



# MDU wardround

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# RAISING CONCERNS

# IN THIS ISSUE

## Features and guidance

- 04 Raising concerns
- 08 The age of the selfie
- 10 Room for improvement
- 12 How to be a successful research scientist
- 14 Top tips for writing a Coroner's statement
- 16 Time to change direction?
- 17 Junior doctors have their say

## Advice line dilemmas

- 07 Difference of opinion
- 09 A message goes astray
- 13 Inaccurate summary
- 15 A colleague on the edge
- 18 An honest opinion

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# *Introduction from the* **medical editor**

The Francis Report into the standards of care provided at Mid-Staffordshire hospital recommended, among other things, that "proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns."

Junior doctors on the wards are often well-placed to notice something is amiss as they move between different hospital placements. For example, a trainee who has recent experience of excellent practice at one post could be acutely aware of incidents of poor care they might encounter at another hospital. Trainees are also less likely to be influenced by the prevailing culture within their new

department, which might inhibit some long-standing employees from speaking out.

While knowing when you need to raise concerns is central to ethical practice, it's equally important to know how to do this effectively. In our experience, there are several pitfalls doctors fall into when raising a concern – the most common are using the incorrect channels; not keeping a record of the action taken; and conflating a concern with a grievance against a colleague. Equally damaging is choosing the 'nuclear option' of going public without giving the hospital trust the opportunity to carry out a proper investigation, a course which can bring the hospital and profession into disrepute, as well as leaving the doctor vulnerable to a complaint.

We encourage all doctors who want to raise concerns to follow their employer's existing policy in the first instance. In the light of media horror stories about victimised 'whistleblowers', it's understandable for trainees to be nervous about the implications for their career. However, be reassured that there are many more unreported cases of doctors who successfully raise concerns. You may even gain recognition and respect if you bring a serious threat to patient safety to the attention of your employer.

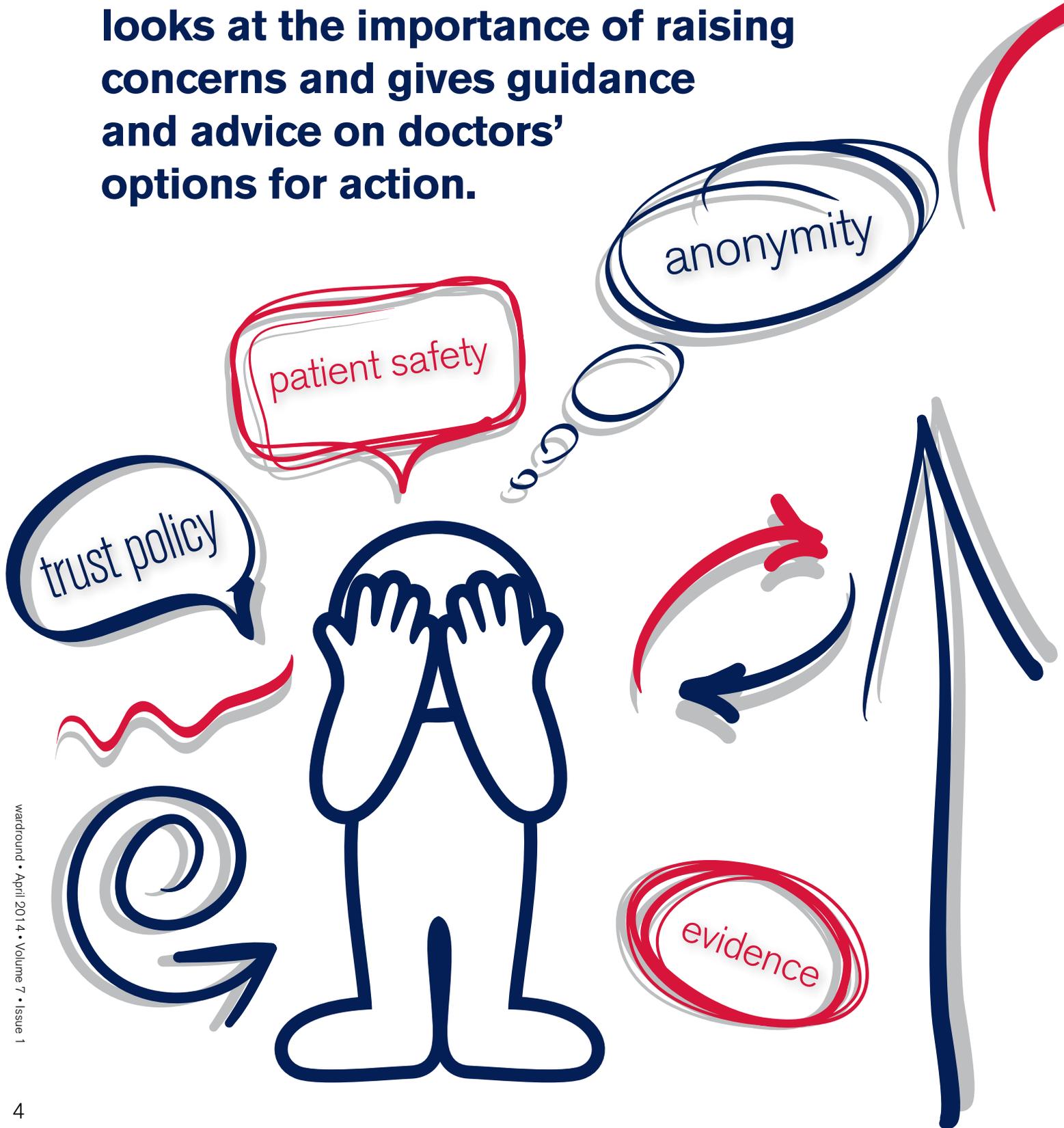
If you are unsure whether your concerns are well-founded or how best to raise your concern, the MDU is on hand to provide specific medico-legal advice. Just call our 24-hour helpline on 0800 716 646.

