HIT THE GROUND RUNNING

GET YOUR FOUNDATION YEAR OFF TO A FLYING START

Welcome to your FYi

WELCOME TO THE FIRST EDITION of *FYi* – a journal that we hope will become a useful source of information as you progress through your foundation training programme.

Starting your medical career can be an exciting but daunting experience. In *FYi* the MDDUS brings together a number of organisations and professionals to offer some insight on issues of concern to junior doctors in Scotland and beyond.

In this issue we focus on getting started on your FY1. In 'Hit the ground running' on **page 4** I offer a few tips that helped me through my first few weeks on the wards, and on **page 12** Tom Berry provides some advice on surviving nightshifts (beyond Pro Plus washed down with Red Bull). On **page 6**, chief medico-legal adviser at the MDDUS, Jim Rodger, points out a few pitfalls best avoided in your early career.

If you're considering the options after your foundation years, then on **page 10**, Andrew Thomson gives us the lowdown on general practice, and if you fancy something a bit out of the ordinary, our profile on the Emergency Medical Retrieval Service provides a glimpse of the challenges involved in airborne and rescue medicine in Scotland – see **page 8**.

Please let us know what you think of *FYi*. It would be great to hear any ideas you have for articles – and not necessarily just about medicine. Do you have an interesting hobby or pursuit outside hospital or the surgery – writer, painter, marathon runner, stand-up comic? Just get in touch; we'd be keen to hear about it.

Until next time, good luck and enjoy!

• **Dr Maggie Cairns**
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PHOTO: WALTER NEILSON

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NOT IN THE PARK

Controversy over "Rate-a-doc" site

A controversial new website that allows patients to rate individual GPs and hospital doctors is causing anger among the profession.

iwantgreatcare.org has been launched by Dr Neil Bacon, founder of the social networking site doctors.net.uk. Visitors to the site can rate doctors using sliding scales for three questions: 'Do you trust them?'; 'Did they listen to you?' and 'Would you recommend them?'.

But recent feedback from doctors has not been overly supportive. Dr Richard Vautrey, vice-chairman of the BMA GP committee, was quoted in the *The Observer* newspaper saying: "There's a significant possibility of it being used in a malicious way, leading to doctors finding themselves under incredible stress and worry, and leaving them open to potential abuse from individuals with a vendetta".

But Dr Bacon said the new site will offer opportunities for doctors. "Doctors have to meet certain patient satisfaction targets, and this sort of patient feedback could help to provide this," he told *E-Health Insider*. "It could also provide them with positive remarks to use in their personal portfolio, when they move jobs".

PHOTO: BMA

MEDICAL STUDENTS ACROSS the country held overnight protests last month over the removal of hospital accommodation support for newly qualified junior doctors.

Thirty tents representing different UK medical schools were occupied by students, many of whom will be left an estimated £4,800 worse off as a result of this change. Ian Noble, chairman of the BMA medical students' committee, led the way by sleeping overnight in a tent in the centre of Edinburgh at the annual BMA conference.

Mr Noble said: "It is a disgrace that the government is adding another financial burden to junior doctors at a time when they are already graduating with average debts in excess of £21,000 – a figure that will rise to well over £35,000 with the introduction of variable top-up fees".

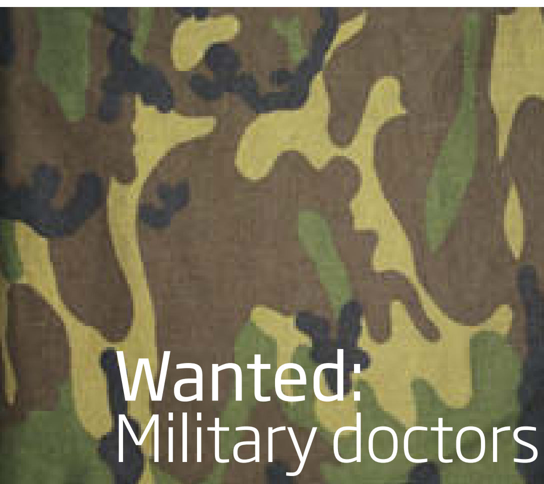
BMA council chairman Hamish Meldrum said the removal of free accommodation was an "abominable" decision which was a scandal and insult to future doctors.

Keep patient data secure

Failure to adequately secure electronic medical records could result in a GMC hearing or even criminal charges. This warning follows the recent theft of a personal laptop containing thousands of confidential patient records from the home of a Midlands GP. A Wolverhampton practice has written to all 11,000 of its patients to alert them and apologise.

"GMC ethical guidance warns that patient records must be effectively protected against disclosure at all times," said MDDUS medico-legal adviser George Fernie. Additionally, the Data Protection Act 1998 (DPA) requires "appropriate technical and organisational measures" to prevent "unauthorised or unlawful processing of personal data". Under Section 55 of the DPA it is a criminal offence to intentionally or recklessly disclose personal data without appropriate consent.

"The law could view taking patient information home on an unencrypted laptop, memory stick or other device, or leaving it in a car or office – all with the risk of theft – as 'reckless'," warned Dr Fernie.



Wanted: Military doctors

With just 20 general surgeons serving in the armed forces, Defence Medical Services is facing tough recruitment challenges. Emergency doctors, anaesthetists and psychiatrists in the military are also all at approximately half strength.

Dr Brendan McKeating, chair of the BMA's armed forces committee, said: "As you will no doubt be aware from the news reports and headlines, troops are being seriously injured on operations, particularly, at present, in Afghanistan".

