Burnt out –
how can we support our mental health?

DON’T DROP THE BATON
Good handovers need good communication

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Why giving an anaesthetic is a bit like flying a plane
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We welcome contributions to New Doctor, so if you want to get involved, please contact us on +44 113 241 0683 or email: sarah.whitehouse@mps.org.uk.

Meet your Regional Membership Co-ordinator: Rachel Lynch

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.lynch@mps.org.uk

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Cover: © ISTOCKPHOTO/THINKSTOCK
Welcome to the third edition of New Doctor, a publication specifically for junior doctors in Ireland.

The contrast between life as a medical student and life as a junior doctor, where you suddenly find yourself responsible for patients, can sometimes be a little overwhelming. It is important to recognise that sometimes, the stresses and strains of internship can lead to burnout. Acknowledging that things might not always be easy is one of the hardest but most important steps. In this issue, we have a special focus on burnout: how to recognise it; how to mitigate it; and how to deal with it, if you – or a colleague – begin to feel under pressure. Turn to page 8 to read more.

One of MPS’s core roles is to provide medicolegal advice to doctors when they need it most. Our dedicated 24-hour telephone advice line is there to support you whenever you have a medicolegal query in your everyday practice. We do, however, provide a variety of other services, including specialist legal advice and representation, and help with writing reports, handling complaints, and dealing with the media. Find out what more your MPS indemnity can offer on page 5.

Our regular section, ‘From the case files’ (page 14), shares some of the most common ethical and legal dilemmas that interns contact MPS for assistance with. I’m sure some of the scenarios might feel familiar. This issue takes a look at the potential pitfalls of social media.

I hope you enjoy this edition and you find it both informative and useful. We’d be very interested to hear your comments and ideas.

Consultation on organ donation

The Department of Health is consulting on the introduction of an opt-out system of consent for organ donation. The government intends to change from the current system where the deceased person’s family is asked for their consent to allow organ donation to take place, to one where consent will be deemed unless the person has, while alive, registered a wish not to become an organ donor after death.

However, under the proposals an assurance is provided that there would be no instance whereby organ donation would proceed against the wishes of the next of kin of the deceased.

The closing date for comments is 20 September 2013.
www.dohc.ie/consultations.

New President for Medical Council

The Medical Council has elected Professor Freddie Wood as President and Dr Audrey Dillon as Vice President for its term from June 2013 to 2018.

Professor Wood is a cardiothoracic surgeon who served as Director of Heart and Lung Transplantation at the Mater Hospital from 1999 to 2010 and is now in private practice. He is a member of the council of the Royal College of Surgeons in Ireland.

National standard for patient discharge summary

The Health Information and Quality Authority has published a National Standard for Patient Discharge Summary Information. It provides guidance on the specific information medical staff should include in a patient’s discharge summary to ensure a smooth transition between different primary and secondary care.

For more information see www.hiqa.ie.

MPS lobbying work in Ireland

MPS undertakes lobbying work to represent your interests. MPS has been actively involved, along with other stakeholders, in the drafting stages of the Medical Practitioners (Amendment) (Medical Indemnity Insurance) Bill 2013. The purpose of the Bill is to ensure that medical practitioners have indemnity or insurance arrangements in place. The Bill is expected to be published this year.

Dr Stephanie Bown, MPS Director of Policy and Communications, leads MPS lobbying in Ireland.
Don’t drop the baton

Good handovers need good communication, says Dr Nigel Rajaretnam

It’s a Wednesday morning: you and your fellow colleagues crowd round a table. There is chatter of interns, house officers and registrars, talking about everything and anything. The night doctor is trying to start a handover of the patients to the new team. More chatter. Papers are flicked through, examined, and dissected. “I remembered I wrote down the findings of the CT somewhere” is muttered. The tired, overworked doctor is trying to make sense and handover a large number of patients to an audience who, unfortunately, are destined not to get the full picture of this patient. The potential for a Serious Untoward Incident (SUI) increases.

Rounds happen. “I was not handed that over” becomes the mantra of the day. Bloods get missed, CTs are not ordered, referrals are not done the next day. Sound familiar?

As health providers, good communication should be one of our strong points. With the advent of the European Working Time Directive (EWTD) and a decrease in working hours, the number of doctors sharing care of the same patient is increasing and handovers have to happen more often. A good handover depends on the accuracy and completeness of the information, and whether it is received clearly and understood by the recipient. 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. Why is it that we sometimes fail to get handovers right?

