaints partner.

Once the patient or their solicitors have investigated the claim, there is a protocol by which they should provide a Letter of Claim, setting out the facts and the allegations of breach and causation. This triggers a four-month deadline in which the NHS organisation needs to provide a Letter of Response. The letter must set out any facts that are disputed and state whether the allegations are admitted or denied. Where they are denied, the hospital must explain why. This protocol provides an opportunity to resolve claims without the need to issue legal proceedings.

The patient should go through the above steps before starting court proceedings, but that isn’t always the case.

There is no formal protocol in Scotland for notification of claims prior to commencing court proceedings.

How long does a patient have to claim?

The time period within which a claim must be brought is known as the limitation period. Court proceedings should be issued within three years (in Scotland the time limit will be increased to five years), running from:

- The date of the negligent event; or
- The date the patient became aware (or the date a court subsequently deems they should have been aware) they had suffered a significant injury attributable to the act they believe to have been negligent (referred to as date of knowledge). Whichever is the latest.

There are some important exceptions to the above:

- The courts have discretion to allow claims to be brought outside the three-year window
- The three-year period does not begin to run until a child’s 18th birthday
- In fatal claims, the three-year period runs from the patient’s date of death unless the three-year period expired prior to death; and
- The three-year period does not begin to run for those who do not have capacity. Some patients may have fluctuating capacity and time will begin to run when capacity returns.

Who manages the claim?

Most NHS organisations have their own claims/legal department but ultimately the claim will be referred to an agency to manage the claim on their behalf. These organisations differ in each of the jurisdictions in the UK. The NHS Litigation Authority (NHSLA) in England, the NHS Wales Shared Services Partnership, the Central Legal Office (CLO) in Scotland, and the Directorate of Legal Services (DLS) in Northern Ireland.

The appointed claims handlers may investigate the matter internally or may instruct an external firm of solicitors. The NHS will incur the costs of legal representation and advice.

What is your role? How is the claim investigated?

If you were the main treating doctor, at the outset it is likely that you will be asked to review the patient’s records and provide a statement commenting on your treatment and involvement.

If you were only involved in a peripheral part of the care being reviewed, this may well be the end of your involvement.

Once all the medical records are available, independent

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www.medicalprotection.org
Despite national initiatives, the prevalence of inpatient harm remains as high as 8-10%. Things do continue to go wrong in hospital and in general practice. But is it a surprise? Medical school teaches you the theory of prescribing, but the gritty reality of medical practice is often learnt on the job. It is well recognised in medicine that this transition is a challenge. You may know that gentamicin can be ototoxic and nephrotoxic, but not necessarily the safest ways to prescribe and monitor levels. You don’t know what you don’t know until the situation arises, so it makes sense to learn from others that have been in your position.

As new doctors struggling with job pressures and a lack of clinical experience for the first time, it is no wonder that the room expands to include junior doctors as the patient contact point. The interplay between hospital specialties every three months. Each time we face new challenges and are required to know different information for each department.

The beginnings
Our project began with a group of junior doctors in Nottingham who were asked to give a presentation to new Frs on how to be a good doctor. We decided to focus on how to avoid mistakes that could harm patients. We looked at the most common avoidable errors and developed an informational guide. From here, Junior Doctors Essentials was born (JDE), a junior doctor-led initiative aiming to reduce clinical errors and smooth this transition, thus helping improve patient safety. Our aim is to foster a bottom-up patient safety culture to reduce clinical errors, increase access to local guidelines and improve efficiency.

Launching patient safety cards
One of our initiatives was the development of JDE cards, which are now available to hundreds of foundation doctors. JDE has produced sets of ten credit card sized guides containing concise, up to date and practical information, designed to aid junior doctors during their first few months. The guides are portable and can be clipped to a lanyard or belt.

We place great importance on the cards remaining up-to-date and accurate so they require a continuous audit cycle. Much like any guidelines, the cards are reviewed annually to ensure the information and advice is current. Through audit and feedback we are continually improving the cards to make them as useful and practical as possible.