"I am proud to report that the standard of care being provided for these troops is of the highest quality, and certainly world-leading in many areas of emergency and trauma care."

However, despite significant pay rises, Defence Medical Services continue to struggle with understaffing.

HYGIENE CAMPAIGN YIELDS RESULTS

New figures from the Scottish Government indicate success in hygiene promotion and other interventions aimed at reducing healthcare associated infections (HAIs).

Reports published by Health Protection Scotland (HPS) reveal an overall reduction in *Staph. aureus* bacteraemia (MRSA and MSSA) although figures for *C. difficile* associated disease continue to rise. A third report published by HPS shows hand hygiene compliance by healthcare staff has increased from 68 per cent in 2007 to 88 per cent this May.

Commenting on the reports, Health Secretary Nicola Sturgeon said: *"The report on rates of Staph. aureus bacteraemia reveals that these infections are at the second lowest level since national reporting began, and that MRSA bacteraemias are at their lowest rate since 2003. This, coupled with a high level of progress towards compliance on our 90 per cent hand hygiene target and other interventions led by the HAI Task Force, indicates that the actions we are taking are beginning to take effect".*

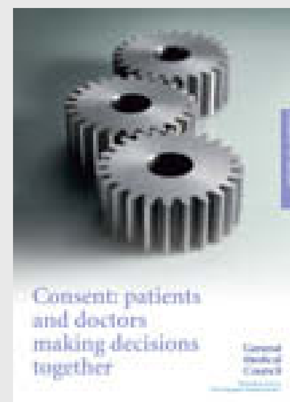
GMC promotes partnership

New GMC guidance on consent urges doctors to rethink their approach to discussing medical issues with patients.

Consent: Patients and doctors making decisions together calls for doctors to actively engage patients in discussions, allowing them to make decisions based on individual needs and circumstances. It views consent not as a tick-box exercise but part of a wider decision-making process in which both parties have an important role to play. The guidance sets out key principles of good decision-making which apply to all care from simple treatments to major surgery.

"Doctors often talk about 'consenting' patients and, whilst this may be convenient shorthand, it misrepresents consent as something done by a doctor to a patient," said Jane O'Brian, head of standards and ethics at the GMC. "Good decision-making should be based on a partnership between doctors and patients."

Download the new guidance at www.gmc-uk.org.



HIT THE GROUND RUNNING

Fresh from foundation year one, *FYi* editor **Maggie Cairns** advises "start as you mean to finish"… apart from the panic

MY FIRST day on the ward as an FY1 followed a summer of mostly unbridled celebration – the roller coaster of final year worries having given way to the euphoria of qualification. Only toward the end of July did my confidence start to wane and self-doubt rear its ugly head. Thoughts of capability were replaced by culpability. Would I be good enough? What really was expected of me? I hoped all my patients would have good veins! Such ruminations persisted despite the completion of the obligatory 'shadowing week'. Nothing could have prepared me for what lay ahead, not even watching endless reruns of *Scrubs*.

Clutching my 'cheese and onion', clenching my teeth, shielded in legitimacy by my

"Consideration of others, appropriate use of listening skills and sharing your own knowledge are de rigueur"

stethoscope, I arrived on the ward for my first placement.

"Maggie, welcome!" Boomed out an unfamiliar voice. "Just in time! Grab some venflons and come over here".

Venflons! Oh no! Beam me up Scotty. I'd rather have met the Klingons!

But as I grew familiar with the new surroundings and got to know the rest of the team I became more at ease. Certainly a warm welcome is helpful and in this I was lucky in my first placement. Only when you are comfortable with your environment can you contribute and work effectively with others.

Not to say that it was easy for me in those first few weeks. I started out feeling certain that I must be the 'worst junior doctor ever'. But such feelings were soon negated by more senior colleagues teasing out my knowledge in a kind and helpful manner. This allowed me to dismiss any feelings that I would be a hindrance rather than a valued member of the ward team.

So what advice could I offer in surviving those first few weeks of foundation year one? If, as they say, "every day is a school day", then working in a structured environment requires self-organisation. Here are a few tips in no particular order.

Chasing results

Proper time management allows a balanced lifestyle and provides welcome breaks and more time for the inevitable chasing of blood results. Nothing can prepare anyone for this. The key principle to success is timely intervention. There is no point in starting result chasing five minutes before a scheduled departure from the ward. All this does is enrage your SHO when you page them for help; it does nothing for your confidence or reputation.

Ward rounds

Another hurdle to cross is the consultant-led ward round, as these take on a whole new dimension in terms of your participation. Being recently qualified assures your position of one rung up the ladder from the final year students. It's amazing how the stammering student reply affords you enough thinking time to answer those awkward questions. Furthermore, the ward round is the time for you to impress your more senior colleagues. Again, preparation is the key to success. Know the results! Nothing more infuriates the consultant than a junior doctor unaware of a patient's condition or progress. Knowing how the consultant likes their tea or coffee will forgive the occasional time when you haven't done what was asked of you.

Blood letting

Another of the duties expected of you is dealing with blood forms left by the phlebotomist, especially those bearing the most heartbreaking statement a junior doctor could face – 'could not obtain'. Even the simplest of procedures such as venepuncture and cannulations are daunting in the first few weeks of work, especially when you are under pressure. The secret is practice. I wish I had spent more time as a medical student on hospital placements using patients as the proverbial pincushion. I know it's easier to go for a coffee at the WRVS instead of attempting that venflon the SHO asked you to do. However, getting lots of 'hands-on' experience at medical school does ensure an easier rite of passage as a new doctor.

