

MORE THAN DEFENCE

Medical  
Protection



# SUPPORTING YOU THROUGH YOUR FOUNDATION YEARS

**A MEDICAL PROTECTION GUIDE**



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## ABOUT MEDICAL PROTECTION

We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support together with the right to request indemnity for any complaints or claims arising from professional practice.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

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## ACKNOWLEDGEMENTS

This guide is published as a resource for foundation year doctors in the UK. It is intended as general guidance only. Medical Protection members are always welcome to telephone our medicolegal advice line – 0800 561 9090 and +44 (0) 113 243 6436 – for more specific practical advice and support with medicolegal issues they may face.

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# INTRODUCTION

Welcome to *Supporting you through your foundation years*, Medical Protection's guide for foundation doctors. To start with, I should say "congratulations!" – if you are reading this book, it is likely that you have successfully navigated medical school, and are embarking on your career as a doctor.

For most, the first few years are both exciting and daunting. At times, when things are going well, your foundation years can be hugely rewarding; at other times you will almost certainly feel under pressure, even out of your depth.

It is important to remember that you are not alone; working in a clinical team allows you to help and support each other, sharing in everything – the successes, as well as the problems. By working as part of a team, managing patients with help and advice from your more experienced colleagues, you can help to make your foundation years both fulfilling and successful.

This book draws on the experiences of other doctors who have been through similar challenges to those that you may now face, as well as the expertise of risk management professionals, who address the same issues from a different angle. We hope that their tips will help you to develop your own ways of managing the new demands on your time, and that their insights will assist in steering a path through the more common medicolegal scenarios that you will encounter. The book also includes advice on managing the next key stage in your career – your application to core or specialty training.

The key message that we offer you is this: you are not alone; along with the support of your colleagues, Medical Protection is here to support and assist you too. If you feel worried or under undue pressure, tell someone. If you don't

know what to do, it's much better to ask. And remember, if you have a medicolegal question, Medical Protection members can access expert medicolegal advice via telephone 24 hours a day or alternatively you can drop us an email.

We wish you every success in your medical career.



A handwritten signature in dark ink, appearing to read 'Gordon McDavid' in a cursive style.

**Dr Gordon McDavid**  
Medicolegal Adviser, Medical Protection

# STARTING OUT:

## TEN ESSENTIAL TIPS FOR YOUR FOUNDATION YEARS

By Dr Jayne Molodynski

1

**Know your limits** – Never be afraid to ask for help. Always work within your competencies and if you are unsure about anything, ask.

2

**Find out the basics** – Make sure you know your way around the hospital and find out about out-of-hours facilities, such as key codes and canteen opening hours. It sounds obvious, but it's no joke when you finally get to go for that sandwich, only to find the canteen closed at 4pm!

3

**Know the ropes** – Make sure you are familiar with your hospital's guidelines, for example, in relation to note keeping. In some hospitals, records are now completely electronic so you need access to a code or a swipe card to get into the system. See if there is a handbook you can read, or if there are any notes published online.

4

**Get organised** – It can be a good idea to carry a notebook to jot down useful numbers and information. However, remember that due to confidentiality, if you jot down a patient's notes, you must make sure you securely destroy them before leaving the hospital.

5

**Make an impression** – Be aware that you will need support, so it is important to have a good relationship with members of the team, especially nursing staff. Introducing yourself and establishing a good relationship from the start will make things easier.

6

**Get on top of paperwork** – Make sure you're up-to-date with paperwork right from the beginning; get assessments filled in as you go along – don't leave them all to the end. Some of the key meetings need to take place in your first few weeks of the job.

- 7** **Communicate** – Arrange to meet senior staff when you start on-call and get to know them. If there are problems, be open and ask for feedback. At the end of a shift, talk through anything you found difficult, and consider how you could do it differently.
- 8** **Work as a team** – Don't be afraid of looking stupid. You are new to the job and will need support from your peers and colleagues.
- 9** **Be on the ball** – Make sure you are up to date with national guidelines, eg, NICE and the GMC. Take a look at the GMC's online scenarios, *Good Medical Practice in Action*.
- 10** **Check your rota** – Look at the on-call rota and find out what your shifts will be. Find out how to access bleep numbers, and the numbers for your team. I used to write them in my Oxford handbook and carry them around.



**Dr Molodynski is a Medicolegal Adviser at Medical Protection.**

She trained as an anaesthetist before joining Medical Protection.



# MANAGING RISK



Everyone makes mistakes; even experienced colleagues can have a bad day and slip up, but the consequences of a medical mistake can be very serious.

However, it is that responsibility, combined with the terrifying, yet exhilarating feeling that lives are in their hands, that draws thousands of people to train hard, pick up the medical baton and dedicate their careers to saving lives. They should not be deterred from doing so by the fear of making mistakes.

A lifetime spent practising medicine is unlikely to be error free. Many mistakes are due to poor communication and bad systems rather than incompetent individuals or lack of skills.

But don't panic – following our “six Cs” guide, which covers the main areas where mistakes are made, can lower the risk of things going wrong, and help you take appropriate action if they do.

# THE “SIX CS” GUIDE TO STAYING SAFE

## 1. CLINICAL RECORDS

An adequate clinical record is one that enables the doctor to reconstruct a consultation without reference to memory. Good medical records summarise the key details of every patient contact.

There are four crucial components to a good clinical record: it should be clear, accurate, legible and, wherever possible, contemporaneous. It should be comprehensive enough to allow a colleague to carry on where you left off.

Good clinical records are vital for ensuring continuity of care, so it is essential that they are as clear and as complete as possible – all entries must be dated, timed and signed.

Any complaint or clinical negligence claim will involve a review of the clinical records to ascertain the facts and can be crucial to the outcome. Imagine if you were unable to defend yourself because of poor or illegible handwriting, and unclear, vague references – or no notes at all.



### SURVIVAL TIPS...

### CLINICAL RECORDS

- Always date and sign your notes. If you realise later that they are factually inaccurate, add an amendment. Any correction must be clearly shown as an alteration, complete with the date the amendment was made, your name and the reason for the addition. Never obliterate or delete the original entry – just run a single line through it.
- Making good notes should become habitual.
- Document a relevant history, the nature and extent of your examination, any clinical findings, decisions made, including differential diagnosis, information given to the patient, patient progress, investigations ordered and results, consent and referrals.
- Do not write offensive or “amusing” comments. Only include things that are relevant to the health record, and write assuming the patient may one day read the notes.





## CASE STUDY

## CLINICAL RECORDS

Dr P is working in a medical ward when she sees Mrs G, a patient referred from the emergency department (ED), with a history of a sudden collapse. She takes a comprehensive history, and does a complete examination. Dr P then notices that some blood samples were taken in the ED, and checks the results server on the hospital intranet. She finds out that the samples “have clotted” and new samples need to be sent. The nurses are quite busy, but they agree that they’ll do it as soon as possible.

Dr P finishes her shift by writing the history, examination findings and results; she also writes “bloods”, followed by a tick, meaning that they have been sent. During the handover she doesn’t tell the next doctor that the blood results need checking. Mrs G becomes unwell within the next few hours, and the ST2 doctor on duty comes to see her. He is reassured by the notes, which imply that recent blood results were normal, and checks on the results server himself. It is only at this stage that it is discovered that the patient is severely anaemic.

Dr P failed to ensure that the documentation clearly indicated what had and what had not been done. Luckily, Mrs G came to no harm.



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## 2. CONSENT

It is good practice to be familiar with consent guidance published by the GMC and apply it.

Consent is founded on the principle of autonomy – it must be given freely by a competent patient voluntarily making an informed decision. Consent is about more than a single decision; rather, it is a process to inform the patient of the nature and purpose of their condition and its treatment.

Consent must fulfill three conditions to be legally valid. The patient must be:

- capable of giving consent
- sufficiently informed to make a considered decision
- giving consent voluntarily.

Patients must be given an explanation of the investigation, diagnosis or treatment, an explanation of the probabilities of success, or the risk of failure or any harm associated with the different options for treatment, and no treatment. The patient should always be given sufficient time to ask questions and as much time as possible to make a decision. Consent is invalid if it is obtained under duress.

To be capable of giving consent, a patient must understand what decision they need to make and why they need to make it. They should have a general understanding of the likely consequences and risks and benefits of making a particular decision. In addition to understanding, the patient must also be able to retain, use and weigh up the relevant information, make a decision and communicate that decision (see Mental Capacity Act).

It is ultimately the responsibility of the doctor taking consent to assess capacity. Unless there is reason to think otherwise, all adults are assumed to be competent. Please bear in mind that patients should not be assumed to lack capacity because they have communication problems, or because of their age, appearance or assumptions you make about their condition. Even if a patient does lack capacity, the onus is on you to include them as much as possible in decisions that affect their lives.





## SURVIVAL TIPS...

## CONSENT

- You must respect your patient's wishes.
- If in doubt ask a senior.
- Record in the notes what a patient has been told, and what the patient has agreed.
- Use your common sense – consent is patient-specific and depends on a particular situation.
- Adult patients are presumed competent to consent unless proved otherwise.
- Each assessment of a person's capacity should relate to a specific decision.
- Any competent adult in the UK can refuse treatment unless they are subject to compulsory treatment under the Mental Health Act.
- The law concerning incompetent adults is different in England, Wales, Scotland and Northern Ireland (See Medical Protection's factsheets on Consent).



## CASE STUDY

## CONSENT

Dr U is in his first week as an F2 in ENT. He is sitting at the desk in the ward filling in forms, when a nurse tells him that there is a patient going to theatre in the next few minutes and the consent form is missing from his notes. She insists that the consultant "will get very cross" if the patient turns up in theatre without all the appropriate documentation.

The nurse mentions that the patient's operation has already been cancelled once, and it would be terrible if it happened again. Dr U explains that he has never consented a patient for a tonsillectomy before, and doesn't think he should do it. But the nurse is insistent, saying "it's only a tonsillectomy, not rocket science".

Dr U rightly ignores the pressure, and hurries to theatre to ask one of his senior colleagues to sort out the consent form. His senior agrees, takes the patient's consent, and the operation goes ahead on time.

### 3. CONFIDENTIALITY

It may be obvious that an individual's health information should be kept confidential, but what may be less obvious is that your duty of confidentiality encompasses all information you hold about your patients.

This includes demographic data and the dates and times of any appointments your patients may have made, or consultations they may have attended. Even the fact that an individual may be a patient of yours or registered with the practice you are working at is confidential.

You should take care to avoid unintentional disclosure – for example, by ensuring that any consultations with patients cannot be overheard. When disclosing information you should ensure that the disclosure is proportional – anonymised if possible – and includes only the minimum information necessary for the purpose.



#### SURVIVAL TIPS...

#### CONFIDENTIALITY

- Except in exceptional circumstances, you must always obtain consent from a patient before releasing confidential information, and take advice from senior colleagues.
- Remember, depending on the context, sometimes even disclosing a patient's name can betray a confidence.
- The disclosure of information about a patient without their express consent may be justifiable, if the public interest in disclosing the information outweighs the patient's interests in keeping it confidential.
- Doctors are required by law to report certain information to the authorities, such as notifiable diseases (eg, TB), births, illegal abortions, unfit drivers and people suspected of terrorist activity. The courts can also require doctors to disclose information.
- Give cause of death accurately on death certificates, even where this might be embarrassing or distressing to relatives.
- Be aware of high-risk items and places where confidentiality is easily breached if you are not vigilant, eg, computer screens, printers, memory sticks, handover sheets, emergency departments, corridors, lifts.
- In certain circumstances, the coroner is required to investigate the circumstances of a death. You are obliged to disclose any information you may hold about the deceased that is likely to be relevant to the investigation.



## CASE STUDY

## CONFIDENTIALITY

Dr A is working in the minor injuries unit, where he sees a variety of patients. One of them is a young man who attends with several cuts on his hands. The man claims that he was washing a glass at home and accidentally shattered it, injuring himself. Dr A believes that the pattern of cuts is unlikely to have been caused by that mechanism of injury, but the patient sticks to his story.