**Dr Sally Old**  
Medical editor



# Raising concerns

MDU medico-legal adviser Dr Sally Old looks at the importance of raising concerns and gives guidance and advice on doctors' options for action.





## ethical duty

Safeguarding patient safety is one of the main reasons for raising a concern in the workplace. When standards of care or behaviour fall below acceptable standards, doctors have an ethical duty to speak up. GMC guidance in *Good medical practice* (2013) emphasises that doctors 'must take prompt action if (they) think patient safety, dignity or comfort is or may be seriously compromised'.

Niall Dickson, chief executive of the GMC, told the MDU, "Doctors have a significant and wide set of responsibilities, including raising concerns. Doctors must not accept the unacceptable."

Since 2012, the GMC National Training Survey has specifically asked doctors in training if they have a concern about patient safety in their workplace. In 2013 11% of trainees who responded said that they had raised a concern and that it had been addressed, but a further 5% reported unresolved concerns. Doctors near the start of their training were more likely to raise concerns, with 8.7% of F1 doctors reporting issues compared to 2.8% of those in ST8<sup>1</sup>. The GMC also comments that doctors who are working in a specialty that is not their ultimate career choice (which is common for relatively junior doctors on rotations) may bring a 'fresh pair of eyes' to a situation. (See the article by the GMC's Chair Professor Sir Peter Rubin on page 17).

In a recent survey of 470 MDU members, more than half of respondents thought that doctors are more willing to raise concerns nowadays than five years ago. Over 50% had raised concerns themselves, although 40% of these reported that the matter was not dealt with to their satisfaction. They were either ignored or told nothing could be done. Only 16% had encountered barriers to reporting concerns.

Raising a concern effectively, without attracting professional or personal repercussions, requires a measured approach and adherence to GMC guidance and your employer's protocols. The MDU receives around 30 calls a week from doctors of all grades seeking help with issues of concern. We guide them through the steps towards raising their concern.

Our experience is that when doctors follow their trust policy and discuss their misgivings with colleagues, they often achieve the patient safety outcome they want. For example, an HCA confided in an F2 MDU member that she believed she had seen another F2 doctor asking a patient out on a date. Our member spoke to a ward nurse who said that the female patient had told her she felt uncomfortable around the other F2. The member broached the subject discreetly with the other F2, who hotly denied that any inappropriate conversation with a patient had ever taken place. The member let the matter drop.

**"In a recent survey of 470 MDU members, more than half of respondents thought that doctors are more willing to raise concerns nowadays than five years ago."**

When he himself witnessed the other F2 speaking to a female patient inappropriately, the MDU member rang us for advice. The MDU adviser reminded him of his ethical duty to protect patients, explaining that the seriousness of this case required him to take action. The adviser suggested he should speak to the HCA and nurse and that they should together report their concerns to senior managers.

The team raised the concern with the trust, presenting written evidence of specific instances, and asking the trust to investigate. The trust dealt with the matter directly with the F2 and informed the team of the outcome. ▶

Compare this with the case of a surgical registrar who judged a colleague's mortality rate to be too high. He reported his unfounded suspicions to the police, without involving his colleagues or employer. There was a complaint to the GMC and the registrar was judged to have brought the profession into disrepute at a fitness to practise hearing.

It's important to distinguish between a genuine patient safety concern and a personal or professional grievance. Members often call to discuss an issue which seems to be a personal issue – for example, that they have been asked to cover an additional clinic when they are already working at capacity. On the surface, this appears to be a straightforward human resources issue. But the effect on the doctor (overwork, tiredness) could have an impact on patients, potentially compromising their safety, and therefore should be raised as a concern.

All healthcare professionals should feel able to raise concerns, but what do you do if your workplace culture discourages you from speaking up? What if your concern is ignored or you find yourself at the heart of a bitter internal row? Niall Dickson says "Even senior staff can feel intimidated and uncertain about raising concerns when the culture is hostile. It can be more difficult still for doctors in training, or those who have limited experience of work."

However, he is "reasonably hopeful" that openness will become the norm. "Mid Staffs was a wake-up call for the profession, and a tipping point for people leading organisations to recognise that the way things were done in the past – that is, protecting the organisation and colleagues at all costs – must be changed."

There is also the possibility that others may raise concerns about your own practice. Mr Dickson advises "It is right and proper for patient safety that an investigation takes place. But being investigated locally or by the GMC is not easy. Our advice is to be straightforward, open and honest, and reflect on lessons learnt from the concern raised."

