



MDU wardround

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TEAMWORK

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Introduction from the medical editor

“Everyone in the NHS should be able to come to work every day knowing they will be treated with respect, supported to do their work and expand their skills, and be appreciated for what they do.”

This is the view of Professor Don Berwick in his recent report into patient safety as he called on patients and carers, senior managers, regulators and members of staff to work together to create a culture of continual improvement within the NHS, a prerequisite for safe and high quality care.

The theme of this issue of *wardround* is teamwork and respect for patients and colleagues. This is now central to medical professionalism and a recurring theme in the latest issue of *Good Medical Practice* (2013). Doctors, the GMC says, must show respect for patients' dignity, confidentiality, autonomy and personal beliefs and they must build respectful relationships with colleagues, treating them fairly and without discrimination.

Respect is also essential to the safe and effective provision of care in a hospital setting. For example, for multidisciplinary teams to provide a co-ordinated service, each person has to understand their own responsibilities and recognise the contribution that other team members make to the patient's care. Professional attitudes and behaviour towards colleagues as well as patients is more likely to earn the patient's trust in your clinical opinions and advice.

Of course, every doctor can still find themselves in an uncomfortable situation where the views of a patient or their family seem unreasonable or their personal beliefs clash with the doctor's own deeply-held values. But this should not prevent you from fulfilling your professional obligation to treat them with consideration, even if you need to transfer the patient's care to a colleague. After all, the real meaning of respect is treating others as you would like to be treated yourself.

If you need specific medico-legal advice from the MDU, call our 24-hour helpline on 0800 716 646.

Dr Sally Old
Medical editor



Working in **teams**

Good, reliable communication between members is vital if a team is to function effectively.

Dr Natalie Hayes, MDU medico-legal adviser, explains the essentials for working in a multidisciplinary team.



You are the F2 on call overnight for the general medical wards and you are asked to review a patient in the middle of the night. You have never seen the patient before, the nurses on the ward cannot find the patient's notes, and the FY doctor on call during the day shift did not hand over the patient to you. The nurses tell you that the patient takes a lot of medications and these all need prescribing; there is no letter from the GP and the patient has no known family. The nursing staff are about to do their drug round and you are being bleeped to see another patient on another ward. It is your first shift in the hospital. What do you do?

Later the same evening, nurses on a different ward ask you to see a patient who has become unwell. Again, the patient is unknown to you. The FY doctor on call during the day did not hand this case over to you either and you cannot read the entry in the notes made by the registrar who saw the patient last. The nurses think that the patient might need some repeat investigations but aren't sure which ones. What do you do?

These sound like nightmare scenarios for a first shift in a new hospital, but they are all too common examples of the problems we can face when we don't work as a team. If you are new to the team, department or hospital, there can be a bewildering number of new faces and names to learn, local policies to become familiar with, not to mention a new specialty to grasp. Finding out who your colleagues are, who does what, and who to go to for help when things go wrong is an essential first step.

Good record keeping

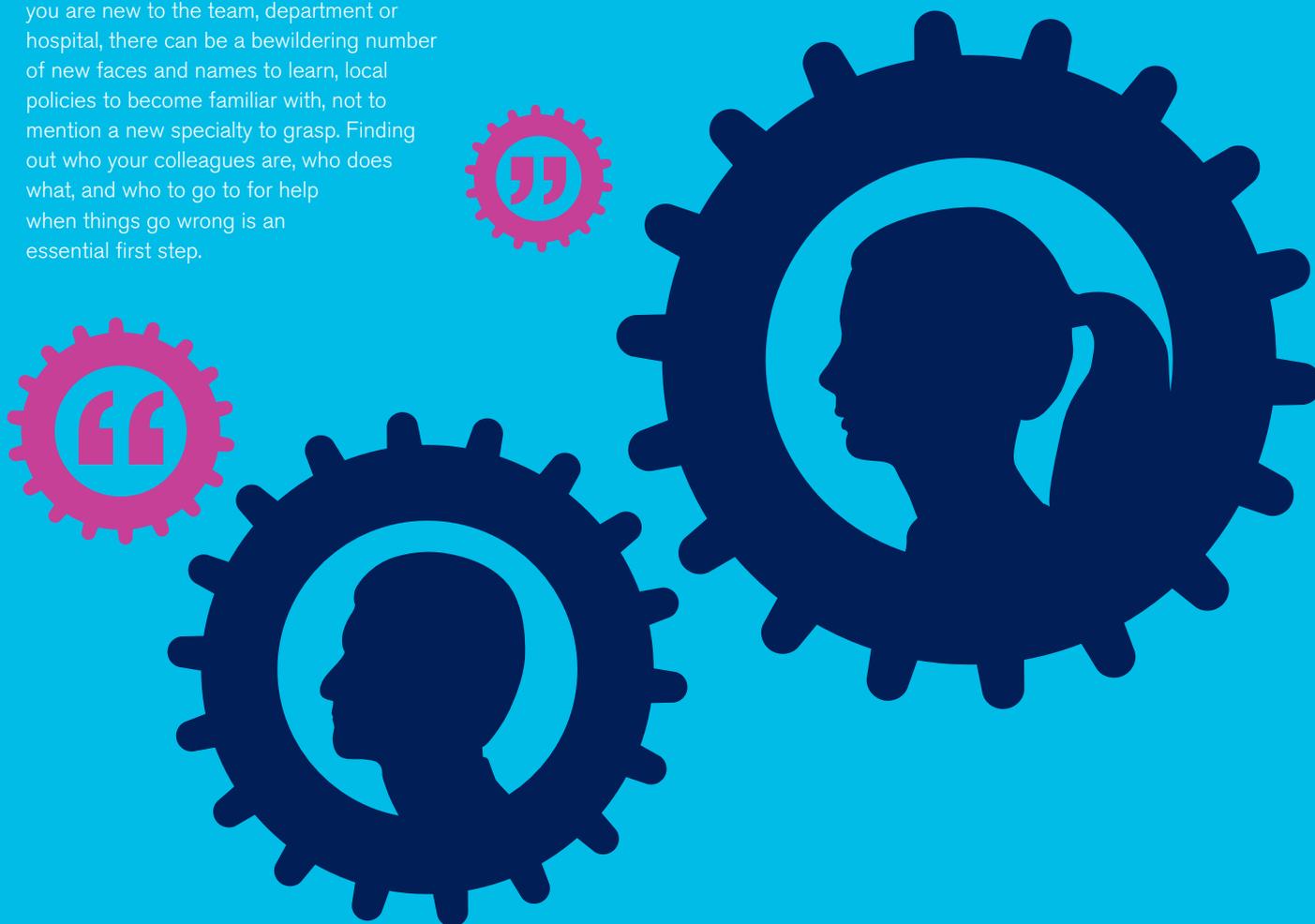
Entries in patient records must be accurate, clear and legible. This is a professional requirement, not just something that those following you on duty will be grateful for¹. And when you hand over task lists and patient information to colleagues at the end of your shift, you should make sure that this information is as detailed as possible. Include any tasks that you need to delegate because you were unable to complete them yourself. It is important to be clear when your responsibility for your patients' care has ended, but you must also be sure who this responsibility has passed to and that they are aware of this².