Communication is taught well in medical school. We learn to empathise, explain procedures, and problem solve, but we are not always taught practical tips on how to ensure a safe patient handover. We might take a lesson or two from our nursing colleagues – handover is a vital part of their day-to-day activity, and it is done with military precision. Having experienced three different health systems it is done in almost the same manner. The idea that a patient’s care can be “shared” is often difficult and it predisposes us to be less open to receiving information about patients that we perceive to be “ours”. The end result is a very paternalistic and individualistic approach to what is very much a team effort.

Sometimes, the handover process itself can be flawed. Often, it happens without any clear format, chairperson, structure, or technology. Most handovers are never audited, and therefore no real change can be made without first studying the very nature of the process.

How can it be fixed? Handing over is not new in other professions. To avoid the same mistakes, we should take a leaf out of pages of others who have learnt what works best.

A good handover

Join me for what I perceive to be a good handover:

It occurs at a set time, in a room fit for purpose, with a large table, plenty of space with several computers and a large screen to bring up x-rays, bloods, etc. In attendance is every team member and a senior registrar. The chairperson would be the most senior in the department, usually a fellow. It runs in the same
Good handovers need good communication, say Dr Nigel Rajaretnam.

As with anything, it could be improved. We are looking into incorporating a typed surgical handover, much like that done in the Adelaide and Meath Hospital in Dublin. This would allow fewer issues with illegible handwriting and provides access to information at a click of a button. Other institutions use the ISBAR (introduction, situation, background, assessment and recommendation) as a pro forma for their handover. The take-home message is that if the handover is done in the same manner, in the same place, headed by the same person, using the same technology, there is significantly less chance of communicative errors which could result in a negative patient outcome.

What can you do today that doesn’t involve major change to the working week? I suggest starting with a debrief after a ward round. Perhaps the senior on the team discusses what tests/bloods need to be looked out for during the course of the day; what should be prioritised and who the sickest patients are. During this time, it would be ideal if the junior doctors could voice their thoughts or concerns, and any potential issues could be dealt with at the outset instead of later in the day. Stay in communication with your team members with whatever method you think appropriate.

A rolling problem list is another idea. Each patient has a problem sheet in the first page of their chart that can be updated, and tests put in (bloods, radiology, etc) and results entered as well. This means at a glance the inpatient activity for the particular patient is easily seen, without even having to open their chart.

As the morning handover in my surgical department, we run through what operations were done overnight, what operations are on the list to be done today in the acute theatre and we determine the order they should be done in. At this time a consultant is usually present. Then we run through our handover list, which follows a set style:

- patient label
- presenting complaint
- history of presenting complaint
- past medical history
- examination findings
- relevant blood tests
- CXR, AXR, MSU findings
- presumed diagnosis
- a problem list, together with what needs to be done for the said patient (pending results to be chased up, radiology to be ordered, etc).

We then outline and troubleshoot any potential problems as a team, before heading away on our daily duty. There is a similar style handover done in the evening and at night, with the consultant on the phone if they are not present in the hospital.

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It might add a minute or two for each patient but it will allow a quick preview to whoever is seeing that patient (in particular, that very same overworked doctor at 2am who still has five reviews to see).

Also, to decrease the potential for error, consider small housekeeping jobs that to you might be simple, but could avoid potentially dangerous medication errors. For example, all patients should have a drug chart – even if it’s just for paracetamol and an anti-emetic. Warfarin dosages should be written up in anticipation for the weekend, if the patient’s INR is stable and there has not been any new medications added that could affect the INR. Drug charts should be rewritten in advance instead of waiting for the night doctor or weekend doctor to do so. IV fluids should be reviewed – there have been many times I have reviewed someone’s fluid chart on the ward to see 5 NaCl 0.9% charted in a row. Ask questions: does the patient need the central line/PICC line/that cannula? Can the NG tube be removed? Why can’t this stable patient go home? We get so lost in our day-to-day work that these simple questions often do not get asked.

As a final word, I encourage you to sit down with your other colleagues, especially those passionate about communication, and see if you can come up with ideas about improving handover. As highly functioning individuals we are very good at coming up with ideas, but unfortunately not as quick to put them into action. An action group would work well, and has the potential to bring about major changes to the patient experience, which, at the end of the day, is why we are all here.