Later that day, a police officer comes to the ED enquiring about any men who may have attended with cuts to the hands. A young man had broken into an empty property through a glass window, and stolen some goods. The police officer suspects that the man was injured in the process. There were no victims, and no suggestion of threat to public safety.

Dr A is unsure whether he should mention anything about his earlier patient. He talks to his consultant, who advises him not to mention this to the police, as he owes a duty of confidentiality to the patient. The consultant points out that there is no risk to the general public, even if his patient was the man in question. He adds that you can breach confidence if it can assist in detecting and preventing serious crime.



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## 4. COMMUNICATION

Good doctors are good communicators – it's that simple. Good communication is key to an effective doctor–patient relationship and is important for all aspects of a patient's care.

Poor communication can lead to numerous adverse outcomes, including failure to follow up test results, inappropriate prescriptions, and incorrect diagnoses and follow-up. These can all have serious consequences, including patient harm, complaints, claims and even disciplinary inquiries.

Understandably patients experience difficulties in assessing the technical competency of a doctor, so will frequently judge the quality of clinical competence by their experience or their interpersonal interactions with a doctor.

Developing good communication skills will improve clinical effectiveness and reduce medicolegal risk.

Tips for effective non-verbal communication:

- Be patient and observe
- Show respect
- Be self aware (posture, eye contact, first impression)
- Be curious
- Assess patients' moods
- Show empathy but be aware that physical contact is not always appropriate.



### SURVIVAL TIPS...

### COMMUNICATION

- Remember good doctors are good communicators – patients frequently judge the quality of clinical competence by their interpersonal interactions with a doctor.
- The GMC's *Good Medical Practice* guidance says that doctors should work in partnership with their patients.
- Be observant, show respect, be patient, be curious, show empathy, assess patients' moods and be aware of your body language.
- Communication between primary, secondary, voluntary and social care should be viewed not as a chain but as a communication net, where all members can contact each other.
- You must interact professionally with colleagues.



## CASE STUDY

## COMMUNICATION

Dr J is a busy junior doctor working on a medical night shift. He takes a call from an F2 doctor, Dr A, in the ED, who wants to refer an elderly patient who has come in with sudden breathlessness. Dr A has taken a history and examined the patient and diagnosed congestive heart failure.

Dr J agrees to admit the patient, but asks Dr A to investigate and treat the patient in the ED before transferring her to the acute assessment unit (AAU). Dr A agrees that he will give a diuretic, perform a chest x-ray and take the bloods before transferring her to AAU.

Later in his shift, Dr J is asked to see an elderly female patient – it is the patient Dr A was referring. However, Dr J notices that the patient is still in heart failure and from the notes, it is apparent that Dr A has not carried out any of the tasks he had agreed to do.

After treating the patient, Dr J wants to clarify what happened, so he contacts Dr A. Dr A says he had not had time to perform the investigations as he was rushed off his feet and he forgot to tell Dr J. Dr J stresses upon him the importance of clear and concise communication with his colleagues, and of accurate handovers.

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## 5. COMPETENCY

Competency, in professional terms, is defined as the ability to perform the tasks and roles required to the expected standard. It can be applied to a doctor at any stage in their career, not only to the newly qualified.

Competency encompasses the need to keep up-to-date with changes in practice and systems that can impact on it. Continued professional development (CPD) is a pre-requisite of many jobs, but no more so than medicine which is constantly evolving. Doctors effectively never stop learning; so a heavy focus is placed on CPD whatever specialty a doctor may work in.

Recognising your own limitations is the key principle behind competency. When providing care, you must work within your own competencies, and ask for advice when you feel out of your depth.



### SURVIVAL TIPS...

### COMPETENCY

- The GMC's *Good Medical Practice* guidance is clear that your duty as a doctor is to recognise and work within the limits of your competence.
- Keep your professional knowledge and skills up-to-date.
- Remember, in an emergency, wherever it arises, you have a professional duty to offer assistance, taking account of your own safety and competence, and the availability of other options for care.





## CASE STUDY

## COMPETENCY

Mrs J, a dancer in her 40s, visits the ED with a sudden thunderclap headache at the back of the head. She is seen by F2 Dr Q. Dr Q organises a CT scan to rule out a subarachnoid haemorrhage, which comes back clear.

His next course of investigation is to test the CSF for xanthochromia. Dr Q begins setting up a tray and equipment to perform a lumbar puncture. A couple of nurses spot that Dr Q is setting up the tray incorrectly, so alert the registrar, Dr A, to what is going on.

Dr A takes Dr Q aside and asks him about what he is planning to do. Dr Q admits that he is unfamiliar with some of the equipment and has only ever read about the procedure. Dr A explains that Dr Q is working beyond his competence, which could have caused Mrs J harm. Dr A uses the opportunity to give Dr Q an impromptu lesson, explaining the procedure as he successfully undertakes a lumbar puncture.

## 6. CAREFUL PRESCRIBING

The financial costs associated with adverse events and inappropriate prescribing amount to hundreds of millions of pounds every year. In a study of 2,400 junior doctors by Edinburgh University, published in the *British Journal of Clinical Pharmacology* in 2008, over 40% did not feel they would achieve the minimum competencies on drug prescribing set by the GMC.

Prescribing should always set off hazard warning lights in your mind. Danger areas include transferring information to new charts, team handovers, over-prescribing, forged prescriptions and prescribing for the wrong patient.

Doctors with full registration may prescribe all medicines, except those set out in Schedule 1 of the Misuse of Drugs Regulations 2001. Only prescribe drugs to meet the identified need of the patient. The GMC demands that, wherever possible, doctors should avoid treating those with whom they have a close personal relationship, and should be registered with a GP outside their family.



## SURVIVAL TIPS...

## CAREFUL PRESCRIBING

- Prescriptions should clearly identify the patient, the drug, the dose, frequency and start/finish dates, be written or typed and be signed by the prescriber.
- Be aware of a patient's drug allergies.
- Refer to the *BNF*. It is accessible online.
- Verbal prescriptions are only acceptable in emergency situations and should be written up at the first available opportunity. Particular care should be taken that the correct drug is used.



## CASE STUDY

## CAREFUL PRESCRIBING

Dr S is on duty in the children's area in ED. He has just seen Jack, a two-year-old child with a high temperature. He sits down to write his notes and takes the opportunity to ask one of the nurses to give Jack 180mg of paracetamol (appropriate for his weight). The nurse asks for it to be prescribed, but Dr S insists that he needs the ED card to write his notes, and the child is in the cubicle opposite the nursing station (he points to it), "you cannot miss him", he says. The nurse agrees reluctantly and goes to get the medicine and Dr S concentrates on writing on the card.

The nurse walks into the cubicle and gives the child the paracetamol. Dr S finishes his writing and approaches the cubicle to find out that there is now a different child sitting there – Alex. He anxiously turns to the nurse and asks her if she has given the medication to the boy who is now in the cubicle, and she says "yes".

Dr S informs Alex's family of what has happened and explains that the paracetamol was not prescribed for their child. He apologises profusely. Luckily Alex is a bigger child, and has not taken any paracetamol recently, so no harm has been done. Dr S makes sure Jack gets his paracetamol, and fills in an incident form; he apologises to the nurse involved and they discuss what happened, and agree that it was an easily preventable mistake. Later that day Dr S discusses the incident with his consultant.



# GOOD MEDICAL PRACTICE



Good communication, with both patients and colleagues, is at the heart of good clinical practice, but knowing where not to communicate information is equally as important. This section explores how to safely interact with social media and offers advice on how to handle day-to-day activities, including: handovers, difficult patients and raising concerns.

Getting the balance right between empathising with patients, coming across as a caring professional, yet remaining emotionally detached enough to do your job well, is explored in the section on empathy.

## THE PERSONAL IS PROFESSIONAL

The GMC takes probity very seriously. Probity in the eyes of the GMC means being honest and trustworthy and acting with integrity, which is at the heart of medical professionalism. How you behave outside the clinical environment can have an effect on your career in medicine; you could be the most diagnostically astute F1 of your year, but if your conduct in the real world is deemed to make you unfit to practise by the GMC, then all your good work will have been in vain.

Don't get caught out. Remember that the GMC states you must inform them without delay if, anywhere in the world, you have accepted a caution, been charged with or found guilty of a criminal offence, or if another professional body has made a finding against your registration as a result of fitness to practise procedures.

## HANDOVERS By Sara Dawson

Good handovers are essential to provide good continuous care, maintain patient safety and avoid errors. After every handover, all members of the team should have the same understanding of what has been done and the priorities going forward.

However, the lack of consistent processes, the absence of best practice guidelines and the limited use of protocols mean that handovers are fraught with risk. Poor handovers create discontinuities in care that can lead to adverse events (and subsequent litigation), such as inaccurate clinical assessment and diagnosis, delays in diagnosis, medication errors, inconsistent or incorrect interpretation of results, etc.

The GMC says that you must be satisfied that suitable arrangements have been made for your patients' medical care when you are off duty. These arrangements should include effective handover procedures, involving clear communication with your colleagues.

The effectiveness of handovers will depend on the accuracy and completeness of the information, and whether it is received clearly and understood by the recipient.

Dr Maise Farhan is an emergency medicine consultant. She has completed research into how end-of-shift handovers can affect patient safety. She says: "A good end-of-shift handover should encompass clinical and organisational issues, communicating any problems encountered during the previous shift. This would enable the oncoming doctors to anticipate problems.

"A really bad handover is one that does not happen; I have experienced this at various stages in my career – you arrive for a new shift and the night doctor has gone home. Another example of a poor handover is one where a list of patients is handed over, consisting of names and a diagnosis. This would contain no indication of clinical prioritisation or acuity of the patients."

## QUICK GUIDE TO HANDOVERS:

The Royal College of Surgeons of England has produced a quick guide to handovers.<sup>1</sup> The 'At a Glance' section includes:

- Begin with a short briefing – “situational awareness”
- Facilitate a structured team discussion
- Establish and develop contingency plans – “what to do if...”
- Encourage questions from the team – there are no “stupid questions”
- As a minimum, ensure the following is imparted:
  - Patient name and age
  - Date of admission
  - Location (ward and bed)
  - Responsible consultant
  - Current diagnosis
  - Results of significant or pending investigations
  - Patient condition
  - Urgency/frequency of review required
  - Management plan, including “what if...”
  - Resuscitation plan (if appropriate)
  - Senior contact detail/availability
  - Operational issues, eg, availability of intensive care unit beds, patients likely to be transferred
  - Outstanding tasks.

<sup>1</sup> The Royal College of Surgeons of England's Safe Handover: Guidance from the Working Time Directive Party (2007)

**Sara Dawson** is a Senior Content Editor at Medical Protection.



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# LEARNING ON THE JOB: MY TOP TIPS

By Dr Charles Brantly

1. **The importance of good communication** – Sometimes the most serious mistakes in hospital are the result of poor communication. By communicating clearly and accurately to everyone involved in a patient's care, you can avoid serious complications.
2. **Notekeeping is essential** – Good notekeeping not only makes it easier for colleagues but it also gives you a better grasp of each case as a whole, not to mention safeguarding your practice should it be questioned.
3. **Highlight errors** – During a procedure one particular error occurred even after all the safety checks had been performed. Our solution was to highlight this event to management and change the guidelines appropriately.
4. **Learn from senior teaching** – Registrars take particular pleasure in watching their juniors carry out procedures successfully. Learn from those with experience whenever possible.
5. **Re-assess your diagnosis** – It is good practice to re-evaluate a diagnosis, even if it has been made by a senior colleague.
6. **Give yourself time** – Pressure comes in many forms, but none more so than time. You cannot do a proper job if you are rushed off your feet, so do whatever it takes to give yourself more time with your patients.
7. **Learn from your cases** – Whether it is a rare genetic condition or a routine infection, each case is a learning opportunity. Learning is both easier and more relevant when related to real patients.
8. **Know your patients** – Consultants love nothing more than a well-informed junior doctor. Keep your ears to the ground and know your patients by name.
9. **Dealing with death is part of life** – Don't leave it to the bereavement officer to talk to the relatives of a deceased patient. Relatives prefer a familiar face in difficult times.
10. **If at first you don't succeed** – As junior doctors we expect to be challenged and to learn new things. However, we don't always expect to fail. Whether it's a tricky cannula or your first arterial line, the worst thing you can do is give up.