Working in a multidisciplinary team

Teamwork is essential for survival in medicine. Therefore, having a 'doctor knows best' mentality is one sure way of exponentially increasing your workload. Such a frame of mind upsets nurses and other members of staff. My advice is to play the game. Consideration to others, the appropriate use of listening skills and sharing your own knowledge are de rigueur. Most importantly, I found all of the former is a good way of finding out those individuals that cannulate/take blood, therefore, making your working life a lot easier.

Work-life balance

The transition from medical student to junior doctor is a massive and daunting challenge. Nothing can adequately prepare anyone for this. It requires a lifestyle change, a juggling of work and personal commitments. It's an art form which must be mastered. Stress and depression are very real issues amongst junior doctors. Being able to leave work and forget about your patients is hard to do. It will become easier and I would advocate to any doctor no matter their grade or seniority to seek help if they are struggling to cope with the demands placed on them at work.

Continuing education

The successful transition onto FY2 is dependent upon a necessary level of competence at work in addition to completion of your e-portfolio and the mastering of those dreaded DOTS (Doctors Online Training System). Leaving such matters to the last minute is both foolhardy and dangerous. Starting early with a continuous input is more productive and satisfying.

Having now finished my first foundation year I feel that, whilst it was a steep learning curve and at times unnerving, it was an experience I will cherish. The insight into others' lives is a privilege, and though as an FY1 you may consider your influence to be minimal, in the grander scheme it is nevertheless much appreciated and worthwhile. FY1 is a fast and short dance on the medical stage so prepare well, learn your lines but most importantly, enjoy!

Dr Maggie Cairns is starting her foundation year two programme at Stobhill Hospital, Glasgow

Tips for surviving FY1

- **A clipboard with a copious quantity of A4 sheets is far better for notes than the back of an X-ray card.**
- **Consolidate all the jobs that you have to accomplish in one 'To-Do' list.**
- **Ensure on ward rounds that you can at least outline every patient's story and there is ready access to notes and test results.**
- **Ensure that your medical notes are legible and avoid abbreviations - especially those with dual meaning.**
- **Get organised before picking up the phone to refer and ensure you know the patient's history well.**
- **Set aside adequate time (and a quiet place) for handovers.**
- **Work-life balance – try to exercise, sleep and eat well; keep in touch with family, loved ones, friends and, importantly, non-medics.**
- **Treat all of your colleagues and patients as you would wish to be treated.**

PEARLS AND PITFALLS

Some words to the wise on risk and responsibility from **Dr Jim Rodger**, chief medico-legal adviser at MDDUS

YOU'VE arrived. You've passed your MB ChB and can now change the designation on your cheque book and look for all the benefits that flow from being Dr rather than Ms or Mr. Deservedly so, because you've worked hard and passed a rigorous assessment process to be allowed to graduate. You will be looking forward to an exciting and slightly scary world of medicine or surgery and being able at last to do 'things'.

With this new phase in your life comes a list of added responsibilities which you may not have thought of or even be aware of. I don't want to dampen the enthusiasm for your new job but simply introduce a measure of realism and a warning about pitfalls that may lurk ahead.

Professional and personal conduct

The General Medical Council (GMC) is the body that records your various states of registration. Once you have provisionally registered you must accept that you are a medical practitioner 365 days a year, 24 hours a day. The reach of the GMC to regulate the conduct and behaviour of doctors is not confined to working hours or solely to when practising medicine. Your behaviour and conduct outside work may have serious consequences for your registration and your ability to work as a doctor.

Any criminal conviction affecting a medical practitioner is automatically notified to the GMC. Examples include drink driving, dangerous driving, assault, fraud and notably in recent years possession of or supplying drugs. These can be drugs of recreation, as well as the abuse of prescription drugs. Doctors charged with any criminal offence should seek appropriate advice from MDDUS before they take any action. Legal representation will not normally be available to doctors in matters not relating to the practice of medicine but MDDUS will give advice on the implications of admitting to or defending any such charges.

The GMC also looks very carefully at and punishes, if proved, allegations of dishonesty or a lack of probity. These might include exaggerating qualifications, inventing qualifications, not divulging details of failures or lack of progress in training. Be careful with the preparation of CVs. FYI and FY2 trainees have also been reported to the GMC in cases of significant underperformance but this is generally viewed as the responsibility of educational supervisors.

Another major concern of the GMC is the health of doctors, particularly when it affects performance and may put patients or other colleagues at risk. Similarly, the GMC seeks to protect doctors from 'themselves'; doctors must recognise when they are unwell and avoid the temptation to self-medicate. Any doctor has a responsibility to ensure they keep in good health and if unable, to seek help and guidance from MDDUS and even the GMC itself.

Many of these issues are covered in the GMC's core guidance document, *Good Medical Practice*. Ensure you read it before you start your job.

Disciplinary matters

Possibly the next best thing after graduation and starting work is your first pay cheque. You may even want to double-check that all your sessions have been properly paid as set out in your NHS employment contract. But have you looked at the rest of this contract?

It contains numerous rules and regulations governing your daily work, relationships with colleagues and general behaviour. The employing body has an expectation that you will turn up for work when required, complete your allotted hours, remain attentive to your work, keep proper notes and be organised in your routines. If not, they can take action against you.

