



NEWDOCTOR



PROFESSIONAL SUPPORT AND EXPERT ADVICE FOR NEW DOCTORS

STAYING SAFE ON SOCIAL MEDIA

A LOOK AT
THE GUIDELINES
AND POTENTIAL
CONSEQUENCES

THIS ISSUE...

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Tips for managing first year difficulties

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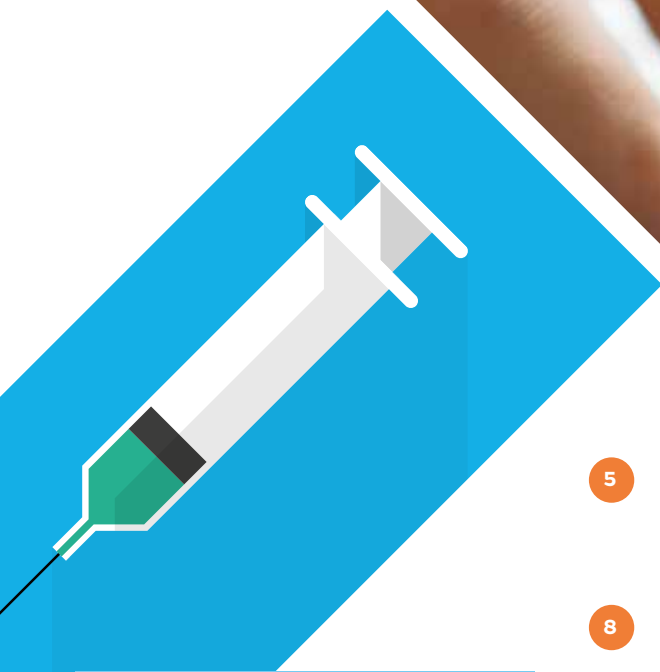
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 New Doctor (Online) ISSN 2042-4183



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NOTICEBOARD



Welcome

Welcome to the latest edition of *New Doctor*.

Technology increasingly impacts on the way that young doctors practice medicine. Appropriate use of innovations such as social media, apps and smartphones can benefit patient care but doctors also have to be aware of the medicolegal pitfalls that technology introduces. On page 6, Dr Gordon McDavid explores the potential issues for doctors who use social media with reference to the relevant GMC guidance and a number of real-world scenarios.

Maintaining professionalism is essential for all doctors to comply with the GMC's Good Medical Practice guidance. Although only a small proportion of junior doctors are investigated by the GMC, data demonstrates that those that are often face allegations relating to probity, drug and alcohol abuse. It is important to remember that the GMC expects you to act professionally both at work and in your personal life. In this edition, we focus on how attending one of Medical Protection's interactive workshops can lower your risk as a foundation doctor.

Many of you will be embarking on your first year of Foundation Training. As we recognise that this can be a stressful time for you, this edition features an insightful and supportive article from Dr Rachel Thomas. She looks back on her experience as an FY1 to offer you tips and advice for you to take with you into your new role.

Inside you will also find some invaluable advice from Dr Clare Redmond on how to assess capacity of a patient who wishes to leave or refuse treatment. Additionally, we seek to familiarise you with the inquest process and also highlight the recent legislative changes to presumed consent for organ donation.

Our 'A day in the life' articles provide an insight into the typical responsibilities and daily routines involved with each speciality. Here, Dr Jonathan Healan shares his experience as an FY1 working in anaesthetics.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or if you have any ideas for topics you'd like us to cover.

Dr James Thorpe
Editor-in-Chief

HOW TO GET PUBLISHED!

Do you have a dilemma and would like to see it addressed in *New Doctor*? Have you worked abroad and want to share your experiences with your foundation year colleagues? Getting research or writing published will make your CV stand out in whatever specialty you go into.

We welcome contributions to *New Doctor*, so if you want to get involved, please email Kirsty Plowman, *New Doctor* Editor, at

kirsty.plowman@medicalprotection.org



HOT TOPIC



Drawing upon a recently reported case, Medical Protection's Senior Medicolegal Adviser Dr Pallavi Bradshaw emphasises why it is important to include reflections in your ePortfolio

Event Analysis reports have to be disclosed if requested, such information should be passed via the Trust legal team. It is unclear why the trainee disclosed what should have been anonymised data directly to the legal agency or whether they had sought advice from their defence organisation first.

As a foundation doctor, not only are you responsible for the care of patients but also for your professional development. You need to demonstrate core competencies and record such achievements through the ePortfolio. The ePortfolio, when used effectively, can help identify learning needs and set individual goals. It is a key part of evidence in demonstrating competence throughout your training.

Another important function is to allow open and honest reflections on clinical incidents or complaints. A patient safety incident, as defined by the NPSA, is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. It is very likely that at some stage of the foundation programme you

will be involved in such an event. In certain situations, where moderate or serious harm has occurred, the new duty of candour will be engaged and certain defined steps will need to be followed as per the Trust's policy. Even where harm has not occurred it is important to reflect on the circumstances of the incident in order to identify lessons learned or training needs.