**Sources of advice**

- MDU advisory helpline 0800 716 646
- GMC helpline 0161 923 6399
- Public Concern at Work 020 7404 6609



**MDU advice on raising concerns**

- Before raising your concern, find out what your employer's policy is and follow it. Most trust policies require you to raise the concern officially with them first.
- You may only speak about your concern to anyone other than your employer under specific circumstances – namely, that you have done all you can to resolve a situation but without success, patient safety is still seriously compromised and you do not breach confidentiality. Please call us for advice before doing so.
- Canvassing your colleagues' views can help verify whether your observations are justified or unfounded.
- If there really is a problem, the most powerful way of putting it right is to act as a team. It may be possible to tackle the issue in the context of a critical incident discussion within the team, in the first instance.
- If a team approach is not appropriate, or fails, the concern should be raised with the trust.
- Compile your evidence in writing and be specific, citing examples of what you have observed. Information may be anonymised if necessary.
- Focus on how patient safety is affected.
- The GMC advises keeping a record of the steps you have taken.
- Finally, be clear about the outcome you expect from the trust.



**Reference**

<sup>1</sup> GMC, *National Training Survey* (2013), <http://bit.ly/wardround28>

# Difference of opinion

## The scene

An F1 doctor contacted the MDU's advice line to discuss the case of an 84-year old patient who had been admitted the previous day with severe left ventricular failure following a myocardial infarction. A do not attempt resuscitation order (DNAR) had been made after consultation with the on-call consultant.

Sometime later, the F1 doctor had received a call from a senior nurse on the ward. The patient's niece had called, very concerned that the DNAR order had been made. She said that she held Lasting Power of Attorney for the patient and was going to make a complaint. She asked to meet the consultant in charge of the patient's care. The F1 doctor had contacted his consultant, who replied that she was too busy to deal with the problem.

**“She said that she held Lasting Power of Attorney for the patient and was going to make a complaint.”**

## Our advice

The MDU adviser explained that the Mental Capacity Act 2005 introduced a Lasting Powers of Attorney (LPA) for personal welfare decisions, including healthcare. A personal welfare LPA allows a patient to nominate someone to make decisions on their behalf should they lose capacity. This may include decisions about end of life care and resuscitation, but this must be stated explicitly within the LPA. However, neither a patient nor the attorney can insist on a course of action or treatment that the doctors considered not to be in the patient's best interests.

Our adviser suggested that the F1 doctor arrange to meet the niece to explain her aunt's diagnosis and prognosis. The doctor should find out the nature of the Power of Attorney held. In our adviser's experience, the majority of Powers of Attorney relate to property and finance, and it is still relatively unusual to find patients who have drawn up LPAs for welfare decisions.

The GMC's guidance *Treatment and Care Towards the End of Life* (2010) addresses the issue of legal proxies who request that resuscitation be undertaken, even when the chances of success are small. The GMC encourages doctors to explore the reasons for the request, but emphasises that if the doctor believes that attempting CPR would not be of overall benefit for the patient, then they are not obliged to offer to attempt it. The reason for this should

be explained and the option of obtaining a second opinion discussed. The doctor was advised to make detailed notes of the discussion.

The adviser also discussed the level of support that the F1 doctor had received from his consultant. He was encouraged to consider whether the consultant's behaviour amounted to a pattern which could lead to junior doctors feeling unsupported, and also impact on patient care. Alternatively, she may have been genuinely unable, through work commitments, to assist with the problem at that time.

## Outcome

The F1 doctor contacted us again following a discussion with the patient's niece. The niece held an LPA for property and financial affairs only. The F1 doctor explained the patient's prognosis, and the likelihood that CPR would be unsuccessful and distressing for her. It had been a difficult discussion, but all parties reached the consensus that a DNAR order was appropriate. The patient died peacefully later that day, with her niece at her side. The doctor also contacted his consultant, who apologised for not being able to assist him earlier in the day. Therefore, the doctor decided not to progress this further.

# The age of the #selfie

## Selfie

**Pron:** /selfi/ (also selfy) **noun** (plural selfies) **informal**

a photograph that one has taken of oneself, typically one taken with a smartphone or webcam and uploaded to a social media website<sup>1</sup>

*Dr Richenda Tisdale, MDU medico-legal adviser, explains how the trend for taking selfies in a variety of locations could land doctors and medical students in jeopardy.*

It may have come as little surprise that the Oxford English Dictionary declared 'selfie' the word of the year in 2013<sup>2</sup>. The word has been used online for around a decade, and has become increasingly widespread over the course of the last couple of years.

No longer the preserve of teenagers and reality TV stars, 2013 brought us selfies featuring world leaders, the royal family and the Pope.

With the apparent acceptability of the selfie and its offshoots including the welfie (a workout selfie), drelfie (a drunken selfie) and the belfie (don't go there), it can be easy to be sucked into a competition to out-do one another on social websites.

You may be tempted to take a selfie at work, posing next to an entertaining x-ray, the gallstones you have just removed, or a patient recovering from an operation, but we advise you to resist doing so.

Even if you do not share the images online, you could find yourself in breach of GMC guidance on confidentiality, trust policy and data protection legislation.

Images that are shared on social media could be seen by people outside of your group of friends and followers. It is worth considering what your patients or colleagues would think of a selfie showing inappropriate behaviour.

We are aware of complaints and disciplinary proceedings arising out of images taken and stored on camera phones, and photographs shared online.

Our advice to members who wish to take photographs or recordings of themselves or of patients to share online is as follows.