**Dr Brantly** was an F1 in ICU at Chelsea and Westminster Hospital.



## EMOTIONAL INTELLIGENCE By Sarah Whitehouse

When things go wrong, doctors are encouraged to be open with patients, show compassion and communicate effectively. But is there room for empathy, or even emotion, in the clinical setting?

Traditionally, empathy in clinical practice was bound up with the vague term “bedside manner” – you either had it, or you didn’t. It couldn’t be taught or improved. Now, however, empathic communication is seen more as a taught skill, and one that is essential in order to fully understand a patient’s condition.

“I don’t think I would be able to do my job properly without being able to empathise with my patients,” says Dr Ayesha Rahim, former Deputy Chair of the UK’s BMA Junior Doctor Committee. As a junior doctor in psychiatry, she explains: “It’s a huge thing for patients to tell you something extremely personal about themselves. It’s important to be attuned to what they are saying, and how they are saying it, by looking out for non-verbal clues.”

Clinical empathy is about understanding a patient’s symptoms and feelings, and communicating that fact to the patient. It is important to check back with the patient when taking a history to show you fully understand, for example, “Let me see if I have this right.” Verbalising the patient’s emotion, eg, “You seem anxious about your chest pains,” demonstrates active listening.

### STOP, LOOK AND LISTEN

Empathy is difficult to express unless it is truly felt. Although there are stock phrases that doctors use to empathise with patients, it is important that these are not repeated with little regard for the individual situation. Empathy as a taught skill can soon become formulaic emotion – something patients do not buy.

Dr Pauline Leonard, a consultant medical oncologist, led a national programme, Connected, teaching doctors how to break bad news. She says: “There should be templates around empathy, but doctors should be encouraged to move the template to fit the patient – that is the art.

“Doctors like templates because they are nervous. Ultimately, doctors are scared that when they empathise really well, so much emotion is unlocked in the room that they don’t feel equipped to cope with the situation and put the patient back together again.”

If you empathise well, however, all you need to be equipped to do is sit and listen. Patients need to know that you are there to answer any questions, that you are not frightened of strong emotions. Tempting though it may be to bring an awkward conversation to a quick end, try not to brush off fear, uncertainty or anger with “Don’t worry, everything will be okay,” or “I know how you must feel”.



## DEALING WITH EMOTION

Sometimes, it is important to know when to step back from a situation. An excess of emotion can blur boundaries. There are a wide range of opinions on what is professionally appropriate. Advice can at best only be general, because of the huge number of differing reactions to a doctor's behaviour by patients. How doctors react and support patients will depend on the previous relationship they have had, and the knowledge that a doctor has of the patient's personality.

The GMC stresses that to fulfil your role in the doctor–patient partnership you must be polite, considerate and honest, treat patients with dignity and treat each patient as an individual, but warns against establishing or pursuing “a sexual or improper emotional relationship with a patient”.<sup>4</sup>

In providing competent and compassionate care, emotion does sometimes creep in – after all, doctors are human too. However, the empathic doctor should not be willing to indulge idle emotion or self-absorbed sympathy; empathy should be given with a strong clinical purpose.

Above all, empathy allows the patient to see the person behind the professional, and the doctor to see the person, and the suffering, behind the patient.



### OUR ADVICE

### STEPS TO EFFECTIVE EMPATHY

- Recognise strong feeling (eg, fear, disappointment, anger, grief)
- Pause to imagine how the patient might be feeling
- State how you see the patient's feelings (eg, “It sounds like you're upset about...”)
- Legitimise the feeling
- Respect the patient's effort to cope
- Offer support (eg, “Let's see what we can do together”)<sup>5</sup>
- Be sensitive about physical boundaries.

**Sarah Whitehouse** was a Senior Writer and Editor at Medical Protection.



## POWER AND RESPONSIBILITY By Dr Deborah Bowman

New doctors who begin practising will be well-versed in their ethical responsibilities. Preparation for finals and applications for foundation year jobs require students to engage with, and demonstrate, their ethical knowledge and how they apply that knowledge in practice. Yet, until graduation, students have few formal responsibilities.

Once the celebrations of finals and the novelty of introducing oneself as “doctor” have passed, the realities of medical practice can be a shock. For many, survival rather than ethical sophistication are the order of the day. Duty of care narrows to the list of tasks accumulated at the behest of seniors. Responsibility becomes burdensome rather than a privilege.

To be ethical is easy in the abstract: ethical dilemmas in the lecture theatre and seminar room often appear to be deftly resolvable. However, the realities of ethical practice are more demanding, which is why some doctors make poor ethical decisions.

For most junior doctors, ethical questions do not relate to the life and death crises that often dominate ethics teaching. The issues are more mundane. Yet, it is their very ordinariness that makes those challenges fundamental to, and at the heart of, what it means to be an ethical doctor.

In a properly organised foundation post, the boundaries of appropriate and inappropriate work, both in terms of content and load, will be defined and regulated. However, it is possible that even the best-run foundation post will bring ethical challenges relating to the shift in responsibility and the particular features of the clinical teams with whom one is working. Consider the experiences of Dr H.





## CASE STUDY

## POWER AND RESPONSIBILITY

Dr H was excited when she began her F1 job at a busy district general hospital located on the outskirts of a large city. Dr H is of the opinion that her consultant, Dr S, is a skilled clinician. However, she has become concerned about some of the interactions between him and his patients, particularly during ward rounds where he rarely acknowledges or discusses their care with them.

One morning, while Dr H is part of a large ward round comprising a dozen people, Dr S reviews the care of a patient who has been admitted for investigations following an unexplained “collapse”. He proposes that the patient have an echocardiogram, an exercise stress test, and begin treatment for hypertension. Dr H notices that Dr S does not explain his decision to the patient.

Later, Dr H is asked by the nursing staff to see the patient who has become distressed and refuses to go down for investigations because he “has no idea what is going on”. Dr H visits him, but the patient will “only talk to the main man – the consultant”. Dr H knows that Dr S has an out-patient clinic followed by a research meeting off-site.

### WHAT SHOULD DR H DO?

One practical approach would be for Dr H to sit with the patient and perhaps rectify the situation by apologising for his distress, explaining what is happening and seeking his consent to proceed. However, even if Dr H has the skills and sensitivity to manage the situation, it will still involve her making several ethical compromises. The patient has explicitly requested to see the consultant; he may agree to see Dr S later, but he is clearly unhappy about the extent to which Dr S has involved him in his care.

Moreover, Dr H's existing concerns about the way Dr S interacts, or rather doesn't interact, with patients are greater than this particular patient's concerns. By seeking to manage the situation, Dr H is making a choice not to engage with an ethical issue that affects the care of her team and strikes at the heart of the therapeutic relationship.

There may be good reasons for not wishing to tackle the wider issue: Dr H may feel that she is too junior to speak out; she may be unsure whether her concerns are legitimate; she may feel that she has responsibility but no power; or she may be keen to preserve her relationship with her consultant. Nonetheless, if Dr H chooses to do no more than merely contain the crisis, she is making a significant ethical choice and one that has implications for patient care.

Dr H should view this as an opportunity to tackle something that is difficult and is likely to recur in her career, namely speaking out or disagreeing with a colleague. Just as it takes practice to hone skills in cannulation or lumbar punctures, it takes practice to learn how to challenge, question and constructively disagree with someone whose approach is compromising patient care.



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## OUR ADVICE

## POWER AND RESPONSIBILITY

The pressure of the clinical workload means that mistakes are inevitable, but a distinction needs to be made between matters of personal conduct and poor performance, and where a doctor's performance may be affected by a health issue (eg. depression, substance abuse etc).

GMC guidance says you should support colleagues who have problems with performance, conduct or health, but action should be taken if this compromises patient care. The GMC recommends that you raise your concerns to the medical director or a senior colleague. Local guidelines will be in place to deal with these situations should they arise. If in doubt, contact your MDO (Medical Defence Organisation) for specific advice.

Challenging a senior colleague is probably one of the hardest things you may have to do in your career, so if you have concerns, contact Medical Protection as soon as possible and a dedicated medicolegal adviser will support you through the process.

**Professor Deborah Bowman** is Professor of Bioethics, Clinical Ethics and Medical Law at St George's University of London.



## STAYING SAFE ONLINE By Sara Dawson

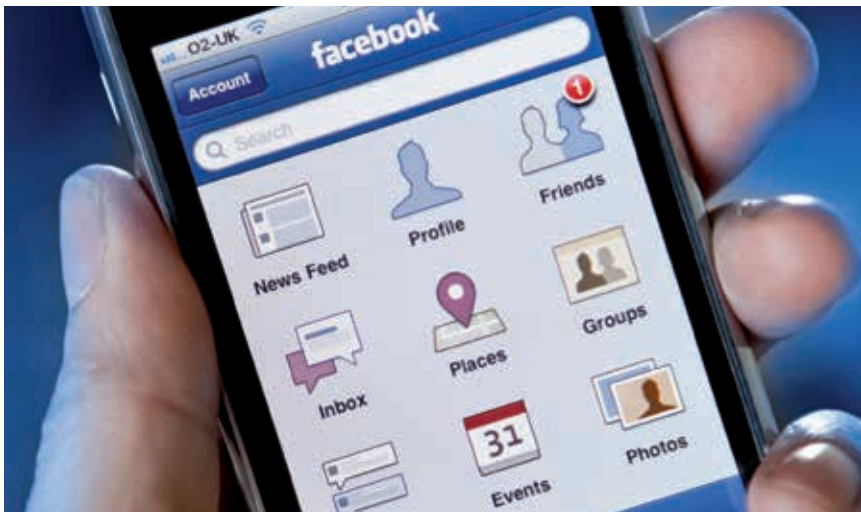
In today's increasingly accelerated society, what was once private is now public; this is largely down to the social media phenomenon.

You need to be especially mindful, when posting material online, of who could be reading what you write. Unguarded comments about patients, your employer or other staff members could lead to sanctions by your trust or the GMC. Comments of a racist, sexist or bigoted nature, or posting inappropriate images or extreme views, could get you into real trouble.

Medical Protection is aware of cases where junior doctors have discussed patients on social networking sites, assuming that they would not be identified – but they were exposed and those involved were disciplined. There have also been cases where patients have mistakenly identified themselves as the subjects of discussions on social networking sites and complained.

NHS Greater Glasgow and Clyde suspended a nurse after it emerged she had uploaded pictures of patients having operations on to Facebook without their consent. Even though the patients were not identifiable, the Scottish Patients' Association said it was "totally unacceptable" and a breach of patients' human rights.

In 2013, the GMC published *Doctors' use of social media*, its first explicit guidance on the safe and professional use of social media. The guidance states that expectations around doctors' professionalism are the same when using social media, and that maintaining boundaries with patients, safeguarding confidentiality and showing respect for colleagues are fundamental aspects of these expectations. The guidance also says that if you identify yourself as a doctor within publicly accessible social media, you should identify yourself by name.



For doctors, there is the additional risk of patients contacting you through social networking sites. In addition to allowing patients access to your personal details, these sites are generally inappropriate for medical discussions. You should certainly avoid adding patients as 'friends', or engaging with them in this way.