In practice
Paediatrics, with drug doses calculated in mg/kg and varying frequencies depending on patient age, is a prescription nightmare.

The NPSA reviewed paediatric patient safety in 2009 showing that 15-17% of incidents are medication related and 13-17% treatment or procedure related.

Simple things like prescribing fluids become invariably more complicated when your patient is a premature baby. Then there is the moment when a baby needs to be intubated and you have to prescribe the drugs in a hurry. Not to mention the perils of amnioncensis prescription and interpretation of therapeutic vs toxic levels.

JDE has expanded the JDE cards to paediatric units across the south west of England and in several units across the country.

Effectiveness
So, the next question is “do they work?” Judging by the positive feedback we’ve had for the answer appears to be “yes.” A staggering 83% of junior doctors who used the cards in two London hospitals in December 2013 told us they improved their clinical practice, whilst 100% agreed they would recommend to future cohorts.

More recently, we developed clinical questions to ask juniors both before and after using the cards, aimed at assessing whether they could build on and improve knowledge. The results showed an average 25% improvement in performance in clinical knowledge of topics covered by the cards.

Recently, we took this a step further by looking at incident reports involving patient safety for a local neonatal unit. Our study shows that incidents in areas covered by the cards fell in the group who had access to the JDE cards compared to the group prior to their introduction. Whilst we cannot attribute all this to the cards alone, they would certainly appear to improve patient safety.

Recognition
We presented at a conference in Melbourne to 15 countries at the International Congress of Paediatrics. Closer to home, our group won an award for the Paper at Royal College Paediatric Safety Congress 2013 in Birmingham, where we presented to over 1000 delegates.

Barriers
It hasn’t been plain sailing. Finance has been our main barrier. When we first started, we designed, printed, laminated and hole-punched them ourselves. As we have expanded, we are printing them professionally to make them wipe clean and user friendly.

Although our cards are non-for-profit, they are sold for £5 a set to cover costs. Hospitals usually use educational funds or charitable funds to pay for them.

Next steps
We would love to see our cards used nationwide and are working to encourage local units to consider whether JDE could help improve patient safety in their area. We are also looking to develop new cards for all patient safety.

If you have any questions or would like to get involved contact us. Our email is info@jdepaeds.org.uk.

Over to you
Junior doctors Drs Katherine Taylor, Christina Parfitt and Linzie Hamilton want to improve patient safety from the bottom up. They developed patient safety cards to help foundation doctors avoid mistakes.


It was once dismissed as the latest craze of a young generation, but in recent years the social media phenomenon has exploded, embodying a far broader representation of society. There have been positive stories in the media around healthcare – the much publicised story of Stephen Sutton’s battle with cancer, although tragic, was incredibly heartwarming, and gave patients a real insight in to how healthcare is delivered to the terminally ill. In contrast it would not have been appropriate for Stephen’s doctors to post on social media about Stephen without his consent, as it would have breached his confidentiality. This may seem fairly obvious, but more and more junior doctors are getting into trouble by posting nameless comments about their patients, who have then been able to identify themselves. Juniors have also got into trouble posting inappropriate material that questioned their professionalism, eg the lying tweet.

In response to this wave of complaints, the GMC issued guidance around social media. Doctors’ use of social media needs to be applied to any social media network, with the underlying message that the standards expected of doctors do not change because they are communicating through social media rather than face to face.

Inappropriate comments

Social media sites blur the boundary between an individual’s public and professional life – many indelicate posts that have landed doctors in trouble are the result of a perceived lack of understanding when it comes to the privacy settings on their accounts. In 2012 a surgeon updated his Facebook status when he finished work. He wrote: “Back and causing chaos. Been on call this week. Been in theatre… slaughtering the innocent.” His comments were flagged to the wife of a patient who died while under his supervision. She was understandably distressed and made a complaint to the health board. The surgeon was disciplined and forced to issue a public apology to the family.