- Be cautious about posting anything that may bring the profession into disrepute.
- Be professional in your comments, especially about patients or colleagues.
- Be aware that anything you upload on to a social networking site may be distributed further than you intended.
- When taking photos of a patient as part of their care or in an anonymised form for teaching or research purposes, you will need to get specific consent from the patient. You should explain why the recording is needed, and how it may be used and stored.
- Specific consent is not necessary to record certain clinical images, such as x-rays and images of pathology slides, but you should explain to patients, where practical, that the recording may be used in anonymised form for other healthcare purposes such as teaching.
- Think carefully before using a mobile phone or tablet computer to take and store clinical images. The image may fall into the wrong hands and the device should be protected with encryption software. Ensure your settings don't allow images to be uploaded to the internet automatically.
- Guard against improper disclosure of recordings made as part of patient care in the same way as you would medical records.

### **i** References

<sup>1</sup> Oxford English Dictionary - online

<sup>2</sup> <http://bit.ly/wardround29>



# A message goes astray

## The scene

An ST1 doctor reached the end of his shift on a general surgical ward. A few hours earlier he had requested a U and E blood test for a patient with a suspected bowel obstruction but had not yet heard back from the lab. The doctor was in a hurry and left a written note for a colleague on the next shift to chase the results. He went off duty for the weekend. When he returned on Monday, the note had gone and the ST1 assumed the test results had been actioned. However, he later discovered that the patient had suffered an acute kidney injury and been admitted to intensive care with multiple organ failure. Extremely distressed, the doctor contacted the MDU for advice.

## Our advice

Effective communication is essential for safe handovers, as well as being an ethical duty. In paragraph 44 of *Good medical practice* (2013), the GMC states that doctors “must contribute to the safe transfer of patients between healthcare providers”. It specifically requires them to “share all relevant information with colleagues involved in your patients’ care within and outside of the team, including when you hand over care as you go off duty” and to “check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient’s care has ended.”

To his credit, the ST1 already accepted he was at fault for leaving the shift without talking to another doctor about the tests and ensuring they would follow this up in his absence. He should now be open and honest with his consultant about what had happened and contribute to any inquiry into the adverse incident, in line with paragraph

23 of *Good medical practice* (2013). He should also apologise to the patient and their family if he has the opportunity.

While this could only be limited consolation, the ST1 was not alone. Several studies have shown that rushed, informal handovers are a common factor in SUIs in the UK. The GMC says that doctors in a leadership role have an ethical duty to “make sure that each patient’s care is properly co-ordinated and managed” and to “be satisfied that systems are in place to communicate information about patient care”<sup>1</sup>. This case showed that the hospital’s clinical leaders might need to tighten their management of shift handovers.

## Outcome

The ST1 doctor immediately went to see his consultant and explained what had happened. He co-operated fully with the subsequent hospital investigation, apologising for his part in what went wrong. This insight counted in his favour and while he was reprimanded, the ST1 was allowed to continue in his post. The investigation recognised that the trust’s procedures were inadequate and a new handover protocol was implemented, including a checklist to ensure outstanding test results were properly noted and the responsibility assigned. The patient eventually recovered and the hospital formally apologised for the failings which had occurred during his care.

## i Reference

<sup>1</sup> GMC, *Leadership and management for all doctors* (2012), paragraphs 15 and 19



# Room for

A female patient with a fractured neck of femur was admitted through the emergency department. She commented that she had been feeling more short of breath than usual so the ED doctor requested an urgent CTPA. The investigation was arranged but straight afterwards the radiologist had to go and attend to several other emergencies. There was therefore a delay in providing a report and it wasn't available when the consultant respiratory physician came to review the patient as requested by the orthopaedic team.

However, the consultant physician reviewed the images on the ward computer and provisionally noted that he could not see any evidence of pulmonary embolism. The patient was booked in for surgery and when the orthopaedic F2 went off shift, she verbally handed over to her colleague, telling him that the formal report was not yet available.

By the time the anaesthetist undertook a pre-operative assessment the CTPA report was available and multiple small pulmonary emboli were identified. The anaesthetist was concerned, however, as he had noted the F2's comment, made after the physicians' review, "CTPA – nil seen". He felt that if he had taken this at face value the patient could have been at risk. He suggested that the F2 reflect on what could have been done to improve care.

This is fictitious but the general scenario, where a number of minor events combine to create a potential risk, may be familiar. In this case, there is the potential that the pulmonary embolus might not be identified, at least not until the patient suffers a potentially fatal embolic event in the theatre recovery room.

Hospitals are expected to have policies and procedures in place to identify all adverse events. There is on-going focus on trusts employing an open and honest culture of identifying and learning from adverse events and avoiding blame. Trusts should have policies in place to encourage adverse event reporting and, should a significant event be identified, may ask the doctors involved to participate in a review. The trust may ask the doctor to write a factual statement of their involvement, or to complete a trust proforma including sections on risks and learning points identified and planned learning activities. The doctors may also be asked to attend an interview with the investigator or a meeting of all staff involved.

## ***Procedures in place***

A review into the care of this patient may have identified that the computers on the ward were of lower resolution than the radiology reporting stations and ensured that the physicians were aware of this. The radiology department may have been asked to ensure that a system was in place to inform the clinicians of potentially significant findings. However, in addition to formal trust procedures, as individual doctors we can also make a difference to patients' experiences in hospital by concentrating on quality improvement both at an individual level and within our larger teams.

