New Doctor

Professional support and expert advice for new doctors

MPS

Putting members **first**

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Think before you Tweet

Advice on using social media

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Welcome

Dr Gordon McDavid – Editor-in-chief and MPS Medicolegal Adviser

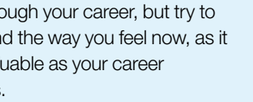
Welcome to your latest edition of *New Doctor*. I'd like to extend a particular welcome to those who have recently embarked on their first FY1 job. It's a scary time, with lots to learn, but please remember there are places you can turn to for help – you are not alone!

At MPS we have long recognised the importance of gathering the views of doctors at the start of their career. We've collated your views about working as junior doctors and created some advice videos (page 4). Your opinions may change through your career, but try to keep in mind the way you feel now, as it will be invaluable as your career progresses.

In this edition we focus on claims – sometimes called litigation or being sued. The thought of being sued is one of the most frightening for doctors at any stage in their career. The thought of interacting with lawyers and having your involvement in a case reviewed by experts is particularly daunting. Although historically rare, and litigation is increasing dramatically.

For those not directly implicated in a medicolegal case, the process is shrouded in mystery. Ashley Dee, a solicitor and claims manager at MPS based in Edinburgh, has written an article on the claims process, which I hope will allay your anxieties. You are a member of MPS for a reason, so if you do become involved in a claim or a complaint give us a call or send us an email.

There's almost too much to mention in this edition – check out Pallavi Bradshaw's explanation of approved practice settings to ensure you know what you can and cannot do as an FY1/2. There's also a heartfelt piece on the risk of alcoholism on page 12-13. As always we welcome any comments or feedback, please do not hesitate to get in touch.



A collection of interesting news and views for junior doctors

Half of junior doctors have concerns about quality of care, survey finds

MPS is calling for a more supportive open culture in hospitals as junior doctors reveal concerns over quality of care.

Over half of the junior doctors (51%) surveyed by MPS had concerns over the quality of care in their workplace.

The survey of 1,052 newly-qualified doctors found that over 60% of doctors in their foundation year 1 confided in fellow trainees about their concerns.

Doctors in their foundation year 2 were more willing to discuss their quality of care concerns, with 67% raising the issue with their clinical managers.

The survey revealed that four in five F1s (82%) said that they had struggled with long hours in the past 12 months. In addition, 85% said that they were working beyond their contracted hours, and 68% said that they were finding heavy workloads demanding.

The survey also revealed that whilst 60% of junior doctors chose a career in medicine because they wanted to help people, 71% of F1s felt they did not have enough time to give patients the care they required, and half found it hard to manage patients with unrealistic expectations.

Dr Pallavi Bradshaw, medicolegal adviser at MPS, said: "We must build an environment which allows junior members of the team to raise concerns about patient safety. It is encouraging to see that those in their second year of training feel confident to report such matters.

"Senior clinicians and clinical managers have a responsibility for creating an open culture and an environment where recognition and discussion of care quality issues is routine."

Dr Bradshaw added: "It is important that junior doctors are supported in their first years on the wards, and with one in five respondents (22%) having been involved in a complaint or claim, it highlights the need to have support available from a medical protection organisation, such as MPS, if something does go wrong."

Useful links

MPS has produced short video guides to help you through your foundation years:

- Preparing for a night shift
- How to handover safely
- Raising concerns
- Why do junior doctors need medical protection?

Read our online guide for new doctors,

Supporting you through your foundation years, featuring sections on good medical practice, how to manage risk, future careers and maintaining a work/life balance.

Access the videos and the guide at: **www.mps.org.uk/newdoctors**.

HOT TOPIC

Approved practice settings

MPS medicolegal adviser Dr Pallavi Bradshaw flags changes to approved practice settings for F2s

Since 2007 foundation year doctors have been restricted to only working in approved practice settings (APS). These are healthcare facilities recognised by the GMC as providing appropriate supervision and appraisal arrangements.

All "designated bodies", which are healthcare providers and other employers approved for the purposes of revalidating doctors, fulfil these criteria.

The requirement to work only in an APS will also apply to your registration, if you are a UK or international medical graduate granted full registration for the first time since 3 December 2012 and have not yet revalidated.