Dr Nigel Rajaretnam is currently a registrar in Pancreatic, Hepato-biliary and General Surgery in Waikato Hospital, Hamilton, New Zealand. Previously, he was a surgical trainee in Ireland.
Burnt out – how can we support our mental health?

The intern years can be a shock to the system – being aware of the challenges can help to identify, and prevent, burnout, says Professor Jim Lucey.

After graduation, the shock of working as an intern can be great. The hours are demanding and the change from largely self-directed student life to life as a junior doctor working within an organised system requires a vast deal of adaptation. In addition, the demands placed on interns are very onerous: much of the paperwork and duties of clerkship are relegated to the intern even in those days when more and more systems are becoming computerised. The sudden exposure to real life patient needs can be overwhelming.

There can be a bewildering demand on interns to adapt to the world of work without much recognition of the transition involved. Some interns can feel that they are being asked to go through a trial by ordeal as a first step in a career structure which seems to place more and more demands upon them while offering them less and less in return. For some, the demand is perfectly reasonable and most doctors bring to the tasks of internship levels of energy and commitment and capacity which are exceptional. However, for others, there is a sudden sense of disillusionment which comes as a real shock and a blow to the original idealised ambitions which originally led the doctor to seek a career in medicine. This disillusionment is particularly toxic when it’s aligned to long hours, exhaustion and unsatisfactory conditions.

What can interns do to prepare themselves for this challenge? The first step is to recognise that denial of these difficulties is not likely to lead to their solution. It is much better to organise and support one another in terms of the professional tasks. Doctors do best when they can progress their individual careers in the context of collective support. Measures such as the European Working Time Directive (EWTD) need to be enforced and upheld and to achieve this today’s intern and other medical staff need to co-operate with each other in a professional manner. The importance of a professional handover cannot be over-estimated in a system which encourages doctors to work shifts.

What can interns do to help their own mental health? The first step is to acknowledge the challenge. Ignorance helps no-one. Once the issue of general health is raised it is surprising how much people can do when they help themselves and when they work together. Try to place general health and mental wellbeing on the agenda for the group working in the hospital. If there is a junior doctor’s residence or leadership committee amongst the interns, there should be an agenda collectively addressing the wellbeing needs of the whole group. Issues like managing the roster and sharing out weekends or nights are as much about professionalism as they are about awareness of the stresses and strains on each of our colleagues’ lives. Interns should have a say in how the balance of work is shared and there should be an attempt to make this equitable.

Each individual needs to look honestly at their own health and the balance of factors contributing to their wellbeing. “All work and no play make Jack a dull boy” is not a new phrase but it is still very true. There are times where prolonged effort and commitment is required, but there must also be time for relaxation and laughter. It is a mistake to give up your interests in sport or recreation or music in your intern year. It is a mistake to have a life without room for relationships and without communication with friends. It helps to have a dedication to the care of others outside medicine and also to sharing time with people you love.

There will be a small but significant number of interns with definable mental health issues and this need to be addressed. In my experience, these issues emerge in the profession at times of great personal stress and particularly at times when demands are placed upon them by onerous work. Issues which could have been contained or may not
The sudden exposure to real life patient needs can be overwhelming

The sudden exposure to real life patient needs can be overwhelming. Have been recognised throughout a college career may emerge during the intern year. The best thing to do is to address them confidentially. It is important to seek help. Most teaching centres which have interns will have a facility for occupational health and this may be an underused resource. It is important to talk about these issues in confidence to someone who can help you address them and genuinely respond with the right kind of focused professional help.

At any one time, 4% of the population will have a depressive disorder of significance. One in five of us will have a depressive disorder in our lifetime in addition to the risks of other issues such as anxiety disorder or substance misuse disorder. The common mental health challenges are no less frequent amongst a body of graduate doctors than they are in the rest of the population. It may be that some of these stress-related issues are even more prominent.

Professionalism involves recognising the duty to maintain one’s own mental health as well as recognising that addressing mental health needs is worthwhile and effective. It is important that we overcome the self-stigmatisation that arises in doctors from the fear of calling for help for our own needs, by speaking up and addressing the mental health needs that exist amongst us. The good news is that most of these issues are readily responsive to support and, where necessary, specific treatment. Most, if acknowledged early, can be overcome in a way which does not damage careers or interrupt life substantially. Failure to address mental health needs can be devastating.

