Assisting at sporting events

JUST HOW QUALIFIED IS NEWLY-QUALIFIED?

Inside this issue:

- The perils of social networking
- Surviving on call – top tips
- Life in Obs and Gynae
The right choice
for doctors in Ireland

We are committed to providing you with professional support and expert advice throughout your career.

We put members first

- We will be here for you whenever your professional reputation is threatened.
- You can turn to fellow professionals with unrivalled specialist medicolegal experience who provide confidential, individual, expert advice 24/7.
- Our whole ethos is focused on putting your needs first and doing our best to help you in whatever way we can.
- Your subscription ensures that we will be here when you need us, today, tomorrow and far into the future.
- We are committed to the value of education and training. We can help you avoid problems and improve the quality of your clinical practice.

Understanding the limits of the Clinical Indemnity Scheme

The Clinical Indemnity Scheme (CIS) protects you from the financial consequences of a clinical negligence claim. It does not provide doctors with representation or support either at disciplinary proceedings or before the IMC – this is where MPS can help.

Keeping us informed: In order to ensure we can provide the best possible support should the need arise, please keep us informed of any change in your circumstances.

Call: 1800 509 441  Online: www.medicalprotection.org
Email: member.help@mps.org.uk
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Rachel has worked in the Marketing Department at MPS for almost ten years:

“I regularly visit medical schools and hospitals to talk to members and arrange medicolegal events for some of the professional organisations in Ireland, including the Royal Colleges.

“If you are organising a teaching event, training day or conference, then you can contact me to help arrange sponsorship or a speaker.”

Contact her on 087 2867491
or at rachel.lynnch@mps.org.uk
News round up

MPS 2012

A new international conference focusing on
QUALITY AND SAFETY IN HEALTHCARE
Making a Difference

MPS international conference

On 15-16 November 2012, MPS will be holding its first International Conference, Quality and Safety in Healthcare: Making a Difference, at Church House Conference Centre, Westminster, London.

While healthcare has become highly effective, improvements in safety has lagged behind. The conference will bring together international experts from around the world to share their knowledge, experience and expertise on quality and safety.

Themes will include: What quality means; patient experience; achieving a safety culture; and will ask the questions is quality affordable and where is the place for professionalism?

Keynote speakers confirmed include:
■ Dr Carol Haraden, Vice President, Institute for Healthcare Improvement (IHI), on Achieving a Safety Culture
■ Dr Lucian Leape, Adjunct Professor of Health Policy, Department of Health Policy and Management, Harvard School of Public Health on Disclosure and Apology: It’s not about the Money
■ Professor David Studdert, Professor and ARC Laureate Fellow, Melbourne Law School, on Reliable Prediction of Doctors’ Medico-legal Risk – Can it be Done?

For more information and to book online visit: www.mpsinternationalconference.org

Medical Council considers late payment fee

The Medical Council is considering introducing a fee for doctors who do not pay their registration fees on time. President of the Medical Council, Professor Kieran Murphy, said that in 2011, just 55% of doctors paid their annual retention fee by the 30 June deadline, causing the Council significant administrative costs in issuing reminders and processing fees past the deadline.

The Council has suggested that the annual retention fee for 2012/13 stays at €490, with an additional fee of €50 for those who do not pay on time.

Prof Murphy added: “The current fee structure, which does not include a penalty for late payment, means that fees collected from doctors who interact with the Medical Council in a timely, efficient and effective manner are diverted from core functions to following up with doctors who do not present fees on time.”

Under the new proposals, all doctors will be required to complete an application form in addition to the payment of the fee through which they will provide short and straightforward information about continuing practice, and also provide a declaration that they are maintaining their professional competence in line with Medical Council requirements.

The consultation for the Council’s new draft rules for its annual retention process closed on 10 May 2012.

www.medicalcouncil.ie

Now wash your hands, doctors are told

Doctors are being reminded to practise hand hygiene to avoid causing their patients harm and to protect themselves. President of the IMo, Dr Paul McKiernan, has pledged his organisation’s support for the HSE’s hand hygiene campaign, acknowledging that doctors can play a big role in helping to stop the spread of infection.

He said: “We medical practitioners have always operated from the principle of ‘Primum non nocere’—first do no harm. We should aim to ensure that our hand hygiene practices are such that we are never responsible for transmitting infection between our patients.”