In the first scenario, the patient's medications should ideally have been prescribed by the admitting doctor. If this wasn't possible, the task should have been handed over to you directly, and the GP should have been contacted for a list of what the patient is taking. In the second scenario, the patient should have been mentioned to you specifically given that they are clearly unwell. The registrar's entry in the notes should be legible, and the nursing records should contain essential information about the patient's status earlier in the day and the medical team's plan. If this was all as it should

have been, your job in reviewing the patient would have been made much easier. More importantly, it is likely that the patient could have been assessed more accurately and treated quicker. Now that the majority of junior doctors (and some senior ones too) work shifts, detailed and thorough handovers between doctors coming on and going off duty is more important than ever for good patient care. You must not rely on colleagues such as the nursing team to hand over information for you, but if you have information that may assist other multidisciplinary team members looking after the patient, then you should of course pass it on.

“Entries in patient records must be accurate, clear and legible.”

The term multidisciplinary team usually refers to all healthcare professionals involved in the care of the patient. For you to play your part in the team, it is essential that you know who everyone is, their roles and how to contact them. ▶





Each team member has specific expertise and experience which is likely to be different from yours. The team structure works best when all members seek advice from each other appropriately and promptly, making sure that referral documentation is clear and correctly filed in the patient's notes. You may have gained experience from previous jobs – wound dressing or helping a patient mobilise, say – but it is essential that patient care is co-ordinated and documented carefully by the person with responsibility for each task³.

“Failure to show respect can cause just as many problems as poor communication.”

A common source of difficulty within teams is when medical or nursing staff fail to involve members of the wider patient care team such as physiotherapists, speech and language therapists and dieticians, early enough in the patient's admission. This can lead to delay in the patient receiving essential aspects of care, poorer progress and even delayed discharge.

Respecting others

Situations like the two examples outlined earlier can test the patience of even the most saintly amongst us and when things go wrong, it can be tempting to vent our frustrations on those around at the time. This will almost certainly make a tricky situation worse. Next to communication, respect for colleagues is a fundamental aspect of working in a team. Failure to show respect can cause just as many problems as poor communication. While it may be true that a team member may have forgotten to do something or overlooked a task, such as prescribing the medication or

handing it over, how you deal with such a situation will have a direct effect on your relationship with that individual, and on the effectiveness of the team as a whole⁴.

Clearly, if a member of the team repeatedly fails to fulfil their roles and responsibilities, and this compromises patient safety, you have a professional obligation to act on your concerns⁵. However, you must balance this against your duty to treat all colleagues fairly and with respect⁶. While you may be justified in pointing out the difficulties the absence of a proper hand over and the patient's notes have created, you must do so in a manner that is respectful and polite.

Finally, be extremely careful when in earshot of your patients. As one of their doctors, they will naturally be very interested in all you have to say.

If this is a rather negative comment on your colleagues' actions or competence for example, you may unwittingly have damaged the confidence the patient has in your colleague, the team, or even the hospital as a whole.

Working in a team can offer some of the most challenging but also the most rewarding of experiences life as a junior doctor can offer. Above all, being an effective team member and helping to ensure the team works well is vital for good patient care.

References

- ¹ GMC, *Good Medical Practice* (2013) paragraph 19 and 21
- ² GMC, *Good Medical Practice* (2013) paragraph 19 and 21
- ³ GMC, *Good Medical Practice* (2013) paragraph 35
- ⁴ GMC, *Good Medical Practice* (2013) paragraph 37
- ⁵ GMC, *Good Medical Practice* (2013) paragraph 25 (c)
- ⁶ GMC, *Good Medical Practice* (2013) paragraph 36

Guidance for effective teamwork

- ✦ Communicate – the value of good communication, written or verbal, simply can't be overstated. Say it, write it down, tell someone you've written it down...you get the picture.
- ✦ Mind your manners – treat all your colleagues fairly and with respect, and remember that you are entitled to the same in return.
- ✦ Know your place – be clear on what your role is, what you are responsible for, and how your colleagues can help you. Know how you can help them too.
- ✦ Ask for help - value the expertise of your team members and use it; don't be afraid to seek advice, or to offer it too.



