Good night and good luck

SURVIVING ON-CALLS

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Podcast with Sir Liam Donaldson
Working in a London hospice
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Welcome

We hope you enjoy our latest edition of New Doctor. Sadly for me this is my last issue as editor-in-chief, as I take on some different responsibilities at MPS. I have really enjoyed working with Sara Williams and the team, but it is time for me to hand over the reins.

We kick-off with an exclusive podcast from global patient safety champion, Sir Liam Donaldson. In the podcast he says that patient safety is every junior doctor’s responsibility.

Dr Leila Touil and Dr Yasmin Ahmed-Little echo Sir Liam’s sentiments in an inspirational piece about leadership, in which they call new doctors to become the leaders of tomorrow.

I strongly recommend that you read Dr Jonathan Bernstein’s Hot Topic on working in approved practice settings. This issue is still causing difficulties for junior doctors, as F2 doctors are often unaware that they need to notify the GMC when they successfully complete their year working in an approved practice setting. It is important that you read this article and follow his advice on what to do following successful completion of your foundation year two.

Our specialties of the issue are ophthalmology and palliative care. Dr Gwyn Williams recalls his first experience undertaking cataract surgery, and Dr Beatrice Baiden provides a snapshot of her placement working in a hospice.

Read on and we hope this is helpful in dealing with some of the challenges and opportunities that await you.
Patient safety is every junior doctor’s responsibility

In an exclusive podcast for MPS, the global patient safety champion Sir Liam Donaldson says that junior doctors hold a prime position on the frontline of healthcare delivery, so can prevent harm by being aware of the wider system of care around them.

Speaking at a recent RSM conference, the World Health Organisation’s Director-General’s envoy on patient safety said that care is inherently unsafe so it is not enough for junior doctors to be trained in the knowledge, skills and art of medicine. He called for junior doctors to understand the risks of the care they provide, and how they could inadvertently harm patients because of those risks.

He added: “Patient safety isn’t about criticising individual doctors or nurses, or the NHS; it is a worldwide problem, so there is an opportunity for junior doctors to play a part in solving it.

“We want the future to show systematic improvements in safety, saving lives, reducing harm, making error less common and, when it does happen, of much lower impact – junior doctors can be at the forefront of this.”

He ended stating that the future will be determined by how well junior doctors are engaged, educated, motivated and instilled with the passion to make healthcare safer.

During the 12 years that Sir Liam was Chief Medical Officer for England and the UK’s Chief Medical Adviser, he produced a series of reports and policy initiatives that shaped public health, NHS care and clinical practice. These included smoke-free public places, regulated stem cell research and the establishment of a health protection service.

PODCAST


Sir Liam’s podcast is one of a number of podcasts covering topical issues that are available for MPS members.

NEWS IN BRIEF

55 foundation doctors referred to GMC

The latest Foundation Programme Annual Report has been published. The statistics reveal that between 2010 and 2011, 30 F1 doctors (0.4%) and 25 F2 doctors (0.3%) were referred to the General Medical Council (GMC) for fitness to practise issues.

The report also reveals that:

■ the top three CCT specialties taken by F1s were general surgery (83%), general (internal) medicine (64%) and geriatric medicine (24%)

■ the top three CCT specialties undertaken by F2 doctors were general practice (42%), emergency medicine (41%), and general (internal) medicine (20%)

■ 59% of F1 doctors and 61% of F2 doctors are female.

■ 71% of F2s went on to specialty training/FTSTA in the UK.

To read the full report visit: www.foundationprogramme.nhs.uk.

GMC cuts annual fees

The GMC has cut fees for all doctors for the first time since 1970. From April 2012, the Annual Retention Fee will be cut from £420 to £390 for doctors holding registration with a license to practise, and from £145 to £140 for doctors holding registration without a license to practise.

Provisionally registered doctors will pay £95. For information visit: www.gmc-uk.org/news/11533.asp.

Junior doctors will lose most in pension reforms

Junior doctors will lose out most in the public sector pension reforms, says the BMA. According to the medical union, a 25-year-old junior doctor who goes on to follow a consultant career path could pay £240,000 in additional lifetime contributions over the current scheme and work eight years more, until the age of 68, to receive a full pension. Their annual pension is likely to be slightly higher, at around £70,000, but it will be based on career average earnings rather than final salary and received for fewer years, giving them less over the course of an average retirement. Overall, a 25-year-old junior could be paying 2.25 times more in to the scheme to get around 16.5% less out of it. For more information visit – www.bma.org.uk/nhs/pensionreform or www.youtube.com/watch?v=C5kqAt1C9s.
HOT topic

Approved practice settings

MPS Medicolegal Adviser Dr Jonathan Bernstein highlights the consequences of not notifying the GMC when you finish your F2

It is an inevitable part of being a doctor that your opinion will be sought on medical matters outside professional practice settings, e.g., with friends at dinner parties. While obvious issues arise from these encounters, such as record keeping, treating relatives and informing their GP, for foundation doctors, there are wider issues that throw up more immediate concerns.