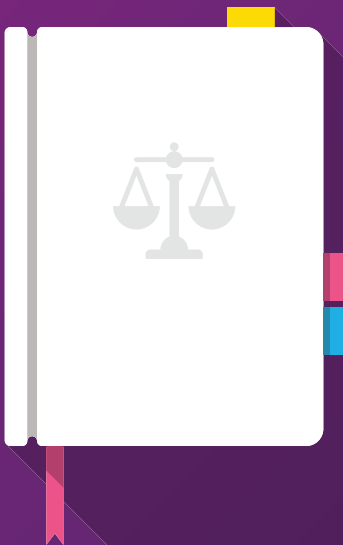
## FREQUENTLY ASKED QUESTIONS

- Q.** *I work as a junior doctor in urology in a large teaching hospital and have been thinking of setting up a blog. What advice would you give?*
- A.** Our advice would be to tread cautiously and to consider all the following pitfalls: breach of patient confidentiality; defamation; breach of contract (your trust or board may not be happy with what you have to say). It would be sensible to obtain the permission of trust/board management and your educational supervisor before taking the matter forward. Don't forget to ensure you adhere to GMC guidance, as specified in *Good Medical Practice*, and other guidance.
- Q.** *A former patient whom I saw when I was a medical student has approached me on Facebook – they want to add me as a friend. What should I do?*
- A.** Don't accept. Social network sites are so called so for a reason. It is extremely important that you retain professional boundaries between yourself, your patients and former patients. The GMC has set down their advice on this, which is available on their website. Whether a patient approaches you in person, by text or online, it is always best to establish a clear boundary from the outset.

## SECTION REFERENCES

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3. Groves, JE, *Taking care of the hateful patient*, *N Engl J Med* (1978)
4. GMC, *Good Medical Practice*, p15 (2006) and GMC, *Maintaining Boundaries*, p1 (2006)
5. Platt FW, *Empathy: Can It Be Taught?* *Ann Intern Med* (1992)

# CAREERS



Whether you have always dreamt of working in a particular specialty, or have not yet decided, your foundation years will introduce you to a host of career options.

It is up to you to maximise the opportunities and thrive on the challenges that will confront you. By keeping your foundation e-portfolio up-to-date you will critically appraise each specialty and begin to identify what specialty you want to work in.

In this section, we hear first-hand from doctors what it is like to work in various specialties, from anaesthetics to emergency medicine. We also share advice on things you can do to boost your career, such as getting published, and what you should not do, such as lie on applications.

# TRAINING AND REGISTRATION

## ASSESSMENT

The Foundation Programme e-portfolio is designed to show that you are meeting the requirements for satisfactory completion of your F1. It should contain:

- a personal and professional development plan
- records of meetings with your educational and clinical supervisor(s)
- workplace-based assessments
- reflective reports and other evidence
- summaries of feedback from your supervisor(s)
- significant achievements/difficulties
- sign-off documents.

It is your responsibility to keep your e-portfolio up-to-date; without it, you will not be able to satisfactorily complete your F1 and the Foundation Programme as a whole.

The best way to tackle this is to get into a habit of updating your e-portfolio from day one, and adding to it weekly. Leaving it until the last minute is nigh on impossible – so don't do it. You will be surprised at what a great learning tool it is.

## BECOMING A FULLY REGISTERED DOCTOR

After satisfactorily completing 12 months of training in F1 posts and demonstrating that you have achieved the required competences, you are eligible to apply for full registration with the GMC.

It is important to remember that your assessments and e-portfolio will help your university/postgraduate dean to recommend you for full registration. You can make your application online, via the MyGMC facility on the GMC website.

As well as making your application for full registration and a licence to practise, you will also need a certificate of experience completed by your medical/foundation school (or deanery where applicable). This form is only available as part of your online application. It can be downloaded after you have paid your fee.

## USEFUL LINKS

- GMC website – [gmc-uk.org](http://gmc-uk.org)
- The Foundation Programme website – [foundationprogramme.nhs.uk/pages/foundation-doctors](http://foundationprogramme.nhs.uk/pages/foundation-doctors)
- NHS Medical Specialty Training (England) – [mmc.nhs.uk](http://mmc.nhs.uk)



## APPLICATIONS AND HONESTY

Junior doctors applying for core and specialty training face tight deadlines for submission of applications, which take no account of individual on-call commitments. This, combined with the pressure of high competition for training positions, may understandably lead some individuals to take “short cuts” when completing their application forms.

However, what may seem like a minor transgression could have serious consequences for a junior doctor’s career. Trusts will usually consider dishonesty on an application form as a disciplinary matter, which may ultimately lead to termination of a doctor’s contract of employment.

If a doctor intentionally makes a false representation in order to gain a financial advantage, he or she may be guilty of a criminal offence under the Fraud Act (2006). GMC guidance in *Good Medical Practice* states that you must always be honest about your experience, qualifications and position, particularly when applying for posts. Indeed, the GMC is known to take a keen interest in matters where a doctor’s probity is called into question.

During the 2007 GP application process, the GMC saw a number of cases where junior doctors were accused of plagiarism on application forms. This led to sanctions ranging from warnings through to erasure from the medical register. Many of the doctors involved had reproduced material from websites, with others being found to have copied from their colleagues.

Whilst it is clearly best to avoid any suspicion altogether, if you do find yourself being accused of plagiarism or dishonesty by the GMC, it is important that you contact Medical Protection to obtain expert advice at an early stage. The earlier we are involved, the better the chances of mitigating any damage to your career.



## SPECIALTIES IN THE SPOTLIGHT



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### ANAESTHETICS By Dr Aidan O'Donnell

#### OVERVIEW

To outsiders, anaesthetics can seem a mysterious and intimidating specialty, full of complicated equipment, pungent vapours and impenetrable physiological formulae. Anaesthetists have at their fingertips useful skills that are the envy of their peers: airway management, fluid management, venous access, analgesia and resuscitation of the critically ill. When a patient is really sick, everybody wants an anaesthetist nearby. Anaesthetists are found all over the hospital, although the operating room, the labour ward, the intensive care unit, the emergency department and the pain clinic are their commonest habitats.

Anaesthetics is the largest hospital specialty. Figures from the Royal College of Anaesthetists indicate that there are more than 10,000 anaesthetists practising in the UK. Anaesthetists are mostly friendly, well-adjusted people who enjoy their jobs, work hard, treat their juniors well and hardly ever shout or throw things. It's a specialty that is somewhat more family friendly than others, so there are opportunities to train and work part-time, and there are good opportunities to train abroad.

The pattern of work is quite linear and predictable, with few interruptions. Sometimes anaesthesia is likened to flying an aeroplane: the complicated parts are the take-off and the landing, but once in midair it is usually quite relaxed. Technical skills play a large part in anaesthetic practice, and anaesthetists become adept at inserting needles into some very elusive places.

Anaesthetists also have many roles in other areas. Intensive care is a specialty that, until recently, was almost entirely populated by anaesthetists; now other specialties are becoming involved, such as:

- Obstetric anaesthesia, which deals with providing pain relief in childbirth, either analgesia for a labouring woman, or anaesthesia for an operative delivery.
- Pain medicine, which is a small, but fast-growing subspecialty.
- Paediatric anaesthesia, where you might anaesthetise a baby only a few days old.
- Cardiothoracic anaesthesia, where you might anaesthetise a patient whose heart is deliberately stopped for an hour during an operation and then restarted again.

The mainstay of anaesthetic practice is providing anaesthesia for surgery. This generally involves assessing and working up patients preoperatively, which often requires an early start, then performing general anaesthesia (or sometimes a regional or neuraxial block, such as a spinal or epidural anaesthetic) on the patient. The anaesthetist remains with the patient throughout the operation, making sure that the patient remains comfortable and safe throughout. Afterwards the patient is taken to the recovery room, and the next anaesthetic is begun.

The anaesthetist is usually responsible for postoperative analgesia, and care of the patient doesn't end at the door of the theatre. Like Jedi, anaesthetists frequently work in pairs, which means that coffee and meal breaks are generally very reliable.



## AT A GLANCE

## ANAESTHETICS

**Personality:** Good technical skills, calm under pressure, attention to detail, patience, sense of humour, leadership.

**Best bits:** Rewarding, one-to-one consultant training, high level of colleague support, patients nearly always feel better after you treat them.

**Worst bits:** Little continuity of care, fellowship exams can be a real barrier for some people, your patients will generally not remember or credit you for their care, finishing work half an hour after the slowest surgeon in the hospital.

**Stress:** Generally low to modest; occasionally high during emergencies or around exam time.

**Competition:** Moderate.

## ADVICE FOR TRAINEES

Working nights and weekends is part of the package for anaesthetists. Trainees may have blocks of night shifts, although consultants still usually take calls from home, and most departments are large enough for on-call nights to be acceptably infrequent.

Anaesthetists have a very different pattern of work from other hospital doctors. Their life is generally free from ward rounds, clinics, paperwork, dictation, heartsink patients and winter beds crises. Each day begins afresh with a new operating list. On the other hand, there is little continuity of care, and opportunities to follow an individual patient through an illness or a crucial period of life are few.

Working in anaesthetics is great, but it isn't for everyone. The best way to experience it is to do it. However, foundation posts in anaesthetics are rare. Explore taster weeks, which are offered in most hospitals – also, most departments will have a selection of friendly approachable anaesthetists who will be happy to let you shadow them for a day.

At its core, anaesthesia is about relieving human suffering. It's also tremendous fun, and offers the daily opportunity to make a real difference in someone else's life. This means it is a very enjoyable and rewarding specialty.

## USEFUL LINKS

- NHS Careers – [nhscareers.nhs.uk](http://nhscareers.nhs.uk)
- The Royal College of Anaesthetists – [rcoa.ac.uk](http://rcoa.ac.uk)
- The Association of Anaesthetists – [aagbi.org](http://aagbi.org)
- Robinson, Neville; Hall, George. *How to Survive in Anaesthesia: A Guide for Trainees*, 2nd edition, Blackwell (2007)
- Visit YouTube and watch “The Anaesthetist’s Hymn” by Amateur Transplants.

**Dr O'Donnell** is a consultant anaesthetist who trained and worked as a consultant in the UK for several years. He now works in New Zealand





## OBSTETRICS AND GYNAECOLOGY By Sara Dawson

### OVERVIEW

With more than 700,000 births a year in England and Wales alone, you can never have enough doctors in this specialty (National Statistics, 2009). Statistics aside, few specialties offer the same opportunity for trainees to work as both surgeon and physician and preserve two lives at the same time. At the heart of the specialty is women's health and the profound physiological changes of pregnancy; obstetrics is care provided during pregnancy and childbirth, and encompasses health issues related to the reproductive organs throughout life.

It is often described as a surgical art, where doctors work with midwives and other health professionals to deliver babies, while putting their critical experience in preventative medicine to the ultimate test by delivering potentially lifesaving antenatal care.

### ADVICE FOR TRAINEES

This mixture of surgery and general medicine has seen O&G develop enormously over the last 30 years. It includes aspects of many different disciplines such as endocrinology, sexuality, pharmacology, psychology, pathology and neonatology. Yet despite the numerous advances in this field and the huge potential for growth, recruitment numbers have in the past been small.

However, the future is looking bright, as more consultant posts are being developed and increasing numbers of medical students are being drawn to the specialty. O&G was one of the first specialties to devise a structured run-through training programme; community gynaecology is growing, and there is greater flexibility in training opportunities in clinical and academic O&G.

## USEFUL LINKS

- Royal College of Obstetrics and Gynaecologists – [rcog.org.uk](http://rcog.org.uk)



### AT A GLANCE

### OBSTETRICS AND GYNAECOLOGY

**Personality:** Empathetic, good stamina, manual dexterity, team player, clear communicator, non-judgmental.

**Best bits:** Treating patients with profound medical problems, strong emotional elements, range of clinical interests, saving two lives for the price of one.

**Worst bits:** Strenuous night work and on-calls.

**Requirements:** MRCOG.

**Stress:** From moderate to highly stressful.

**Competition:** Moderate.



### PROFILE:

### DR MELISSA WHITTEN

I first became interested in O&G when I was a medical student. On my placement I helped deliver babies, so it was this challenge and the sense of amazement in the labour ward that first attracted me. I liked surgery, medicine and psychiatry, and O&G brings these specialties together. As a trainee, I was fortunate to work in a number of different units with a wide variety of experience, and great colleagues. As a consultant, I leave work each day with a sense of achievement because I'm working in a specialty that I think that I can make a difference in.