The scene

After working for several weeks under a general surgeon, an FY2 doctor had been so inspired that he decided to apply for CT1 training. The surgeon was a member of a multidisciplinary team (MDT) overseeing the care of a 68-year old woman with non-small cell lung cancer. After discussing her biopsy results and scan, the MDT concluded that it was inoperable and she should be referred for chemotherapy. However, the FY2 doctor later witnessed the surgeon speak disparagingly about the defeatism of his colleagues and tell the patient he was ready to 'have a go'. With the patient's agreement, the operation took place but the surgeon was unable to fully remove the tumour, leaving the patient in need of several weeks' recuperation before she could begin chemotherapy. The doctor was concerned the surgeon had put the patient at unnecessary risk but was reluctant to cause trouble for him. He contacted us for advice.

Our advice

The FY2 doctor's duty to act on his concerns must override his personal and professional loyalties to the surgeon.

Given his inexperience however, the doctor had correctly followed *Good Medical Practice*¹ by first contacting the MDU. He could also have sought advice from a senior doctor at the hospital. This would enable him to 'sound out' an experienced clinician about whether his misgivings were reasonable and whether he would be justified in raising them through the hospital's formal procedures.

The surgeon might be able to justify his behaviour but it was not up to the FY2 doctor to determine whether or not he had acted recklessly. The GMC states that "you will be able to justify raising a concern if you do so honestly on the basis of reasonable belief and through appropriate channels, even if you are mistaken"².

If the FY2 doctor decided to raise concerns, he should do so clearly and in writing. Where possible he should use the established hospital procedures and keep a record of the action he had taken for future reference. The GMC says it may also be appropriate for doctors in training to raise concerns with a named person at their Local Education and Training Board (LETB) such as the postgraduate dean.

If the FY2 doctor was not satisfied that appropriate action had been taken he could consider approaching the GMC which has set up a confidential helpline for doctors to raise serious concerns and seek advice on patient safety³.



A maverick surgeon

Outcome

The doctor contacted his head of department to express his concerns about the surgeon. It later emerged that the MDT lead had also made a complaint as it was the third time the surgeon had ignored the conclusions of the meeting and acted independently. After a disciplinary investigation by the trust, the surgeon was referred to the GMC and was later given a warning by a fitness to practise panel.

References

- ¹ GMC, *Good Medical Practice* (2013), paragraph 25c
- ² GMC, *Raising and acting on concerns about patient safety* (2012), paragraph 10c
- ³ GMC, raising concerns helpline telephone number: 0161 923 6399.

Respecting beliefs

In the context of medical practice respect for the views and beliefs of others, whether our patients or our colleagues, is essential. Dr Sally Old, MDU medico-legal adviser, explains.

You are asked to review an adult patient on chemotherapy. She has a neutrophil count of 0.4, haemoglobin 7.2 and a platelet count of 5. The patient is haemodynamically stable with a temperature of 37.8. You arrange for antibiotics to be given according to the local protocol.

The protocol also recommends platelet and blood transfusions. You explain this to the patient. She categorically states that she will not accept any blood or blood products because of her religious beliefs. She shows you an advance decision she signed before treatment started.

You advise her of the risks she runs by not having the transfusions now, especially the possibility of a fatal catastrophic bleed. Having spoken to the patient at some length, you are in no doubt about her capacity to make this decision.

You return to the doctors' office confident that she has made an informed choice to refuse treatment but uneasy about whether you should have put more pressure on her to have the transfusion.

You are relieved to see in the notes a treatment plan for the use of growth factors and other supportive treatment in just this scenario. This had been formulated before treatment by the oncology team, with the consent of the patient and after discussion with her religious advisers.

A patient's personal beliefs may lead them to refuse treatment that we consider would be of benefit to them. Conversely, there may be situations where patients ask for a procedure purely for religious, cultural or social reasons¹.

The GMC advises that we must respect a competent patient's decision to refuse an

investigation or treatment even if we think that decision is "wrong or irrational". We may advise the patient of our clinical opinion but must not put pressure on them to accept our advice. We must be careful not to "imply judgement of the patient or their beliefs and values" in our words or actions².

In this scenario, it was reasonable to discuss the patient's religious beliefs because it was directly relevant to care. Furthermore, she was happy to discuss them. However we should not put pressure on patients to discuss or justify their religious beliefs (or lack of them). We should not impose our beliefs and values on patients, or cause distress by discussing them³.

Doctor's beliefs

A doctor may have religious beliefs or conscientious objection to a particular treatment that prevents them from agreeing to carry out certain actions, as the following example illustrates.

A colleague asks you to complete the cremation forms for a patient who died the



previous day. Your colleague explains that because of his religious beliefs he is uncomfortable signing the paperwork.

You review the notes and cremation paperwork and see that Form 4 should be signed by a doctor who has seen and treated the patient within 14 days of death. You are confident that you meet these criteria and tell your colleague you are happy to help.

The GMC⁴ says that doctors may practise medicine in accordance with their beliefs, provided that the following criteria are fulfilled:

- we must act in line with relevant legislation
- we must not treat patients unfairly
- we must not deny patients access to appropriate medical treatment or services
- we must not cause patients distress.