Ireland has the highest level of vancomycin-resistant enterococci in Europe and hand hygiene is vital to help prevent the spread of such infections.

He added: “It is a simple, low-cost intervention that effectively prevents the spread of healthcare-associated infections and is one of the most important actions any doctor can take in protecting the health of his/her patients. In addition, proper hand hygiene protects doctors from infection in the clinical environment.”

www.imt.ie
Working for change to protect your interests

Not only does MPS support doctors when things go wrong, we also closely monitor the regulatory environment and make representations to decision-making bodies and parliamentarians to protect and promote our members’ interests.

Back in February, MPS hosted a reception (shown above) in Dublin for stakeholders in healthcare, where we shared the organisation’s recent medical and dental claims experience, as well as the medicolegal challenges on the horizon in Ireland.

The reception, hosted by new MPS Chief Executive Simon Kayll, was held at the Royal College of Physicians of Ireland and attracted more than 70 important figures from the healthcare and legal arenas.

Another major focus for us is on whistleblowing, and the need to create a culture of openness when reporting concerns. Raising concerns about patient safety is a professional responsibility and organisations must support staff who do so. MPS has campaigned over the last few years to promote greater openness between healthcare professionals and patients when things go wrong. Such openness must also apply when healthcare staff report patient safety concerns.

We provide a confidential helpline for all members, who can contact us when dealing with issues surrounding whistleblowing. MPS actively encourages doctors in these situations to seek advice and guidance. We are calling for a culture of early identification of concerns to maximise opportunities to prevent patient safety incidents; organisations to play an active role in providing support, training and mentorship to staff in raising concerns; and an open culture that encourages and rewards doctors to fulfil their professional responsibilities.

The government has announced its intention to publish proposed legislation dealing with the protection of whistleblowers this summer – we will be closely monitoring developments.

MPS Mastering series of workshops

New dates are now available for the MPS Mastering series of communication skills workshops. The following three-hour workshops are available and are free for MPS members to attend.

**Mastering Your Risk**
Provides practical tools, tips and strategies to improve communication behaviour and effectively manage patient expectations.

**Mastering Adverse Outcomes**
Covers the effective and ethical management of patient care following an adverse outcome.

**Mastering Professional Interactions**
Examines communication breakdown between doctors and introduces effective strategies to reduce the associated risk of patient harm.
Assisting at sporting events

MPS receives a number of calls each year from junior doctors who are keen to get involved in assisting at sporting events, whether it is a GAA game, a horse trial or a motor rally. Sometimes, these requests are from doctors who do not have appropriate skills. Additional qualifications, such as an ATLS certificate, are necessary to equip you with the effective triage and emergency medicine skills you will require when assisting with medical emergencies outside the hospital setting. Without the necessary experience and qualifications you should consider very carefully whether you will assist at an event in a medical capacity.

Dr Sonya McCullough, MPS Medicolegal Adviser, says: “If you are interested in assisting at sporting events, you should contact MPS’s Membership Services in the first instance and put to them in writing your proposed additional duties. This way, MPS can clarify whether or not you would be adequately covered to perform the role. This ensures that your profile is kept up-to-date to make sure that you are adequately indemnified for the duties you are carrying out.”

Most medical volunteers are involved in providing medical care for the crowds, officials and the administrators, alongside voluntary organisations and paramedics when required.

The importance of being indemnified
Appropriate indemnity is a key component when assisting at any sporting event. The Medical Council’s A Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009) states that: “You must ensure that you have adequate professional indemnity cover for all healthcare services you provide.” (50.1)

Make sure you are competent
You should only volunteer if you are able to do what you say you can do and work within the limits of your competence.

Helping out at sporting events might be exciting, but it is important to be aware of your limits, says Sarah Whitehouse

MPS advice for assisting at sporting events:
- Ensure all skills are up-to-date and that qualifications are appropriate for the event.
- Acquire basic knowledge of the sport, risks and possible injuries participants may sustain.
- Ensure that appropriate medical equipment to the sport is available according to the ruling body’s requirements and professional opinion.
- Become acquainted with the guidance of the sporting organisation.
- Be familiar with the local emergency services.
- Discuss and arrange appropriate professional indemnity.
- Ensure the level of responsibility is agreed with the event organisers.
- Should you be required to provide treatment to a member of the team, you should document your findings clearly and retain this record.
Any situation that is beyond your competence may still benefit from your input, to a degree. For example, you can use your clinical skills to take a history, make an examination to reach a preliminary assessment, and give an indication of the likely differential diagnosis. You can also suggest options for the management of the situation pending arrival of support.