It is possible to have a life outside this specialty. Flexible working patterns are common in O&G. It's an acute specialty, so there is night and weekend work, but like all specialties this is governed by working time regulations to keep it in proportion. Most trainees at my hospital either work one weekend a month, or work days or nights. As a consultant, I work on average, one night every eight days during the week, and one weekend every two months where I am on call for the whole weekend. I work with a team of junior doctors and midwives both during the normal working week and on call.

The biggest challenge I've encountered in my career so far is working for a huge organisation – the NHS. Capacity, logistical and organisational issues can sometimes encroach on how you spend your days at work. For example, a woman who goes into premature labour when the neonatal unit is already full and there aren't any neonatal unit cots available within 100 miles means spending three hours on the phone trying to find a bed.

Another big challenge can be dealing with decision-making regarding ethical issues, for instance when scanning babies where there is an abnormality and discussing the options with the parents, sometimes it can be a struggle to determine "what is 'normal'?" Also, when there is a baby at risk of a poor outcome, and where the course of action you advise is at odds with what the parents want can be challenging.

In the past, traditionally about 4-5% of medical graduates would go into O&G, but this level has fallen during the last few decades. This seems to have been down to medical student perceptions about disadvantaged male doctors, heavy night-time work commitments and the fear of litigation.

There is some evidence that women will be more likely to decline male student doctors assisting in pelvic examinations or childbirth than female students. This is worrying, as male medical students can come away with the perception that they won't be able to treat patients if they go into O&G, which is a false impression. It can be just as fulfilling a career for men as for women. A lot of work has been done in recent years to support student experience in O&G and we hope that this encourages more students to consider it as a career. The job prospects are good, women's health is an expanding field rather than one going out of fashion.

In terms of tips for success I suggest aspiring O&G medics talk to their local trainees and tutors, work on developing good communication skills, as there is a lot of communication work within this field, do a foundation module in women's health, get involved in relevant audits or project work and register with the RCOG as a junior affiliate to get information and support when applying for jobs.

**Dr Whitten** is a consultant obstetrician specialising in fetal and maternal medicine.





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## GENERAL SURGERY By Sara Dawson

### OVERVIEW

To succeed, surgeons must be shrewd, confident, focused and, above all, dedicated to the role. General surgery is one of the biggest pullers of the nine surgical specialties, boasting 31% of the total number of surgeons in the UK. According to the NHS Information Centre there are 19,500 surgeons and surgical trainees in the UK, which equates to 4.5 million surgical procedures a year – that's one every seven seconds. The NHS annual spend on surgery is £1.55 billion.

Many different sub-specialties fall under general surgery, including breast surgery, gastrointestinal surgery, coloproctology, as well as oncological, transplantation and vascular surgery. Consultant general surgeons are usually practitioners in one of these sub-specialties. In surgery you need to be a master of dissection and excision, and be both mentally and physically strong enough to survive the gruelling hours spent in operating theatres.

Surgeons operate on all parts of the body, addressing injury, disease and degenerative conditions. Daily tasks include managing pre-op and post-op patients from both acute and elective settings. Consultant surgeons lead surgical teams and supervise the juniors, and treat patients in the wards and in out-patient clinics.



## ADVICE FOR TRAINEES

Surgeons need a thorough understanding of physiology, biochemistry, pathology and anatomy. It is more scientifically based and dependent on audit and measurement of outcome than the other disciplines. There are a limited number of training courses, just as there are a limited number of consultant posts. Nevertheless, every surgeon needs to get appointed to a recognised basic surgical training post through the training board of the regional colleges of surgery.

Over two years, trainees gain experience of general surgery, emergency work, orthopaedics with trauma, and a surgical specialty. Trainees then sit for their MRCS or AFRCS; if successful, they can choose their specialist area and apply for a specialist registrar grade post, which lasts for six years. In order to become Fellows of the Royal College of Surgeons (FRCS), trainees have to sit exams. Surgeons who pass the exams are awarded a Certificate of Completion of Training (CCT) and are free to practise independently.

Surgery is notorious for not having enough training posts. Traditionally, consultant work only comes up when someone retires or dies. Wannabe surgeons may have to relocate in order to further their career, but staying put can have its advantages. Trainees tend to move around at ST1 and ST2 level, but once a trainee reaches the level of specialist registrar, staying put could make it easier to get a consultant post.

## USEFUL LINKS

- The Royal College of Surgeons in England – [rcseng.ac.uk](http://rcseng.ac.uk)
- Joint Committee on Surgical Training – [jchst.org](http://jchst.org)



### AT A GLANCE

### GENERAL SURGERY

- **Personality:** Manual dexterity above all, caring attitude, good hand–eye co-ordination, organisational ability, good communication skills, stamina, focus, being receptive to new ideas.
- **Best bits:** Giving life back, working in a team, using practical skills, challenging operations.
- **Worst bits:** Complications, getting out of bed at 3.30am, overbooked clinics, complaints.
- **Stress:** Moderate to high, prolonged stress.
- **Competition:** Very competitive.



PROFILE:

DR OLIVER HULSON

## A DAY IN SURGERY

Beep, beep, beep, beep... It can't be 6:30 already, can it? Up, shower, shave, dress, out. The streamlined precision of the morning routine perfected over months, shaving seconds off the commute each day, winning back seconds of sleep. Breakfast in the mess (saves buying milk and bread at home) then on the ward for 7:45, hurriedly putting forgotten bloods in before the phlebs arrive, and updating 'The Sheet' – the dreaded handover sheet. How can one sheet of a few jotted words per patient seem as important as the Holy Grail when faced with your registrar or consultant?

"But it's not on the sheet," he'll say. And so to the ward round, or the more aptly titled ward race. Never have you seen your boss move so fast as when he's galloping around the ward, with registrar, junior and nurse in tow, you lagging behind, laden with 18 sets of notes, trying in vain to figure out which patients he has seen, who he is seeing now and predicting who he will see next.

"Morning Mrs Smith," he'll boom. "How are we today? Home by the weekend I expect," he'll reel off, as he buries his fist in her abdomen; she flinches but is far too awestruck to cry out in pain. "Actually, Mr Surgeon, my anastomosis is leaking, causing a faecal peritonitis and subsequent sepsis, and so unfortunately I won't be able to eat or drink for weeks, and will require TPN, a catheter and bowel rest and am unlikely to be home by Easter," she should say.

Ward round done in record time, a list of jobs that's growing by the second, and then: BEEP, BEEP, BEEP, BEEP. "Hello, can I help?" I say, without thought, as I simultaneously take blood, order an x-ray, write a discharge letter and talk to a patient's family; who says men can't multi-task? "Oh hello doctor," the nurse will say, in a tone that seems unnervingly pleasant. "One of your ladies, Mrs Brown, down here on the rehab ward, her stoma output has been nil for 10 days." "I'll be down within the hour," I'll say, through gritted teeth, angry, yet unsurprised that something so simple as her bowel movements has been overlooked, in favour of how many stairs she can climb, and whether she can still use a tin opener, when you know full well she lives in a bungalow, and that she has single-handedly nursed her husband through his cancer care the year before, and is one of the fittest, stoical patients you've ever met. And irrationally annoyed that the rehab ward is a whole six minutes walk away, six minutes where you can't get anything done, and six minutes you will inevitably make up for after work.

And so the day goes on, the list gradually becomes bearable, your colleagues offer you a hand and there's a moment's respite from the relentless beeping to grab lunch at about 4pm. The gourmet selection on offer in the staff canteen leaves much to be desired, but to be honest, I'd eat my own shoe at this point, and enjoy it. Just as I go for that first forkful of shepherd's pie, BEEP, BEEP, BEEP, BEEP – it's theatre. I consider not answering it, letting them beep someone else, but the conscience inevitably intervenes, prising you from your food towards the phone. It's your consultant, he needs you in theatre, the junior has gone AWOL (you're sure you saw him headed towards the library).

I take one mouthful of pie, savour the greasy goodness, and drag my feet to theatre, mentally preparing myself for the two-and-a-half hour retractor challenge, knowing full well that by the time I manage to escape it will be approaching 7pm, I'll still have half a dozen bloods to chase and the dreaded list to update, and I'm back in less than 12 hours. Would I ever consider doing something else? Not a chance.

**Dr Hulson** was an F1 in breast and general surgery at Dewsbury District Hospital.





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## GENERAL PRACTICE By Dr Katie MacLaren

### OVERVIEW

General practice is the first port of call for anyone in the health service. People visit their GP to be diagnosed and treated, or to be referred to a specialist in hospital. GPs diagnose and treat both complex and minor illness, monitor chronic disease, educate and prevent disease, and foster better healthcare; and, as the patient's advocate, we often get involved in the social aspects of patients' lives and help their families help themselves. We help patients deal with the impact of a condition on their life, no matter how trivial it may seem.

I work in a practice in Scotland. I usually arrive around 8am and do paperwork, then spend two hours seeing patients (every ten minutes): this usually amounts to around 12 patients, before setting off on home visits. The afternoons are very similar, with longer surgeries. No two days are the same; in between patients and surgeries you find yourself following up on enquiries, checking prescriptions and checking results that have arrived for your patients, and often dealing with emergencies. Practice schedules are often staggered so that while one GP is going on home visits, another is seeing patients and hence a wide range of contact opportunities are available for patients at all times.

## ADVICE FOR TRAINEES

One thing that struck me when moving into general practice from hospital is that, as trainees, you are used to being with colleagues of a similar age and ability, who share your interests. So starting to work on your own can initially feel quite isolating and you feel very pressured to suddenly have to see, diagnose and treat all on your own.

This doesn't last long and you soon settle into the general practice team and learn to use time as a great ally. I chose general practice over hospital medicine because I enjoy the challenges of diagnosis, but also feel the value in helping a patient cope with illness over a variety of timelines. GPs see patients over their lifetime and hence they can pinpoint the different factors that are contributing to a particular ailment, as they have got to know the patient over several years. In hospital you only get snapshots of people's lives.

However, a consequence of this is that you take home a lot of emotional weight. A patient places their trust in their GP, and if you make a wrong call it can be disastrous. There is always the fear whether you've diagnosed the right thing, or prescribed the right medicine, but you have to learn to trust your instincts and safety net.

The patients I particularly worry about are the ones with the unknown diagnosis that you just aren't sure about, but know there is something wrong. Talking with colleagues is a great way of helping calm anxieties and getting suggestions as to what to do next. Exploring alternatives and finding individual solutions is part of being a GP, as is helping patients through difficult periods.

Once you have qualified as a GP you have a huge number of opportunities. You can follow the traditional route and become a partner in a practice, or you can become salaried or work as a GP locum, which means that you don't have as many business responsibilities. Increasingly, people are opting for "portfolio" careers where they divide their time between clinical and other interests, such as medical politics, teaching, emergency medicine, journalism and out-of-hours work. You can also develop a special interest and work as a GP with a special interest (GPwSI).

Another consideration is what sort of practice you want to work in; whether it is in a city, semi-rural, rural or remote. I worked for six months at a city practice, but I'm now completing my GP training in a rural practice. I have enjoyed both immensely, but there are definite differences in working patterns and patient expectation. I would advise every trainee to try and experience a variety of practices prior to choosing which suits them.

## USEFUL LINKS

- Royal College of General Practitioners (RCGP) – [rcgp.org.uk](http://rcgp.org.uk)
- GP notebook – [gpnotebook.co.uk/homepage.cfm](http://gpnotebook.co.uk/homepage.cfm)



## AT A GLANCE

## GENERAL PRACTICE

- **Personality:** Good communicator, adaptable, committed, good at listening, driven in every specialty, well-rounded.
- **Best bits:** Seeing success of prolonged therapy/contact, exciting, rewarding.
- **Worst bits:** Dealing with uncertainty, constant paperwork, the complexity. Perceived lack of partnership opportunities, getting enough training.
- **Stress:** Moderate.
- **Competition:** Moderate.