Most F1 doctors recognise that their status as “provisionally” registered doctors restricts their ability to practise and prescribe medicines, but F2 doctors, some international medical graduates (IMG) and doctors returning to medicine after a career break, are also prohibited from working as doctors outside “approved practice settings”.

An approved practice setting, which includes primary and secondary care training centres, must satisfy the GMC that they have:
- appraisal systems
- systems for clinical governance
- risk management policies
- supervision arrangements
- procedures to identify and act on performance concerns
- procedures to act on and learn from complaints
- procedures to ensure that medical practice is non-discriminatory
- procedures to ensure and facilitate conformity with the GMC’s guidance in Good Medical Practice.

On successful completion of the F1 year, F2 doctors (IMGs, etc) who are now fully registered, are still required to practise in approved practice settings. When a doctor completes F1, from the doctor’s perspective, there is an automatic process by which the GMC is informed of their successful completion of that year and they are awarded full registration on the medical register. For doctors completing F2 it is slightly different, as the GMC requires notification that they have successfully completed the year in an approved practice setting – there is no automatic process. The onus is on the doctor and this can be done electronically through the GMC website.

Although this regulation came into force in 2007, most doctors are still unaware of this requirement. MPS has assisted doctors who issued private prescriptions believing that they were permitted to do so as they were well beyond their F2 year. However, they were reported to the GMC by the pharmacists processing the prescriptions because when they checked the doctors’ registration on the GMC website they found that the record indicated that the doctors could only prescribe in approved practice settings.

For most doctors this issue is likely to arise once they qualify as GPs or hospital specialists and start to prescribe outside approved practice settings for the first time. Avoid the stress and trauma of a GMC investigation. Notify the GMC when you successfully complete your F2 year, or you could get bitten later on.

<table>
<thead>
<tr>
<th>Event</th>
<th>When</th>
<th>Where</th>
<th>What</th>
<th>Useful links</th>
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<tbody>
<tr>
<td>MPS Communication Skills workshops</td>
<td>Throughout the year</td>
<td>Across the UK</td>
<td>Mix with other specialties and lower your risk at MPS’s popular communication skills workshops</td>
<td><a href="http://www.mps.org.uk/workshops">www.mps.org.uk/workshops</a></td>
</tr>
<tr>
<td>National Conference for Aspiring Surgeons</td>
<td>24/3/12</td>
<td>University of Bristol</td>
<td>There will be opportunities for discussion with consultant surgeons and the Royal College about a career in surgery</td>
<td><a href="http://scrubs.org.uk/conference.html">http://scrubs.org.uk/conference.html</a></td>
</tr>
<tr>
<td>World Extreme Medicine Conference</td>
<td>15-18/4/12</td>
<td>London</td>
<td>This conference aims to deliver knowledge, insight and innovation in the field of remote medicine and its sub-disciplines, such as expedition and wilderness, pre-hospital and disaster relief</td>
<td><a href="http://www.extrememedicineexpo.com">www.extrememedicineexpo.com</a></td>
</tr>
<tr>
<td>Medicine and the Media (MWF Spring meeting)</td>
<td>1/5/12</td>
<td>Colchester</td>
<td>The conference aims to enable doctors to better understand how they can interact with the public through the media and its various forms</td>
<td><a href="http://www.medicalwomensofengland.org.uk">www.medicalwomensofengland.org.uk</a></td>
</tr>
<tr>
<td>Foundation Programme Sharing Event</td>
<td>13/6/12</td>
<td>London</td>
<td>This is a great opportunity for foundation doctors to present and share experiences of good practice</td>
<td><a href="http://www.nact.org.uk/educational_meetings/foundation_programme_events">www.nact.org.uk/educational_meetings/foundation_programme_events</a></td>
</tr>
</tbody>
</table>
Collateral damage

Collateral damage is damage to people or property that is unintended or incidental to the intended outcome; in new doctor terms it could be the unintended harm to a patient, or poor communication that leads to a complaint. The collateral damage around such factors can be mitigated the sooner advice is sought.

We all worry about making mistakes, harming patients, disagreeing with our consultants or being summoned to the GMC – these are not part of the routine curriculum taught in medical school. It is reassuring to know that when things do go wrong during our foundation years, MPS can be a valuable source of support, while also providing advice and educational material to prevent medicolegal problems later on.

Why call MPS?
In 2010 and 2011 MPS’s medicolegal helpline received 820 calls from foundation doctors. Figure 1 reveals the top calls that were received, excluding general advice (273 calls). The most common queries will now be discussed followed by advice on how to handle them.

Inquests and fatal accident inquiries
One in five calls to MPS from foundation doctors was to receive advice on inquests or fatal accident inquiries.

A case will be referred to a coroner in certain circumstances, eg, when a patient may have died from a medical intervention or the cause of death is unknown. A coroner will also make inquiries about when the death of a patient occurs within 24 hours of a hospital admission or a surgical procedure. You must assist the coroner with their investigation, the purpose of which is a fact finding exercise to determine who died, when, where, and how and in what circumstances.