If any of these criteria cannot be met, doctors must provide effective patient care, advice or support, whatever their personal beliefs. The GMC explains that if an individual doctor is the only one legally able to sign a cremation certificate they should not refuse to provide this service on the basis of their personal or religious objections. In the scenario described, however, you were able to help your colleague and it was right to do so to avoid inconvenience for the family of the deceased patient.

“A patient’s personal beliefs may lead them to refuse treatment”

There are areas where doctors can exercise a conscientious objection. For example, the Abortion Act 1967 allows doctors in England, Wales and Scotland to refuse to participate in terminations of pregnancy (other than when necessary to save the life of, or prevent grave injury to the woman)⁵. This right to refuse is,

however, limited to the procedure itself and not to pre- and post-termination care⁶.

If a doctor wishes to exercise a conscientious objection they should make sure that their employers are aware of this. The doctor should also explain their position sensitively to the patient. They should arrange for another doctor, who does not hold the same objection, to see the patient without delay. In an emergency no doctor should refuse to assist solely because of a conflict with their own personal beliefs⁷.

References

- ¹ GMC, *Personal beliefs and medical practice* (2013) paragraph 17
- ² GMC, *Personal beliefs and medical practice* (2013) paragraph 24
- ³ GMC, *Personal beliefs and medical practice* (2013) paragraphs 29 – 31
- ⁴ GMC, *Personal beliefs and medical practice* (2013) paragraph 4
- ⁵ Section 4(1) of the Abortion Act 1967. This act does not apply in Northern Ireland
- ⁶ GMC, *Good Medical Practice* (2013) paragraphs 8 - 13
- ⁷ GMC, *Good Medical Practice* (2013) paragraph 36



Healthier doctors better for you, your team and your patients

When it comes to personal wellbeing, doctors remain one of the hardest to reach groups of professionals. Often they fear that asking for support might be perceived as a sign of weakness or failure or they worry about accessing confidential healthcare where they are known as a doctor. Dr Clare Gerada and Richard Jones from the Practitioner Health Programme provide some advice on personal wellbeing.

Doctors, like their patients, become ill. If your health suffers this can adversely affect not just you, but also the care of patients, healthcare costs, and the lives of your colleagues, family and friends. Or, as the Boorman review into NHS Health and Wellbeing put it:

'Healthier staff, teams that are not disrupted by sickness, or where staff are not under undue stress... all contribute both to the quality of care given to patients and to patient satisfaction. By contrast, where staff are unhappy and unhealthy, where there are high sickness rates, high turnover and high levels of stress, there are likely to be poorer outcomes and poorer patient experience'¹.

When they fall ill, many doctors tend not to consult their own GP but may have 'corridor consultations' with colleagues, often finding innovative ways of obtaining healthcare, running the risk of inappropriately self-diagnosing, self-prescribing and even self-referring. The good news is that when doctors do access appropriate help, they make

excellent patients and have better outcomes when compared with the general public. One specialist service for doctors² manages to achieve an 81% abstinence rate for doctors with drug and alcohol addiction. This compares to around a 10-20% abstinence rate for the general public³.

So, why don't doctors seek the help they need? The simple answer is fear. Fear that their progression, training or registration will be affected and that everyone in the work place will find out. Fear that this proves they are weak, and that they'll be forced to take time out or, worse, that they will be referred to the GMC and erased⁴.

Getting help

Admitting to yourself that you might have a problem is a first and vital step. It sounds simple but it is often the hardest part for practitioners. If a friend or patient who had been training hard for a marathon came to you complaining of muscle pain or a sprain, you wouldn't advise them to ignore it and hope it goes away.

Nor would you ever suggest that they train harder and faster, or imply that they were weak or had somehow failed.

You might suggest a referral to a physiotherapist to learn new methods or techniques to train without pain. You might provide support bandages, or prescribe medication. You might also advise a period of rest, with a gradual return to training. The same applies to the beginnings of any mental ill health or creeping addiction.

Like most problems, early recognition and treatment can mean these problems are easier to manage. Making small changes to the way you think, respond and behave, can have hugely beneficial and lasting effects. Many of these initial modifications can be done using self-help strategies, and without the need for professional help.

Some easy strategies

- Write your worries down before you go to sleep at night, or keep a list of important tasks. When written down, we're more likely to view our problems objectively.
- Making time to learn to relax is also vitally



important. If you think you don't have time - make time. It will pay off.

- Increasing your activity level in any way possible will also help. Building it into your daily routine will mean it takes less time and effort.
- Eating healthier and drinking less alcohol will also help to lift your mood and decrease anxiety.

A problem shared

When these problems are more serious or self-help techniques have failed, getting the right professional help as soon as possible can pay dividends in the future.

If you feel you can, try and share your concerns with a family member or supportive friend. Your GP is also a great source of help. The vast majority of issues can be dealt with by your GP, but in some cases an onward referral might be needed⁵.

As a doctor you have exactly the same rights as the patients you treat, including confidentiality, but concerns around access to confidential services often stop doctors seeking help. In most cases, these fears are unfounded⁶.

Recognise the signs

When we get depressed, stressed or are heading towards burnout, this is what we typically do, think or feel.

- We overestimate our problems and underestimate our ability to cope with them. We create even greater problems in our heads.

- We may try to avoid the thing that's bothering us, or isolate ourselves from others.
- We will often see ourselves as complete failures, and beyond help.
- We often drink more alcohol as a way to cope, and stop engaging in activities, perceiving we don't have the time, energy or drive that we used to have.
- Our sleep patterns, appetite and libido may change. We may experience more physical complaints and bowel problems.
- We might notice that we are more irritable or aren't able to concentrate or make decisions.