A number of the techniques can be used. There is increased awareness of the benefits of modalities such as mindfulness as an effective stress management technique. Specific psychotherapy such as cognitive behavioural therapy (CBT) can give remediation for stress-related disorders relatively quickly and this is not hard to access once the issues are acknowledged. A small number of doctors who are clinically ill would be better taking time off and addressing their distress where that is required. Doctors very infrequently declare their own illness and this is something which is problematic. Under reporting arises from concealment and denial of illness, which is made worse by fear and shame. The doctor as superman may find himself or herself prescribing for their own difficulties and self-medicating. This is a road to professional and personal disaster and should never be done. It is important to find a mentor, someone who can be trusted completely, so that the best response within the profession can be made when a crisis is feared or worse, when one strikes.

Each intern (and indeed every doctor) should have their own GP; someone that we can share difficulties with and look to for help. As interns we first experience life as carers for others. The best preparation for a life in medicine includes acknowledgement of our need to care for ourselves.

To find out more, listen to Professor Lucey’s podcast on mental health and burnout, recorded at MPS’s General Practice Conference 2012: Spotlight on Risk, in Dublin: www.medicalprotection.org/ireland/podcasts/mental-health-and-burnout

There is no doubt that attention to physical health is very important, but young people frequently ignore this. Make sure you:

■ get sufficient sleep and remain sober
■ take exercise
■ eat well.

These simple things are significant benefits to people in times when resilience is required. Exhaustion and intoxication help no-one. The number of people who disregard what they can do for their own contentment is amazing, and this is so even amongst well informed health professionals.
In this all-action world, patience is not often regarded as a virtue; it is a fault. This modern attitude is becoming increasingly evident in medicine, where the business of running a successful and profitable hospital or surgery increasingly becomes the focus.

Doctors are under increasing pressure, with increasing demands on their time. Doctors are no strangers to stress, but these attitudes certainly do not make their jobs easier: stress needs to be tackled effectively or it will lead to burnout. Not only can stress eat away at a doctor’s physical and emotional health, also adding strain to relatives or colleagues close by, but the impact on patient safety is potentially severe.

The association between stress levels and clinical negligence claims has been demonstrated in studies in the US, while the intervention of stress prevention programmes has also been shown to reduce the likelihood of errors and ensuing clinical negligence claims.1

An intern perspective
To work in the Irish health service as an intern can be a challenge. Here, Dr Michael Daly, a former intern currently working in New Zealand, describes just how difficult his personal experience was.

In the same vein that a victim of kidnapping shares an intrinsic bond with his or her kidnapper, so too many NCHDs and their employers are held to symptomatology and behaviour that can only be representative of Stockholm syndrome. Even to this day some speak of the darkest times of their internship as Hollywood fantasy, a psychological escape, quoting Band of Brothers as if we too were veterans of some unjust war for our soul.

I still think of my former comrades every day. I have survivor’s guilt. Part of my guilt extends to my insight that veterans of any description are not readily replaceable. For the first time in its history, the Irish health service is losing its Senior House Officers and Registrars en masse. The provision of healthcare in our country depends on the retention of this group of Resident Medical Officers. I’m reminded of...
the words that we share with those who understand that war leaves no participant innocent of injury. We are not a happy few, but we are a band of brothers, walking wounded, in unison together.

Recovery
Recovery is always the same. The addict is sick and tired of being sick and tired. The false confidence of the personal vacuum, the spiritual drought that addiction can breed takes its toll until there is no other alternative than recovery. They take that first childlike, fumbling, emotionally charged step, silently convinced that they are still unique, still bulletproof, still them.

For an alcoholic or someone suffering from depression, it might be as simple as attending their local community hall or counsellor, though this supposedly simple and initial logistical step evades many. On reflecting on my own depression, metaphorically and literally, I could not have travelled further from my own home or from my sense of myself. It was only at the ends of the earth that I could try again. It began with exploring the truth.

The truth was that our duties regularly extended to 70, 80 or 90 hours a week, and mine were mostly unpaid after 38. It’s fair to say I didn’t sleep, sick with worry that the last patient I reviewed prior to laying down, for 90 minutes in 36 hours, on tattered sheets in a non-ventilated Portakabin that functioned as my residence while on duty at night, would be sleeping altogether too well as a result of the bleary-eyed “treatment”, in its loosest sense, I had administered in a cognitive fog.