The GMC is explicit in its advice that we must make the care of patients our first concern, take part in activities that maintain and develop our competence and performance and contribute to and comply with systems to protect patients. More specifically, we are advised to take steps to monitor and improve the quality of our work and regularly reflect on our standards of practice and the care we provide. There is no substitute for experience, of course, and allowance is made for our stage of training. However, we can all learn from events and improve patient care.

# improvement

Dr Lynne Burgess, MDU medico-legal adviser looks at how medical errors on the ward can be avoided and explains how reflective practice can lead to better patient care.

## Personal development

Current training offers multiple opportunities for reflective practice, indeed we are required to provide evidence of our learning in order to progress in our training. It's vital that we maintain and improve our clinical skills. Junior doctors are expected to attend essential training and undertake CPD activities and workplace-based assessments. You may also be involved in audits or research.

In order to learn from events, the potential problems first need to be identified. This can be challenging as it is not always easy to identify what we do not know, to see where our actions could have been improved. However, as no doctor is perfect it is likely that any clinical scenario can be a potential learning experience. Doctors in training have the benefit of clinical and educational supervisors to review the clinical care and identify any learning points. It can also be helpful to review any local or national guidelines to ensure that you are following the accepted standard. We are expected to work within the limits of our experience and obtain suitable senior advice as required.

## GMC complaints

Not all learning points are clinical. The GMC in its publication *The State of Medical Education* (2013) states that 7% of complaints made to the GMC were regarding communication with patients and 24% involved clinical care combined with concerns about communication. A further 2% of GMC complaints related to working with colleagues, such as when a doctor does not share relevant information with other members of the healthcare team. As part of quality improvement it may also be helpful to review our communication and

note keeping, particularly at handovers from shift to shift.

The GMC advises<sup>1</sup> that clinical records should include relevant clinical findings, the decisions made and actions agreed, who is making the decisions and agreeing the actions, the information given to patients, any drugs prescribed or other investigation or treatment and who is making the record and when. It can be simple to audit whether your clinical records are timed, dated and legibly signed. Medical records are usually made contemporaneously with the events. They may appear detailed and clear to the person writing them with full and recent knowledge of what has happened. However, if you are asked to write a report, many months may have passed. From your notes it should be possible to say exactly what history and examination was undertaken, including the negative findings, and who did what and when. Are your conversations recorded along with the names of the people you spoke to? If your colleague needs to review the records for on-going care will all the events be clear?

In the scenario the doctor could reflect on whether she followed this advice. Is it clear from her notes who reviewed the patient's CTPA, in what circumstances, and what their full opinion was? Will her colleagues realise that a formal report was required?

We are all potential patients, so it is reassuring that the NHS is focused on continual assessment and improvement of the quality of healthcare. As doctors, we have a role to play in improving patients' experiences. Evidence that a doctor in training reflects on the quality of their clinical care and communication can stand them in good stead in their career.

## Ideas for possible reflective practice

- Ensure your essential training is up to date.
- Plan your workplace-based assessments to demonstrate a wide range of skills.
- Consider reviewing your clinical care with a supervisor as part of your reflection.
- Undertake a note keeping review. Make sure your notes include all relevant information.
- Reflect on your written and verbal communication with your colleagues and patients.
- Review any clinical guidelines for each case.
- Identify any relevant CPD opportunities.
- Review the GMC guidance.
- Are there opportunities for audit?
- Co-operate with any trust procedures.



## Further reading

GMC, *Good medical practice*, (2013)

GMC, *The State of Medical Education and practice in the UK report* (2013)

Sir Bruce Keogh, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* (2013)

National Patient Safety Agency, *seven steps to patient safety, the full reference guide* (2004). [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

## Reference

<sup>1</sup> GMC, *Good medical practice*, (2013) paragraph 21.

# How to be a successful research scientist



*Professor Darren Griffin is Professor of Genetics at the University of Kent. He runs a lab researching human fertility, birth defects and genome evolution, and a Masters course in reproductive medicine. Here, he gives his top tips for getting involved and flourishing in research.*

I have supervised medically trained people in my lab many times and, I have to say, all fare far better than I ever would in the clinic. It's very hard to generalise but, on the whole, I find their work ethic and presentational ability exemplary – great traits to have as a scientist.

Keep in mind, however, that manual dexterity is essential in the lab and remember that you're starting from scratch in a whole new environment. Doing something out of your comfort zone (and it will be) can be a highly rewarding experience but just remember, for a little while you'll be the new kid at school.

*For doctors looking to move into a research role, here are my dos and don'ts.*



The only way to do good research is to get on with it. There's really no advantage in having good ideas if you don't put them into action. You must be prepared to apply the same work ethic as you would in the clinic and put in the hours in the lab.



Successful research is often more about timing than resources. It's a popular misconception about research that you just throw money and lots of people at an idea and it will work. Not always true. You need to shoot at the right time to hit the target.



Be prepared to seize every opportunity. Research is all about finding what is new and exciting. It may not be the structured, clinical world that you're used to. Research projects rarely take you where you expect.



If the system doesn't work for you, change it or do something else. If you think something can be improved, be proactive and decisive in changing it.