A recently reported case raised concerns when a GP trainee's personal reflections on an incident were released to a legal agency and apparently used against him in court. This is a very unusual situation and while I am not familiar with the particulars of the case, I am confident that the reflections in themselves would not have led to the success of a claim in negligence. While it is true that Significant

Crucially, following the media reports, Health Education England confirmed that personal reflections must be recorded in portfolios – a view shared by Medical Protection. Portfolios are invaluable for skills and career development and helps foster an open and reflective culture in the health system. Ultimately, if a claim is pursued there are many factors which will be taken into account and subjective reflections in themselves will not be determinative. Further, there is a greater risk to you by not recording an incident or complaint as this may lead to allegations of dishonesty which can be far more detrimental to your career. Failing to provide written reflections on such incidents in the portfolio may also lead to concerns about a lack of insight or failure to learn, again leading to possible scrutiny.

Every issue trainees send in their dilemmas

Ask Medical Protection

THIS EDITION: STAYING SAFE ON SOCIAL MEDIA

Social media in healthcare has many benefits. However, as with any novel way of working, Medical Protection's Medicolegal Adviser Dr Gordon McDavid says it is essential to consider the potential consequences that may accompany the advantages



Social media has enabled any individual to publish comments online to a potentially national or global audience; accordingly it also carries risks that doctors should keep in mind. For example, information intended to remain private, or between 'friends', can inadvertently make its way into the public domain. Doctors hold a unique position of trust in society and it is vital that they remain cognisant of their ethical duties and that their conduct online echoes the persona they wish to convey at work.

Inappropriate posts online could invite a complaint, disciplinary action or even a referral to the GMC. Medical Protection has seen an increase in doctors seeking advice relating to the use of social media in recent years. The GMC's guidance on the topic is outlined in *Good Medical Practice* (2013) and *Doctors' use of social media* (2013)¹.

Based on our experience, Medical Protection has long advocated the following, which we are pleased to see echoes the ethos of the GMC's guidance:

ENSURE YOU ARE STRINGENT WITH YOUR SECURITY SETTINGS

Social media has, in effect, blurred the boundary between personal and professional life.

Doctors should ensure appropriate security settings are in place on their online profiles, as patients may be able to access information about their private lives and/or make contact on a personal level if settings are insufficient. This may leave patients feeling as though they have struck up an inappropriately

close relationship with their doctor. In such circumstances, doctors should discuss online contact with their patient to ensure this is entirely professional, including redirecting the patient to their professional website and reinforcing boundaries where required.

ALWAYS ENSURE PATIENT CONFIDENTIALITY IS MAINTAINED

It is all too easy to make a comment online about a difficult or unusual patient interaction. Such action could constitute a breach of confidentiality by releasing identifiable information about a patient, even if their name has not been used. It is important for doctors to ensure they remember their duty of confidentiality and be aware that any comments they make may reach a far wider audience than intended.

UNDERSTAND THE GUIDELINES AND REGULATIONS

Guidance on using social media is developing as its use in healthcare increases. Although some of the guidance may appear obvious or common-sense, its aim is to ensure appropriate and consistent conduct and should be read by all doctors that use social media.

It is important to remember that anything posted online has the potential to be widely distributed and held indefinitely, so before commenting and pressing 'enter', doctors should think about whether they would be satisfied with their patients or employer reading it.



CASE 1

Dr A, a CT1, wrote on Facebook that he was in close proximity to people using drugs. He joked that he may have attended work whilst affected by such substances after his numerous nights out. His comments were picked up by his employing Trust who disciplined him and placed conditions on his practice.

LEARNING POINTS

Dr A's attitude and subsequent actions could have put patient safety at risk and brought the profession into disrepute. His Trust would have had no choice but to investigate his actions.

ENFORCE BOUNDARIES

Whilst social interaction with patients (particularly in certain situations, like working in rural practice) is unavoidable, it is of the utmost importance that doctors remember their professional duties and responsibilities when communicating online.

When interacting face-to-face with patients, even outside the consultation room, it is often obvious if a professional doctor-patient relationship diverts from the norm and early correction can occur. However, this is not always clear when using social media as seemingly innocent online discussions with patients can be misinterpreted. It is therefore important for doctors to keep any online interaction with patients strictly professional and to not accept 'friend' requests from patients on personal accounts.

BE WARY OF RELATIONSHIPS THAT COULD BE INTERPRETED AS 'SOMETHING MORE'

A patient could, potentially, allege that their doctor used their position to pursue an improper relationship and demonstrate this with examples of online interactions. Developing a close social relationship with a patient online is inappropriate, and the GMC's guidance reflects this where it states that: "You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them."

Whilst such criticism may seem unlikely, it could be very difficult for a doctor to justify an online personal relationship with a patient as being entirely professional and appropriate.

REMAIN PROFESSIONAL

If doctors decide to use social media to interact with patients, it is important to remember that this could constitute the provision of care and they are expected to act as they would in a traditional consultation. This means that records should be kept, all conduct should be in line with acceptable practice and the patient's care should not be compromised.

THE WAY FORWARD

There is no intention to suggest that doctors should not use social media as it can offer many benefits, including access to international expertise and allowing doctors to engage with patients in innovative and convenient ways. Medical education can also be enhanced as information from around the globe can be easily and flexibly accessed and shared.