The rumination that if I worked in any half-decent restaurant with the same hours I’d earn twice as much with half as much stress came to me in the small hours. I didn’t address it.

Lunch is for wimps
One of the major contributing factors to how I felt, and the illogical, irrational and truly insane behaviour I exhibited during my internship, was a lack of nutrition. Caloric nutrition, social nutrition, spiritual nutrition. I didn’t get to eat or sleep. In fact, I didn’t eat anything that could be readily identified as an organised meal, never mind a balanced diet, for the initial three months of my time in that Dublin hospital, colloquially referred to at the time as boot camp.

Boot camp is busy. You eat when you’re told to eat. I wasn’t told to go to lunch, so I didn’t. Any biochemist will tell you that if you don’t eat you can’t nourish the most finely-tuned piece of biological engineering we have yet encountered in all our explorations of the universe. Nutrition is a characteristic of life, remove this from daily routine through stress or activity, depression or burnout, and you remove 1/7th of the scientific basis for life.

We practise medicine: we don’t just ‘do’ medicine. We have to get better at it or we stagnate clinically. With reduced financial income, more introverted anxiety, less sleep and spending what little free time I had ineffectively studying to improve my performance, you can see how my mind was a fertile breeding ground for the negativity, isolation and depression that would consume two full years of my young life. It did not make me a better doctor; it barely left me a person.

Despite all that the conditions of Internship took from me, it left me with a fellowship that I will carry with me throughout my life. Knowing that when I cannot carry myself, the memories of a shared coffee in the damp res, or silent tears in an October rain that accompanied a supportive hug on the steps of an emergency department, or the brushing of a hand against my shoulder while I picked up yet another pager to carry around my waist for a day and a night, sustains me. The brushing of that hand was simple human contact to remind me I still was one. I had forgotten.

Addressing burnout
If burnout is to be addressed it needs to be addressed individually and immediately on recognition. But how many of us really look beyond ourselves on a daily basis? Activism speaks of the fierce urgency of now, but beyond ourselves on a daily basis? Activism speaks of the fierce urgency of now, but activity requires energy and we are all tired. We are all burnt out.

In order to break this fatalistic cycle we must paradoxically do what seems so counter intuitive. We must be inactive to be active. We must let go, cease ruminating on our failures, celebrate our successes and practise mindfulness together. Minimise all that which we cannot affect and focus on the recurrent moment of the present tense in which we can. Above all, seek help when it is available; it almost always is in one form or another.

Dr Michael Daly is Honorary Senior Clinical Lecturer, Otago School of Medicine, Wellington, New Zealand.

HOW TO DEAL 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
■ 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, organise time for reflection with colleagues
■ Be open – say you’re feeling stressed.

The Medical Council has established a Health Sub-Committee which monitors and advises Council about the health of individual doctors who have relevant medical disabilities. This includes mental illness and addictions such as alcohol and drug dependence.

If you have concerns about your health or the health of a doctor you know please consider the following options:
■ Discuss with your family doctor
■ Discuss with an Occupational Health Physician
■ Make contact with the ICGP’s Doctors’ Health Programme www.icgp.ie/go/in_the_practice/doctors_health

MPS counselling service
MPS 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 MPS website at www.medicalprotection.org/ireland/counselling-service.
A day in the life of … an anaesthetist

Giving an anaesthetic is a bit like flying an aeroplane: the take-off (induction) and the landing (waking up) are the two periods of tension, with a bit of autopilot in-between, says Dr Lindi Snyman

Anaesthetists as a group are often considered to be ‘OCD’: particular, pedantic and precise. To our colleagues we are the ‘go to people,’ the specialists other physicians turn to when things are going wrong or a patient is very ill. To the public, our practice is a bit vague, not yet glamorised by the likes of House, ER, or Grey’s Anatomy. Yet on an average day, providing an anaesthetic service is a pleasing combination of patient interaction, delving a little into the unknown, and practising the art of medicine.

I don’t bother much with dressing up for work – part of the joy of being an anaesthetist is the thought of comfy scrubs and a hat to hide the hairdo. Combine that outfit with a stethoscope around the neck and a pen in the pocket and I have my armour donned to face the day ahead.