With good people, you can do anything. Interacting with my colleagues is one of the most rewarding aspects of my work.



Don't ask why, ask why not. Don't take no for an answer, because every no is one step closer to a yes.



Research is about imagination and ideas. A certain level of knowledge is essential, but you can always look up anything you don't know. Think about the process of coming up with new ideas, drawing on the talent of those around you for inspiration.



The journey can be as rewarding as the destination. Remember to enjoy the ride. It's such a wonderful thing, being a scientist, because you're in the process of discovery. It's a lot of fun, so enjoy it.



Consider what you can offer. Why should I, or any other academic, take you into my research lab? I can give you the germ of an idea, the infrastructure and the benefit of my experience. What can you give me?



Be nice to people. I think this is ultimately most important – not only because it's the right thing to do morally, but also because you never know when someone will have something that you want. They might return the favour you once did them.

# Inaccurate summary

*You are writing a discharge summary for a patient sent home earlier in the day when you are interrupted by a call from the ward about another patient. You call up the latest results for that patient and then go to review her. In line with good practice, you lock your computer screen while you leave the office for a few minutes.*

*Some time later, having dealt with several matters on the ward, you return to your desk to complete the discharge summary. You want to include the scan results and go to check them on the computer. When you reactivate the computer the ward patient's results are still there as the last ones you reviewed. You forget that you had called these up and mistakenly assume that the screen shows the results of the patient whose discharge summary you are writing and include them in your report.*

*A week later the discharged patient is readmitted and you are asked to see him once again. When you read the notes you realise that the summary you had written was inaccurate and included the wrong scan findings. What should you do?*

Discharge summaries are an important tool for communicating essential information between the discharging team, patient, GP and other hospital departments. There could be serious consequences for the patient if their future care is based on the wrong information. It comes as no surprise therefore that the GMC advises in paragraph 19 of *Good medical practice* (2013) that "documents you make (including clinical records) to formally record your work must be clear, accurate and legible."

You may be tempted to just amend the copy of the summary in the hospital records. However, this will not reach all the recipients of the inaccurate document and there will be no explanation of why you have made the changes.

To provide safe patient care you will need to communicate the corrected information to all the relevant parties, explain your mistake and ask for copies of

the inaccurate summary to be removed or to be clearly marked as erroneous.

An apology would also be appropriate. As the patient will have had a copy of the incorrect summary it will be important to say sorry personally and explain what has happened and how you will put things right. As with any discussion with a patient, you will need to make a note of it in the clinical records and this will give you an opportunity to document your mistake and how it arose.

The GMC also expects doctors to contribute to the recognition of adverse incidents and to learn from events. You should report the error using your hospital incident reporting system and discuss what has occurred with your educational supervisor and/or consultant. Whenever referring to records or results, whether on screen or on paper, you should take a moment to ensure that you have the correct patient's details in front of you.

# Top tips for writing a Coroner's statement

You are an ST1 doctor in A&E on a week of nights. You see a 43-year old patient with chest pain which does not sound cardiac. All bloods and the ECG are normal. The patient is discharged home with an outpatient exercise test. The following night you are informed that the patient died later at home. You are asked to provide a report for the Coroner. How should you go about it?

## One

### **Stay calm**

Coroners are seeking a factual report detailing the care you provided. They are not trying to catch you out – they simply want to find out what happened.

### **Seek our advice**

The MDU's 24-hour medico-legal advisory helpline is available to assist with cases such as this. The adviser will provide initial guidance on drafting a statement for the Coroner and ask you to send it to us for review.

## Two

## Three

### **Co-operate with the trust's legal department**

As an employee of the hospital trust, you are indemnified by the trust. They will usually support and guide you through a Coroner's process too, so you will be advised by the MDU to liaise closely with them.

### **Document your recollection of events**

It is often helpful to make an anonymous record of your memory of events as soon as you know you will need to write a report. Memories fade with time and the sooner you can jot down your honest recollections the better. You can include your recollections in your Coroner's report, providing you state this is what they are.

## Four

## Five

### **Obtain a copy of the clinical notes**

Any report to the Coroner must concur with the clinical notes you made at the time you cared for the patient. Request a copy of the notes from the trust so that you can review them when you write your report.

### **Never amend records**

Never be tempted to amend the records when you go back to review your own notes to write a Coroner's report, even if with hindsight you feel they are not complete or clear.

## Six

## Seven

### **Consider your normal clinical practice**

If you haven't included every single detail of the care you provided, consider your normal clinical practice. It is quite acceptable to include a comment on your normal practice in your report.

### **Talk to a senior colleague or mentor**

Being under the spotlight of the Coroner is stressful. Discuss the care you provided with a senior colleague or mentor to obtain feedback and support throughout the process.

## Eight

## Nine

### **Consider what you have learnt**

We all learn from cases – such is the nature of clinical medicine. Use an experience such as this to reflect on what you did well in the case and what you can improve on for the future. Document these reflections in your portfolio and act on any shortcomings that may be exposed.

### **Don't ignore it!**

There is likely to be a deadline for submission of your Coroner's report. Act early, get advice and don't leave the report until the last minute.