MPS can support by advising on draft reports, which could also later be reviewed by an appointed educational/clinical supervisor. As foundation doctors will be looking after NHS patients, the legal services department of your trust will be able to provide legal advice and support and, if appropriate, will assist you at the inquest or fatal accident inquiry. However, if there is a conflict of interest between a foundation doctor and the trust, MPS may assist by providing legal representation.

Complaints
The second most common call relates to complaints. Receiving a complaint from a patient or family member is stressful, particularly for a new doctor, who lacks experience in dealing with them. As a foundation doctor, the most effective way to deal with a complaint is to acknowledge it, and direct the patient or relative to PALS (Patient Advice and Liaison Services).

The next step is to discuss the complaint with your educational supervisor. It is worth making your own personal notes, in case you need to refer back to them at a later stage. Foundation doctors may be asked to provide a statement of their involvement with a patient, when a trust is investigating a complaint.

MPS can address any concerns you have regarding a complaint and can advise on your statement before you submit it to the trust.

GMC
The thought of being investigated by the GMC so early in your career is frightening, but it does occasionally happen. Figure 1 reveals that many foundation doctors call MPS regarding their fitness to practise, eg, medical

The sooner you call MPS about an ethical or legal dilemma, the sooner the matter can be resolved. Professor Carol Seymour, Dr Tom Mosedale, Dr Richard Brittain and Sara Williams explore how and why foundation doctors get into trouble

<table>
<thead>
<tr>
<th>Figure 1 – Main reason for call</th>
<th>Total calls 2010/11</th>
<th>% of calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inquest/fatal accident inquiry</td>
<td>106</td>
<td>19.4%</td>
</tr>
<tr>
<td>Complaint</td>
<td>70</td>
<td>12.8%</td>
</tr>
<tr>
<td>GMC</td>
<td>60</td>
<td>10.9%</td>
</tr>
<tr>
<td>Writing a report</td>
<td>51</td>
<td>9.3%</td>
</tr>
<tr>
<td>Employment matter</td>
<td>49</td>
<td>8.9%</td>
</tr>
<tr>
<td>Adverse incident report</td>
<td>37</td>
<td>6.8%</td>
</tr>
<tr>
<td>Disciplinary matter/NCAS</td>
<td>29</td>
<td>5.3%</td>
</tr>
<tr>
<td>Criminal investigation into member’s actions</td>
<td>26</td>
<td>4.8%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>24</td>
<td>4.4%</td>
</tr>
<tr>
<td>Clinical judgment</td>
<td>23</td>
<td>4.2%</td>
</tr>
<tr>
<td>Membership enquiry</td>
<td>18</td>
<td>3.3%</td>
</tr>
<tr>
<td>Hospital inquiry</td>
<td>15</td>
<td>2.7%</td>
</tr>
<tr>
<td>Consent</td>
<td>14</td>
<td>2.6%</td>
</tr>
<tr>
<td>Disclosure/access to clinical records</td>
<td>13</td>
<td>2.4%</td>
</tr>
<tr>
<td>Ethics</td>
<td>8</td>
<td>1.5%</td>
</tr>
<tr>
<td>Claim for compensation</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Business matter/fees</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total</td>
<td>532</td>
<td>100%</td>
</tr>
</tbody>
</table>
council and disciplinary matters and criminal investigations.

The GMC will investigate a doctor’s fitness to practise if there are concerns about professional misconduct, poor performance, criminal convictions (or caution), or physical/mental ill health. Outcomes of such investigations may include no further action, a warning, practice restrictions, suspension, or erasure from the medical register.

MPS often takes calls from foundation doctors after the GMC has alerted them that they are under investigation. In many cases this is because they have failed to report a caution or a conviction, eg, driving or alcohol related offences. Any conviction or caution must be reported to the GMC without delay. For more information read A Guide for Doctors Reported to the GMC – www.gmc-uk.org/A_guide_for_doctors_referred_to_the_GMC.pdf_28163655.pdf.

Writing reports
One in ten calls was about writing reports. An adverse incident can be investigated in many different ways – your written report may be the starting point of an investigation into the circumstances leading to or surrounding an incident. Above all else your report should be based on your recollection of events, the medical records and your usual practice. Read a factsheet on writing reports here – www.medicalprotection.org/uk/uk-factsheets/report-writing.

Employment and training issues
Advice on what to do after a dispute arises in the workplace is a common reason why foundation doctors contact MPS. These include disputes over contracts, salary and banding. Detailed advice regarding this is outside the scope of the benefits of MPS membership, except if it is referred by a fitness to practise committee. The BMA is the best source of support regarding these issues. Visit: www.bma.org.uk/employmentandcontracts/employmentcontracts/junior_doctors/bmacontractcheckingservice.jsp.

Confidentiality
Many doctors contact MPS for advice around confidentiality, eg, raising concerns about a patient, whistleblowing, etc. MPS can advise on medicolegal issues, but cannot give clinical advice. The MPS website has a wealth of factsheets on common medicolegal issues and concepts – www.medicalprotection.org/uk/uk-factsheets.