However, Medical Protection recommends that doctors hold separate social media accounts to keep their professional activity distinct from their personal activity. This is reiterated by the GMC: "If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile."

It is important that caution is exercised so that doctors can ensure they use social media responsibly to minimise the risk of inadvertently finding themselves in difficulty.

For more advice on using social media see the factsheet on our website. Please visit:

[medicalprotection.org/uk/resources/factsheets](https://www.medicalprotection.org/uk/resources/factsheets)



For advice when needed, call our medicolegal helpline on **0800 561 9090**



Got a dilemma for Medical Protection to tackle? Email Kirsty Plowman at:

kirsty.plowman@medicalprotection.org



The cases mentioned in this article are fictional and are used purely for illustrative purposes.

REFERENCES

1. [gmc-uk.org/guidance/ethical_guidance/21186.asp](https://www.gmc-uk.org/guidance/ethical_guidance/21186.asp)

CASE 2

Following the death of a patient, Dr S engaged in a conversation with another doctor on his Facebook wall about what happened. The conversation was brought to the Trust's attention and both doctors faced internal disciplinary proceedings.

LEARNING POINTS

Most social networking sites have limited privacy settings. Although Dr S did not identify the patient by name, hospital or treatment, the fact the patient could have been identified, e.g. by family members, meant that Dr S and his colleague had breached patient confidentiality. It is important not to share identifiable information about patients, even when using professional blogging sites, which are not accessible to the wider public.

CASE 3

While working in emergency medicine, FY1 doctor Dr G wrote a blog about her experiences. Although all of her posts were anonymous and she made up a lot of her stories, her Trust were unhappy with her comments as it identified key members of staff within the hospital. She was called into a meeting with her Trust and the matter was formally investigated.

LEARNING POINTS

Before setting up a blog, tread cautiously and consider all the following pitfalls: breach of patient confidentiality; defamation and breach of contract – your Trust or Board may not be happy with what you have to say and this may breach contractual obligations or workplace policies, as was the case with Dr G. It would have been sensible for Dr G to obtain the permission of the Trust or Board and their educational supervisor before she created the blog.

ASSESSING CAPACITY



Dr Clare Redmond, a Medical Protection Medicolegal Adviser, examines the legislation and guidance that assists foundation doctors in assessing capacity of patients wishing to leave or refuse treatment

Any intervention or treatment provided by a doctor requires the consent of the patient involved. For consent to be valid the patient must have capacity to make the decision to accept the intervention or treatment.

When in hospital, patients make decisions about numerous aspects of their care including whether to remain an inpatient, whether to allow staff to check their vital signs and whether to undergo an investigation or operation. In discussions about treatment decisions, you are presuming the patient has the capacity to make the decision and providing them with the information they require to help them come to a decision, as set out within GMC consent guidance¹.

When do concerns about capacity arise?

Concerns about the capacity of a patient to make a decision can arise at any time during their hospital stay. It may be that during your conversation with a patient about a treatment you become aware they appear somewhat confused and disorientated. You may have doubts that they understand the information being provided. On other occasions you will be alerted to concerns about capacity by nursing staff; when a patient appears acutely confused or when they seem to be making irrational choices, such as leaving hospital in the middle of the night.

Legislation

In England and Wales the Mental Capacity Act (2005) governs all decisions made for those who lack capacity; in Scotland it is the Adults with Incapacity Act (2000) and in Northern Ireland the Mental Capacity Act (2016) has gained Royal Assent, although has not yet come into force. These Acts apply to those aged 16 or over, and every doctor must be aware of the relevant capacity legislation wherever they work in the United Kingdom when it comes to making medical decisions for patients who lack capacity.

Approaching the assessment of capacity

The GMC has introduced a new interactive tool that may help if you have concerns about the capacity of a patient to make a decision².

As a first step, it is helpful to gather as much information about the patient as possible from the medical records and nursing staff. This is particularly important if you do not know the patient and have been asked to assess them out of hours. Depending on the situation you may be able to gather information from the family prior to seeing the patient. You must ensure you maintain confidentiality if you have not yet discussed with the patient whether they are happy for information to be shared with any family members. You should seek advice from a senior colleague early in the assessment process if you have any doubts about the assessment, or if the decision to be made

involves complex treatment choices or the patient's life is at risk.

An important principle within legislation in England and Wales, Scotland and Northern Ireland is the presumption of capacity; it is not the patient's responsibility to demonstrate they have capacity, but the healthcare professional's duty to demonstrate it is lacking.

Another common principle is that any decisions made must be in the best interests of the patient and in the least restrictive manner possible. All practical steps must be taken to support a patient to make a decision, using communication aids for example.

In England and Wales a patient must not be treated as unable to make a decision merely because they make an unwise choice, and in Scotland the principles require you to take into account the patient's previous wishes, and set out a list of those people who must be consulted about any decision.

In order to lack capacity to make a decision there must be evidence of "an impairment or disturbance in the functioning of the mind or the brain" of the patient (England and Wales) or evidence of "mental disorder or inability to communicate because of physical disability" (Scotland).