If a doctor persists in personal conduct that is judged by the Trust or Board to be

"You are a medical practitioner 365 days a year, 24 hours a day"

serious or detrimental to the efficient discharge of a doctor's duty, they may make that doctor subject of a disciplinary process that can result in dismissal from a post. Some leeway is obviously given to young doctors early in their training, but perhaps not much. You must be clear on your responsibility to the organisation that is paying for your services.

Patient complaints

The last thing you ever think about when you start to work in medicine is that someone, patient or relative, is going to complain about you or your actions. Everyone who takes up medicine as a career is aware that it involves a high degree of altruism and commitment. To have this questioned by anyone is a blow to one's ego and sense of professionalism.

Do not be under any illusions – we no longer operate in a paternalistic environment where medical care and its application lie solely in the hands of the profession. This is a consumer-based society and medical care is regarded as no different in some ways from other service industries. Patients have expectations of the service and how it is delivered.

Therefore, it is inevitable that some patients, carers and relatives will complain. The NHS is not perfect and without significant investment cannot render a fully comprehensive service of healthcare. Thus patients' expectations, unrealistic or not, will not always be matched. Those on the 'shop floor' must bear the brunt of these failed expectations. This is simply now part of the 'job' and truly professional doctors must accept that and learn to live with it. Complaints are normally of great value to an individual or an organisation in order to learn from mistakes and determine why such failings occur and how they can be prevented in future.

You will face complaints from early on in your career. You must always seek advice about how to respond to complaints, particularly in these early years. You must never rush into responding, either in an overly apologetic or angrily dismissive manner. Responses to complaints must be measured and informative.

The most common complaints that all sections of the health service receive are those about the attitude of doctors, nurses and other staff. There are many and good reasons (tiredness, overwork, stress etc) why people may be rude, short or dismissive as perceived by patients. However, it is a professional responsibility to remember that patients, carers and relatives are in very unusual and vulnerable states when their or their relative's health or life is at risk. Always remember that your attitude may be more important to a patient than your competence, but try to avoid being a 'charming quack'.

The future

Few doctors are dismissed or struck off during foundation training. This two-year period is meant to be educational as well as service-related. It should be the 'foundation' of your medical career and – considering a possible 40-year stint – is relatively short. Friendships formed in your early years often last a long time. It may sound like a bunch of old buffers talking – but many doctors look back on their training as the best years of their career.

Make the most of them!

Dr Jim Rodger is a medico-legal adviser and Head of Professional Services at MDDUS

THE SPIN DOCTORS

Bringing critical care to Scotland's most remote regions – Dr Andrew Inglis of the Emergency Medical Retrieval Service talks to **Adam Campbell**

FLAME-RETARDANT flight suits, helmets, boots, ear defenders – it's a far cry from the hospital scrubs usually worn by doctors dealing with acute medical emergencies. Neither do many critical care consultants travel to work by helicopter. But for ICU consultant Dr Andrew Inglis and his colleagues in the Emergency Medical Retrieval Service (EMRS), tasked with the safe transfer of critical cases from remote parts of the west of Scotland to an appropriate medical facility, the clothing is standard-issue and the chopper a vital cog in the wheel of this 'flying doctor' lifeline.

"We look at it as taking the critical care out to patients," says Dr Inglis, who is based at Glasgow's Southern General Hospital. "Something like one in nine people in Scotland live more than an hour by road and/or ferry from a district general hospital with either a full accident and emergency department or a full intensive care unit. It is a significant proportion of the population that is denied the same access to those facilities the rest of us have."

Optimal triage

The majority of patients in remote areas have long been adequately served by the paramedic staff of the Scottish Ambulance Service, with whom the EMRS team work in close collaboration. But Dr Inglis and his colleagues are concerned with beefing up the care provided to that 10% of transfers requiring skills over and above what can be offered by traditional air wing crew. This might include, for example, administering emergency anaesthesia and ventilation or installing a chest drain.

Patients who have already benefited from the service include an Islay woman with meningitis, who received life-saving catheterisation of an artery in her wrist and a large vein in her neck. She was then flown on a ventilator directly to a Glasgow hospital, where she made a full recovery.

"One of the problems we had before was that patients with a head injury might go to the local community hospital and then the district general and then to the Southern in Glasgow. Now we do what we call 'optimal triage', so the patient goes from the referring point to the hospital they should end up in," says Dr Inglis.

The service is the brainchild of a group of Glasgow-based consultants, Dr Inglis among them, most of whom have experience of similar systems elsewhere, most notably Australia. In Dr Inglis' case, this involved a stint as a specialist registrar in Adelaide in the late 1990s. "I went out to work in intensive care and when I arrived I discovered that if you worked in intensive care, you were part of the retrieval team. Within the first week I was out and flying into the Outback," he says.

"From Adelaide, we could be sent out to Alice Springs, which is four hours by jet, to bring someone back." Other colleagues had worked in New South Wales, while EMRS lead consultant, Dr Stephen Hearns, had experience from the London Helicopter Emergency Medical Service.

"Collectively, we had the experience and we could see that there was an unmet need in Scotland," says Dr Inglis. "So we knocked heads together in 2004 and came up with a voluntary rota that would nominate someone who would be available to go out and assist with these transfers."

That voluntary rota kicked off with a smaller geographical remit – Argyll and Bute – and was so successful that in June the Scottish Government awarded £1.5 million to fund an 18-month pilot for the west of Scotland. "Now

"The pioneering team are hopeful that one day the service will operate on a national level"

the time is counted as part of our NHS job plans – it's a huge step forward," says Dr Inglis, who is currently on-call for the service one day in ten.