The GMC stance has changed for F2 doctors, who will now meet the APS requirements as long as they hold and maintain their connection with a designated body. In practice this means that an F2 with a designated body can work outside their substantive post or training programme, providing they ensure their educational supervisor is aware of this and they comply with any reporting requirements set by their employer and training body.

It is important to note that full GMC registration alone does not remove the obligation to work only in an APS. Almost all F2s will still be unable to undertake any medical practice in the UK unless they are connected to a designated body. The situation remains unchanged for provisionally registered F1s, who cannot work as a doctor outside an APS.

It should be noted that a foundation doctor (F1s included) could volunteer at events as a first aider, for example, as long as the activity is not reserved by law to licensed doctors.

Finally, any foundation doctor wishing to work outside their approved practice setting must ensure they have adequate indemnity arrangements. For NHS locum shifts this will ordinarily be provided by the NHS. Where such arrangements are not in place, MPS members may be able to extend the benefits of their membership to include indemnity for this work. Members wishing to work in this way should contact MPS's membership team before undertaking or agreeing to undertake such activities.

From ward to world...

Running up the UK's highest mountains in 24 hours

Running 2,659 miles from Scotland to the Sahara, then running seven ultra-marathons on seven continents in a week, was not enough adventure for GP and Scottish distance runner Dr Andrew Murray, who recently ran up the 'big ten' in the UK in one day

The aim was simple – run the ten highest mountains in the UK in a day with Donnie Campbell from Team UVU. The challenge is different than my day job, but the principles are the same:

1) Have a clear focus
2) Involve the right people
3) Tackle difficult situations with a level head
4) Manage uncertainty

Scotland's mountains are nothing if not unpredictable, the route could be hindered by cloud, the rain could make the rock wet and slippy and the wind could blow you sideways.

So how do you prepare for an event like this? Run up hills morning and night in and around surgeries. I ran on average 80-110 miles per week.

The Big 10 are spread across three ranges, with Ben Lawers north of Loch Tay, the Nevis Range adjacent to Fort William, and the Cairngorms east of Aviemore. Beforehand an apocalyptic weather forecast ensured all waterproofs were packed.

Ben Lawers at 1,214m was our first ascent. We were joined by BBC Scotland's *Adventure Show*, who filmed our trip. We reached the top in an hour, before heading to the Ben Nevis range. My back and hip were niggling, so I grabbed some paracetamol from the car; it actually made the pain worse.

The clouds broke as we tackled the next four peaks Aonach Mor, Aonach Beag, Carn Mor Dearg and Ben Nevis itself. Doing live radio whilst running along the Carn Mor Dearg arête was challenging.

While heading to Cairngorm we made steady progress of the stock of food in the car. It was the only mountain not clouded over so the views were spectacular.

By the time we summited MacDui it was raining, making the boulderfield descent into the valley treacherous. With the legs emptying and the weather deteriorating we pushed on to Braeriach, Angels Peak before finishing up on Cairntoul.

By the end I felt wet, tired and relieved that my back had not 'gone', and the weather had been short of the disaster forecast. Apparently this was the first time the highest ten mountains in the UK have been run in under 24 hours. We finished in 13 hours 10 overall, running for 9 hours 10.

My wife sounded pleased as we arrived at the pub afterwards; "you didn't lose my hat, that's good", she quipped. As I approached the bar I requested a pint and a new pair of legs!

Visit: **www.docandrewmurray.com**, *follow* **@docandrewmurray**. *Andrew raises money for a few charities he is passionate about, with support from the Scottish Association of Mental Health through "the Big 10"* **www.justgiving.com/runners4getactive.**

© DR ANDREW MURRAY

MPS Claims Manager Ashley Dee, who is based in our Edinburgh office, explains the claims process step-by-step and what it means for you

The chances are, at some point in your medical career, you will become involved in a clinical negligence claim. Whether you're the treating doctor whose care is subject to allegations/criticisms, or a witness in an ongoing claim, the increasing frequency of claims is part of the current climate that doctors work in.

However, it's not all doom and gloom, and junior doctors starting out in their career often have some misconceptions about what being involved in a claim entails and the implications.

Who pays?

Well, rest assured, it's not you.