If this impairment of the mind is present, then the next question is whether the patient is unable to make the specific decision for themselves. Can they:

- **UNDERSTAND** the information relevant to the decision?
- **RETAIN** the information in order to make the decision?
- **USE** or **WEIGH** the information provided in order to come to a decision?
- **COMMUNICATE** the decision?

Other factors to consider

You must also be sure you have knowledge of the information relevant to the particular decision at hand. You should not be assessing the capacity of a patient for an intervention or procedure that you do not fully understand, or if you are not fully aware of the risks and benefits involved.

Remember that it is a matter for the professional responsible for the patient's overall care to ensure that capacity has

been assessed (usually the consultant responsible for the treatment decisions). You should discuss any concerns you have regarding the capacity of your patient to make decisions with a senior member of your team.

If it may sound obvious, but you should also remember to ask the patient (who lacks capacity) the question to which the decision relates, and document their answer. You should also document your full capacity assessment and record where a patient has been unable to understand, retain, use/weigh and/or communicate information and their decision.

If the patient's incapacity is likely to be temporary you should consider whether the decision can wait until they regain capacity. If there is evidence of a mental disorder requiring treatment, you should discuss the care of the patient with a psychiatrist.

Next steps

Once the patient has been assessed as lacking capacity to make a decision, the next step is in ascertaining what is in their best interests. The patient should continue to be involved at all stages, and any steps necessary to ensure their involvement should be organised (interpreters, specialist support workers).

The aim is not to achieve the outcome that the professionals prefer, but to consider what is best for the patient themselves. This involves taking into account the patient's previous wishes and the

opinions of those close to them, always remembering that the least restrictive option should be chosen.

Additional considerations

You should always seek the views of those closest to the patient, including anyone holding Lasting Power of Attorney (for health and welfare) in England and Wales, or Welfare Power of Attorney in Scotland, or any Court Appointed Deputy or Guardian.

Where decisions involve the refusal of treatment, consideration should be given to whether an Advance Decision exists. In England and Wales, a valid and applicable Advance Decision refusing treatment is legally binding. In Scotland and Northern Ireland they should be taken into consideration when making decisions about treatment.

In Scotland, for all treatment other than in an emergency, a Certificate of Incapacity must be completed, and then reviewed as specified. In all jurisdictions there are exceptions to the treatments that are permitted under capacity legislation, often under mental health legislation or where treatment choices are very controversial (such as the sterilisation of a patient where there is no clinical reason for the decision) and further advice should always be sought in these cases.

Decisions about life sustaining treatment can also be contentious and these decisions should be made by senior members of the team. Where there is dispute or uncertainty,

the Court of Protection (England and Wales) or Mental Welfare Commission (Scotland) may be approached to make decisions about what is in a patient's best interests.

Where it is considered that a patient may be deprived of their liberty as a result of their treatment regime, hospital policies should be followed to request assessments to ensure any deprivation of liberty is lawful.

REFERENCES

1. gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
2. gmc-uk.org/Mental_Capacity_flowchart/

Further advice

Medical Protection has factsheets on Mental Capacity and these can be found at medicalprotection.org/uk/resources/

Other sources of Information

The Mental Capacity Act (2005) legislation.gov.uk/ukpga/2005/9/contents

Adults with Incapacity (Scotland) Act (2000) gov.scot/Publications/2008/03/25120154/1

Mental Capacity Act (Northern Ireland) (2016) (Not yet in force) legislation.gov.uk/nia/2016/18/contents



A DAY IN THE LIFE OF...

AN FY1 ANAESTHETIST



DR JONATHAN HEALAN DESCRIBES A BUSY DAY IN ANAESTHETICS

Running down the corridor at the beginning of the on-call shift, I headed for the Obstetrics and Gynaecology ward in response to the bleep my senior house officer (SHO) and I had received about a clinically unstable patient with an ectopic pregnancy. It was a scenario that, throughout med school, had been red flagged as critical.

Arriving on the scene, I was greeted by a couple in their twenties – she was on the bed in clear pain; her husband was white as a sheet.

The SHO asked me to gain better access as she only had a small pink cannula inserted – certainly not sufficient for emergency surgery. The SHO, cool as a cucumber in contrast to my own nerves, indicated the orange 14G cannula before rushing off to call down to theatre. I went through the now well-rehearsed routine of employing the tourniquet, checking for veins and administering local anaesthetic – noting the small veins. The patient's haemoglobin was 60g/L with a raging tachycardia. She needed to get into theatre as soon as possible. This was pressure...

Flashback and a smooth flush! The previous two months of relentless IV insertion in theatres was clearly paying off. The tide of relief released the breath I had been holding for the past few moments.

My time on this rotation has only served to confirm that anaesthetics is an exciting branch of medicine. There is a real satisfaction in appreciating the balance of physiology in the body and being able to influence the cause and effects of medicines. The specialty involves patient contact and collaboration with colleagues across the hospital.

A typical shift involves getting the theatre list, joining the consultant for the pre-assessment of patients (specifically looking at the airway and whether they have had anaesthetic before), discussing the type of anaesthetic with the patient (regional or general) and going to theatre to prepare the necessary drugs. Although patient contact is more limited than I have experienced on the medical wards, I have found the job rewarding – patients are often anxious about their upcoming surgery and it is an opportunity to give them reassurance about their anaesthetic.