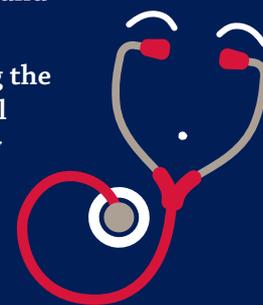
Anti-depressant medications may be an option but there are also a variety of different talking therapies to suit your preference, the most common and effective being Cognitive Behaviour Therapy (CBT).

References

- ¹ nhshealthandwellbeing.org
- ² www.php.nhs.uk
- ³ PHP 3 year report <http://bit.ly/wardround26>
- ⁴ <http://bit.ly/wardround24>
- ⁵ Some areas offer additional services and support. Visit php.nhs.uk for more information
- ⁶ The NHS careers website has some useful guidance on confidentiality and disclosure <http://bit.ly/wardround25>

If you're at all worried about your own mental health or drug and alcohol use, please don't ignore it, address it.

- **Small changes, early on, can have a big effect.**
- **Warning signs can be physical and mental.**
- **Avoiding the issue will probably make it worse.**



Dr Clare Gerada (GP and chair of the RCGP) and Mr Richard Jones, cognitive behaviour therapist and specialist mental health nurse, both work for the Practitioner Health Programme, a specialist service for doctors and dentists in the London area with mental health/addiction problems.

Clare and Richard have suggested the following websites which may be of interest to some of our readers.

www.bddg.org
www.sick-doctors-trust.co.uk
www.getsomeheadspace.com

Inappropriate delegation?

“All doctors have an ethical duty to recognise and work within the limit of their competence...”

The scene

A core trainee doctor was a few weeks into her placement in a gastroenterology department when a locum consultant asked her to carry out a gastroscopy on a patient with a suspected bleed. The trainee was worried about going ahead without supervision and contacted the MDU.

Our advice

All doctors have an ethical duty to recognise and work within the limit of their competence¹ in the interests of patient safety. This means the trainee should not undertake the procedure if she is not trained and experienced, unless she can call on another senior doctor to supervise her.

As well as the risk to the patient, there could be serious consequences for her if she carried out the gastroscopy unsupervised, despite her misgivings. An adverse outcome could easily result in a complaint and might also lead to disciplinary action by the hospital, a GMC referral or even a coroner's inquest if the patient died. In the event of a clinical negligence claim against the trust, the law makes no allowance for lack of experience: a junior doctor is expected to meet the standard of a competent and skilled doctor working in that field².

The consultant could not be held accountable for the actions of the trainee doctor although he retains overall responsibility for the patient's care and could face criticism for delegating the task without checking the trainee had “the knowledge, skills and experience to provide the relevant care or treatment; or that [she] will be adequately supervised”³.

To discharge her duty of care, the core trainee doctor should ask a senior colleague with the necessary experience to supervise the procedure. She could also consider using her hospital's procedures to raise concerns about what she had been asked to do by the consultant.

The GMC expects doctors to take prompt action if they think that patient safety is or may be compromised because of inadequate policies or systems and to keep a record of the steps they have taken.

Outcome

The core trainee doctor called the registrar on duty. He agreed to oversee the procedure which she carried out successfully. The doctor also raised concerns with her clinical supervisor about what she had been asked to do and the consultant was later warned by the clinical director about his decision to delegate.

References

- 1 GMC, *Good Medical Practice* (2013), paragraph 14
- 2 *Wilsher v Essex AHA* [1986] 3 All ER 801.CA
- 3 GMC, *Delegation and referral*, (2013), paragraph 4

Distressed parents

The scene

An ST1 was working in the oncology team one night when an 8-year old boy was admitted in a confused and drowsy condition. The patient had previously been treated for a brain tumour but the cancer had recurred and a further scan showed that the tumour was now growing rapidly. The oncologist considered that aggressive treatment was not clinically appropriate. However, when he gently raised the subject with the boy's parents they became angry and accused the hospital of giving up on their son. The ST1 had accompanied the consultant to the meeting and, shaken by the family's reaction, he called us for reassurance.

Our advice

The parents' anguish was understandably difficult to witness but the doctors had a duty to make the care of their patient their first concern and determine what was in his best interests.

As the patient did not have capacity, the consultant needed to discuss with the boy's parents the treatment options and seek their consent, as directed in the GMC's guidance on end-of-life care¹. This had to be managed sensitively and it was important to reassure the parents that every effort would still be made to ensure their

son's condition was monitored and that he was comfortable and as far as possible free of pain and other distressing symptoms.

The GMC expects all members of the care team to "acknowledge the role and responsibilities of people close to the patient. You should make sure, as far as possible, that their needs for support are met and their feelings respected, although the focus of care must remain on the patient"². For example, the family could be offered support from the hospital chaplain or counselling service.

Emotions were running high during the meeting and it was likely that the boy's parents would need time to consider the situation. However, if they continued to disagree with the doctors, it might have been helpful to hold a case conference or obtain a second opinion or to involve others such as independent advocates or mediators.

Ultimately, doctors are not obliged to provide clinical treatment if they do not consider it to be in the patient's best interest but the GMC says they should aim

to reach a consensus. Where agreement cannot be reached, it may be appropriate to involve the trust's legal department with a view to seeking a court order.