Summary
Doctors in their foundation years will confront difficulties and it is reassuring that organisations exist to provide support and expert advice.

REFERENCE
1 The headline refers to the 2002 action film Collateral Damage. This is not a bona fide medicolegal term.

Dr J is midway through his foundation year two placement working in general practice. The practice is small and there is only one GP principal Dr M, who is also the F2 supervisor.

One morning Dr J sees Mr Z, a 50-year-old patient with back problems; he requires referral to an orthopaedic specialist. Mr Z tells Dr J that he takes a lot of codeine. Dr J is concerned that Mr Z is in danger of becoming dependent on it; she tries to persuade him to take paracetamol instead. Mr Z refuses and says he won’t take paracetamol because 30 years ago he had a massive overdose. Dr J explores Mr Z’s medical records, but there is no evidence of the overdose.

Midway through the consultation, Dr M pops his head round the door to advise on the referral. When he leaves, Mr Z asks Dr J not to document the paracetamol overdose, or to discuss the management of his case with Dr M. Dr J responds by stating that the GMC requires her to write notes of all relevant factors, and this is relevant. She also states that she is working under supervision and will need input from Dr M.

Mr Z gets aggressive and intimidates Dr J into not recording the historical overdose. The consultation ends on a bad note as Mr Z storms out. Dr J contacts MPS for medicolegal advice on the situation.

MPS ADVICE
By Dr Angelique Mastihi

Situations such as these can be very difficult, particularly as a junior doctor. Unfortunately, patients do on occasions provide information to doctors, which they then ask is not recorded. Dr J’s initial stance was the correct one; it is not possible to ignore information. Any relevant information that the patient provides during the consultation should be recorded contemporaneously. See GMC, Good Medical Practice, paragraph 3(f).

The practice may wish to consider how it publicises the fact that some of the doctors are in training and therefore may need to discuss patient care with the supervising doctor. If a patient makes it clear that they are not happy for their medical information to be shared within the wider team, the doctor must consider whether that disclosure is essential for the provision of safe care. See GMC, Confidentiality, paragraph 27.
Follow the leader

Dr Leila Touil and Dr Yasmin Ahmed-Little call all junior doctors to rise to the leadership challenge. Here they show you how

What is leadership?

Leadership is about creating a vision; engaging others, and motivating them to be part of it. It is a dynamic process, even more so in a diverse environment such as the NHS.

The hallmark of good leadership is accountability and self-awareness. Other qualities of a successful leader include the ability to listen to, motivate and inspire people.

Why is leadership so important?

Lord Darzi said that strengthening leadership across the NHS is vital for the future. His Next Stage Review established a shared vision of an NHS with quality of care at its heart; clinical leadership is an essential ingredient of this success. Building on Lord Darzi’s work, the NHS White Paper Equity and Excellence: Liberating the NHS sets out the government’s long-term vision for the future of a more patient-centred NHS; in which patients are at the heart of care at its heart; clinical leadership and management is so important.

In the workplace

By getting involved in sustainable and meaningful projects, we can improve the health service not just for those that use it, but also for those who work within it. There are a number of ways to develop your leadership style during each rotation:

- Shadow seniors to identify effective styles and behaviours
- Attend a management or directorate meeting to get a better understanding of your workplace
- Join local committees, eg, Local Negotiating Committee
- Seek opportunities to undertake additional leadership activities in your department, eg, improving the handover system.

Also, always be on the lookout for local sources of funding to support bigger ideas. Many regions now run Dragons Den style events to help allocate resources to junior doctors with a good idea for quality improvement.

Don’t be shy in approaching suitable individuals as potential mentors. If you have significant experience, why not train to be a mentor to someone else? The NW Mentoring Scheme has supported many junior doctors to do just that (www.nwmentoring.nhs.uk).

If you do have an idea about implementing change that has been realised in your workplace – shout about it. One good way is to share your idea across the NHS as a case study. Visit – www.forum.the-network.org.uk/index.php?page=projects.

Networking

Joining a network of like-minded enthusiastic leaders of tomorrow can take your projects to the next level. Joining networks of other junior doctors will keep you up-to-date with what is happening in the world of leadership and management, and will enable you to make contact with inspiring clinicians.

Examples of a few such networks are listed below:

- Emerging Clinical Leaders Network – http://ecln.co.uk
- The Network – www.the-network.org.uk
- Faculty of Medical Leadership and Management – www.fmlm.ac.uk

Regionally

The North Western Deanery is an example of a deanery that has developed many opportunities for junior clinicians to engage in NHS leadership and management. See – www.nwpgmd.nhs.uk/medical-leadership.

Another example is the North West Medical Leadership School (www.nwpgmd.nhs.uk/content/north-west-medical-leadership-school), which hosts regular evening events that bring junior doctors together to network and meet senior leaders from the system. The ‘Buddy Scheme’ is the first to bring together junior managerial and clinical leaders and build better relationships for the future.