When embarking on my foundation year programme, I based my decision primarily on an existing interest in anaesthetics. The focus on complex physiology appealed to me. Has the experience met my expectations?



Additionally, the day to day variety is greater than I anticipated – one of the biggest attractions of this speciality as cases could involve anything from tonsillectomy to spinal surgery.

I have to say it has; the specialty is fundamentally about problem solving and tweaking the bodily processes to regain balance. In that way, practitioners get to see immediate results and the practical side, surprisingly, is more fun than I imagined. Additionally, the day to day variety is greater than I anticipated – one of the biggest attractions of this speciality as cases could involve anything from tonsillectomy to spinal surgery. Moreover, the skills I have honed in this area are fundamental in times when patients are in extreme situations such as cardiac arrest. My time in anaesthetics has undoubtedly prepared me to go into other specialities.

Dr Jonathan Healan is an FY1 at Royal Gwent hospital in Newport, South Wales.



PRESUMED CONSENT FOR ORGAN DONATION



DR JAMES THORPE, EDITOR-IN-CHIEF OF NEW DOCTOR, REPORTS ON THE EVOLVING LEGISLATION SURROUNDING ORGAN TRANSPLANTATION



Since the first successful kidney transplant in 1954, advances in immunology and anti-rejection medication have revolutionised the field of transplantation. Transplantation of organs, entire hands and most recently the face has captured the public imagination in a way that few other branches of medicine have.

With an ageing population and a worldwide explosion in chronic diseases such as diabetes, the number of individuals on transplant waiting lists continues to rise. In the UK, the most recent available figures show that there were 6,943 patients waiting for a transplant at the end of March 2015.¹ Although 4,431 patients benefited from a transplant, 429 patients died on the waiting list and a further 807 were removed from the list as their health had deteriorated due to advancing disease. The fundamental problem is that there are simply not enough suitable organs available to satisfy demand for these life-saving procedures.

Until December 2015, all parts of the UK had an 'opt-in' system for transplantation under the terms of both the Human Tissue Act 2004 and the Human Tissue Act (Scotland) 2006. With respect to transplantation from a deceased donor, consent can be given by an individual whilst alive or by an appropriate representative of the deceased after death. Signing the organ donor register is considered an indication of consent but only 33% of the UK adult population have signed the register – Scotland has a slightly higher rate with 41%.

In an effort to increase the number of organs available for transplant, a number of European nations including Spain and Portugal have long employed an 'opt-out' or 'deemed consent' system for organ donation. This system means that unless an adult has opted out of becoming an organ donor, their organs will be available

for transplant in the event of their death. Opt-out organ donation systems remain controversial and it can be argued that the very term 'deemed consent' is misplaced.

Despite these concerns, there have been increasing calls for a similar system to be adopted in the UK. The issue was considered by the UK Government Organ Donation Taskforce in 2008 and they concluded that there was insufficient evidence to support a change in policy, recommending that rates of organ donation should be increased by improving funding and infrastructure for transplant services.²

Human Transplantation (Wales) Act 2013

Although there has been an increase in organ donation since 2008, The National Assembly for Wales remained concerned about the shortage of organs available for transplant resulting in the passage of the Human Transplantation (Wales) Act 2013.³ In December 2015, Wales became the first UK nation to operate an 'opt-out' or 'deemed' consent model for deceased organ transplantation. Where an individual has not expressed an objection to organ donation whilst alive, their consent for organ donation will be assumed. The Act applies to all adults over 18 who have been resident in Wales for over 12 months and who die in Wales. The legislation does not apply to anyone living in Wales temporarily and both prisoners and members of the armed services required to reside in Wales are exempt.

Wales operates a 'soft opt-out' model which means that family members are approached after an individual dies and given the opportunity to indicate whether they are aware that the deceased had any objection to organ donation. Donation will not proceed if the family believe the individual would have objected.

Early results

Recently published figures have shown that in the six months to 31 May 2016, 60 organs were transplanted in Wales from 31 individual donors, 10 of these donors had their consent deemed under the new legislation. There was an increase in the number of donors compared to the same time period in 2014-2015 when 23 donors donated their organs.⁴

These positive figures have led to renewed calls for change in England, Scotland and Northern Ireland. The British Medical Association has long supported an 'opt-out' model for organ transplantation and passed a motion at its 2016 conference to lobby the UK Government and the devolved administrations.⁵ Although a Member's Bill was recently rejected by the Scottish Parliament, the Scottish Government has stated their intention to consult further on the issue and the Human Transplantation Bill remains under consideration by the Northern Ireland Assembly. The longer term results of the change in the law in Wales will be closely observed by these other jurisdictions and all doctors should familiarise themselves with the evolving legislation.