Outcome

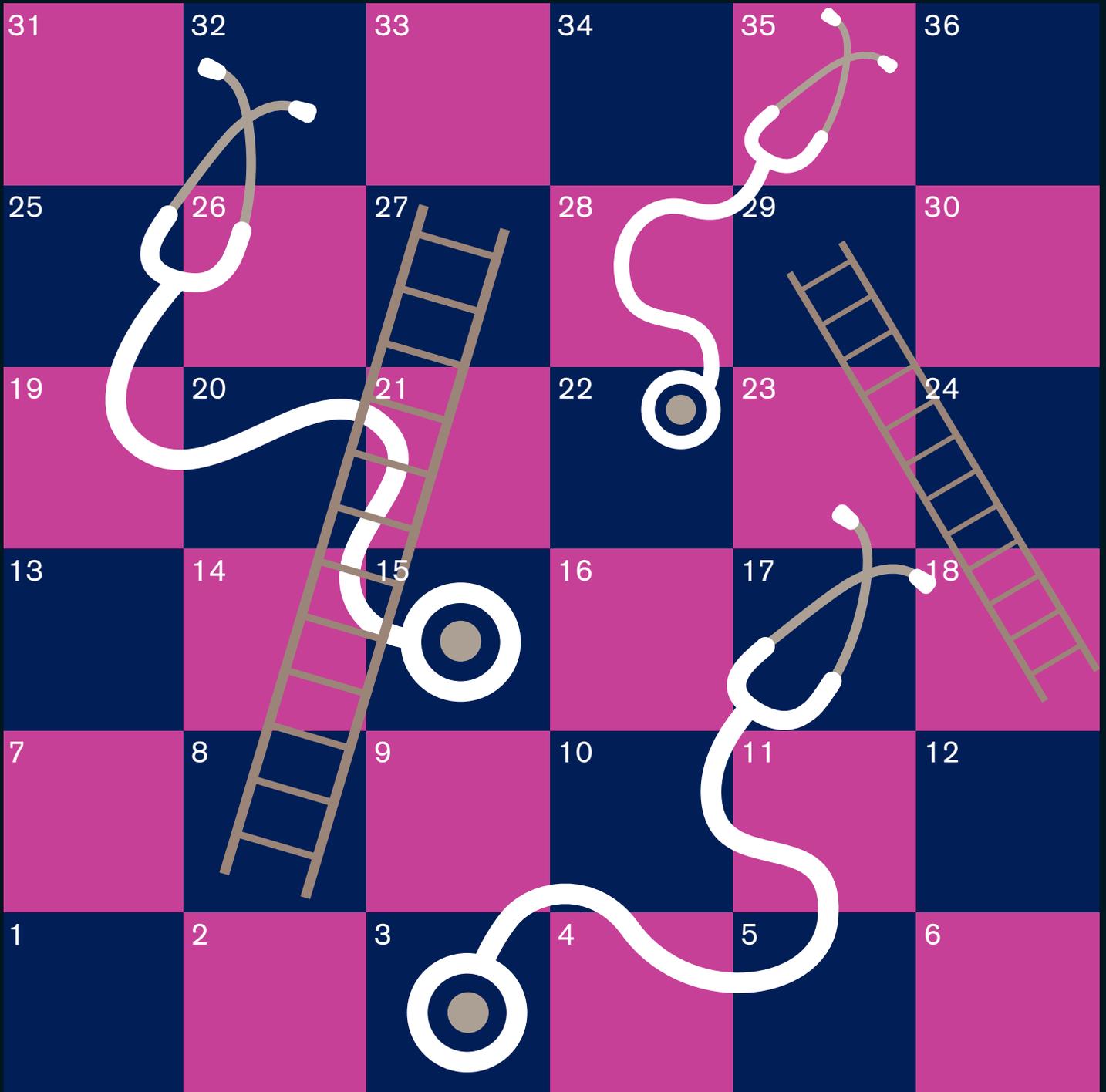
Later in the shift, the consultant discussed what had happened with the ST1. He said he was planning to invite the parents to a case conference with members of the multidisciplinary team the following morning so they could ask questions about their son's condition and treatment and suggested the ST1 could also attend. At the meeting, the neurosurgeon explained why the results of the patient's latest scan indicated the tumour was now inoperable, while a palliative care nurse explained how their son could be made comfortable at home. The parents eventually accepted that further aggressive treatment would be futile and risked distressing their son. He was later discharged and died at home the following week.



References

- ¹ GMC, *Treatment and care towards the end of life* (2010), paragraph 104
- ² GMC, *Treatment and care towards the end of life* (2010), paragraph 18

Professional conduct at work



What is the difference between a profession and a job? And what standards of behaviour are expected? Dr Philip Zack, MDU medico-legal adviser, sheds light on what it means to be a professional.

Consider these hypothetical scenarios.

- ✦ A highly competent dermatologist is examining a young woman's skin, which has improved greatly on treatment. He compliments her on her looks and asks for her phone number.
- ✦ A GP, generally well-regarded by her patients, is asked to complete a 'Yellow Card' to report a patient experiencing a side effect to a new drug. She refuses, saying that it's a waste of time.
- ✦ A new patient is referred to your clinic by a colleague you know to be knowledgeable and caring. The referral letter is unclear and leaves out important information about the patient.
- ✦ Your consultant, whom you regard as an able clinician, arrives on a ward round smelling of alcohol and looking unsteady.

In each of these scenarios, the doctor's knowledge, competence and compassion are not in question. But their professionalism is.

Medical professionalism is defined in the Royal College of Physicians' report *Doctors in Society: Medical Professionalism in a Changing World* (2005) as "a set of values, behaviours and relationships that underpin the trust the public has in doctors."