References

1. DH, Equity and Excellence: Liberating the NHS, HMSO (2010)

Dr Touil is a core surgical trainee in plastic surgery in the North Western Deanery and Dr Ahmed-Little is a specialist registrar in public health in the Mersey Deanery.
Explore what is going on in your region. If schemes do not exist set up your own network or scheme.7

Nationally
Apply for a Fellowship. The NHS has a National Leadership Council with a specific work stream focusing on emerging leadership within the NHS. See – www.nhsleadership.org/workstreams-emerging.asp

Other national programmes include the NHS Medical Directors’ Clinical Fellows Scheme. See – www.fmlm.ac.uk/about-us/clinical-fellows-scheme. Junior clinicians have also published reflections from their experiences on such programmes.6

Develop a ‘leadership style’
There are many leadership styles – these are influenced by our personal attributes and the experiences that make us unique. Effective leadership styles are best developed by engaging in leadership experiences in the workplace.

The ‘visionary model’ of leadership suggests that a leader can be influential by creating a vision with which others can identify and by inspiring and motivating them. The ‘traits theory’ identifies personality traits associated with successful leadership, such as intelligence, whereas the ‘situational approach’ proposes that no single style of leadership is appropriate to all situations. Situation and context certainly influence the effectiveness of leadership styles in the NHS.9

In day-to-day management people generally prefer a relaxed democratic leadership style. However, during times of crisis staff may prefer strong, authoritarian leadership.

Explore opportunities and look for situations where you can practise different styles and evaluate your leadership style by completing a self assessment questionnaire, such as Myers Briggs.10

Leadership challenges
Culture
Leadership training does not rank highly on the medical training agenda; as a result there is a lack of education about the organisational structures of hospitals, trusts, practices and the NHS as a whole. The mindset among junior doctors is often that “it doesn’t apply to me”. However, at some point in our careers we may be responsible for the budget and resources in our directorate.

In an organisation that traditionally has a hierarchical leadership structure, as junior doctors it can be difficult to challenge the day-to-day activities in our departments. Most doctors in training never meet their chief executive, let alone contribute to change initiatives. The challenge for the future is to recognise how junior doctors can lead as part of a multi-disciplinary team.

Change
The ability to adapt positively to a changing role, organisation and environment, is crucial to becoming effective leaders of the NHS. We need to equip ourselves with the tools to respond to future challenges and change, to recognise what kind of leaders the NHS needs now and in the future and what qualities we need to develop.

Service commitments
It is difficult to deliver improvements for the future at the same time as managing today’s services with all their pressures and demands. Systems do not simply stop to allow change to take place; therefore developing leadership skills needs to be incorporated into our training. The short rotational nature of our posts also makes it difficult to see change initiatives through to completion. However, we could use this to our advantage and share our experiences of successful initiatives across trusts.

Rise to the challenge
Junior doctors are the future of the NHS. It is therefore essential that the natural leadership qualities we all possess are developed to equip us with the essential skills to be proactive in changing the way our NHS is run. Are you willing to rise to the leadership challenge?
Ask any final year medical student about their biggest worry about becoming a doctor and they will answer “on-calls”. Here is the advice we wish we’d had when we started doing on-calls.

Seek senior support

The main worry about on-calls is being responsible for someone dying or becoming really unwell. The truth is, yes there are sick people in hospital, and yes, you will have to see them – but the important point is that you are not the only doctor in the hospital. Senior doctors are there for advice – be proactive in seeking it.

Assessing sick people

After reading a patient’s history consider:

■ Why are they in hospital?
■ What has happened to them since they have been in hospital?
■ Have they got a significant past medical history?
■ What investigations could rule in/out

If you’re still unsure after doing this, whomever you handover to will appreciate that you have done appropriate investigations.

Use time efficiently

If you are called to the wards to write up fluids call the ward first and ask them to get the fluid chart, so it is ready when you get there. It is a good idea to try and persuade the ward to get together any other jobs that need doing so you can do them in one batch.

Discussing patients with their family

This can be difficult if you don’t know the patient. Have a look through the patient’s notes and talk to the nurse to find out more. If you still do not feel like you are in a position to answer these questions, do not feel pressurised to do so. This is often best left to the day team who know the patient.

What to expect on-call

In January 2010, we audited the jobs medical or surgical F1 doctors were asked to do on-call in Torbay Hospital. The total jobs are shown in the table below.

During the week in Torbay Hospital, there is:

■ one medical F1 (5pm – 11.30 pm)
■ one surgical F1 (5pm – 10.30 pm)

At the weekend there are:

■ three medical F1s who work different shifts 9am – 5pm, 10am – 10pm, 11.30am – 11.30 pm
■ two surgical F1s who do 9am – 6pm, 3.30pm – 10.30 pm.

Advice on most common on-call jobs

Reviewing bloods

The majority of F1s’ on-call time is spent reviewing blood tests. The majority of these are required at the weekend as practitioners need daily reviews of common things, like U&Es, HB and inflammatory markers.