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3. Human Transplantation (Wales) Act 2013, National Assembly for Wales, senedd.assembly.wales/mglIssueHistoryHome.aspx?Ild=5178
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5. Organ donation opt out could save hundred of lives, doctors hear, BMA, bma.org.uk/news/2016/june/organ-donation-opt-out-could-save-hundred-of-lives-doctors-hear

LAYING THE FOUNDATIONS



Dr Rachel Thomas offers her top five tips to successfully managing the difficulties you may face during your first year in Foundation Training

Congratulations on completing Medical School. All your studying and effort has paid off, and you have earned the 'Dr' in front of your name. You are now about to embark on your Foundation Training, and are most likely aware that the practicalities and day-to-day activities for being a good FY1 may differ greatly from those for being a good medical student. For a start, you are now responsible for patients!

Many students may feel stressed and under-prepared for what may be expected of them on their first day as an FY1. This is the day on which there is an abrupt switch from you being 'only a student' to actually being a 'real doctor'. However rest assured, your Medical School training, together with a few practical tips, will help ease this transition:

1) Always be respectful.

This includes respecting your patients, your colleagues, and your seniors. Be polite, friendly and professional, even when you feel stressed or overwhelmed. Introduce yourself, and try not to feel apologetic for being new. Everyone was new once and it can help to remember this – even if others may seem to have forgotten their first day!

Ensure that you turn up on time for ward-rounds and meetings. Not doing so wastes everyone's time, leaves a bad impression, and may be interpreted as being disrespectful. Plan ahead, particularly during your first few days of a new placement, and leave extra time to get anywhere, as hospitals can be laid out with maze-like confusion.

Starting any new job can be stressful so remember to look after yourself, ensuring that you take care of the basics such as having enough sleep and remembering to eat! This will allow you to remain as focused as possible as you embark on your career.

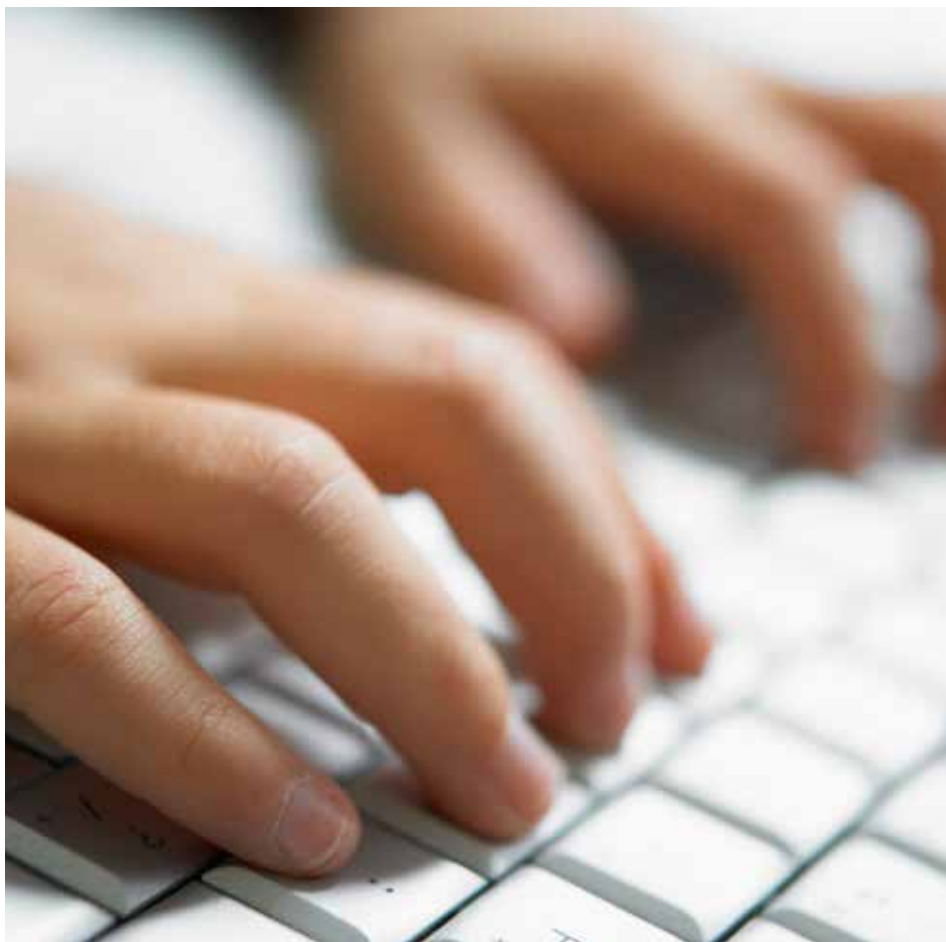
2) Understand what is expected of you.

Compulsory induction will often cover many practical components of your new role, such as operating computer systems. Mandatory shadowing of the out-going FY1s is a key period of time during which you can ascertain exactly what will be required of you on a daily basis. Ensure that you make the most of this time; these FY1s can act as a template for you, passing on key knowledge that is often only gained through on-the-job experience. How does your consultant like the patient list written up? Where is it saved on the computer? How do you update it? How is your ward run?

Familiarising yourself with these details will greatly help you once you formally commence your own role as the FY1. Become familiar with not only what your team expects of you, but with what the GMC, your Deanery and your training programmes expect.