## Ten

# A colleague on the edge

## The scene

An F2 doctor was halfway through her placement in a paediatric department. A few weeks before, the sudden death of a patient had upset everyone but one of the F1 doctors was hit particularly hard, becoming withdrawn and distracted. The F2 was increasingly worried about her colleague and had covered for him on several occasions when he had been late for his shift. She was reluctant to get him into trouble but one morning she was alarmed to smell alcohol on his breath and called the MDU for urgent advice.

## Our advice

The F2's sympathy for her colleague was understandable but on this occasion her ethical duty was clear. The GMC's guidance states that all doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by their colleagues' practice<sup>1</sup>. This duty overrides any personal or professional loyalties. Raising concerns would also be in the F1's interests as he was risking his own career and might benefit from professional help.

Depending on their professional relationship, the F2 could consider approaching her colleague. She would need to encourage him to leave the shift and talk to his supervisor and/or GP, making it clear she would take action herself if he did nothing. However, she should be prepared for the possibility that he would not take her seriously, react angrily or refuse to accept help.

If she was uncomfortable with the idea of talking to the F1 doctor or had tried to do so unsuccessfully, she would need to follow her hospital's established procedures for raising concerns. This would usually require concerns to be raised in writing but given the situation, it would be better to speak to the designated person in her department straight away. The GMC also expects doctors to keep a record of their concerns and the steps they have taken to resolve them<sup>2</sup>.

The F2 should expect to be updated by her consultant as long as this did not breach her colleague's confidentiality. In the unlikely event that no action was taken and the F1 doctor remained a serious threat to patients, she could escalate her concerns. This would mean contacting a more senior manager within the trust, the postgraduate dean at her Local Education and Training Board or approaching the GMC.

Having acted on her concerns, she should steer clear of any departmental gossip about the doctor: he was entitled to the same degree of sensitivity and confidentiality about his health as any other patient.

## Outcome

After the F2 doctor raised her concerns with the consultant in charge of her team, he spoke to the F1 and arranged for him to take a period of sick leave. The doctor was referred to a counsellor to help him come to terms with the patient's death and reflect on his response. He eventually returned to work within a different department where he was mentored by a senior doctor.



## References

- <sup>1</sup> GMC, *Raising and acting on concerns about patient safety* (2012), paragraph 7
- <sup>2</sup> GMC, *Raising and acting on concerns about patient safety* (2012), paragraph 15

# Time to change direction?

*If you're not sure if your career is heading the right way what are the main things you need to consider? Dr Caroline Elton provides some guidance.*

*I'm an ST2 in histopathology and I think I have made the wrong career choice. Previously I completed core medicine and I have got my MRCP exams. But I found life on the wards really stressful, to say nothing of the on-calls, so I moved into a role away from front line patient care. The problem is I am really missing patient contact and even though I find the work reasonably interesting, my heart really isn't in it. What should I do?*

There are a number of important factors to consider when facing a decision like this. First, is there something going on in your current rotation that has nothing to do with the choice of specialty – for example, difficulties with colleagues or your supervising consultant – which is having a detrimental effect on your enjoyment of your work? Difficult colleagues can zap your motivation, but if your dilemma is more about a specific colleague or the atmosphere in a team, than about the specialty itself, you might find you enjoy your current specialty more in your next rotation.

Second, are there things going on in your life outside of work that might be contributing to how you are feeling about your job? This might be impacting on your mood, and colouring your attitude to your work, with the net result that you aren't enjoying your job very much.

If neither of these seems to apply, you could try a thorough career self-assessment. In the same way that you approach a clinical decision by taking a patient history, when faced with a career decision you need to review your own career history. That will help you identify your abilities, skills, interests and core values, as well as highlighting aspects of work you find particularly stressful.

Finally, you may want to explore the career 'tipping point'. Simply put, this means identifying the smallest career shift that produces the greatest psychological gain. For you, the smallest shift could be to work out if there are any options within histopathology that you might enjoy more.

If you are still not sure, your next task might be to explore the 20-plus ST3 medical specialties which are open to you because you have already successfully completed core medical training.

You may be able to find some that would suit your preferences better, for example, among the less acute, out-patient based options (given your previous experience with ward based work). CT1/ST1 specialties may be worth a look, too.

Only after you have discounted all these options would you start looking at jobs such as medical writer or medical statistician i.e. jobs that draw on some, but not all, aspects of your clinical training.

The process of stepping back slowly and incrementally from your current job until you identify the 'tipping point' offers a systematic way of approaching a career shift.

Given that you have already identified that a key missing ingredient in your current job is patient contact, I suspect that one of the different ST3 medical specialties will work well for you in future.

Dr Caroline Elton is an occupational psychologist and former head of the Careers Unit at London Deanery. In February 2014 she set up CPD: Career Planning for Doctors/Dentists [careerplanningfordoctorsanddentists.com](http://careerplanningfordoctorsanddentists.com)

# Junior doctors *have their say*

*The GMC's National Training Survey (2013) revealed that junior doctors are more likely to raise concerns. Professor Sir Peter Rubin, Chair of the GMC, expands on these findings.*

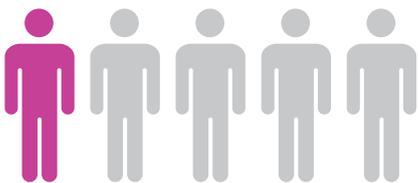
In his report on the failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC made it clear that all doctors have a duty to protect patients and that doctors in training are invaluable 'eyes and ears' for what is happening at the front line of patient care.