Prescribing fluids

Prescribing fluids is a very common job. This is mostly maintenance fluid for people with insufficient oral intake to match their needs. Always check the patient’s renal function before prescribing fluids, in particular their sodium and potassium. Before speed up fluids, or giving fluid challenges for patients who are becoming unwell, remember to assess their fluid balance and past medical history. Fluid overloading a patient can be just as dangerous as leaving them dehydrated.

Prescribing meds

Often this is night sedation, eg, zopiclone, changing from IV to oral antibiotics, or prescribing a new patient’s regular medication. Whatever the reason, make sure you know the medication and why you are prescribing it. If in doubt ask. Do not prescribe just because a nurse tells you to. Be particularly careful when prescribing sedating drugs to elderly and confused patients. Contrary to what people may tell you, diazepam is not always the answer.

Reviewing scans

This means reviewing chest x-rays and looking for consolidation or fluid overload. Other common investigations include ECGs, abdominal films (especially if you’re a surgical F1) and bone x-rays. If you are unsure, ask a senior colleague. Also, be sure to check that the name on the scan matches that on the patient’s wrist bands.

Prescribing warfarin

There is no need to check a patient’s INR four or five times a week if it is stable.
Take care in prescribing warfarin if it could be affected by antibiotics and other medications.

**Acute reviews**

Take your time when reviewing someone who is becoming unwell. Use stepwise approaches like ABC for airway, breathing, circulation and remember to call for help if you need it. You are not expected to look after every sick, dying patient in the hospital on your own!

**Reviewing medications**

Rewriting drug charts is the most unpopular F1 job at our hospital. This is a job that should be done by the day team; it is not fair to ask an on-call doctor to do this. Similarly, completing discharge summaries should not be the role of an on-call doctor.

**Reviewing patients for discharge**

There should be a clear plan in the notes on the criteria the patient must meet before discharge. If you are unsure, do not send the patient home; review the patient and discuss with a senior.

**Helping colleagues on-call**

You are part of a team: here are some things to think about:

- Make sure drug charts have plenty of space for overnight or over the weekend; rewrite them yourself if they don’t.
- If you want a patient reviewed over the weekend, write a clear plan in the notes. Be precise. A clear instruction like “if haemoglobin less than 7, transfuse 3 units and re-check tomorrow” is easier to follow than “if hb low, give blood”.
- Try to order fewer bloods over the weekend so there are fewer results to be checked.
- Do your routine bloods earlier in the day, so you will get the results sooner.
- Ensure fluids are prescribed for overnight so a doctor isn’t called to the ward to write-up maintenance fluids.
- Have a ward round with your nursing staff before you go. Make sure they haven’t got any issues or questions; if they don’t ask you now, they’ll phone an on-call doctor who, again, will not know the patient.

**A final word**

Being on-call will be intimidating as you will face unfamiliar situations that you have not been trained to deal with. Just remember to take your time, assess the situation and see what you can do. Remember to call for senior support early if you think a patient is deteriorating. Use your on-call time to become familiar with new topics and shadow your seniors. Treat it as a unique learning opportunity that could boost your CV by providing interesting topics for CBDs and mini-CEXs. You will soon realise that you learn more on-call than at any other time.

Good night and good luck!

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**My first on-call**

**By Dr Kyle Stewart**

When I did my first on-call, I remember picking up the on-call phone, and being petrified when it went off immediately. A post-op patient had become drowsy on one of the surgical wards. I ran to the ward, *Oxford Handbook* at the ready, racking my brain to remember the causes of drowsiness. When I got there the patient had her eyes closed. As I ran over, my heart was pounding. When I got to her bed I shook her and shouted across the bay “Can I have some assistance, please?” As I frantically searched for anyone, I turned back to the patient, who was wide awake and staring up at me. “Is everything alright dear?” she calmly asked, as two nurses flew over to the bay. They had seen me grab the poor 92-year-old, who was recovering from hip surgery. It turned out she was tired from her surgery and wanted a nap. That day I learnt that when people are asleep they are unresponsive unless you wake them up! Always remember to think of common things first and be systematic in your approach. You will be able to think much clearer when you aren’t panicking.

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**Being on-call will be intimidating as you will face unfamiliar situations that you have not been trained to deal with**

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**Dr Wootthipoon** (top) is an F2 in elderly care and **Dr Stewart** is an academic F2 in gastroenterology at Torbay Hospital in Devon. Thanks to acute care consultant **Dr Nigel Benjamin** for his help with this feature.
No one forgets their first phacoemulsification

ST3 Ophthalmology trainee Dr Gwyn Williams remembers when he first performed cataract surgery

N o-one ever forgets their first experience of driving a car. The memory of my 17th birthday is dominated by the build up and subsequent hideous disappointment of going for my first driving lesson with my father. I was studying A-levels in the main science subjects at the time, and I naively assumed that if the basic scientific principles of operating a motor vehicle were known, then learning the practicalities would be a piece of cake.