Twenty years ago surveys of public attitudes showed that most people regarded professionals such as doctors and bankers to be trustworthy. Opinion has now shifted and although most people still have a high regard for medicine, the reputation of banking is poor. What changed in the banking sector to cause a decline in trust? Essentially, some bankers failed to act with the professionalism expected of them.

The behaviours and attitudes expected of medical professionals are set out in the GMC's *Good Medical Practice* (2013) and other explanatory and supplementary guidance. Each of the scenarios above highlights a particular aspect of medical professionalism, and the standards that underpin them are rigorously upheld.

Professional boundaries

Professional boundaries between doctors and patients are important for ensuring that we earn and keep our patients' trust. A close emotional or sexual relationship between doctor and patient runs the risk of

compromising the doctor's objectivity in decision-making. It might open the doctor to allegations of taking advantage of a vulnerable patient. Paragraph 53 of the GMC's *Good Medical Practice* (2013) lays down clear rules about this

"You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them".

A doctor who learns or suspects that a colleague may have displayed sexual behaviour towards a patient has a duty to raise a concern. In its supplementary guidance *Sexual Behaviour and Your Duty to Report Colleagues* (2013) the GMC says that doctors must "promptly report... to a person or organisation able to investigate allegations".

Contributing to safety

Does it really matter if a GP refuses to report that a patient has experienced a side effect from a drug?

The important point here is the doctor's attitude. Medical culture requires doctors to take the lead in safeguarding patients' safety and wellbeing. An apparently uncaring attitude could undermine the confidence of patients and colleagues in the doctor's professionalism.

Paragraph 22 of *Good Medical Practice* (2013) states "You must take part in systems of quality assurance and quality improvement to promote patient safety".

Even if the contribution of completing a 'Yellow Card' seems small, it is part of a system designed to keep patients safer, and professionals must each play their part.

Team working – effective communications

Modern medicine is a team activity, involving medical and non-medical specialists providing a coordinated service for their patients. Each member has a role in the team and as a professional; you take responsibility for your role, making sure that you pass on clear and complete information to colleagues.

Paragraph 44 of *Good Medical Practice* (2013) states "You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers".

This applies whether you are delegating a single task to a colleague, handing the patient over for just a few hours at the end of a shift, or referring a patient to another doctor.

Doctor's behaviour or health – putting patients at risk

Doctors are human – we all have bad days, and occasional health problems. But as a professional it is up to you to make sure that your problems do not affect patient safety. If you are having personal or health problems, you should seek help and support at an early stage, and co-operate with measures intended to protect patients (for example, by taking a few days sick leave rather than spreading a gastroenteritis virus around your ward).

Where other doctors' behaviour or health is putting patients at risk, GMC guidance requires you to seek advice from an appropriate source – such as a senior colleague or the MDU – and to report your concerns if necessary.

Most doctors are proud to be doctors, and justifiably so. But belonging to a profession with a high public reputation means we need to earn and maintain that reputation by behaving in a professional manner.

i Further reading

- GMC, *Good Medical Practice* (2013)
 - Contribute to and comply with systems to protect patients (paragraph 22 Take part; paragraph 23 Report problems)
 - Respond to risks to safety (paragraph 24 promote culture, paragraph 25 Take prompt action)
 - Work collaboratively with colleagues (paragraphs 35-37 Collaboration & respect; paragraph 38 Job offers)
 - Continuity and coordination of care (paragraph 44 transfer of care; paragraph 45 delegation)
- Raising and acting on concerns about patient safety
 - Duty to raise concerns (paragraph 7)
 - Steps to raise a concern – local procedures first (paragraph 11)
- Delegation and referral
- Maintaining a professional boundary between you and your patient
- Sexual behaviour and your duty to report colleagues

Information the GMC holds about complaints

The GMC closes less serious cases after initial assessment, but holds information about the doctors concerned indefinitely. The doctors involved will not usually be notified that there has been a complaint. The complaints in question are those which the GMC decides do not raise a concern about fitness to practise. The GMC does write to the doctors involved if it decides not to investigate allegations relating to something that took place more than five years ago. It must have the complainant's consent to do so.

However, it does not tell doctors about the other cases it closes after initial assessment. Looking at the GMC's figures for 2012 alone, this would include many of the 6,240 cases that were closed at this stage¹.

Under current arrangements, details of these complaints are kept on file indefinitely. The GMC consulted last year on changes to its policies about how long it keeps information. Under those proposals, in future this information will be kept for four years, at which time the original record will be destroyed but the GMC will keep a summary record indefinitely.

The summary record will contain the complainant's name, the doctor's name, the date of the complaint, a brief description of the issue and the reason for closure. The GMC says its purpose for keeping this information is to enable it to respond to future enquiries about whether it had received specific complaints. The GMC would not normally disclose information about cases closed after initial assessment but says there may be circumstances where

The GMC uses its website and other material to inform doctors of the way it uses information about them, but from our conversations with members and representative organisations, we believe many doctors do not know that it may hold information about them.

it would consider it appropriate, for example, in response to a public enquiry about subsequent serious concerns.

We have raised concerns with the GMC about the practice of retaining a summary record. As the complaints have not been investigated, the GMC has no way of knowing whether the allegations in the summary record are accurate. The doctor is unaware of the complaint and has not been given an opportunity to comment on the factual accuracy of the information held, or any other aspect of it.