Patient safety is our top priority at the GMC and we believe all doctors, regardless of their seniority, should feel supported in improving the standards of care for their patients. The very best organisations have a culture of openness where mistakes and near-misses are promptly and widely reported and lessons for improvement quickly learned.

Junior doctors are in an ideal position not only to draw attention to potential problems in their training environment but also to highlight any concerns they have about patient safety.

We know from our latest National Training Survey<sup>1</sup> that doctors nearer the beginning of their training are more likely to raise concerns, as are doctors whose primary medical qualification is from the UK.

More than 2,000 doctors in training (5.2%) raised a concern about patient safety through the survey in 2013 - more than half of which related to lack of staffing or resources. Most of these trainees told us they had also raised the issue locally.



**One in five doctors in training has witnessed someone being bullied in their current post.**



**Said they had experienced bullying at work.**

We believe that doctors in training should raise their concerns through local channels where possible. However, the important point is that the concern is raised, so we'd encourage trainees to use the survey if they feel more comfortable reporting a concern in that way. We can then liaise with the Postgraduate Dean to check that the matter is followed up.

### **Bullying**

The survey also revealed that nearly one in five doctors in training has witnessed someone being bullied in their current post. More than one in four has experienced undermining behaviour themselves and 13.2% said they had experienced bullying at work. This is unacceptable and clearly more needs to be done to support junior doctors to build the positive, supportive culture that is essential to patient safety.

We know that the best care is always given by professionals who are supported and encouraged. We strongly support openness and transparency and we feel that doctors in training should be able to raise their concerns, without fear of reprisal or being disadvantaged in some way.

Reassuringly, 5,863 respondents (11.1%) said they had been concerned about patient safety, and their concerns had been raised and addressed locally. This, and other examples of good practice from the survey, shows how organisations which had experienced problems managed them positively and effectively.

# 5,863

**Number of respondents who said they had been concerned about patient safety, and their concerns had been raised and addressed locally.**

Employers will want to reflect on these results and engage with doctors in training, using their experiences to help change the culture of their organisations.

The survey highlights the importance of listening to young doctors working on the front line of clinical care. The significance of their views cannot, and should not, be underestimated.

The National Training Survey runs again this year until 8 May<sup>2</sup>. I'd encourage all doctors in training to take part, to ensure their views and any concerns they raise are taken forward and to play their part in improving postgraduate medical education in the UK.

### **References**

<sup>1</sup> GMC, *National Training Survey (2013)*, <http://bit.ly/wardround31>

<sup>2</sup> <http://bit.ly/wardround30>

# An honest opinion

## The scene

An F2 doctor was asked by her consultant to provide a statement as part of an investigation into a complaint. A patient had alleged that the consultant had been rude and dismissive during a consultation at which the F2 doctor had been present. The complainant went on to allege that the consultant's poor communication skills and bullying attitude had led to a failure to reach the correct diagnosis. The F2 considered that the patient's complaint was justified, and had raised concerns about the correct diagnosis at the time, only to be put down in front of the patient. The consultant had also been rude to her and other colleagues on several other occasions during his placement. She rang the MDU for advice on how to respond.

## Our advice

It is becoming increasingly common to be asked to provide comments on a colleague's conduct or performance. Often this is by way of a 360° appraisal, which every doctor must undergo during a five year revalidation cycle. However, there are other situations, such as disciplinary hearings, investigations by the GMC or when a report is needed, where it is necessary to provide an account of another doctor's actions. The majority of doctors might feel comfortable in providing feedback through a 360° appraisal, which involves a tick box form submitted via an independent company so that the appraiser remains anonymous. However, many would be uncomfortable or concerned about providing a report that is critical of a senior colleague. It is understandable not to want to say anything negative about a colleague, but doctors might also be anxious about counter-accusations or jeopardising their career prospects. The GMC states that doctors have an obligation to act if they think that patients are being put at risk by a colleague's performance, conduct or health. The booklet *Raising and acting on concerns about patient safety* (2012) provides additional detail, and while acknowledging that there may be obstacles to raising concerns there is 'a duty to put patients' interests first and act to protect them, which overrides personal and professional loyalties'.

Hospitals are obliged to have a policy on raising concerns at work. The policy will usually include an option of being able to raise concerns anonymously. While this may seem an attractive option, doctors should be aware that raising concerns anonymously can hamper an investigation and also deny the doctor concerned the opportunity of responding adequately to the concerns. There are also times when the concerns raised are of sufficient severity that anonymity cannot be protected.

In summary, the same principles apply whether a doctor is providing feedback anonymously via 360° appraisal or a written statement as part of formal proceedings. The doctor must be honest and fair to all concerned and not be afraid of providing a truthful account through fear of reprisals.

## Outcome

In this case, we helped the F2 doctor to write a statement setting out what she had observed during the consultation, which did include corroboration of the patient's account of the incident. The adviser also suggested that the F2 speak to colleagues with a view to jointly approaching her Foundation Programme Director or Education Supervisor about the consultant's attitude towards her junior colleagues.

## Learning points

- Keep any statement factual and avoid opinion.
- Be specific – include dates, times etc.
- Identify other witnesses/colleagues by name.
- Include patient identifiers if confidentiality allows.
- Contact the MDU for advice.
- Be discreet.



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