In the unlikely event that legal proceedings follow, members would be entitled to apply for assistance, no matter which country the legal proceedings are commenced in.

When assisting at sporting events, the medicolegal risks remain the same as any other clinical encounter. Be sure to work within the limits of your competence, ensure good communication with and make sure you document any treatment given or decisions made. Domhnall MacAuley, Primary Care Editor of the BMJ, sums up the role of the medical volunteer: “Like many of the backroom staff, their success is measured in how little you see of them.” You should be prepared and well-equipped to help immediately in those rare instances that you are needed.

REFERENCE
Surviving on call

Intern Dr Louise Hickey provides some practical tips on preparing for on call, dealing with sick patients – and time management to maximise your sleep

Most incoming interns will regard “call” with some degree of trepidation. This is to be expected, and bar those who are exceedingly enthusiastic, or insomniac, call shifts are something to be endured, not enjoyed. However, there are some benefits. The main upside is the chance to practise medicine, to cover unfamiliar specialties, and have increased clinical responsibility. In the junior doctor day job, you will become exceedingly competent at blood extraction and you will develop extraordinary organisation skills. Unless you get lucky with a team who provide on-the-job teaching, “on call” shifts may be the only time you learn how to manage acute medical presentations. If you are planning on moving onto medical SHO schemes, or to sunnier pastures abroad, this may be expected, and bar any incoming interns to bring food with them to avoid the lure of artery-clogging fast food. Take-aways do nothing for your waistline (I learnt the hard way), or your productivity.

Routine tasks

Once your appetite is satisfied, and the scrubs are donned, it’s time for the real work to begin. The vast majority of tasks on call are fairly routine, and with practice you will become efficient at completing them. In the initial weeks, carrying a list of common medications with their dosing is advisable. You will be repeatedly asked to prescribe anti-emetics, laxatives, analgesia etc, and having a list will avoid you having to continually reference the BNF. Inserting cannulas is another thread on the fabric of an oncall shift. There is no quick tip for doing them, merely that with practice they will become easier, and quicker. Patient admissions at night are commonplace and these should not cause much difficulty to junior doctors who are likely proficient in history taking and physical exam. Most elective admissions are pre-operative patients, and hence will need a preoperative work up; bloods (very importantly include a sample for the blood bank), ECG and chest x-ray as indicated. Doing this on call will save the admitting team’s junior doctor (possibly your friend) much panic in the morning, and hopefully the favour will be returned.

Dealing with sick patients

While completing the aforementioned mundane tasks will occupy the majority of your time on call, being called to a sick patient presents the real challenges. The first key hurdle is to differentiate the truly sick patient from those with more minor ailments. Often, you will be asked to review a patient with, for example, leg pain, or constipation. The complaint must be taken in context. For example, leg pain in a young, mobile patient may be managed with simple analgesia, whereas the same complaint in an obese, postoperative patient could trigger further investigation. As a rule of thumb, always ask the referring nurse for the patient’s vital signs over the phone; this helps you determine how quickly the patient needs to be seen. Once assessing the patient, senior help should be enlisted if you feel their management is outside your scope of expertise. At the start of the year, this scope will be narrow, and you may need to call the medical registrar frequently. The registrar expects this, so draw on their experience, rather than make decisions you’re not comfortable with. Most senior colleagues are friendly and helpful, but if a patient is stable they will expect relevant basics to be completed when you contact them, ie, the “intern package”. This involves arterial blood sampling, routine bloods, ECG, blood cultures and plain films. Additionally, you should have a good grasp of the patient’s background history, current complaint, current medications and vital signs. Having all this done, or in progress, will facilitate swift management decisions to be made by the registrar, optimum outcome for the patient, and a quick return to bed for you.