The funding is an enormous vote of confidence for the pioneering team, who are hopeful that one day the service will operate on a national level. From early data it is believed that, of 250,000 people in Scotland who live in remote and rural areas, around 300 people per year would benefit.

Team game

Of course, the consultants who provide the most advanced treatment are not alone in staffing the service. In addition to the duty retrieval consultant, a typical callout will involve the referring GP, a pilot from the Scottish Ambulance Service or, in adverse weather, the Royal Navy, a paramedic and a trainee. It is a coming together of skills rarely seen in other walks of medicine. "It's very much a team game with the air wing paramedics," says Dr Inglis. "We're working much more closely with the ambulance service than most hospital people usually do. We're also relying on the pilots and their skills, and we're relying on our rural colleagues communicating with us."

For the duty consultant, there are the additional stresses of operating what is, to all intents and purposes, a mobile intensive care unit. "It's not always the problems that you

anticipate that you run up against. There can be transport problems and you can get left rather longer than you expected in rural areas. It is then that you become very familiar with what drugs you carry and do not carry! It's not simply a case of phoning round the corner to get additional supplies, because you're it."

Staffing the service has proved relatively straightforward so far, as there are, says Dr Inglis, a surprising number of consultants in Scotland who have experience of these systems from abroad. For the future, he says, "Our aim is also that the trainees who are participating would ultimately be in a position, when they become consultants, to be candidates for places on the service. The aim is to make it a sustainable service with a ready supply of consultants. It's a new challenge."

Qualifications

For those young doctors who want to help the EMRS meet this challenge, the way in, says Dr Inglis, is to get a background training in either emergency medicine or intensive care. The service would be looking for candidates with three or four years' post-registration experience, with at least six months of anaesthetics. "Something like 70% of our patients require emergency anaesthesia, so that's really the key skill. There's very little point in sending out junior trainees who are not comfortable with that," he says. "There's also an exam through the Royal College of Surgeons of Edinburgh in prehospital care and the additional qualification is very relevant to the service we provide."

Beyond the qualifications, he says, motivation is absolutely crucial, as is flexibility, since around a third of the calls run over shift boundaries. "Just because you're not on call the morning after doesn't mean you will not still be out the morning after," he says, knowing only too well that emergencies don't run to a schedule.

And, of course, since taking to the skies is central to the role, a love of flying wouldn't go amiss either.

Adam Campbell is a freelance editor living in Edinburgh

PHOTOGRAPHS: THE HERALD/EMRS

SPEAKING GENERA

Nearly half of all qualifying doctors will opt for general practice post-FY2 – so what is the appeal asks **Cherryl Adams**

GENERAL practice forms the largest sector of the NHS, with 90% of all patient contacts occurring in the primary care setting. Almost half of qualifying doctors will specialise in general practice, and there are around 56,000 GPs working in the UK – more than all consultants in all specialties combined.

The aim of general practice has always been to treat patients holistically, offering continuing care to patients and their families. An intrinsic and unique part of the GP role is that of 'co-ordinator', dealing with patients who often have complex health needs and a requirement to access several health and social care systems simultaneously.

Training in general practice was only formalised in 1956, with The University of Edinburgh being home to the first independent Department of General Practice in the world. Virtually all medical schools in the UK, and many in the developed world, have since followed suit, recognising the importance of this element in the teaching of undergraduate medical students.

With few other specialties offering the variety and scope of this arm of medicine, it is no surprise that entry into GP training remains highly competitive. However, an ageing GP workforce has led to an increase in the number of medical school places and various incentives to encourage GPs to work in under-resourced areas.

Training

On completion of foundation training, doctors apply to undertake a Certificate of Completion of Training (CCT) Programme to specialise in general practice. Prior to, and during, the application process The National Recruitment Office for General Practice assesses eight qualities deemed essential in a good GP:

- Ability to care about patients and their relatives
- A commitment to providing high quality care
- An awareness of one's own limitations
- An ability to seek help when appropriate
- Commitment to keeping up to date and improving the quality of one's own performance
- Appreciation of the value of team work
- Clinical competence
- Organisational ability

Since August 2007 the Royal College of General Practitioners (RCGP) is responsible for setting the training curriculum for general practice, and completion of the College's assessment, known as the nMRCGP, is now compulsory. Successful completion of the 3-component assessment, in conjunction with the CCT, grants doctors the eligibility to practise independently as a GP. Throughout the training programme trainees will work for two years in a variety of approved hospital training posts and a minimum of one year as

PHOTO: COMMERCIAL EYE

ALLY

Q&A - Dr Andrew Thomson, general practitioner

• What attracted you most to general practice?

The opportunity to provide a level of continuity of patient care that is simply not possible within hospital practice, so-called 'cradle to grave' care. I also value being part of a close multi-disciplinary team while maintaining career flexibility, making portfolio working and work-life balance real possibilities.

Add to this limitless clinical diversity and the ability to lead, direct and develop a small business thus improving the services provided to your local community, then a career as a GP seemed the only logical step.

• Now that you're in the job what do you enjoy most?

Seeing patients... getting to know them and their families; coping with challenging situations or patients, the so-called 'heart-sinks', is what makes me tick. Another GP challenge and highlight for me is managing patients' undifferentiated illnesses. Then, like a detective, I can hunt for that elusive diagnosis.