My day begins with the ritual drawing up of anaesthetic drugs and a mechanical check of the machines. This is followed by a careful perusal of the day’s list and a discussion with the consultant to put an anaesthetic plan in place for each of the patients.

Patients coming in on the day of surgery are visited on the day ward to discuss their health, their surgery and the planned anaesthetic. A lot of patients presenting for surgery have their first contact with an anaesthetist at this stage. While they are mentally prepared for the surgery, frequently they are frightened of the prospect of having an anaesthetic: of what happens when they are being ‘put to sleep,’ or else they’re afraid of not being put to sleep enough, or of feeling pain.

I spend a few minutes with each patient obtaining a pertinent history, performing a focused exam, and reading through the chart to glean important information ranging from previous anaesthetics and admissions to current blood results and investigations. All the while I’m building a rapport with the patients, calming their fears, explaining what we anaesthetists do and reassuring them that they will be well looked after and safe.

It’s back to theatre then and the list starts. Giving an anaesthetic is almost like flying an aeroplane: the take-off (induction) and the landing (waking up) are the two periods of tension, with a bit of autopilot in-between. The first patient arrives and gently drifts off to sleep as the ‘white stuff’ is injected. Although there is calm in the room, with just the rhythmic beating of the pulse oximeter in the background, everyone is on full alert.

Every surgery is different and every patient is unique, so although there is a ‘formula’ of what to do and when to do it, it is tweaked to suit each situation. The surgical period is dotted with periods of joking interaction between the staff, re-analysis of the anaesthesia and minor adjustments of drugs or fluid to accommodate what’s happening. As the surgery nears the end the surgeon looks up and questions the room: ‘Has the next patient been sent for?’

The preparation to wake the first patient begins as I start preparing for the arrival of the next one. The surgeon finishes the surgery and leaves the room. I wake the patient, transfer them to the care of the recovery nurses making sure that they are calm and comfortable, and return to the next patient in theatre.

Thereafter, the day could almost be copy, paste and repeat. The day is interspersed with visits to the recovery room to check on postoperative patients, visits to the ward to review patients planned for surgery, and doing preoperative visits for the next day.

Being an anaesthetist exposes you to a range of experiences, from performing an epidural for pain relief for a woman in labour, to the excitement and adrenaline rush that comes with being on the team of a patient receiving a heart transplant. There are repetitive days where it’s all about getting through the list: one case after yet another, and there are days where one case will take up to ten hours. There are days in ICU where you manage sick patients, and see them get better; or know that you’ve done your best if they don’t.

In Ireland, some of the larger hospitals offer intern rotations in anaesthesia. However, if you go through medical school and your internship year only interacting with anaesthetists when you ring them for a cannula, then there are many six-month SHO posts where you can be exposed to anaesthesia to decide if it is a career you wish to pursue. Any experience will stand you in good stead for the future, whether you choose anaesthesia as a career or not. Anaesthetists are enthusiastic teachers and the practical skills learnt will boost your confidence to deal with any clinical situation that you may encounter.

Dr Lindi Snyman is an Anaesthetic Registrar (SPR 1) at Letterkenny General Hospital.
A guide to working in General Practice

Choosing a specialty can be hard. Dr Shane McKeogh (MB BCh BAO MRCPI MICGP DCH) sheds some light on what it’s like to work in general practice

“I’m a male GP in my late 30s and I work as a principal GP in a medium-sized GP surgery in Rathfarnham, Dublin 14. I work with two other doctors, two nurses and three administrators. This is a medium sized GP surgery. The surgery is computerised, meaning all patient records are recorded in practice management software, referrals are done through the software, and incoming paper correspondence is scanned into the system.

An average day starts at 8.30am and I see 25-30 patients per day at 15 minute intervals, typically in two blocks (or “sessions” as GPs often call them), starting at 8.30am and 1.30pm. In between these blocks of patient-facing time is where a significant amount of time is spent doing paperwork. This typically comprises following up on paperwork from the last session (referrals to hospital OPDs, allied health professionals, etc), reporting on incoming blood results, reading and acting on incoming post, preparing repeat prescriptions for patients, as well as doing any house calls which may be necessary. I typically have a sandwich sitting at my desk doing paperwork.