Managing your time

Time management on call is key. Depending on your hospital you may be alone on call or with a partner. Either way, each night should begin with a sweep of the wards. This ideally should take place approximately 30 minutes after nursing handover has occurred to allow the nurses to gather all the jobs they need done for the night and compile a list for you. After completing each task from the list, I always check with the nurses on the wards that there aren’t any outstanding jobs, before moving on. This approach should minimise
call-backs. During your hospital sweep you will inevitably be interrupted by bleeps from other wards. If the issues are non-urgent, I usually ask the nurses to add them to their ward list and assure them I will complete it on my “sweep” of that ward. Giving ward staff an idea of how long you’ll be before reaching them is useful, as it allays their fears that you have forgotten them, and avoids being contacted again over the same issues. If you are lucky enough to have a partner, usually the bleeps are split over the course of a night so as to allow for protected sleep. Classically, the shifts will be midnight until 4am and then 4am until 8am; however, in the initial weeks, getting the sweep finished by midnight would be a solid achievement!

Though being on call can be hectic, the great thing is that you are essentially your own boss for the shift. There is no growling consultant on your case like during the day job, so tasks can be done at your own pace, without too much pressure. All that’s left to say is... bleep.

Dr Louise Hickey is an Intern at St. Columcille’s Hospital

MPS top tips

Before on call:
■ Be organised – Pay bills etc, before starting a week of nights.
■ Be healthy – A healthy and active lifestyle may reduce the negative effects of working nights.
■ Be prepared – For common clinical problems that you will see on call, eg, pain and common postoperative conditions.

During a night shift:
■ Eat and drink properly – Follow a similar eating pattern to the one you follow in the day.
■ Double-check calculations – Your responses are not as reliable as they are during the day.
■ Ask if you need help.
■ Drink caffeine moderately.
■ Take naps.

After a night shift:
■ Limit the effects – Use earplugs, black-out curtains, and turn off your phone to help you sleep during the day.
■ Be extra vigilant – Consider the risks of driving home after a night shift.
■ Don’t take sleeping pills – They can cause hangover-like symptoms and addictive effects. Consult your GP if you think they are necessary; never self-prescribe.
Have you ever Googled your own name? What came up? An old photo from your long since deactivated Bebo account? A photo of “that night,” an occasion infamous among friends and acquaintances for the levels of wine imbibed and the generally uncivilised way in which you conducted yourself?

With the ever-expanding use of social networking sites, the ease of access to information can be a wonderful but alarming thing. Facebook recently surpassed 900 million active users; among them many potential past and future patients. As students, we might not have associated our behaviour with something that could affect our future career; nowadays, it is something that should be given greater consideration. With a few clicks of a mouse, what information could a patient or future employer access about you that you would not reveal during a consultation or interview? The information available is often not the most recent, but rather old photos, blog posts or tweets that are long since forgotten in your own memory, but forever immortalised thanks to the internet.

Maintaining patient confidentiality
A number of issues arise with the increased use of social networking;

Dr Laura Murphy looks at the potential pitfalls of practising medicine in the social media age and provides some top tips on keeping your professionalism intact, both on and offline.
in particular, patient confidentiality and professionalism. The principle of confidentiality is central to trust between patients and doctors. The Irish Medical Council’s A Guide to Professional Conduct and Ethics states that: “Patients are entitled to expect that information about them will be held in confidence. You should not disclose confidential patient information to others except in certain limited circumstances outlined in paragraphs 26 to 30.” (24.1)

These circumstances include disclosures with the patient’s consent to relatives and carers, disclosures required by law, disclosure in the interest of the patient or other people, and disclosure in the public interest.

The Guide also states that: “You should ensure as far as possible that confidential information in relation to patients is maintained securely and in compliance with data protection legislation.” (24.4)

In most hospitals and medical schools, doctors are required to sign a code of confidentiality pledging to maintain patient confidentiality. In such a document, all of the situations pertaining to confidentiality relate to discussion amongst colleagues, case presentation or research. Although the inclusion of social networking as a form of discussion is presumed, perhaps this should be outlined more clearly.