Your ePortfolio contributes to how you are assessed – like it or not! The ePortfolio layout can be time-consuming and confusing to negotiate, so start logging onto it early, even if only to view its different sections and familiarise yourself with it. Ensure that you understand the components that you must complete, such as the number of DOPs and CEX forms, and the time-frame within which they must be done.





3) Learn to manage your time.

Time management is a key skill for doctors, and one which you may have started to learn during Medical School. Certain parts of your jobs will be predictable – such as Fridays! Fridays will always be busy, since you will also be planning for your patients' care during the weekend. By anticipating this heavy Friday workload you may be able to spread your work more evenly throughout the day (or even the previous day) so that you can ensure aspects like medication cards for inpatients have been prescribed accurately until the following Monday.

Prepare the discharge summaries punctually, and in advance, as much as possible, for weekend discharges. You will, in time, provide weekend ward cover, when you will understand why it is so important to do this!

Learning to manage your time will also help you to achieve more of a work-life balance. Safe, effective and thorough handovers are also a key part of time management. While there will undoubtedly be many days when you don't quite leave on time, always ensure that you handover properly for continued optimal patient care.

4) Be organised.

Write things down. Learn to prioritise and to delegate accordingly. Important, urgent tasks need to be done by yourself, or delegated and handed over to a colleague if you are unable to do them. When actions are handed over to you, keep track of them, as they are your responsibility now.

Ensure that patient lists are up-to-date, well-maintained and accurate. Finding out the essential bleep numbers, such as the on-call bleep, before you need them is a necessity. During an emergency is not the time to search for bleep numbers! Keep a single diary – not multiple ones – so that you can plan your week and not miss any activities such as protected learning-time lectures, or multi-disciplinary team meetings.

5) Ask for help.

Do not be afraid to request help, both on and off the wards. Nursing staff can be a wealth of knowledge, and are probably familiar with FY1s negotiating their first days. Your fellow FY1s may be having similar feelings to yourself, and communicating these with each other can help to relieve

the pressure. While your seniors will be busy, they are rarely too busy to help you, if you select the time you approach them sensibly.

There a number of invaluable sources of support available to you from your first day on the wards. Guidance from the GMC and resources available from the Medical Protection website can be of help in difficult times. Ensure that you have access to the British National Formulary, a handbook such as the Oxford Clinical Handbook and relevant local anti-microbial guidelines for quick reference.

It is a normal physiological response to feel stress. This stress can help keep us focused and sharp. However, if ever the stress becomes overwhelming or ever-present, ensure that you ask for help. During medical school you may have realised what activities help you cope with stress. These are often simple measures, such as exercise, seeing friends, or reading. Activities such as meditation may also help, as well as ensuring that you protect your relaxation time in activities away from medicine.

Rest assured that the stresses of first becoming an FY1 will generally settle as you become accustomed to being a doctor, and before you know it, you will have your successor FY1's shadowing you.

Dr Rachel Thomas qualified as a doctor with the B.M.B.Ch from Oxford University. She also holds a B.Eng (Biomed) (Hons 1) and a B.Sci (Physiol) from the University of Sydney. She has completed her second medical textbook (Practical Medical Procedures at a Glance, and Medical School at a Glance, both published by Wiley-Blackwell), writes for various journals and websites, and is involved in developing novel health-tech solutions.

Find out more

Medical Protection has drawn on doctor experiences and expert advice from our risk management professionals to bring you the 'Supporting you through your foundation years' guide. Download a copy of the guide at medicalprotection.org/uk/advice-booklets



GREAT EXPECTATIONS

Every year, a significant number of foundation year doctors require Medical Protection assistance when their professionalism is called into question. Kirsty Plowman looks at how a Medical Protection interactive workshop can help members lower their risk

Professionalism lies at the heart of everything doctors do during their working lives. Whilst most junior doctors are aware of the standards set by the GMC they are often surprised that their regulator also expects them to uphold the standards of the profession when not on duty.

According to GMC findings, newly qualified doctors are proportionally more likely to be investigated about probity than any other type of allegation, with 53% facing matters related to alleged dishonesty. In addition, matters related to health including drug and alcohol use are proportionally higher in the early years of practice. These types of allegations are more likely to reach the GMC threshold for investigation and lead to a sanction or warning¹.

If you are unfortunate enough to have your professionalism called into question you may find yourself accountable to the standards set out by the GMC. The GMC outlines its expectations in *Good Medical Practice* (2013) – it is your responsibility to be familiar with this and the explanatory guidance which supports it, and to follow the guidance they contain.

To support members, our training session – ‘Professionalism and Accountability’ – highlights how professionalism applies to foundation doctors. The hour-long session covers topics including honesty and trustworthiness, fitness to practise, use of social media, good medical practice and the role of the GMC. Our trained facilitators draw upon case scenarios and statistics in the sessions enabling audiences to ask questions and generate discussions.

You learn how to avoid potential scenarios relating to professionalism which have previously called into question a healthcare professional’s fitness to practise. These scenarios aren’t designed to frighten but rather highlight the real life situations that foundation doctors have faced and demonstrate how your actions outside

of working hours greatly impact your reputation as a doctor and the profession as a whole.