• Are there any downsides?

Stop the clock!! Time pressure and pigeonholing patients into 10 minute slots can be the most challenging and frustrating element of the job. Feeling isolated - when you've not left your consulting room all day, having had more interaction with your computer than the team. Incessant external pressure to change can also be very frustrating, especially when you feel that this has more to do with politics than patients, quotas than quality.

• What's your most memorable experience so far?

It's difficult to pick a single experience as there are many but they tend to relate to moments of realisation that you have made a difference; whether that is a result of gratitude from a patient or their family or reaching a timely or unusual diagnosis. Often it is picking up on the non-verbal queues in a consultation that can deliver the most rewarding moments.

• Has anything about the role surprised you?

I've been surprised by the huge value that patients place on personal continuity of GP, even in an age where information continuity is easily delivered. Another surprise is the speed with which patients develop a trust in you and your decisions - first introductions to life changing decisions in a 10 minute consultation.

I was also shocked by the paperwork - measured by the ton/gigabyte! Results, outpatient/secondary care letters, medication requests, medical reports etc - with this significant daily burden you must develop workflow systems to stay up to date with and for your patients, hopefully never missing that important result.

• Are there any myths about general practice that you'd like to dispel?

The 21st century GP practice bears little resemblance to Dr Finlay's casebook. GPs provide community hospital, specialist chronic disease review clinics and a host of other services that were a secondary care remit only a few years ago. The other important myths to dispel are that this is not a Monday to Friday, 9-5 option and we don't all earn over £100K...sorry.

a GP registrar in a training practice. Flexible training options, including part-time, are also available.

In practice

Ultimately, most GMS (General Medical Services) GPs work in practice within a primary healthcare team consisting of GPs, practice and community nurses, health visitors, midwives, practice managers and administrative staff.Since the late 90s there has also been the opportunity to become a GP with a Special Interest (GPwSI). This includes working in chronic disease management, dermatology, palliative care and respiratory medicine. The aim of the GPwSI is to decrease the burden on secondary care and bring more services in-line with the 'community based' ethos.

Further opportunities include academic GPs, media doctors, police surgeons and armed forces. Some GPs will also work on a sessional basis as a locum covering sessions as and when required over a number of practices.

"It's no surprise that entry into GP training remains highly competitive"

The salary

There have been many reports in the press recently of GPs routinely earning in excess of £150,000. More realistically, a salaried GP can expect to earn between £50,000 to £80,000. The salary structure has changed recently under the new GMS contract and practices now receive a global sum for the services provided and additional payments if they meet quality markers as laid out in the Quality and Outcomes Framework (QOF), for example in the management of patients with common chronic diseases such as asthma and diabetes, or extra services offered such as child health and maternity services. These figures can therefore vary greatly dependent upon practice activity.

The future

There are many challenges facing today's general practitioners, with increasing patient expectation and the intense glare of the media spotlight fixed eternally on the NHS. The RCGP vision of the future is that, following improvement and a 'federated approach', virtually all health problems will be dealt with in the primary care setting with the lines between 'primary' and 'secondary' care becoming increasingly blurred. But many GPs and the College oppose the introduction of the 'polyclinic', fearing that continuity of care will be compromised. It's a controversial area that will no doubt be so for a long time yet.

Cherryl Adams is Associate Editor of FYi

GOOD NIGHT AND GOOD LUCK

Tom Berry, FY2, offers some tips for surviving the nightshift

WHEN considering nightshifts your first thoughts may be tinged with apprehension - that is only to be expected. If your consequent thoughts are vats of coffee, Pro Plus, matchsticks for eyelids and thumb tacks in your shoes, then you are setting off on the wrong foot (and a soon to be bleeding one at that).

Know your enemy

It's not that scary consultant in A&E, it's fatigue. Let's not get physiological about this but your body is fighting to tell you to sleep. Outside it's dark, your hormones are in flux and a baseball programme is on Channel 5; you should be hugging teddy. If, however, you equip yourself properly for battle, nightshifts can become some of the most fruitful times of your early career.

Preparation

Trying to sleep before the first nightshift is hard and there are a multitude of techniques that each individual will advocate as the most successful. Tempting as it may be, a night of drink and dance until the sun glints on the rooftops will not best prepare you for the ensuing nights of work and concentration. A lie-in followed by an afternoon nap is probably a suitable way to ease into a new sleep pattern.

Your bedroom needs to be just that: a room with a bed for sleeping. I find black-out material which I Velcro over the blinds helps plunge me into foetal darkness. You may prefer an eye-mask or the addition of earplugs for those times when your neighbours all decide to Hoover at once.

You must remember to eat, and getting your shopping done to cover the period of your nightshifts will save an exhausting traipse round the supermarket post-shift, or an infuriating early rise in the evening to shop pre-shift. Caffeine-laden comestibles are, in the main, best avoided. A brief period of heart-pounding alertness will signal an even deeper tiredness and the inability to sleep in the morning. Water and fruit juices to combat dehydration and "slow release" foods like nuts and dried fruit are good. Cereal bars are always handy to carry in a pocket and munch on between wards. Ideally you'd have a veritable banquet laid on by the HDU staff each night as I happily experienced once, but I can't guarantee it.

Make sure you have all the usual tools of your trade: stethoscope, pens and the rest. You'll see lots of the usual night's calls, such as dropping BP, decreased urine output, chest pain, falling Sats and requests for night sedation. Read up on these beforehand if you need to and revise your resuscitation guidelines. Carry a helpful book you trust such as an Oxford handbook or good on-call book (pocket-sized preferably). If your hospital/NHS Board has a prescribing guide then take that too.

