Looking after yourself – good practice for trainee paediatricians

Training Services team
This guidance is intended to answer some of the most common concerns and queries arising from the high profile case involving a paediatric registrar in the UK. It advises on regular reflection in your practice, impact of understaffed shifts, return to clinical work after absence, legal aspects and self-care. It also lists further resources.

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1. Reflection

Why should I bother to reflect?

Within the GMC’s (General Medical Council) Good Medical Practice, it is laid out that doctors should be engaging in regular reflection.

Reflection can help you to:

- identify how best you learn, making you a more effective learner
- develop critical thinking, an important skill in medical practice
- improve your clinical practice
- demonstrate your learning for ARCPs, as a trainee and revalidation, as a consultant.
Can my reflections be used in court?

There is no absolute legal protection for a doctor’s reflections so it is, at least in theory, possible that they could be demanded by the court. In addition, if used as part of a doctor’s defence (to demonstrate learning, etc.) these reflections are then in the public domain and can potentially be used by other bodies, eg tribunal processes.

The GMC have stated that they would not use reflections in a fitness to practise hearing, however there is still some uncertainty around this. It is prudent to write reflections as if they could be shared in a court of law. It is certainly vital that you can show evidence of reflection which is one reason why it is so important to do.

How should I reflect?

There is no absolutely correct way to reflect; indeed, there is little evidence on the best way to do it and the evidence that exists is largely theoretical. Certainly it is advisable to be measured in your reflections and not to write them in the heat of the moment when emotions may be running high. The Academy of Royal Colleges has produced a document to guide the use of ePortfolio and reflective practice.

Key components include:

- Keep reflective notes as fully anonymised as possible, eg ‘child with a respiratory complaint’ rather than ‘a 2 year old boy with viral induced wheeze’.
- Take advice from a senior, experienced colleague when writing reflection about cases that may be contentious or result in an investigation.
- Word the reflective notes in terms of:
  - Brief description: what are you reflecting on? Outline the circumstance in general terms. Ensure that you anonymise data.
  - Feelings: what were your reactions or feelings to the event in general? Don’t be judgemental, both to yourself and others, particularly when your reactions and feelings are still raw. If they are, then now is not the time to write this down. Arrange a discussion with an experienced colleague.
  - Evaluation: what was the outcome? What was good and could have been done differently about the event?
  - Analysis: what have you learnt? What steps will you now take on the basis of what you have learnt? – This is the most important section and will allow the other sections to be brief, generic and unidentifiable. This section will demonstrate both the learning outcome and reflection.

Adapted from Guidance on Reflective Writing by Dr C Hine, from the West Midlands School of Paediatrics ARCP handbook.

2. Understaffed shifts (and system failures)
What are my rights and responsibilities in terms of work, including covering when short staffed?

The best source of information is the BMA guidance (see link below). One key point is that you should always exception report whenever you work outside your agreed work plan. This is true regardless of your grade (terms and conditions of the new junior doctor contract apply to all of us even if you are currently pay protected).

- Cover for emergencies – this is for absences up to 48 hours, no longer. This does not apply to foreseeable short or long term gaps, should be compensated with pay or time, and trainees with university commitments should have these respected and protected.
- Normal duties (09:00 – 17:00) – the consultant or clinical director should be informed if cover needed/rota gap. You are not obliged to work outside your job description, where you think patient care may be jeopardised or in a way that would jeopardise care of patients already under your care.
- Work intensity – whatever your workload you should receive ‘natural breaks’ – defined as 30 minute uninterrupted break every 4 hours.
- Out of hours cover – if your employer wishes to change your working pattern, including increasing the number of hours you work, they must get the approval of the majority of post holders even if no change to pay.

What should I do if asked to work a shift with inadequate staffing, eg fellow colleague on nights calls in sick?

The first thing to do is to speak to the on-call consultant and then if necessary the clinical director and/or duty manager. The precise arrangements will depend on workload and local policy – sometimes the consultant may cover or another junior colleague may be asked to come in and support you. It is also very important to exception report this and to complete an incident form (eg Datix) to ensure any wider problems are identified.

What should I do if I have concerns about patient safety where I work?

The BMA advises raising concerns including ‘Systemic failings that result in patient safety being endangered, eg poorly organised emergency response systems or inadequate/broken equipment’ and ‘Poor quality of care’. This could include short staffing and one of the simplest ways of doing this is through exception reporting.

The GMC advises that “if you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body (ie talk to your clinical director). If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them”. Good Medical Practice (Paragraph 6)

- Use email in addition to spoken word to raise concerns to ensure data trail
- Use local incidence reporting tools to highlight problems
Are my consultants obliged to act down if we are short staffed?

There is no national guidance and consultants are not contractually obliged to cover for junior staffing gaps. NHS Employers don’t endorse any one approach and suggest ‘employers should take account of the doctor’s other commitments and how these can be covered; and the requirement for, and arrangements for provision of compensatory rest.

Employers should also take account of whether the doctor has the appropriate and up-to-date skills to cover this work’. Importantly, each Trust should have their own policy – discussion with your clinical directors could be a starting point.

3. Return to clinical work after a period of absence

Who can I talk to about my return to work after a period off?

Your educational supervisor is there to support you even when out of programme or on maternity leave. We would recommend meeting with them within two months of your return to work to consider challenges, address concerns and plan solutions. If you are on parental leave then this meeting can be counted as a “keeping in touch (KIT)” day.

You are entitled to take up to 10 KIT days before you return to work and working any part of a day will count as a whole KIT day. You are entitled to pay at the basic daily rate for the hours worked.

What should I do about out of hours shifts?