**Dr MacLaren** is a GP in Scotland and the ex chairman of the BMA GP Trainee Subcommittee.





## PROFILE:

## DR BETH MCCARRON-NASH

In 2008 I was elected as a UK Negotiator for the General Practitioners Committee (GPC) of the BMA. Two days each week, my role is to represent GPs at a national level, negotiating changes to the GMS contract and enhanced services with the NHS Executive, as well as representing GPs on professional issues, such as revalidation, GP training and practice accreditation.

I've always been interested in politics. As an undergraduate I spent my BSc module in the public health department. Since qualifying I have worked with directors of public health looking at the health of populations and health inequalities. When I lived near Leeds I worked for the PCT helping them implement the new contract, by going into practices and helping them improve their systems.

If you have an interest in a certain area of general practice, try to pursue it. During your foundation training, look for extra-curricular skills that will broaden your experience and consider areas that you might be interested in for the future. If you are interested in medical politics get involved with the BMA, and join your junior doctor's committee while working at hospital. Then, as a GP trainee, get involved in your local medical committee (LMC).

From here GPs can be elected to the national GPC. It was from the GPC that I was elected as a national negotiator. In the future, new doctors should be aware of the perceived lack of partnership opportunities. Under the new contract, funding goes to practices who decide how to manage their workforce. In some cases when a partner leaves, due to funding uncertainties, many practices have decided to review the skill mix, and employed either more practice nurses or salaried GPs. We hope this situation starts to settle down for future GPs.

Another issue is getting good quality training that matches educational needs. Some new GPs feel that they haven't acquired all the skills they need within their three-year training. GPs need to make sure that they continue their education after qualification. My advice is to follow your gut instincts; if there is something you want to do, do it, even if it falls outside the national system.

**Dr Beth McCarron-Nash** is a portfolio GP and drove the establishment of a bigger GP subcommittee, and is well known for her work on the Support your Surgery campaign.





## EMERGENCY MEDICINE By Dr Monica Lalanda

### OVERVIEW

Emergency medicine (EM) is a young, challenging, dynamic and exciting specialty that is constantly evolving. Emergency physicians (EPs) are responsible for assessing, resuscitating and stabilising patients with serious illnesses and injuries before they hand them over to the appropriate specialists at the hospital for definitive management. They are also responsible for assessing, treating and discharging patients who attend with less serious but urgent conditions; who are then sent back to the care of their GP.

In recent years the role of EPs has expanded, allowing them to manage certain pathologies for longer periods, based on adjacent wards often called Clinical Decision Units or Observation Wards. These extend beyond the shop floor, with all its usual activity and adrenaline, to a ward-style environment, where patients stay for up to 48 hours under the sole care of the emergency physicians. This allows further investigation, treatment and support of patients with a temporary condition, such as chest pain, head injury, an asthma attack or an overdose.



Other elements of the job include working in the returns clinic, where you can follow up patients with minor trauma, seeing patients in the observation area (or clinical decision unit), supporting nurses and performing research. The work is varied and unpredictable!

Most departments also have separate facilities to deal with children, which have specialised staff to assist the EPs, such as registered children's nurses, nursery nurses and play specialists.

Working in an emergency department (ED) means you are at the centre of the emergency pathway and the gatekeeper of the hospital. The specialty has developed a thorough curriculum and had a number of specific examinations one has to pass to work in it.

Unlike other areas of the hospital, the ED is open 24/7 providing a consistent level of care. The work pattern is either in full or partial shifts. There is little long-term commitment to your patients, as every work day is independent from the next; this makes EM the ideal specialty if you want to work part-time without disrupting your clinical undertakings, so it is easy to combine both family and work lives.

## ADVICE FOR TRAINEES

Training begins with the obligatory foundation years. It is ideal to get a post in EM, but they are very popular and therefore difficult to get. If a candidate does not get one, they will have to complete a taster week in an ED, become an advanced life support provider (ALS) or get a relevant audit done.

Once a specialty training programme has been secured, the first two years (CT1 and CT2) will be taken up with acute medicine, followed by anaesthetics and intensive care medicine. To enter the third year of core specialty training (CT3) trainees will have to pass Part A of the membership examination of the College of Emergency Medicine (MCEM). If successful during this year, trainees will need to achieve the competencies required to care for children and patients involved in trauma, by taking appropriate posts.

Once completed, trainees will move on to the last three years of their training or specialty training (ST4, 5 and 6). These are designed to allow trainees to gain additional clinical competences and skills in academic EM, critical appraisal and management. Part B and C of the membership examination are required for entry to ST4.

It is also possible to work in EM as a staff grade or an associate specialist. The work can be as exciting and fulfilling as that of a consultant, but the level of managerial responsibility is more limited.



## AT A GLANCE

## EMERGENCY MEDICINE

- **Personality:** Assertive, confident, able to make decisions quickly, under pressure, good sense of humour, friendly, good coordinator, good leader, strong team player, able to deal with tragedy, compassionate.
- **Best bits:** The challenge of the unpredictable, solving clinical conundrums under pressure, the feeling that you can make an immediate difference and save lives, working in a team (they become like a second family), the limited follow-up responsibilities.
- **Worst bits:** The frustration of management targets, not finding out if your clinical judgment was right or wrong, handling the “obstructive” colleague who doesn’t value you, dealing with sudden death (particularly in the young), the management of violent, disruptive or intoxicated patients when you are at risk.
- **Stress:** Depends on the day!
- **Competition:** High, but most definitely worth it!

## USEFUL LINKS

- The College of Emergency Medicine – [rcem.ac.uk/](http://rcem.ac.uk/)
- The Emergency Medicine forum at DNUK – [doctors.net.uk](http://doctors.net.uk)
- Paediatric Emergency Medicine UK – [apem.me.uk](http://apem.me.uk)
- *Oxford Handbook of Emergency Medicine* (2012)
- Chapman, Gareth Rhys. *Pocket Emergency Medicine – A Quick Medical Reference Guide for Use on the Wards*, Wiley-Blackwell (2010)





PROFILE:

DR WILLIAM DAWSON

## HOW I SURVIVED EM

### THERE WILL BE BLOOD

Emergency medicine (EM) is a wholly different option from most other hospital specialties, but a common rotation during foundation year and GP training. It's a far cry from most things you have done before, and can seem an intimidating and terrifying prospect, so you are going to need to know how to survive.

### FASTEN YOUR SEAT BELTS

Be ready for a hard slog, and not just for yourself. EM is well known to be an unforgiving job, especially with your time. Be prepared to sacrifice nearly all your extracurricular activities and weekends as you adapt to a different way of living. Make the most of days off and, if you need particular time off, contact your colleagues or the rota co-ordinator early on, preferably before the job starts.

Remember your lost life doesn't just affect you, often it can be your close ones that struggle the most. Make sure your partner and family really understand the state of play. Nights – and often weeks – of spending little or no time with you is always surprisingly difficult, especially if they have no medical background, so it is important to spend quality time with loved ones whenever possible.

### BE PROFESSIONAL, BE RESPECTFUL AND DON'T BE LATE

Teamwork is a crucial part of EM. Be punctual, more than in any other specialty, and that means dressed and ready and picking up your first patient card as your shift starts. It may sound obvious, but in such a pressurised environment no-one likes tardy colleagues at handover. After an exhausting shift, the last thing you want is your replacement to be late.

### COMMUNICATION

We all know that good communication is of the utmost importance. However, multiply that by a million in EM. Due to the critical nature of patients, capacity and time restraints, everyone likes to know what is going on with your patient. Telling your colleagues what you are doing will put them at ease, speed up treatment, and confirm that you are doing the right thing. This also applies to patients – let them know what you are doing so they don't feel left out.

## DECISION TIME

This is probably the first time you will have to make decisions about the management of patients. You will be using your knowledge to assess and treat patients and make them better. Remember, you trained for five years to do this, not to dictate discharge letters and write in the notes on ward rounds. No-one is expecting you to know everything. Simple, immediate, appropriate management is the name of the game, so do the basics and, if you are unsure, ask for help early on.

## TAKE YOUR BREAKS

Yes, you have done a wonderful job with your first patient of the day, and now you can just sit and relax while waiting for the investigations to be done. No. You will be expected to deal with more than one patient at a time. While you are waiting for those bloods you can start assessing another patient, or review the results of the previous one. But be sensible and don't overload yourself or you will miss things, delay treatment or get things wrong, and patients' management will suffer.

Remember to take your breaks. It is up to you to do so; no-one else will remind you. Check with colleagues so you don't all disappear at the same time, but don't be tempted to wait for a quiet moment to go, as some days it will never come.

## ENJOY IT

EM is a common rotation and though it may be something you never considered as a career, make the most of your time there and you can really enjoy it. This is a time you can really grow as a doctor, in confidence and capability.

You will gain a wide variety of medical experiences and skills you won't get anywhere else, from suturing to psych assessments.

You will develop new and better ways of working in a team, dealing with patients, and most importantly you will go from a TTO-writing, ward-round-documenting encyclopaedia to a thinking, decision-making doctor, and you may find yourself not wanting to leave.

Oh, and there will be blood.

**Dr William Dawson** is a GP in West Yorkshire.



## HOW TO GET PUBLISHED By Frances Warneford

You've lived on a diet of scientific facts since you first decided to go to medical school, and you thought your creative writing days were over when you wrote your last essay for GCSE English.

But don't hide the Shakespeare away in the attic just yet. You may not be attempting any sonnets, but writing is a key skill for a successful medical career. Getting research or writing published will make your CV stand out in whatever specialty you go into. Even writing patient notes and case reports needs good writing skills, correct grammar and clear English.

Here are our top tips on getting started:

### 1. **Voice your opinion**

Got something to say? Writing a letter to a medical journal, or writing to a newspaper on a hot medical topic, can be a good way of getting your name in print without the need for heavyweight research to back up your opinions. Most national newspapers have much bigger circulation and readership figures than medical journals, so it's worthwhile keeping up with public health issues and taking any chance to comment. There's a lot of competition to get letters published, so getting yours in print can go on your CV as a real achievement.

### 2. **Keep it real**

As a new doctor, you are going through some unique experiences, seeing and doing things that most people never get a chance to do. You are also in a profession that is endlessly fascinating to the public (just look at the number of medical dramas on TV). You have a wealth of subjects to write about, from your first real patient to the challenges of dealing with distressed relatives. Of course, you will need to approach all these topics with sensitivity and make sure you never breach patient confidentiality.

### 3. **Don't get carried away**

Even one-off mistakes, in circumstances such as breaches of patient confidentiality, plagiarism, poor attitude or alcohol misuse, could harm your chances of obtaining substantive registration and your future career. Here are a few pitfalls to be aware of:

- *Patient confidentiality always applies.* For example, *Student BMJ* requires that everyone who submits articles or photos containing medical details has written consent from the patient, whether or not the patient is named in the article or is identifiable from the photos.
- *Check all your facts.* The rules of publishing mean that you could fall foul of defamation law (harming someone's reputation) – not to mention damaging your own career prospects – if you publish incorrect or potentially damaging information about people, whether in hard copy or online.

- *Don't write about anything that might affect your reputation as a doctor, eg, excessive drinking, drugs or the wilder side of hospital social life. A career in medicine brings many privileges, and also responsibility – you should set out to be a role model from now on.*
- *Always include references for any quotes or information gained from other publications or authors. Plagiarism, or passing off others' work as your own, is severely frowned-upon and, in serious cases, could even lead to your being subjected to fitness-to-practise proceedings.*

#### 4. **Publications that accept articles from new writers include:**

- *Junior Doctor:* A free lifestyle magazine aimed at trainee doctors from their first day at medical school, through their sleepless foundation years and tough specialist training until they become consultants. How to contribute: Writers can either send articles directly or run ideas past the editorial group, which meets every few months. They also have a 'Team Email List', which anyone interested in writing can join. The list keeps their team updated with what's happening and how to get involved. Email [team@juniordr.com](mailto:team@juniordr.com) or phone 020 7193 6750, [juniordr.com](http://juniordr.com).
- *New Doctor:* A magazine produced by Medical Protection for doctors in their first two years qualified. How to contribute: If you would like to contribute to the next issue of New Doctor with a burning issue that you would like us to discuss, please contact us on 0113 241 0377 or email [sam.mccaffrey@medicalprotection.org](mailto:sam.mccaffrey@medicalprotection.org).