First night nerves

Be on time and write everything down. Make sure you know who else is on with you and who to contact if you have a problem. I worked with a Registrar who, on the first night, would head off saying: "Call me if you need me". He would then lope down the corridor before coming back and asking: "What's my page number?" Invariably the junior wouldn't know it and hadn't thought to ask. Make sure you do.

Get a good handover from the evening shift. It's tempting to be magnanimous and graciously say: "I've got it, you head off". Resist this admirable temptation and find out what is left over from the previous shift – problem patients, tasks to be completed at certain times overnight or results that must be available for morning rounds.

Tiredness breeds laziness. Strongly resist the urge to cut corners and ensure you write fully in the notes. Three in the morning is rarely a good time to drastically change a patient management plan unless your seniors

"Tiredness breeds laziness. Strongly resist the urge to cut corners and ensure you write fully in the notes"

have approved it.

Don't let nightshift be lonely; there are plenty of other people in the same boat, wandering the hospital. Help those around you and they, in turn, will help you. Teamwork is especially important at night.

Napping may be of benefit for short periods of 20-45 minutes. Longer may lead to deep sleep and grogginess upon waking. Times are changing and on-call rooms disappearing but you are entitled to breaks and these may be utilised for naps if you so wish. Remember to eat, drink and use the "facilities" as mother might say.

Although there is often a pleasurable sense of autonomy in working at night, you should be well-supported by an experienced team including more senior medical personnel on-site. Remember the maxim: get help sooner rather than later.

The morning after

Keep in mind the tired and emotional state that you may occupy come morning. A particular diagnosis or event may elicit a hyped-up mood or a sad event may hit you harder than you feel it might on a day shift. Taking time to talk these over at handover in the morning or with a colleague coming off shift will help to clear your head.

Driving home after a nightshift puts you at an increased risk of being in an accident. Ideally take public transport home or rest before driving. However you make your way

home be aware your alertness is not functioning at peak capacity.

For all kinds of good reasons don't stay up watching daytime TV. This is also not the time to make that trip to the bank, return those books to the library or meet that friend for lunch.

Have a light meal, turn your mobile to silent, set an alarm and head to your well-prepared, dark and peaceful, bedroom.

And in the end

Getting back into daytime mode can be difficult and you'll feel discombobulated for a day or two. Try having a brief sleep in the morning, a nap late afternoon and a good attempt at a proper night's sleep that evening.

Although daunting, nightshifts can provide excellent opportunities to improve clinical and diagnostic abilities. So grab your stethoscope and a banana, and get stuck in.

Dr Tom Berry is an FY2 in Glasgow and a BMA Scottish Junior Doctors' Committee representative

More information

- Horrocks N, Pounder R on behalf of an RCP Working Group. Working the night shift – preparation, survival and recovery: a guide for junior doctors. RCP, 2006. **http://tinyurl.com/5cs2md** (accessed 3 Jun 2008)

- Robinson G, Bernau S, Aldington S, Beasley R. From medical student to junior doctor: the night shift. sBMJ 2006(Nov); 14: 397-440

"Turn your mobile to silent and head to your dark and peaceful bedroom"

EWTD Explained

In a year's time, the European Working Time Directive (EWTD) will come into full effect for junior doctors. This legislation, which is designed to protect the health and safety of workers, will restrict the time junior doctors can spend in hospital to 48 hours a week. The current limit is 56 hours. NHS Boards in Scotland are in the process of developing plans to deal with this reduction in hours, and over the coming months many junior doctors will find their working patterns changed and posts are re-banded.

The EWTD is UK and European law and as such is not voluntary. Because a significant proportion of direct patient care is delivered by junior doctors, it was agreed that the new working hours should be phased in gradually over five years. In 2004, working hours were reduced to 58 hours, reduced further to 56 hours in 2007 and, as of August 2009, the 48 hour limit will apply. Employers must also meet standards for rest requirements in order to comply with the legislation.

The EWTD is not the set of agreements which defines your basic pay and banding supplement - that is the 'New Deal' contract. Under the New Deal contract, all juniors are paid a basic salary and then an additional banding supplement, depending on hours worked. Following the implementation of EWTD in 2004, the New Deal continues to be relevant and, where there is variation between the conditions, the most favourable will apply (fewer hours, longer rest periods). Posts that are Band 1 include 48 hours of actual work a week. There are sub-groupings within Band 1 depending on the out-of-hours work you do.

It is possible for employees, such as consultants, to opt out of EWTD so that they can work in excess of 48 hours a week. However, junior doctors tend to work in teams on a rota, making opting-out complicated; the SJDC view is that only those junior doctors who have independent control over their working hours should be able to consider opting out. It is not possible to opt out of the Directive's rest requirements, and where rest breaks can't be taken on any day, the missed rest can be made up later as 'compensatory rest'.

According to a recent BMA survey, junior doctors believe that they should be protected from working excessive hours, and recognise that the ability to provide safe medical care to patients has been compromised by pressures to work excessive hours. However, juniors are also concerned that the reduction in working hours will impact on the quality of training so it's important that junior doctors get involved in local planning processes for their NHS Board area in order to influence any changes.