- As an FY1/2 you are obliged to work in an approved practice setting. This will usually mean you will be covered by NHS indemnity. Put simply, it is the NHS organisation that is sued, as opposed to any individual/named practitioners, and the NHS that will be responsible for any compensation payment that may be awarded by the court or any out of court settlement that might be agreed.
- The position is different for claims against GPs and private practitioners, who would be sued personally and would rely on support from MPS.
- FY1/2s on placement in a GP practice will still be covered by NHS indemnity.

What is the law/legal test for negligence?

The patient has to prove:

a) That they are owed a duty of care: it is taken as read that a doctor owes his/her patient a duty of care; and

b) That there was a breach of that duty: in other words, that the standard of care fell below that to be expected from a responsible body of medical practitioners; and

c) Causation: that, on the balance of probabilities (ie, it is more likely than not), the failings in the standard of care identified, directly caused or materially contributed to the patient's injuries/outcome.

The onus is on the patient to establish breach and causation to the civil standard of proof, which is the balance of probabilities, and not to the criminal standard (beyond reasonable doubt). The test is subtly different in Scotland.

How is a claim started?

More often than not, a hospital or general practice is notified of a claim being investigated when the patient (usually through their solicitor) requests their medical records and advises it is in contemplation of a claim. There may also have been a complaint made before notice of a claim is received. Hospitals usually have a complaints department. General practice complaints tend to be dealt with by the practice manager or a nominated complaints partner.

Once the patient/their solicitors have investigated the claim, there is a protocol by which they should provide a Letter of Claim, setting out the facts and the allegations of breach and causation. This triggers a four-month deadline in which the NHS organisation needs to provide a Letter of Response. The letter must set out any facts that are disputed and state whether the allegations are admitted or denied. Where they are denied, the hospital must explain why. This protocol provides an opportunity to resolve claims without the need to issue legal proceedings.

The patient should go through the above steps before starting court proceedings, but that isn't always the case. There is no formal protocol in Scotland for notification of claims prior to commencing court proceedings.

How long does a patient have to claim?

The time period within which a claim must be brought is known as the limitation period. Court proceedings should be issued within three years (in Scotland the time limit will be increased to five years), running from:

- The date of the negligent event; **or**
- The date the patient became aware (or the date a court subsequently deems they should have been aware) they had suffered a significant injury attributable to the act they believe to have been negligent (referred to as date of knowledge); whichever is the latest.

There are some important exceptions to the above:

- The courts have discretion to allow claims to be brought outside the three-year window
- The three-year period does not begin to run until a child's 18th birthday
- In fatal claims, the three-year period runs from the patient's date of death **unless** the three-year period expired prior to death; and
- The three-year period does not begin to run for those who do not have capacity. Some patients may have fluctuating capacity and time will begin to run when capacity returns.

Who manages the claim?

Most NHS organisations have their own claims/legal department but ultimately the claim will be referred to an agency to manage the claim on their behalf. These organisations differ in each of the jurisdictions in the UK. The NHS Litigation Authority (NHSLA) in England, the NHS Wales Shared Services Partnership, the Central Legal Office (CLO) in Scotland, and the Directorate of Legal Services (DLS) in Northern Ireland.

The appointed claims handlers may investigate the matter internally or may instruct an external firm of solicitors. The NHS will incur the costs of legal representation and advice.

What is your role? How is the claim investigated?

If you were the main treating doctor, at the outset it is likely that you will be asked to review the patient's records and provide a statement commenting on your treatment and involvement. If you were only involved in a peripheral part of the care being reviewed, then this may well be the end of your involvement.

Once all the medical records are available, independent

expert evidence will be obtained to comment on the standard of care afforded to the patient. For example, if the case centres on an alleged failure by the emergency department to diagnose a fractured wrist, then a report will be obtained from an expert in emergency medicine. A report may then be obtained from an orthopaedic surgeon to comment on what, if any, difference any failure to diagnose has made to the patient's outcome, and what their current condition and prognosis is.

Deciding whether to defend or settle claims are largely governed by the expert evidence. Experts, whilst instructed and paid by either the claimant or the defendant, are independent and their report is prepared to assist the court. Once court proceedings are issued there are various procedural timescales that the lawyers will deal with.

Will I have to appear in court?

Most claims are discontinued or settled by negotiation ahead of the trial, or a 'proof' in Scotland. It is therefore highly unlikely that you will need to attend court to give evidence, but it cannot be ruled out.