“Stop, stop – STOP” my father shouted. “The starter motor will burn out if you keep the key turned for so long” – the day had not gone well. Having stalled 13 times over the first hour it dawned on me that driving was as much an art as a science, and I was at the foot of a long learning curve. To this day I still recall with a shudder the feeling of helplessly being carried along the road by a ton of metal, with only a rudimentary knowledge of how to guide the untamed beast away from pedestrians, cyclists and other cars.

Although that indescribable feeling receded into my unconscious mind, it was unexpectedly pushed to the fore again when I started learning cataract surgery. Learning how to perform modern cataract surgery, where the cataract is destroyed and extracted in a process termed phacoemulsification, has been a long and difficult learning curve. I suspect this is the closest a surgeon will ever come to operating a one-man band.

During the operation the right hand holds the main instrument, the phacoemulsification probe; with the left controlling the vital second instrument, the job of which is to break apart the cataract in a way that allows successful extraction. The left foot controls the microscope with movements forward and to the side affecting zoom and focus. The right foot is akin to the accelerator on a car. By moving the foot forward or back the destructive power of the phacoemulsification probe is altered; turning the foot right or left alters the amount of suction pulling fragments out of the eye.

The progress of the operation is viewed by both eyes through the operating microscope – binocular vision is essential in judging the depth of the various structures seen. Lastly, the machine running the probe is tuned in such a way as to emit sounds of various tone and pitch, dependent on how much power is being used, the degree of obstruction of the probe tip and the amount of suction being used.

Ophthalmic trainees are prepared in various ways, before being let loose with all this technology on the eye of an unsuspecting patient. I attended the compulsory basic microsurgical skills course run by the college, in which trainees are taught through lectures and tutorials the science behind the operation. Vector forces are explained, as are the merits of the various settings on the phacoemulsification machine. All very straightforward I thought to myself, as I descended the stairs to the practical session involving real instruments and plastic eyes, held in the basement.
Having seen real cataract surgery performed by experienced consultant colleagues prior to doing the course, it all fitted together nicely. A harmony of man and machine, in which the very latest technology was gently guided by the human operator using common sense scientific principles, with the aim of restoring sight to those afflicted by cataract. As easy as learning to ride a bike, or perhaps driving a car.

After attending the course I spent several months learning easy steps in the operation, those that did not require much adjustment of focus, or any use of the phacoemulsification probe, and my belief that I’d soon be as good a cataract surgeon as my seniors was utterly undiminished. Chomping at the bit for more action, the day finally came when I could use the probe for the first time and be a proper phaco surgeon.

Having inserted the probe into the eye I gently touched the cataract and pushed the right pedal forward with my foot. “No no no” my consultant grimaced. “Push deeper, but hold on… that’s too fast, slow down.” I hadn’t expected the experience of using the pedal and probe to be so difficult. Judging how far to press or depress the pedal, interpreting the sounds and analysing the movement of the cataract through the microscope, were all superficially simple things to do, but together, the task seemed Himalayan. Coupled with all this I had always assumed my motor skills were smooth and well controlled, but under the uncompromising magnified glare of the microscope and beamed for all to see on a screen on the theatre wall, my movements seemed jerky and tremulous.

My first attempt at phacoemulsification was brought to a swift conclusion when the consultant asked me to remove the probe as he was worried my experimental forays were stressing the zonules – the supporting ligaments of the crystalline lens. I cannot remember if I managed to hide my crushing disappointment, but what I do remember most vividly about that first attempt at phacoemulsification was the return of that feeling of being powerless in the face of dangerous technology first experienced on my 17th birthday.

Over time my skill has improved, much the same way as I was eventually able to drive to school and back without ending up in a hedge. It is said that advancing technology will at some point make the surgeon either redundant, or at the very least reduce his role to that of a mere technician operating machinery to achieve their surgical aim – I disagree. With expanding technological horizons fine touch, eyesight and hearing are more important than ever to the surgeon, with an ability to assimilate all three to form a concerted plan of action the most precious skill of all.

Dr Williams works at Singleton Hospital in Swansea.
A week in the life of... an F2 working in a hospice

Dr Beatrice Baiden shares her experiences of working in palliative care

“Isn’t palliative care simply a case of morphine and a good pillow?” asked a surgical SHO when I shared my interest in the specialty. Fortunately health professionals do not generally hold this view; palliative medicine is increasingly being recognised as a fascinating blend of patient-centred care, pharmacology and end-stage disease management. It is receiving increasing recognition, reflected by the well-defined career structure and increasing competition for training posts. Recent developments have seen the realisation of Dame Cicely Saunders’ revolutionary vision, with end-of-life care pathways being integrated into most major clinical specialties.

In my medical undergraduate curriculum this field was covered in a fleeting one-day slot in our three-year timetable. After the recognition that I could not base my career choice on eight hours’ worth of experience I arranged to spend time at St Joseph’s Hospice, a 100-year-old hospice in the heart of London’s East End.