In support of this policy, the GMC has said it is satisfied it is not breaching the data protection requirements in respect of doctors whose information it is processing in this way. Under the Data Protection Act 1998 doctors can request access to any information the GMC holds about them, including a summary record, if one exists. The GMC would also have to disclose such a complaint if it wished to use it because it was considered material to a further investigation about the same doctor. The GMC consulted on both aspects of this policy during 2012 and the majority of respondents supported it².

For the MDU's part, we can see that seeking consent from around 6,000 complainants and then writing to around 6,000 doctors in circumstances where the complaint is not being pursued would have considerable financial and administrative implications. The GMC needs to consider the potential impact on registration fees, and the effect on individual doctors of knowing that a complaint has been made.

However, we cannot support the practice of making a summary record after four years and keeping the information indefinitely. We believe the information should be destroyed at that stage. We are bringing this to members' attention because the information retained might be about you, and we want to make sure you know what is happening.

Dr Michael Devlin

Head of advisory services at the MDU

i References

- ¹ GMC Council paper, 7 February 2013 Chief Operating Officer's report <http://bit.ly/wardround27>
- ² GMC Council paper, 5 December 2012 Report on the Outcome of the Consultation on GMC's Records Retention Policy. <http://bit.ly/wardround22>

Conscientious objection

An F2 doctor was due to start her placement in a hospital obstetrics and gynaecology department, but as a Christian she was concerned that she would be asked to clerk patients for termination procedures. The doctor contacted us to ask whether her moral objection meant she could refuse this task in all circumstances.

Our advice

Doctors with a conscientious objection can legally and ethically refuse to participate in terminations of pregnancy but they cannot refuse medical care where a patient who is awaiting or has undergone a termination could otherwise die or seriously deteriorate.

The legal right of healthcare professionals with a conscientious objection to refuse is set out in Section 4(1) of the Abortion Act 1967 which continues "Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

It would be sensible for the doctor to inform her clinical supervisor of her position as soon as possible so that alternative arrangements can be made for clerking patients who are seeking a termination. This is set out in the GMC's guidance on personal beliefs¹ which says "You should also be open with employers, partners or colleagues about your conscientious objection. You should explore with them how you can practise in accordance with your beliefs without compromising patient care and without overburdening colleagues." It's unlikely to be the first time that the department has been faced with this situation and there is likely to be an established policy on conscientious objections.

Despite her opposition to termination procedures, the doctor still has an ethical duty to be respectful of patients' dignity and views. For example, if a patient who was awaiting a termination asked her for advice about the procedure, the doctor could

explain that she cannot advise her and mention her conscientious objection, but in doing so she should be careful not to cause distress or imply any judgment of the patient. As it isn't practical for the patient to arrange to see another doctor, the FY2 doctor would need to make sure arrangements are made for a suitably qualified colleague to advise her.

The GMC says "You must bear in mind the patient's vulnerability and act promptly to make sure they are not denied appropriate treatment or services"².

"You should also be open with employers, partners or colleagues about your conscientious objection."

Outcome

The doctor informed her clinical supervisor about her conscientious objection and one of her colleagues agreed to undertake the clerking of day-case terminations. Later during her placement, a patient who had had a termination suffered a severe haemorrhage and the doctor was a member of the clinical team which treated her.

References

- ¹ GMC, *Personal beliefs and medical practice* (2013), paragraph 11
- ² GMC, *Personal beliefs and medical practice* (2013), paragraph 13

Your future career

What are the key things to think about when planning your future career? Dr Caroline Elton offers some tips.

It's just over five years since I set up the Careers Unit at London Deanery, and during that time I have counselled over 250 doctors. The issue of specialty choice is not the only concern that these doctors have, but wondering whether they have chosen the right specialty is an issue that crops up again and again.

From my perspective as an occupational psychologist, the longer I do this work, the more it seems to me that good career decision making relies less on fancy psychometric tests (although I use them from time to time), and far more on thinking critically and honestly about day-to-day stuff.

To give you an example, I recently saw an unhappy doctor many years into his paediatric training, who did well in medical school finals, except for paediatrics. Why, you may ask, did he choose that specialty? The answer is that he found paediatric colleagues friendlier than others, and of course, it might have worked out differently. But what he failed to do when choosing his specialty, or later when he started to fail, was to reflect on the fact that he had actually struggled with the specialty from the outset.

It can also be useful to draw a clinical parallel: when taking a clinical history there are a number of different bodily systems that you need to review systematically. Similarly, when reviewing your career history there are different career issues that should be put into the frame.

First, think about your skills and abilities – subjects and practical skills which seemed to come easily to you. Second, you need to think about what interests you most within medicine (because there can be things which you do well, that don't actually interest you that much). Which patients do you find most interesting? Which topics always grab your attention when flicking through a medical journal?

“What are the things that are really important to you and which you hold dear?”

Third, you need to think about work values. What are the things that are really important to you and which you hold dear?

And how might these priorities alter over the next five or so years? These might be issues that relate to your work context (e.g. working as part of a team) or they might relate to how you want your work to fit in with other out of work responsibilities.

And finally it is worth thinking about the flipside - the things that you find particularly stressful at work. It is worth spending a bit of time considering whether you have chosen options that minimise rather than exacerbate your vulnerabilities.

My late father brought a Second World War army maxim into our family lexicon - time spent on personal reconnaissance is seldom wasted. Substituting 'reflection' for 'reconnaissance', I would suggest that when choosing your specialty, time spent on personal reflection, covering all the issues listed above, can avoid mistakes that are difficult (though not impossible) to remedy at a later date.

Dr Caroline Elton is an occupational psychologist and Head of Careers Support and Planning, Shared Services, London



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