Efforts by NHS Boards to make rotas EWTD compliant may have an effect on banding (known as 're-banding'), and if a post is 'down-banded' while you are working the rota, your existing banding payments will be protected for the duration of the post. There is a strict protocol for the re-banding of posts that employers must follow, and working patterns should not change at short notice.

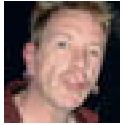
The new legislation is complex and there are still grey areas so it is important to be aware of the detail of the directive.

Further information and advice for junior doctors can be found in the guidance, The *Final Countdown*, which is available on the BMA website (www.bma.org.uk). If you have any queries about the EWTD, rotas or any other issue please contact your Regional Junior Doctors Committee (RJDC). There are RJDCs throughout the country keen to have new members - contact details are available on the BMA website (http://www.bma.org.uk/rjdc). BMA members can also contact the BMA for employment advice on 0870 60 60 828.

Dr Katie MacLaren, Deputy Chair, BMA Scottish Junior Doctors Committee

OUT THERE

THROW IN THE TOWEL Doctors removing a growth from a patient in Japan found that it was not a cancer that had been causing him pain but a 25-year-old surgical towel left behind in a 1983 operation to treat an ulcer. The man is in discussion with the hospital over compensation. *Source: AFP*



ROTTEN NO MORE **John Lydon, aka Johnny Rotten of the Sex Pistols, has spent $22,000 on fixing his trademark decaying teeth. "It wasn't vanity that sent me to the dentist," he is quoted as saying. "I was poisoning myself with gum infections. My gums were receding and I was starting to look seriously weird."** ***Source: Dentistry Magazine***

HICCUP NO LAUGHING MATTER A 24-year-old musician from Lincoln hiccupping for 15 months was pinning hopes on keyhole surgery by doctors at Nottingham's Queen Medical Centre. The man has tried a variety of cures including hypnosis and yoga but with no success. *Source: BBC News*

WHAT ARE WE LOOKING AT?

Stumped? The answer is at the bottom of the page

PHOTO: SCIENCE PHOTO LIBRARY

Pick: DVD - The Diving Bell and The Butterfly

Directed by Julian Schnabel; starring Mathieu Amalric, Emmanuelle Seigner, Max Von Sydow; screenplay by Ronald Harwood (The Pianist); 2007

At the age of 43 Jean-Dominique Bauby, brilliant editor of French ELLE magazine, suffered a stroke and developed 'locked in' syndrome - a condition which left him unable to communicate except by blinking his left eye. In this way, with infinite patience and the help of an equally persistent assistant, he wrote the book on which this film is based, one letter at a time. Bauby is played by Mathieu Amalric, left (soon to be seen as the villain in the new Bond film), and the film conveys with a quiet intensity, the experience of being helpless yet determined; it's essential viewing for anyone who is interested in what it is like to be a patient.

By Philip Raby, Lecturer, 'Doctors in the Movies', Bristol University

Book Review: Trust Me, I'm a (Junior) Doctor

MAX PEMBERTON MUST HAVE known he was taking a risk when straight out of medical school and starting his first job he agreed to chronicle his experiences for the *Daily Telegraph*. But it was a gamble that has certainly paid off with a selection of writings based on his popular 'Finger on the Pulse' column having now been published in paperback. *Trust Me, I'm a (Junior) Doctor* chronicles the twelve-month white-knuckle ride, of which any FY1 will be only too well aware, commencing with that frightening first week in August.

It's surely one way to manage the stresses and strains, the slings and arrows, of FY1 fortune. Like when you sleep in for a Monday morning ward round after working solidly through the weekend. Worse than being told off, Max discovered that his consultant and his registrar only got on with it themselves, apparently not even noticing his presence after arriving more than half an hour late.

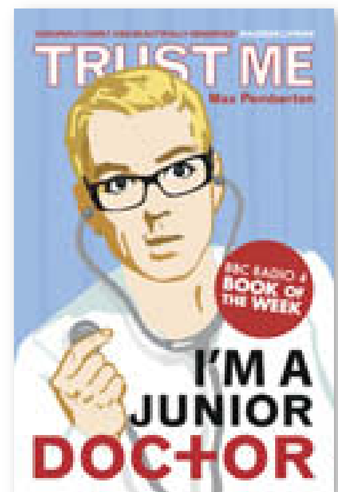
Still, it's good to know where you stand. On the first proper shift of Week One, after days of the standard orientation and induction talks, working relationships were helpfully clarified with the words: "I'm not your friend, I'm your registrar. If you don't bother me, I won't bother you." By the end of the month, Max was clear on the concept: "This is the golden rule of medicine: if someone is senior to you, they are right. Always."

Then there are the time-honoured sporting traditions of nursing teams. Summoned to a suspected kidney failure, his pager goes off again just as he appears on the relevant ward. It's about another patient at the other end of the hospital, this time with high potassium. And so the tag continues, with neither patient appearing to get any worse, until finally the nurses take pity. The lesson: some emergencies are more of an emergency than others. Knowing which is which, that's the trick.

If your first ethical duty to patients is that they should be able to trust you as a (junior) doctor, a prerequisite of this is that you manage to survive the rollercoaster of FY1. My hunch is that putting it down in words was a big part of getting Max Pemberton through a scary twelve months – and reading this book in your few spare moments may help do the same.

By Dr Al Dowie, MDDUS Senior University Teacher in Medical Ethics, Law and Risk

Trust Me, I'm a (Junior) Doctor by Max Pemberton is published by Hodder & Stoughton (£12.99).



WHAT ARE WE LOOKING AT? *Aspirin crystals*

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