**MONDAY**

9am – The day begins with a handover followed by a ward round. The first patient is hyponatraemic and mildly confused, which may be attributable to his malignancy. The consultant explains the importance of looking for and treating reversible causes of any new symptoms. We spend ample time with each patient; this is far removed from the “blink-and-it’s-over” surgical ward rounds I’m used to.

2pm – I clerk in a Buddhist HIV patient, who has been admitted for a blood transfusion. He has an extensive past medical history that includes sclerosing peritonitis, a side effect of his anti-retroviral medication that causes recurrent sub-acute bowel obstruction. I’m amazed at the number of pathologies he has and the strong stoical spirit in which he deals with them.

3pm – I attend an MDT meeting in the truest sense – the board includes a chaplain, social worker manager-come-counsellor, physiotherapist, occupational therapist, speech and language therapists, complementary medicine therapists, specialist nurses, staff nurses and doctors.

4pm – I tour the various departments, the beautiful chapel and an area called Finding Space, which is open for community events. This area serves as a welcoming space for activities, such as yoga, civil ceremonies and local charity group gatherings. This reflects the contemporary trajectory of the hospice and encourages the public to associate the hospice with tranquillity and social activity.

**TUESDAY**

10am – I meet with my supervising consultant. This is my chance to ask her a myriad of questions about training schemes and further educational opportunities. She offers extremely useful insights from her personal career progression.

11am – I attend an MDT with the Tower Hamlets Community team. Patients seen on specialist nurse home visits are discussed by the panel. This offers a chance to consider the complex medical and social needs of patients. The team have a thorough awareness of what is going on in their patients’ lives, not only from a medical perspective, but psychologically and, to some degree, emotionally. Attempts are made to broadly consider the wider aspects of their end-of-life experience and how it would affect the patients. One such case involves a gentleman estranged from his sister, who is known to the team, and how the two might be reconciled.

1pm – I undertake home visits with a specialist nurse. Some patients prefer their home environment and therefore decline hospice admission. One patient is keen to avoid the hospice as he feels it is overly inhabited by nuns. The specialist nurse explains that the St Joseph’s team often have to prevail against common misconceptions; he is admitted.

3pm – We assess another patient and bring her in for respite care. She has a UTI and her daughter needs rest from her demanding role as the full-time carer. Respite care has a dual purpose of giving palliative patients a change of environment and their full-time carers time to recuperate.

**WEDNESDAY**

9am – A GP with a special interest in palliative medicine introduces local medical students to the hospice and gives a “how-to” guide on prescribing anti-emetics. A forum called “Gold-fish bowl” provides space for a man who is enduring end-stage emphysema to reflect on his experiences with the student audience. He enthusiastically shares intimate final realisations with the group of near-doctors. A palliative registrant then presents a retrospective cohort study on the controversial use of B-blockers in end-stage emphysema. A specialist nurse rounds off the day with a presentation on managing epilepsy in patients with brain tumours.

**THE HIGHS AND LOWS**

**Highs**
- Friendly patients and staff
- Talking through practical career options in palliative medicine
- Seeing a different side to the patient experience by doing home visits
- Interesting teaching sessions

**Lows**
- Shadowing ward doctors
- Unfamiliar environment.
Thursday

10am – I attend teaching by Parkinson’s UK, the research and support charity. The emphasis is on accurate diagnosis, medications to be given and avoided, and simple ways to help patients. After this session I visit the day hospice, which is reminiscent of creative clubs I attended at school. The patients here have access to alternative therapies and are encouraged to collectively exhaust their creative energies in music, pottery and painting.

2pm – I have an impromptu shadowing session of the ward doctors. We admit a gentleman with recurrent ascites secondary to hepatocellular carcinoma for therapeutic abdominal paracentesis. The palliative registrar demonstrates the technique and emphasises the importance of clamping every two hours and taking blood pressure readings, to exclude hypovolaemia secondary to huge fluid shifts, before continuing ascitic drainage. It is a very simple procedure that immediately reduces his pain and discomfort.

4pm – I had meetings with the chaplain and the social worker manager. Interestingly, there was tremendous overlap between their respective roles. Both of them were very involved in counselling patients and their relatives.

Friday

10am – We see two new home referrals with the specialist nurse.

3pm – I spend my last afternoon shadowing the ward doctors. I observe them handle a patient during an acute episode of paranoid schizophrenia, which is complicating his terminal illness.

5pm – I end the placement on a high and mull over how fantastic it was, as it transported my clinical inclinations to definite career aspirations.

When arranging a work placement:

1) Schedule in time to discuss career options with your supervisor.
2) Use your supervisor’s time efficiently by preparing questions beforehand.
3) Arrange an on-call shift with your team.
4) Find a unit with teaching sessions.
5) Avoid packing your timetable full of activities. Some of the most interesting things you’ll see could be while you are roaming the wards during your placement.
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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

What our members say about our service:

96% of members said they would be likely or very likely to recommend MPS to their colleagues.

92% scored good, very good or excellent for the service they received from our medicolegal advisers.

94% scored good, very good or excellent for the service they received from our membership team.

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