In Australia, the NSW Medical Board issued a general caution to medical practitioners when one patient complained after reading derogatory comments made by a doctor on Facebook. This issue is even more pertinent in a country with such a small population like Ireland. There are more than 2,500 GPs in Ireland for a population of nearly four and a half million people, working out at approximately 1,800 patients per GP. In rural areas, with close-knit communities, it is easy to imagine how one or two comments posted flippantly online could provide enough information to recognise the person in question, even if you think you have been responsible in anonymising information. Whilst it may not be the patient concerned that sees it, it is equally dangerous for a friend, relative or neighbour to garner this information which would not normally be given freely over afternoon tea. Moreover, it is rarely everyday stories that would be the subject of a Facebook post or blog entry, but more likely the weird, wonderful or generally embarrassing stories which patients would and should expect to remain privileged information.

**Remaining professional online**

Professionalism is defined as a set of values, behaviours and relationships. This includes integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team. Analysing the list of complaints made to the Irish Medical Council in 2010, the number of submissions relating to a particular doctor’s conduct was almost double the number made due to inappropriate or inadequate treatment. Whilst it is perfectly acceptable to expect that doctors will engage with social networking sites, it is prudent to remember that not only friends and family will necessarily have access to what is posted online. Unguarded comments about patients, your employer, or other staff members can lead to sanctions by your hospital board or the Medical Council.

Comments of a racist, sexist or bigoted nature, or posting inappropriate images or extreme views, are also likely to get a junior doctor into trouble. One particular aspect that can lead to seemingly unprofessional posts is the feeling of anonymity afforded to people by the internet. This can often lead to people posting things online they would never dream of saying in real life. For example, a Welsh student was recently jailed for 56 days over his comments when the Bolton footballer, Fabrice Muamba, suffered a cardiac arrest as members of the football world looked on in horror. His callous comments were made after a significant alcohol binge and were regretted in the cold light of day. However, he has now suffered the consequences of undoubtedly thoughtless actions and been expelled from his university. Whilst this is an extreme example, it highlights the potential negative repercussions when reality and the internet collide.

As doctors and medical students, we are not only representing ourselves, we are also in this for the profession. Doctors are afforded a privileged position by their access to patients and information divulged in communication with them. To abuse this is to erode trust and confidence in the doctor–patient relationship.

Although there is no specific guidance on social media, the general principles of confidentiality still apply, whether you are on or offline.
I'm currently working as an intern in general surgery. Yesterday, I misplaced my theatre list on the ward and later found it next to a patient who had read its contents. Do I need to tell someone or will it be ok?

Confidentiality is central to the doctor-patient relationship and patients are entitled to expect that information about them will be held in confidence. Any inadvertent breaches of confidentiality must be dealt with seriously, no matter how small they might seem.

The patients on the list (ie, those who are affected) and the data controller (ie, your employer) should be informed of the loss of data in the first instance. All incidents of loss of control of personal data in manual or electronic form by a data processor must be reported to the relevant data controller as soon as the data processor, in this case you, becomes aware of the incident.

The relevant person on the ward should in turn inform the Data Protection Commissioner, in accordance with the Data Protection Act.

Working on call in the ED, a patient becomes very angry about his treatment and starts to challenge me about it, raising his voice and making threatening gestures. What should I do?

When dealing with challenging or difficult patients it is important to try and remain calm at all times. Ask about the cause of the problem, speaking calmly and slowly and attempting to resolve the situation. Do not raise your voice.

If you are asked to examine or treat a patient who presents a risk of violence, the medical council states that you should make reasonable efforts to assess any possible underlying clinical causes of the violent behaviour. However, you are not obliged to put yourself or other healthcare staff at risk of undue harm in the cause of such assessment or treatment.

I have just helped to treat an eight-year-old girl in the ED who had a cut to her head that required stitching, following a fall. She also has bruising over her arms, but I am concerned that this is not consistent with the history of her fall. What should I do?

Firstly, you should discuss any concerns you have about child protection with a senior colleague. As a doctor, you should be aware of the Children First: National Guidelines for the Protection and Welfare of Children. The Medical Council states that if you have any concerns regarding alleged or suspected abuse of children, you must report this to the appropriate authorities and/or the relevant statutory agency without delay. You should inform the child's parents or guardians of your intention to report your concerns, unless informing them might endanger the child. Giving information to others for the protection of a child would be a justifiable breach of confidentiality, if you feel that it is in the patient's best interests. The Criminal Justice (Withholding of Information on Offences Against Children or Vulnerable Persons) Bill is currently under consideration in the Dáil, which will legislate for mandatory reporting.