What particular skills do you need? General practice is a very rewarding career choice, but it’s not for everyone. Some questions you could ask yourself to see whether this might be the career for you are:

Do you like people? You will meet the same people and members of the extended family again and again over years. This is an incredibly privileged position to be in, and whole families will put their trust in you as “their doctor” for the majority of their medical needs. They will come to you in times of medical need, either minor or major, and will follow your advice about their health. This allows you to build up a very important relationship with a patient and interpret illness not just from a physical point of view, but in the context of their psychological and social situation.

Can you deal with uncertainty? This is not as simple as it sounds. GPs are often the first point of call for a patient when they are unwell. A significant amount of the time, a symptom may be a manifestation of a trivial illness which will resolve spontaneously. However, it may also represent a more serious underlying problem. The patient is looking to you to make a decision about how to proceed. History and examination are the first line of any doctor’s assessment, but the timescale to get investigation results as a GP is much slower than our hospital colleagues. Blood tests and radiology investigations can take a week or more to return. Decision-making about when to investigate and when to use time as a tool to observe is a nuanced art that GPs develop over time.

Do you enjoy working independently? Although most practices are now group practices and have a team of doctors, nurses and admins, much of the working day is spent in a room face-to-face with patients as opposed to part of a hospital team on rounds in OPD. This can be a lonely experience for some, or rewarding for others as you are more reliant on your own abilities.

Do you enjoy being a business person as well as a doctor? In time, many GPs become principals in their surgery. This is not just the lead clinician but also the employer and “boss” of their team. This is both rewarding and stressful. You are responsible for payroll, paying suppliers, staff issues and conflicts among staff members. You are where the buck stops. Many find this a positive in their career but others find this a negative experience – many GPs will say that it is this element of practice that causes them the most headaches!

Would you value the ability to develop a career portfolio? A very attractive part of general practice is that you control your own working life. This means that you can choose to work out of hours if you wish, but it is not necessarily an inherent part of the job as most GPs are part of large co-operatives now which reduces their out of hours commitment to a minimum. It is quite possible to work part-time as a GP and part-time in another role, for example teaching, getting involved in leadership positions within the profession and, of course, spending time with one’s family.

Speaking personally, I’m delighted I chose medicine as a career and general practice as a specialty. If I got to go back and do it over again, I wouldn’t change a thing! The best of luck to you all no matter what career path you choose!”

PATHWAY TO GENERAL PRACTICE

- There are 14 general practice training programmes in Ireland, distributed country-wide.
- GP training is a four-year programme, with two years spent in relevant clinical attachments and two years spent as registrars in a GP practice. Training programmes also operate day release programmes.
- When a trainee successfully completes their training they are issued with a Certificate of Satisfactory Completion of Training. This certificate, along with passing the four modules of the MRCGP exam, allows a trainee to become a fully-qualified GP.
- The Irish College of General Practitioners (ICGP) is the body responsible for overseeing the professional development of GPs and is also the organisation through which applications to become a GP trainee are made. For more information see www.icgp.ie
Learning points

- Always maintain professional boundaries, which social networking can sometimes blur.
- Do not accept current or former patients as friends or followers.
- Exercise caution when accepting friend requests from colleagues.
- Use the most secure privacy settings on social networking sites where available – but remember that not all information can be protected on the web.
- Certain behaviours might affect your professional reputation, and possibly trigger an investigation by the regulator, for example irresponsible drinking. Certainly don’t publicise such behaviour online.
- You have a duty to maintain the standards expected of a healthcare professional.
Communicating with colleagues

Precise communication with the right degree of detail can make the difference between good patient care and an adverse event

Handovers on a busy night shift
Dr J is a busy SHO working on a medical night shift. He takes a call from an intern, 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. Dr A agrees that he will give a diuretic, perform a chest x-ray and take the bloods before transferring her to the acute assessment unit.

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.

A case of mistaken identity
Dr S is on duty in the children’s area in ED. She has just seen Jack, a two-year-old child with a high temperature. She 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 she needs the ED card to write her notes, and the child is in the cubicle opposite the nursing station (she points to it), “you cannot miss him”, she 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 her writing and approaches the cubicle to find out that there is now a different child sitting there – Alex. She 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. She 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; she 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 her consultant.
Putting members first in Ireland

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We put members first

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- You can turn to fellow professionals with unrivalled specialist medicolegal experience who provide confidential, individual, expert advice 24/7.
- MPS is an international organisation with members in over 40 countries and assets of £1.8 billion. You have the security of knowing that our whole ethos is about putting members first.
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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.

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