Giving evidence in court is (usually) not as dramatic as an episode of The Good Wife might have you believe. TV courtroom dramas are usually about as realistic as Holby City is to NHS medical practice.

If you are required to attend court in relation to an NHS claim, you will be there as a witness of fact to be questioned by a barrister instructed by the NHS's defence team first, before being questioned by a barrister for the patient's legal team. The solicitors representing the NHS will talk you through the process and will usually show you the court room and explain the set up in advance.

For GPs or private practitioners, MPS's legal team will assist and support members through this process. MPS successfully defends 76% of medical claims and potential claims.

Trials are usually held in public and the media can be present. There are no jury trials in civil claims in England, Wales or Northern Ireland. They do exist in Scotland but are rarely used in medical negligence cases.

What impact will a claim have?

Most claims are resolved without any further implications for the doctor. However, it is possible that a claim could trigger other investigations. Take the example of the death of a patient: the death could be referred to the Coroner or Procurator Fiscal for consideration of whether an inquest or Fatal Accident Inquiry is required (there are no inquests in Scotland, but there are Fatal Accident Inquiries convened by a Sheriff) and there could be a criminal/police investigation, depending on the circumstances of the death.

The family could also make a complaint to the hospital, which could be referred to the Parliamentary and Health Service Ombudsman in England; the Scottish Public Services Ombudsman; the Public Services Ombudsman for Wales; or the Commissioner for Complaints In Northern Ireland (known as the NI Ombudsman).

Then there could be a referral to the General Medical Council, either by the family, the hospital or because the GMC have seen details of the trial in the press. In these circumstances it is important to seek advice from your medical defence organisation as early as possible.

Being subject to a claim can be stressful and worrying, but the claims itself will not present any financial risk for you personally. If you are worried or concerned about a claim contact MPS sooner rather than later.

OVER TO YOU

Junior doctors Drs Katherine Taylor, Christina Parfitt and Linze Hamilton want to improve patient safety from the bottom up. They developed patient safety cards to help foundation doctors avoid mistakes

Despite national initiatives, the prevalence of inpatient harm remains as high as 8-10%. Things do continue to go wrong in hospital and in general practice.

But is this a surprise? Medical school teaches you the theory of prescribing, but the nitty gritty of medical practice is often learnt on the job. It is well recognised in medicine that this transition is a challenge. You may know that gentamicin can be ototoxic and nephrotoxic, but not necessarily the safest ways to prescribe and monitor levels.

You don't know what you don't know until the situation arises, so it makes sense to learn from others that have been in your position.

As new doctors struggling with job pressures and a lack of clinical experience for the first time, it is no wonder that the risk of error increases. The same applies when moving between hospital specialties every three months. Each time we face new challenges and are required to know different information for each department.

The beginnings

Our project began with a group of junior doctors in Nottingham who were asked to give a presentation to new F1s on how to be a good doctor. We decided to focus on how to avoid mistakes that could harm patients. We looked at the most common avoidable errors and developed an informational guide.

From here Junior Doctors Essentials was born (JDE), a junior doctor-led initiative aiming to reduce clinical errors and smooth this transition, thus helping improve patient safety. Our aim is to foster a bottom-up patient safety culture to reduce clinical errors, increase access to local guidelines and improve efficiency.

Launching patient safety cards

One of our initiatives was the development of JDE cards, which are now available to hundreds of foundation doctors. JDE has produced sets-of-ten credit-card sized guides containing concise, up to date and practical information, designed to aid junior doctors during their first few months. The guides are portable and can be clipped to a lanyard or belt.

We place great importance on the cards remaining up-to-date and accurate so they require a continuous audit cycle. Much like any guidelines, the cards are reviewed annually to ensure the information and advice is current. Through audit and feedback we are continually improving the cards to make them as useful and practical as possible.

In practice

Paediatrics, with drug doses calculated in mg/kg and varying frequencies depending on patient age, is a prescription minefield.

The NPSA reviewed paediatric patient safety in 2009 showing that 15-17% of incidents are medication related and 13-17% treatment or procedure related.