Getting into trouble is not all about the law – how you behave has a significant influence. Honesty and integrity are central to professionalism and define how any professional should act which is vital in healthcare as the doctor-patient relationship is balanced on trust.

To evidence your learning, you will be presented with a certificate for your portfolio. If you think a ‘Professionalism and Accountability’ workshop would be good for your programme, ask your tutor to contact our education team at education@medicalprotection.org

REFERENCES

1. The state of medical education and practice in the UK report: 2012, www.gmc-uk.org/publications/23435.asp

To familiarise yourself with the standards expected of you as a doctor as set out in GMC guidance *Good Medical Practice* (2013), visit gmc-uk.org/guidance

To read our guide on ‘Professionalism’, a publication that takes a closer look at what it means to be a professional, visit medicalprotection.org/uk/advice-booklet

If you receive a complaint and need advice, contact one of our medicolegal advisers who can assist with letter and report writing on **0800 561 9090** or querydoc@medicalprotection.org

TOP 10 TIPS FOR PROFESSIONALISM

- 1 Ensure your actions are appropriate and comply with national standards.
- 2 Take time to read and understand GMC guidance ‘*Good Medical Practice*’ (2013).
- 3 Keep your clinical skills, knowledge and judgement up to date.
- 4 Ensure moral values are upheld as action can be taken on your registration for non-clinical matters.
- 5 Be courteous and respect the rights, dignity and autonomy of those who consult you in a professional capacity.
- 6 Have open and honest communication with patients especially when things go wrong.
- 7 Take steps to verify what you are saying. Never sign a form unless you have read it and you are absolutely sure that what you are saying is true.
- 8 Be honest about your experiences, qualifications and position.
- 9 Honour commitments and ensure that tasks and duties are completed and addressed.
- 10 If you are uncertain double check your work with a senior colleague.

INQUESTS – AN OVERVIEW

Many doctors practicing in England and Northern Ireland will have involvement in an inquest at some point in their career. Whilst undeniably stressful for any healthcare professional called to give evidence, knowledge of the process is invaluable and can help you navigate it. David Ford reports

What is an inquest?

An inquest is a fact-finding exercise that is conducted by the coroner and, occasionally, in front of a jury. It aims to find out who the deceased was and when and where the deceased died.

An inquest is held in cases where the death was:

- violent or unnatural;
- when a person is in state detention, including prison/police custody, detention under the Mental Health Act; and
- when the cause of death is still uncertain after a post-mortem.

Inquests are usually held when a death occurs within 24 hours of admission to hospital or a surgical procedure, although this is not mandatory. If there is a possibility that a medical procedure contributed to or caused the death, it should be discussed with the coroner, regardless of the timescales involved. You should record the details of referral to the coroner in the patient's records.

The coroner may also hold an inquest if the death was due to natural causes and an inquest is in the public interest.

Giving evidence at an inquest

An inquest is a public, formal proceeding. Unlike a court case, there is no prosecution and defence but witnesses may be represented by lawyers. A coroner does not seek to apportion blame. Their role is to establish the facts and circumstances around a death.

The coroner decides who to call as a witness, and as part of the investigation will request a statement from you and may call you as a witness.

As a witness you are under legal obligation to tell the truth – make sure that any evidence you give or documents you write or sign are not false or misleading.

Verdicts

The coroner can bring the following verdicts:

- Natural causes;
- Accident or misadventure;
- Suicide;
- Narrative, which enables the coroner to set out the circumstances by which the death came about;
- Unlawful killing;
- Miscellaneous (drug dependence/ industrial)
- Neglect; and
- Open, meaning that there is insufficient evidence to decide how the death came about – the case is left open in case further evidence appears.

The coroner can refer a doctor to their regulatory body if the coroner considers that it would prevent a recurrence of the incident that caused the death.

The standard of proof applied at an inquest is the civil standard – the coroner and jury must be sure that it was more likely than not (on the balance of probabilities) that the facts have been found proven to support the verdict. There are exceptions: if the suicide or unlawful killing verdict is reached, it must be proven beyond all reasonable doubt.

Notifying the GMC and NHS England

The GMC publication *Good Medical Practice* (2013) includes an obligation (set out at paragraph 75[a]) for a doctor

to inform the GMC (without delay) in circumstances when they have been criticised by an official inquiry (which would include a coroner's inquest).

Doctors have an obligation to inform NHS England if the coroner has found that their actions have caused, or contributed to, the death of the deceased, or otherwise had their conduct brought into question at an inquest conducted as part of an investigation under the Coroners and Justice Act 2009.

What happens after an inquest?

The coroner can write a report in cases where the evidence suggests that further avoidable deaths could occur and that, in the coroner's opinion, preventative action should be taken. The report will be sent to the person or authority that may have the power to take the appropriate steps to reduce the risk, and they have a mandatory duty to reply within 56 days.

If you are asked to submit a report to the coroner or give evidence at an inquest you can seek advice from a medicolegal adviser at Medical Protection by emailing querydoc@medicalprotection.org or calling **0800 561 9090**



For more information on GMC guidance about giving evidence or when to notify the GMC in a case such as this, read *Good Medical Practice (2013)* at gmc-uk.org/guidance





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