**Frances Warnford** was a Writer at Medical Protection.



# WORK AND LIFE



Exciting, daunting, stressful, thrilling, terrifying, enjoyable, exhausting, rewarding and life-altering – these are some of the words new doctors have used to describe their foundation years.

In this section, we look at how to deal with the stresses and strains of putting five or six years at medical school into practice as a new doctor. Dr Laura Davison offers her top tips for foundation doctors, and we share advice on how to survive a night shift.

# TIPS FOR SURVIVING YOUR FOUNDATION YEARS

By Dr Laura Davison

Congratulations, you've passed your finals! You're finally a doctor, but that was the easy bit – now the real work begins.

Medical school is a necessary evil to obtain the prestigious title and status of doctor, but I will warn you – everything you learnt in the safety of the lecture theatre will be forgotten as soon as you set foot on the ward. But, never fear, this is normal! All you need to know to be a good doctor you will learn by working in hospital.

Foundation year one, aka the dogsbody year, is definitely the deep end: you have to learn to swim fast. It sounds scary, and it feels it. But it gets easier, I promise!

You may feel despondent during your first weeks as a new doctor, when your first patient dies, when your consultant throws a strop, or when you've had a beastly on-call and you haven't even had time to pee, but remember this mantra – "It gets better as I get better". It does and you will.

## YOUR FIRST DAY

On your first day you are likely to have to ask how to spell paracetamol and then have to look up the dose too, in secret. The BNF is every doctor's best friend, and will be for many years. Don't be ashamed to use it for every drug you prescribe if need be. It's the only way to learn practical pharmacology and be safe for your patients.

F1s are newbies, the babies, and hence can expect to be treated as such. However, you will mature quickly and this lowly status and work life will improve as the year goes on, as you earn trust and respect from the already hardened NHS workers.

## HANDLING SENIORS

It is normal to get grilled by seniors – in every department, in every profession – and though you may feel tiny at the time, you will learn quickly how to survive future grillings.

Preparation is key. If you know you have to go and discuss a patient with another colleague, be prepared: know your patient's details inside out. Bloods, images, home situation, which leg is weak, which arm hurts, how the problem started, what their favourite hobby is, whether they're big or small, whether they're claustrophobic, etc.

The senior doesn't need to know all this gumph 99% of the time, but they will ask for it just to make sure you don't cut corners and are kept on your toes, so make sure you can surprise them!



## COPING WITH THE STRESSES

When you get home you will want to vent about the strains and idiocies of your day, so warn housemates, spouses or parents that being a doctor will turn your home life into a rant zone! There's nothing worse than bottling up fear, frustrations, anxieties and stresses. You won't last the year. Get it off your chest somehow. Taking it out on the nurses and patients the next day will only come back and bite you harder than you can imagine. Although it can be necessary to let off steam, avoid going into the kind of details that compromise patient confidentiality.

From my experience, the best thing I ever did was live in the hospital accommodation. No-one will understand how rubbish your day was better than someone who has gone through it too. It's soothing to be able to vent your frustrations about the day, the patients, the staff, the seniors, the system and the canteen food to someone else who has also witnessed it.

## ACCLIMATISING TO LIFE OUTSIDE HOSPITAL

At the end of a day you will be so tired you will be willing to watch anything on TV, including *The One Show*. You will not be able to get the hospital smell out of your clothes or off your hands until the weekend. You will bring up inappropriately graphic topics and stories at non-medical dinner tables and in the pub (but, a word of warning, never, ever breach confidentiality).

A few tips – lay folk don't appreciate you saying that *Holby City* is medical tosh; TCP is not an acceptable odour to wear in public; and describing what colour vomit you got on your shoes today at the dinner table is not acceptable – unless you're with other medics.

On the plus side, as a junior doctor you have few outside work commitments, so relish it! For the first time in five years you have no homework, no assignments due, no tutor chasing you, no exams looming. In the words of Ferris Bueller: "If you don't stop and look around once in a while, you could miss something." Embrace this freedom and enjoy it.

## THE WIDER PICTURE

Being a real-life doctor is not glamorous; it is hard work and can be an unforgiving and thankless task at times, but it can also be extremely rewarding if you go about it in the right way. Respect your colleagues, treat others the way you would want to be treated, and above all treat yourself to the canteen pudding at lunch and you'll enjoy work much more, guaranteed. Good luck, and remember – it gets better as you get better.



© Mark Thomas/Science Photo Library

## HERE ARE MY TOP TIPS FOR ALL “NEWBIES”:

1. **Nurses are your best friends** – You are not above them and you never will be. Keep them sweet, ask them for their opinion (even if you decide not to follow it) – they have been there a lot longer than you! Buy them the occasional box of biscuits and ask about their weekend. Treat a nurse like a slave and you will NEVER have a peaceful shift.
2. **Locate the nearest BNF** – and don't be embarrassed to use it!
3. **Wear comfortable shoes** – You will walk miles every day. Girls, beware of heels; it is very embarrassing to walk down a quiet ward in clip-clop heels.
4. **Smile** – You'll get away with (almost) anything.
5. **Communication is the magic word** – To ensure what you want doing is done, communicate it! Write instructions down CLEARLY (there is no excuse for illegible handwriting). Hand it over, inform the nurse – every time.

6. **Ask for help** – You're new. You are not expected to know everything (or even anything in your first few weeks). If you are struggling with the workload, tell someone. What's harder, asking for help or explaining to the boss why it all went wrong?
7. **Don't stay late** – Well, don't make a habit of it. No-one will thank you for it and you will hate it. Good handovers are essential. Don't handover day-time cross though (like drug charts and TTOs); it will come back to haunt you.
8. **Lunch and pee-breaks come first** – If you don't eat you are no good to anybody. The only reason to miss a lunch break is a crashing patient.
9. **Get an Oxford Handbook** – The *Foundation Programme Guide* is excellent. Have it nearby, particularly if you're on-call. It's a godsend. I still use it now in ST1.
10. **Be organised** – To your team, you are the dogsbody, the "Gofer", the team PA. You need to know who your patients are and where they are, so keep an up-to-date list every day. Have to hand: investigation results on all patients, a spare pen, a stethoscope and a tourniquet. Know where your SHO, registrar and consultant are to ask for advice and to avoid when you're on a break. Also, you'll see many, mainly female, junior docs carrying around little shoulder bags brimming with stuff; I just recommend pockets and belt-loops. Bags get in the way when leaning over patients all day long.

**Dr Davison** is a clinical governance facilitator and patient safety lead in Buckinghamshire.



## TACKLING STRESS By Sara Dawson

The effects of stress are felt by thousands of health professionals. According to the Health and Safety Executive (HSE), millions of working days are lost every year as a result of depression and anxiety, costing billions of pounds. Everyone suffers from some pressure in their lives: it can be a good thing, motivating us to get our work done and raising performance; however, when demands and pressures become excessive, they can cause problems.

### HOW COMMON IS STRESS?

Hospitals are challenging places, full of demanding individuals, who openly confront the staff that run them. In the face of this, junior doctors must maintain a calm, well-presented and attentive demeanour, while multi-tasking in an often frenetic environment.

The BMA Doctors for Doctors Support Service has identified the common issues that junior doctors contact them about:

- Career issues
- Bullying/racial harassment
- Issues with staff
- Complaints procedures
- Feelings of exploitation
- Co-existent health problems/stress
- Psychological support
- Inappropriate relationships with staff and patients
- Work/life balance
- Burnout.

Dr Mike Peters, who set up the service, said: “When doctors have a health problem, suffer from stress or burnout, or are going through a complaint or litigation, they tend to reflect on their career and whether they should change or indeed leave medicine – so they contact us.”

## DEALING WITH STRESS

It is important to get help early. Not being aware of the depth of your feelings could escalate a problem, such as depression or drug and alcohol dependency.

### TIPS FOR MANAGING STRESS:

- **Put up boundaries** – learn to say no
- **Take time out** – particularly when you start to feel stressed
- **Keep a stress diary** – to identify what things are causing you stress
- **Acknowledge your limitations** – work within your competency
- **Get a good GP** – see them when you are not well and listen to their advice
- **Hold regular meetings** – we're all human: working at the "coal face" leaves little time for this, so organise time for reflection with colleagues
- **Be open** – say you're feeling stressed.



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## MEDICAL PROTECTION COUNSELLING SERVICE

Medical Protection has launched a counselling service to help members experiencing stress and emotional or behavioural concerns arising from a medicolegal matter or adverse incident. This service offers all members free and immediate access to confidential and independent counselling support and assistance. For further details, visit the Medical Protection website.

## USEFUL LINKS

- Doctors' Support Network – [dsn.org.uk](http://dsn.org.uk)
- BMA, Doctors for Doctors – [bma.org.uk/doctors\\_health/index.jsp](http://bma.org.uk/doctors_health/index.jsp)
- NHS Practitioner Health Programme – [php.nhs.uk](http://php.nhs.uk)
- Healthy Working UK – [healthyworkinguk.co.uk](http://healthyworkinguk.co.uk)
- British Doctors and Dentists Group – [medicouncilacol.demon.co.uk/bddg.htm](http://medicouncilacol.demon.co.uk/bddg.htm)
- Sick Doctors Trust – [sick-doctors-trust.co.uk](http://sick-doctors-trust.co.uk)



### PROFILE:

**DR FIONA DONNELLY**

I ran Doctors' Support Network, a peer support group for doctors, which receives 2,500 posts each month. I experienced stress and depression, brought on by a series of events that occurred in a short period of time. I got married, bought my first house, started my first psychiatry post doing the job of a higher level trainee as my consultant was off sick, and then I was assaulted by a patient.

I left my illness untreated for a very long time. I felt very guilty, as there was a perception that people made things like this up to get out of work. I could do the job fine, but when I got home I wouldn't leave the sofa or speak to my husband.

My illness may have been diagnosed sooner if I'd had better support around me. Junior doctors should be aware of the signs of stress in their colleagues. Some areas take a hard line on illness, and offer support and encourage staff to take time off. However, I know of other areas where the attitude is old fashioned – if you can't take the stress you shouldn't be doing the job.

I was an inpatient for six months and afterwards went back to work. Despite a few relapses, I have moved on and taken control of my life again – working as an SpR in psychiatry and bringing up two children. I attribute my success to sharing my feelings and supporting others through Doctors' Support Network.

Working as a junior doctor can be one of the most stressful periods of your career, but if the avenues to support services are well signposted and explored, stress can be managed, to the benefit of both staff and patients.

**Dr Fiona Donnelly** was the chairperson of the Doctors Support Network.



## WORKING NIGHTS By Sara Dawson

What do industrial incidents at Bhopal, Chernobyl and Three Mile Island have in common? They all happened at night.

Many studies of human efficiency and mental agility have shown significant dips between 10pm and 6am, and the risk of injury is 30% higher on a night shift compared to a morning one. Night work requires doctors to remain awake and alert at the time when they are physiologically programmed to be asleep.

As a result of the European Working Time Directive (EWTD), it is now a standard element of most new doctors' rotas. The role involves covering several hospital wards and managing acute admissions.

On the one hand, working nights is a great learning opportunity for new doctors to cover unfamiliar specialties, have increased clinical responsibility and deal with acutely ill patients for the first time. But on the other hand, it is associated with sleep deprivation, insomnia, disorientation, irritability, digestive trouble and poorer mental agility.

In the medicolegal world, a mistake by an overworked and tired doctor is still a mistake. Exhaustion is no defence for poor decision-making. Doctors who adequately prepare for a night shift minimise the risks for themselves and their patients, and reduce the likelihood of making errors.