For more information see MPS’s factsheet on Safeguarding Children, www.medicalprotection.org/ireland/factsheets/safeguarding-children

I keep having headaches that I think might be migraines. Can I self-prescribe?

Tempting though it may be to write yourself a quick prescription ready to take to the pharmacy after work, this might mean you don’t get the best treatment possible, or a valued second opinion. You should make an appointment to see your own GP instead – the Medical Council in A Guide to Professional Conduct and Ethics advises that if you become ill, you should seek advice and help from another doctor rather than treat yourself (52.1).

Similarly, the Medical Council advises that a doctor does not treat, issue prescriptions, or write sick certificates or reports for family members (52.1).

I have just received a conviction for being drunk and disorderly after a staff night out. Should I tell the hospital?

If you are convicted of a criminal offence, the Medical Council will be notified, and they will investigate the circumstances involved. Claiming that you were not on duty at the time of the offence will not help you avoid an inquiry, which could potentially affect your professional registration. It is much better to share this information with your employer in the first instance, rather than keep quiet in the hope that they won’t find out.

A patient, Mr T, is extremely unhappy with the standard of care his mother, Mrs T, is receiving. Mrs T has had a stroke. Shortly after the ward round, you were making an entry in Mrs T’s notes when Mr T approached you and asked to have a quick look at his mother’s medical records as he is very concerned. Should I have let him?

Patient’s relatives and close friends may understandably be concerned, but you must not disclose information to anyone without the patient’s consent, if they have capacity. This can be hard, especially if family members ask for a quick look and say they only have their mother’s best interests at heart.

You must first check that Mrs T has capacity following her recent stroke, otherwise failure to disclose would put others at risk of serious harm. You should only discuss a patient’s care with their family if there is a lack of capacity and it is in their best interests. You would need to assess whether Mrs T has capacity following her recent stroke.
One of my intern colleagues appears to be suffering from acute psychological stress and it’s beginning to impact on his work. What should I do?

If you are concerned about a colleague’s conduct or competence, you should talk through your concerns initially with the doctor in question. The best way to support a colleague is to advise them to seek expert help or consider referral to the Medical Council’s Health Sub-Committee.

You must also act to prevent any immediate risk to patient safety by notifying the relevant authority about your concern as soon as possible. If you are unsure who to report your concerns to, ask a senior colleague for advice, or contact MPS.

I am working on the vascular ward. Should I give each patient the same amount of information when taking informed consent for an elective operation?

Every adult patient is presumed to have the capacity to make decisions for themselves and you have a duty to provide information in a clear and comprehensive manner. You should take a functional approach when assessing an individual’s capacity, based on:

- Their level of understanding and retention of the information they have been given
- Their ability to apply the information to their own personal circumstances and come to a decision. (Medical Council, A Guide to Professional Conduct and Ethics, 34.3)

The Guide’s ‘Appendix A’ contains details of the information that patients should be provided with prior to giving consent, for example: details of the diagnosis and prognosis; details of the procedures or therapies involved, including methods of pain relief; and preparation for the procedure and what the patient might expect during or after the procedure, including common and serious side effects.

For more information, see MPS’s Consent booklet at: www.medicalprotection.org/ireland/booklets/consent
How quickly the rhythm of life changes from being a student to being an intern – in a matter of days, the five years of student life becomes relegated and romanticised into hazy memory! When I was a student I could take the time to coordinate an outfit, stroll to a ward round, fall into the back of the litter of white coats ten minutes late and no-one would notice (or so I thought). Yet now, I am rushing to the ward early to organise the charts before the rest of the team members even arrive. When I was a student, no-one held me responsible for a delayed scan, a leaking cannula, or a missing chart. Often as a junior doctor you feel the failings of an entire health system somehow come to rest on your shoulders!

But would I swap my life now for my life as a medical student? Never! Yes, life as an NchD can be busy and challenging but it is also interesting, fast-paced, fun, educational, humbling, moving and above all else full of hope for our careers and our futures.

For interns, the days fly by in a haze of admissions, discharges, consults, organising scans, ABGs, ECGs, cannulas and catheter insertions. Some interns love their current rotation and begin to imagine a future in it, some are turned off certain specialties forever, and a lucky few start the year knowing what they want and end the year equally as convinced of their commitment to their chosen specialty.