Consequences

An ill-advised post does not simply bring an individual doctor’s reputation into question; it subsequently impacts on the reputation of the medical profession as a whole. Your trust or health board will take an equally dim view of you posting less than flattering comments about patients – it’s safer to exercise caution. It is worth noting that defamation law can apply to any social networking sites. Although Dr S did not identify the patient by name, hospital or treatment, the fact the patient could have identified themselves meant that Dr S and his colleague had breached patient confidentiality. It is important not to share identifiable information about patients, even when using professional blogging sites, which are not accessible to the wider public.

What next?

In the future we may see hospitals and practices impose stricter policies on appropriate usage, but for now you should follow the GMC’s guidelines on how to use social media professionally and responsibly.

Advice

Before setting up a blog treat cautiously and consider all the following pitfalls: breach of patient confidentiality; defamation; breach of contract – your trust or board may not be happy with what you have to say, as was the case with Dr G. It would have been sensible for Dr G to obtain the permission of his trust/board management and their educational supervisor before she created the blog.
Coping with alcoholism

Learning how to manage stress is a huge part of being a good doctor. Consultant anaesthetist Dr Rachel Black opens up about her struggles with alcohol and how she overcame them.


I returned to work and on paper I had it all: a fulfilling career, enough money, two healthy children, and a supportive husband. Life was full and busy until coping by compartmentalising. I was a doctor at work, a mother at home, a friend when socialising. ‘Me time’ had to be found and protected. Me time was wine o’clock and began as soon as the children were in bed and the chores complete. I would sit down with a glass of wine to allow my buzzing brain to relax.

Over time, wine o’clock started earlier, the volume of wine increased and the treat became first a need, then a dependency. I became concerned I was drinking too much and asked my husband’s opinion. “Is it not as if you’re drowning a bottle of wine a night, are you?” he once asked.

“No, I wasn’t, but by now I was regularly having half a bottle per night (sometimes two-thirds). A colleague then remarked she and her husband would have a bottle of wine each at night; red for her, white for him. This reassured me. This must be normal.

Very soon I too was drinking a bottle of wine most nights, and paying the price during the day; red for her, white for him. This reassured me. This must be normal.

The resulting magnitude of change in my life, my priorities, my thoughts, my likes and dislikes has astounded me. I now have more time, more attention, better concentration. I am a better mother, wife, friend and doctor. I am happier. I no longer seek parties and big nights out as before. I am content. I am productive in the evenings now they are no longer a blur, and can drive my children to their activities without resentment. I am better able to deal with problems and stresses; my first thought being “Thank goodness I’m not hungover too”.

Dr Black wrote a book about her struggles with alcohol. Her book is called Sober is the New Black.
Dr Dorcas (Dee) Obeng shares her observations working in a hospital outside Johannesburg

A

ough I was born in Crawley, West Sussex to a family of six, my parents are from Ghana, so I’ve had a strong African influence in my upbringing. I’ve been lucky enough to visit Africa and love it and all its flaws – that’s why I wanted to work in a deprived area in South Africa, helping women deliver.

P

aternalism

There was a paternalistic relationship between healthcare providers and patients. Doctors would not introduce themselves or explain their examination. The patients would rarely question their doctor or their management. Many did not know the names of their medications or even what they were for.

M

idwives would shout at women if they made too much noise or were perceived not to work hard enough during labor. I was told ‘you have to be tough on these women or they become spoilt and will refuse to push.’

The absence of kindness, empathy and positivity, was surreal for me. Although the midwives were physically harming the women it felt barbaric.

The midwives truly believed that their approach was effective, as it would force the woman to work, harder, ending labour sooner.

In a hospital where epidurals were non-existent and pain relief was rationed, I began to understand their thought process, even if I didn’t agree with it.

G

ender inequality

My biggest inspiration in life is my mother who is a vivacious and successful woman despite being brought up in a culture where gender inequality often stifles females. I noticed the obvious gender inequality in the hospitals, eg, only the patient’s male partner would be addressed by the doctor.