Contact your rota co-ordinator early and request that your first few shifts are in-hours, ideally for the first two weeks. This will give you a chance to familiarise yourself with the systems, regain your confidence and have some experience of time management and clinical activities. This is particularly important coming to a new trust or role.

When you come to work your first out of hours, make sure that your consultant knows that this is your first time after a period away from clinical work. Your Educational Supervisor should have made them aware that you may have more questions than usual, and need some extra support but it is helpful to remind people when you first get back to clinical work.

What practical steps can I take to prepare?

Consider writing a “return to work action plan”, with a list of perceived educational and practical needs, and how you plan to address them. You can even begin to formulate this before you go out of clinical practice.
Many schools/deaneries run return to practice courses which include simulations of emergency situations and challenging communication scenarios. Speak to your educational supervisor and/or local LTFT rep for advice (even if you are not LTFT). If there is no such course locally, talk to your TPD about setting one up. Attending regional teaching days can also be helpful to brush up on your knowledge. Again, this can be a KIT day if you are on parental leave.

Ensure you attend trust induction before starting work. If there is not one on the date of your return consider asking to attend at the nearest date before your return. If possible schedule some time before your start to reset all your passwords with IT as they will probably have expired while you have been away.

**What if I have to run a resus when I first return to work?**

Ideally you would not be holding a crash bleep immediately after returning to work. However, it is important to ensure that your life support (eg NLS, APLS, EPLS, PILS) certificates are up to date before you return to work. If you have not attended a course recently consider reading through the course manuals. You can still claim funding from your study leave budget, and count the day as a KIT day if on parental leave.

### 4. Legal aspects of clinical practice

**Do I need to arrange my own medical defence coverage?**

Yes, absolutely. Hospitals have their own indemnity arranged via the Clinical Negligence Scheme for Trusts. However, both the BMA and individual Trusts advise that all doctors employed by the NHS retain their defence body membership or take out other personal indemnity insurance. Personal coverage should include the provision of medico-legal support and advice.

In addition it is worthwhile noting that the GMC are able to check that any doctor practising in the UK has adequate/appropriate indemnity or insurance and can remove a doctor’s licence or stop a doctor from practising if found to be inadequate. Remember too that your fees to your medical defence organisation are tax deductible via HRMC. The BMA and GMC have advice about this (see below). The most frequently used UK Medical Defence Organisations include the MDU, MPS and MDDUS.

**How do I protect myself medico-legally with my documentation?**

Poor documentation is a common finding during medico-legal investigations. All documentation should be clear, accurate and legible. Ideally, you should document at the same time as the events you are recording and (or as soon as possible afterwards) and certainly before you finish that shift. If there is a delay, document both the time of the event and the time the entry was actually written.

Documenting the finite details of every interaction, action and decision is sometimes not possible, but we can all improve our standards. Simple steps including documenting the date/time and which medical professionals are present/involved will significantly improve the
clarity of documentation.

The GMC’s Good Clinical Practice recommends that all clinical records should include:

- relevant clinical findings
- the decisions made and actions agreed, and who is making the decisions and agreeing the actions
- the information given to patients
- any drugs prescribed or other investigation or treatment
- who is making the record and when.

5. Self-care and team working

What should I do if I need more senior clinical input on a shift?

It is very important that you recognise the need for more senior clinical input and seek it early. This would usually be the on-call consultant in the first instance but if you have ongoing concerns that you feel are not being adequately addressed, seek support from another consultant and make the site manager aware.

Frequently we forget the Nursing team are a huge resource and if you need support then the senior nurse could be involved to advice and offer guidance, they have their own escalation policies.

What should I do if I feel that I am not coping at work?

Speak to your Educational Supervisor or other senior colleagues you get on with. As alternatives, your local Director of Medical Education, Training Programme Director or Head of School may be able to offer support and can direct you to local and regional services who can offer counselling, careers advice, mentoring schemes and access to professional support units. Talk to your colleagues and share experiences.

The BMA also have a doctor support service. The most important thing is to recognise that you are struggling and seek help. Equally, it is important to look after your colleagues and encourage them to seek support if they are not coping.

Further resources

1. Reflection

- [GMC Improving feedback and reflection to improve learning: a practical guide for trainees and trainers](#) - see our [response to this guidance in December 2018](#)

2. Understaffed shifts

- [BMA: Guidance on rota gaps](#)
- [BMA: Guidance on exception reporting](#)
- [BMA: Guidance on raising concerns](#)
- [NHS Employers guidance, including consultants acting down](#)
3. Return to clinical work

- **Health Education England**: Returning to clinical work (includes lots of practical tips for returners)
- The Academy of Royal Medical Colleges have produced a “Return to practice” guideline available on our [less than full time working guidance](#)
- **BMA**: Returning to clinical practice - A model process
- **BMA**: Returning to work after maternity leave

4. Legal aspects of clinical practice

- **GMC**: Advice about indemnity
- **BMA**: Advice about indemnity
- **MDU** (Medical Defence Union)
- **MPS** (Medical Protection Society)
- **MDDUS** (Medical and Dental Defence Union of Scotland)
- **MDU**: Advice about documentation
- **Paediatric FOAMED**: Specific advice about safeguarding documentation

5. Self-care and team working

- **Enhancing our wellbeing and resilience webinar** - by Dr Bov Jani, RCPCH Officer for Professional Development
- **Not for profit organisation** set up for doctors offering confidential psychotherapeutic consultation service for all doctors in the UK via self-referral

1. Good Medical Practice, General Medical Council, 2013, [www.gmc-uk.org](http://www.gmc-uk.org)