## GUIDE TO SURVIVING NIGHTS

### Before a night shift

- **Be organised** – Sort out personal issues such as paying bills, etc, before starting a week of nights.
- **Be healthy** – The Health and Safety Executive (HSE) found that offshore oil rig workers who worked a split shift system – seven nights, then seven days – had a higher risk of heart disease than those who worked 12 nights or days straight. So generally living a healthy and active lifestyle may reduce the negative effects of working nights.
- **Be prepared** – Several common clinical problems occur on night shifts, including shortness of breath, chest pain, hypertension and hypotension, confusion and agitation, fever, hyperglycaemia and hypoglycaemia, pain and common postoperative conditions.
- **Get plenty of sleep** – A doctor who has had no sleep during the day leading into a shift will have gone 20 to 25 hours without sleep. This could reduce their psychomotor performance to the level of someone with an alcohol concentration of 0.10% – the legal limit to drive is 0.08%.
- **Avoid your bedroom when you're awake** – Associate your bedroom with sleeping by playing video games, etc in another room.
- **Socialising** – See your friends or undertake a sporting activity.

### During a night shift

- **Eat and drink properly** – Follow a similar eating pattern to the one you follow in the day. Eat a main meal before you start, have “lunch” halfway through the shift and an easily digestible meal when you get home.
- **Double-check** – Your responses are not as reliable as they are during the day, so repeat calculations, double-check drugs, etc.
- **Staff support** – Although MDTs are becoming commonplace, there are still fewer nursing staff on the wards, so patients are not as closely observed as they would be during the day.
- **Ask for help** – If you need help ask for it. Grappling with a cantankerous consultant is better than having to deal with an adverse incident that leads to a patient's death. The one thing you don't have is experience.
- **Drink caffeine moderately** – The circadian nadir is between 3am and 6am, so it may be tempting to drink more coffee to keep awake, but remember if it is consumed within the last four hours of your shift it will make it harder to sleep.



- **Take naps** – Short naps have been shown to provide positive benefits for shift workers, but they should not last more than 45 minutes. Set an alarm beforehand to prevent yourself from falling into a deep sleep. If you take a small dose of caffeine before your nap, you should start to feel the effects when you wake up, which may help overcome the sleep inertia you will normally feel after a nap.
- **Maximise exposure to light** – Exposure to bright light has an alerting effect on the brain and improves performance.

### After a night shift:

- **Limit the effects** – Our bodies are controlled by our body clocks, situated in the suprachiasmatic nucleus (SCN) in the hypothalamus. It generates circadian rhythms that regulate the physiological processes in the body. Working nights causes a mismatch between the circadian timing system and environmental synchronisers. Circadian rhythms are strongly influenced by natural light and dark, so wearing dark glasses on your way home, using earplugs and black-out curtains, and turning off your phone will limit the effects and make it easier to sleep during the day.
- **Be extra vigilant** – If you're planning to drive home, consider the risks of doing so. If in doubt, take a taxi.
- **Sleeping pills are not recommended** – They can cause hangover-like symptoms and addictive effects. Consult your GP if you think they are necessary; never self-prescribe.

## USEFUL LINKS

- Horrocks, N and Pounder, R, *Working the night shift: preparation, survival and recovery: A guide for junior doctors*, Royal College of Physicians (2006)
- Shift work linked to health risks, BBC news website (20 April 2005)
- Hobson, John, Shift work and doctors' health, *Student BMJ* 12:393-436 (November 2004)



## DIARY OF A NIGHT SHIFT By Dr Jacqueline Simms



**10am**

Tonight is my first night shift as an F2 covering the emergency centre and medical wards. I'm very excited about being let loose to deal with sick patients; the experience will definitely enhance my confidence. Staying up all night will be easy – late night revision sessions and post-exam nights out have trained me well.



**3pm**

Not sure what to do with myself this afternoon. I've tried sleeping, but instead dim panic has set in as I consider the responsibility of the on-call bleep. I decide to swot up on emergencies.



**9pm**

As soon as I arrive I get stuck into the handover. There are already six patients waiting to be seen. As I make a note of my jobs for the night, I take the bleep from a weary day doctor. The fresh energy among our night team battalion is comforting, but I have little time to enjoy it, as the shrill of my bleep sounds.



**11pm**

I'm exhausted. The bleep has not stopped. The wards are constantly bleeping me, while I try and clerk in patients. "Good organisation" and the "ability to prioritise" are no longer simply buzz words for job application forms – they are a means of survival.



**2am**

Hospitals at night are eerie places. Bleeps and bells are distorted by the deafening silence of long corridors and sub-delirious minds – I haven't had a break yet. I'm called to see more unwell patients – pulmonary oedema, ventricular tachycardia. It enthalls me sorting out these patients first hand.

**4am**

I'm experiencing a bizarre mixture of hunger and nausea. My cortisol levels must be rock bottom. A lull in the emergency centre permits a dash to the wards to review an elderly patient. I crash into a hospital bed on the way, waking the entire bay. I locate the patient and resist the temptation to sedate and my assessment is rewarding – he has a pneumonia brewing, but where are his notes?

Weary and frustrated, I slump down heavily at the desk. The bleep barks at me and I want to bark back. It's sister in emergency centre saying to "get down here – there are five waiting". I feel tearful... Luckily, my guardian angel arrives in the form of a nurse, who places a cup of tea in front of me, complete with the patient's notes. The kindness and unspoken understanding from my fellow night worker picks me up and I journey on.





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**6am**

The sun is rising and I am aspirating a large haemorrhax; I feel dizzy but strangely euphoric, thinking how much I love my career – what other professions have this in the job description?

**8am**

Time for post-take ward round. Feeling proud of surviving the night I am ready to present all the wonderful management plans I instigated. Yet I feel deflated as fresh-faced seniors remind me of diagnoses I did not consider, tests I still need to book – all reasonable points, but my tired brain only hears criticism. I won't let this ruin my mood, off home now for food and a warm bed.

It was a busy, stressful experience, but dare I say...good fun? Fortunate, because I have another three nights to go.

**Dr Simms** was describing her first night shift as an F2 at the Kent and Canterbury Hospital.



# HOW MEDICAL PROTECTION CAN HELP YOU



We are the world's leading medical protection organisation, putting members first by providing professional support and expert advice throughout their careers.

## GETTING THE RIGHT PROTECTION FOR YOUR FOUNDATION POST

Having a patient's best interests at heart will not always protect that patient from harm. Likewise the best intentions will not always protect a doctor from human error and professional scrutiny. This is why having the right protection and access to 24-hour medicolegal advice and support is vital.

### NHS INDEMNITY

As a foundation doctor working in an NHS hospital you will benefit from NHS indemnity to cover the cost of claims. However, NHS indemnity usually provides little or no support for the individual doctor and NHS indemnity will not protect you against other risks to your professional practice, making it essential that you have membership of a medical defence organisation in order to secure your peace of mind.

## SUPPORT AND ASSISTANCE

The areas you can approach us for assistance as a foundation doctor are:

- *Telephone advisory service available 24/7* – Members can phone us for specialist medicolegal advice to help resolve everyday dilemmas as well as the more complex scenarios arising from your professional practice. Calls are confidential and we encourage members to get in touch if they are in any doubt over a medicolegal issue.
- *Handling complaints* – If you become the subject of a complaint arising from your professional practice, whether it was made to the GMC or directly to you, we can help you formulate a response and assist and support you through to its resolution.
- *Specialist legal advice and representation* – Medical Protection can provide first-class specialist legal advice and representation in a range of circumstances which are not supported by NHS indemnity, such as disciplinary hearings and GMC fitness to practise proceedings.
- *Writing reports* – We can help with preparing a report for the coroner (or procurator fiscal in Scotland) and offer advice and representation at an inquest or FAI.
- *Media and press relations* – Medical Protection can issue statements and act as a spokesperson should a case or complaint against you receive unwanted media attention.
- *Criminal proceedings* – We can help members who are the subject of criminal investigations that arise directly from their provision of clinical care to patients.

## WORKING ABROAD

If you are planning to work overseas, we want to ensure you are properly prepared so that you can make the most of your experience. Whether you are relocating permanently, for just a year, or working on an expedition or voluntary project, it is vital that you have appropriate protection: new countries and new roles mean new risks. Medical Protection has members practising internationally, so if you are planning to work overseas, membership may be arranged.

Members who plan to work abroad must contact Member Operations on +44 113 243 6436 or email [member.help@medicalprotection.org](mailto:member.help@medicalprotection.org) well in advance of their intended travel date, providing the details and dates of any work they are intending to undertake overseas.

When you contact Member Operations to discuss working in Australia please have the following details to hand:

- your UK address and telephone number
- email address
- Australian address and telephone number
- Australian work address
- dates of practice.



## SUPPORT FOR YOUR DEVELOPMENT AND E-PORTFOLIO

We are committed to helping you avoid problems whilst providing the best care for your patients. We have a dedicated Educational Services Department with a team of more than 100 staff organising and delivering educational interventions to healthcare professionals worldwide.

### WORKSHOPS

Medical Protection runs a series of communication skills workshops which are free for members to attend as a benefit of membership. These workshops are designed to provide practical advice, techniques and models required for your current and future roles. You can find out more at [medicalprotection.org/workshops](http://medicalprotection.org/workshops).





## E-LEARNING HUB – PRISM

Medical Protection's free e-learning hub allows members you to learn online in your own time. We have created an online programme of interactive learning modules covering the key risk areas. Once you have completed a module you can download a certificate for your CPD.

## PUBLICATIONS

Advice on a variety of medicolegal subjects is available on the Medical Protection website. You can download comprehensive booklets and factsheets on topics, such as consent and medical records, and back issues of our member magazines.

## RESOURCES FOR NEW F1 AND F2 DOCTORS

Medical Protection has developed a range of specific resources for F1 and F2 doctors. These include:

- *New Doctor* magazine – this uses real experiences to highlight some of the common risks you face and to educate foundation doctors on medicolegal issues.
- *Casebook* – our flagship magazine – contains features, news and case reports.
- *Medicolegal talks* – our team may visit your hospital to deliver teaching sessions on topics such as professionalism, medical records and consent.
- *Guide to General Practice for F2 doctors* – this handy guide contains all the important medicolegal information you need to practise safely.
- *Professionalism – A Medical Protection Guide* – a collection of articles designed to get you thinking about what it means to be professional; in particular the characteristics and behaviours that uphold professional qualities.

# FURTHER INFORMATION



## GENERAL

- **The Foundation Programme**  
[foundationprogramme.nhs.uk](http://foundationprogramme.nhs.uk)
- **GMC Guidance**  
[gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://gmc-uk.org/guidance/good_medical_practice.asp)
- **Medical Protection information for Foundation Doctors:**  
[medicalprotection.org/uk/foundation-doctors-qa](http://medicalprotection.org/uk/foundation-doctors-qa)

## PUBLICATIONS

- **New Doctor magazine**  
[medicalprotection.org/uk/advice-and-publications/new-doctor](http://medicalprotection.org/uk/advice-and-publications/new-doctor)
- **Student BMJ**  
[student.bmj.com](http://student.bmj.com)
- **Junior Doctor magazine**  
[juniordr.com](http://juniordr.com)
- **A Guide to Medical Protection membership**  
[medicalprotection.org/uk/membership/guide](http://medicalprotection.org/uk/membership/guide)

## PODCASTS

Medical Protection has produced a series of fitness to practise podcasts, which are downloadable from the Medical Protection website: [medicalprotection.org/uk/advice-and-publications/podcast](http://medicalprotection.org/uk/advice-and-publications/podcast).

## MEDICAL PROTECTION FACTSHEETS

Medical Protection factsheets are short guides on particular medicolegal issues. They provide essential and practical advice for doctors practising in the UK. The factsheets provide only a general overview of the topic and should not be relied upon as definitive guidance.

If you are an Medical Protection member, and you are facing an ethical or legal dilemma, call **0800 561 9090** and ask to speak to a medicolegal adviser, who will give you specific advice, or email [\*\*querydoc@medicalprotection.org\*\*](mailto:querydoc@medicalprotection.org).



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## **MEMBERSHIP ENQUIRIES**

Tel 0800 561 9000  
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Calls to Member Operations may be recorded for monitoring and training purposes.

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