A doctor I shadowed told women not to trust their husbands as they were having a hysterectomy because their husbands would not allow the procedure due to a myth that it was just different for women to make a sexual intercourse. I met women who refused the Mirena coil (IUCD) because their husbands didn’t agree with it.

I was never asked if I wanted the operation to happen. I was never asked if I wanted the operation to happen. I was never asked if I wanted the operation to happen. I was never asked if I wanted the operation to happen.

Lessons learned

I learnt to use a glove as a tourniquet, to line the wail of the child who was delivered by caesarean section, followed by the NeuroITU meeting – which were hopeless on the day 21 births took place. And then there was always the question of the children that did survive. What chance did they have of being able to afford an ultrasound scan, medication or doctor’s appointment when they fell pregnant?

Respect

What I revelled in most was observing how alike we are as humans. The 43 year old woman, who hugged me when I confirmed her pregnancy after numerous miscarriages, the wall of the child who was delivered by emergency caesarean after an eclampsia, the woman holding and crying with a woman who lost a baby – these scenes will never leave me. I have huge admiration for the women here and the hardships they suffer.

G

raditude

We’re all guilty of having a grumble about the state of the NHS, but we’re so lucky to have free healthcare. Children who should have survived died in SA due to poverty, poor facilities, HIV and a lack of education.

There was one evening when the power cut so no surgeries could be performed.

Women who could not afford the transport to the hospitals would go the full length of their pregnancies without ever seeing a midwife.

There were only two neonatal incubators, which were hopeless on the day 21 births took place. And then there was always the question of the children that did survive. What chance did they have of being able to afford an ultrasound scan, medication or doctor’s appointment when they fell pregnant?

A day in the life of an F2 in neurosurgery

Dr Varun Shankar gives an insight into a busy day on the neurosurgery wards

I’m 728am and I’m on my way to the big morning handover, where all the doctors and nurses go through every one of 70 patients in the neurosciences ward. Most of my patients are currently stable, so there isn’t too much to worry about. However, my firm (one of four neurosurgical teams) is on call today, so I know I’m in for a bruizer.

Next it’s the neuroendocrinology meeting where all the referrals from surrounding hospitals are discussed, followed by the NeuroITU meeting – my favourite part of the day being a budding F1 doctor I’d gained all the knowledge I can.

My team has four patients; one of them is being transferred to a local hospital, as there is unfortunately not much more we can do for her. Remember when she came in a month ago with a big bleed. Her family have accepted that she won’t return to normal, but it is still upsetting that a previously well woman in her 60’s will never be the same again.

I have time to think or dwell too much, as it’s back to the ward for the ward round. My SpR is ruthlessly efficient so this is where I need to move with real purpose. Thank god I mastered how to write and walk during my F1.

I can hear his chest from four feet away – they never leave me. I have huge admiration for the women here and the hardships they suffer.

As I walk back to the office at 7pm I get things in order for handover. Ten minutes to finish, I get a page from a nurse. Mr M’s son is here and is giving my F1 answers. I’m in for a bruiser.

Once the CT is done I call my SpR in theatre.

I’m in for a bruiser.

As I walk back to the doctor’s office at 7pm I get things in order for handover. Ten minutes to finish, I get a page from a nurse. Mr M’s son is here and is giving my F1 answers. I’m in for a bruiser.

Once the CT is done I call my SpR in theatre. My consultant answers the page and informs me that he will send for Ms G in 20 minutes. Ms G’s mother has arrived and asks what is happening. Luckily I know her quite well so I sit down in an office and explain things. She’s used to the swing of things, but it is understandably worried.

Oh, now the biggest job is done it’s time to sort out the other CTs, then it’s the blood round followed by urgent discharges. I get a page from the ward to check in with a patient for his replacement therapy.

Dr Shankar was working in Leicester.
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