I always had an inkling that I liked obstetrics and gynaecology and envisaged a career in it. I chose to use my internship as an opportunity to explore other options and vowed that for one year at least, I would keep an open mind and approach each rotation with enthusiasm as if it were “the one”. But as time passed, I became more and more certain. I began to see each rotation as an opportunity to hone my knowledge on how different specialties impacted on the obstetric patient as well as being an opportunity to familiarise myself with the day-to-day practicalities of the job. The overlap and need for multidisciplinary approach in management of the complex obstetric patient is enormous. I would advise anyone interested in obstetrics and gynaecology to use their time as interns to experience medical and surgical teams’ interaction with the obstetrics team – cardiologists, gastroenterologists, haematologists, endocrinologists, psychiatrists – to name but a few, are often called upon to help with obstetric management and are usually only too pleased to allow interested interns insight into their work.

For those interns unfortunate enough to not have an obstetric rotation during the year (myself included), obstetricians and gynaecologists are usually happy to involve interested interns in research, audit or even just to shadow colleagues on a typical day in the maternity. The Royal College of Obstetricians and Gynaecologists allow you to sit Part 1 of the MRCOG in your first SHO year. The exam gives a great focus to those interested in obstetrics and gynaecology and thankfully can be repeated if unsuccessful. Balancing work and study can be challenging, of course, but can definitely be achieved with some forward-planning (and plenty of plans for post-exam rewards!).

Incidentally, the Royal College of Obstetricians and Gynaecologists and Institute of Obstetricians and Gynaecologists of Ireland both have excellent websites well worth checking out, especially prior to interviews. Most of us have little experience of interviews but just like final year, advance preparation certainly improves performance and calms jittery nerves!

Regardless of where you envisage your career taking you, the basic premise is the same – talk to those in the years ahead of you, keep an open mind on where you are going and what you want to achieve and above all else, enjoy yourself! Good luck.

Dr Neville is a Senior House Officer in Obstetrics and Gynaecology at Cork University Hospital.
Reprinted for 2012, Confessions of a Junior Doctor has gone on to establish itself as a classic, with a cult following amongst doctors and patient alike.

For two years, Dr Michael Foxton wrote about his experiences as a junior doctor in the NHS in the UK newspaper The Guardian, before they were all printed in one place. The column format makes it easy-to-read – being split into 800-word anecdotes. The narratives focus on the trials and tribulations of the poorly-prepared junior doctor, entering an overworked and underpaid NHS system.

Dr Foxton’s purpose is to show the general public audience the true, and comic, nature of being a junior doctor in the NHS. Whilst allowing for the differences of NCHDs, it is easy to make comedic parallels with your own hospital experiences as an intern – and the anecdotes inspire a regular sigh of relief: “At least that hasn’t happened to me.”

With the recurring theme that doctors are initially thrown into the deep end, but somehow, with a bit of “fluffing”, end up swimming like a fish in water, Dr Foxton tells a series of hilarious stories from his Medical/Surgical House Officer, casualty and psychiatry rotations to his end-point as a consultant – and why and how he ended up there. Life in psychiatry plays havoc with Dr Foxton’s pre-disposed ideas of the medical training programme. “The last thing I remember is delivering babies and drinking beer all day at med school. Suddenly, I’m a psychiatrist…wearing a tweed jacket.”

As a junior doctor working in the Irish medical system, I most definitely found myself laughing at the sheer accuracy of Dr Foxton’s short stories. From his amusing account that: “I have already been a doctor for the purposes of: upgrading my aeroplane seat (unsuccessfully),” to the more dubious: “the crash bleep went off…no doctor in sight…no way I was wading in there on my own: I turned and saw the loo. Of course I hid,” his ability to say it how it is will have your eyebrows raised and pointing at that page yelling… I know exactly what you mean fellow doctor!

My overall response to the book? I found myself talking about it to my peers, giving examples and quotes. “Get some of those stick-on sideburns, a nice jumper, and become a GP,” was one of my favourites.

In conclusion, this book is sheer reality with a sprinkling of lots of humour. When I walk the endless wards, and ward rounds, I have found myself relating more and more to Dr Foxton’s confessions of a junior doctor, and I must confess…he is right.

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