Simple things like prescribing fluids become invariably more complicated when your patient is a premature baby. Then there's that moment when a baby needs to be intubated and you have to prescribe the drugs in a hurry. Not to mention the perils of aminoglycoside prescription and interpretation of therapeutic vs toxic levels.

JDE has expanded the JDE cards to paediatric units across the south west of England and in several units across the country.

Effectiveness

So, the next question is "do they work?" Judging by the positive feedback we've had so far, the answer appears to be "yes". A staggering 83% of junior doctors who used the cards in paediatrics in Severn deanery during 2013 told us they improved their clinical practice, whilst 100% agreed they improved patient safety and 100% said they would recommend us to future cohorts.

We also developed clinical questions to ask juniors both before and after using the cards, aimed at assessing whether they could be said to improve knowledge. The results showed an average 25% improvement in performance in clinical knowledge of topics covered by the cards.

Recently, we took this a step further by looking at incident reports involving patient safety for a local neonatal unit. Our study shows that incidents in areas covered by the cards fell in the group who had access to the JDE cards, compared to the group prior to their introduction. Whilst we cannot attribute all this to the cards alone, they would certainly appear to improve patient safety.

Recognition

We presented at a conference in Melbourne to 119 countries at the International Congress of Paediatrics.

Closer to home, our group won an award for our poster at the Patient Safety Congress 2013 in Birmingham, where we presented to over 1000 delegates.

Barriers

It hasn't all been plain sailing. Finance has been our main barrier. When we first started, we designed, printed, laminated and hole-punched them ourselves. As we have expanded we are printing them professionally to make them wipe clean and user friendly.

Although our cards are non-for-profit, they are sold for £5 a set to cover costs. Hospitals usually use educational funds or charitable funds to pay for them.

Next steps

We would love to see our cards used nationwide and are working to encourage local units to consider whether JDE could help improve patient safety in their area. We are expanding to cover new specialties and are also developing cards for allied healthcare professionals.

Our medium-term goal is to develop a smart phone app which could support the cards and add a new dimension to the way they function.

As juniors, we know first-hand the problems we face on the front line and, year on year, we hope to continue to make life easier for new doctors.

If you have any questions or would like to get involved contact us. Our email is info@jdepaeds.org.uk.

What happens on tour stays on tour, but what happens on Twitter stays on Google forever. Doctors should be cautious when posting on social media sites, says Jack Kellett assistant web editor

It was once dismissed as the latest craze of a young generation, but in recent years the social media phenomenon has exploded, embodying a far broader representation of society.

There have been positive stories in the media around healthcare – the much popularised story of Stephen Sutton's battle with cancer, although tragic, was incredibly heartwarming, and gave patients a real insight in to how healthcare is delivered to the terminally ill.

In contrast it would not have been appropriate for Stephen's doctors to post on social media about Stephen without his consent, as it would have breached his confidentiality. This may seem fairly obvious, but more and more junior doctors are getting into trouble by posting nameless comments about their patients, who have then been able to identify themselves. Juniors have also got into trouble posting inappropriate material that questioned their professionalism, eg, the lying down game.

In response to this wide tide of complaints, the GMC issued guidance around social media. *Doctors' use of social media* can be applied to any social media network, with the underlying message that the standards expected of doctors do not change because they are communicating through social media rather than face to face.

Inappropriate comments

Social media sites blur the boundary between an individual's public and professional life – many indecent posts that have landed doctors in trouble are the result of a perceived lack of understanding when it comes to the privacy settings on their accounts.

In 2012 a surgeon updated his Facebook status when he finished work. He wrote: "Back and causing chaos. Been on call this week. Been in theatre… slaughtering the innocent." His comments were flagged to the wife of a patient who died while under his supervision. She was understandably distressed and made a complaint to the health board. The surgeon was disciplined and forced to issue a public apology to the family.

Consequences

An ill-advised post does not simply bring an individual doctor's reputation into question; it subsequently impacts on the reputation of the medical profession as a whole. Your trust or health board will take an equally dim view of you posting less than flattering comments about patients – it's safer to exercise caution.

It is worth noting that defamation law can apply to any comments posted on the web made in a personal or professional capacity, so think before you Tweet.

What next?

In the future we may see hospitals and practices impose stricter policies on appropriate usage, but for now you should follow the GMC's guidelines on how to use social media professionally and responsibly.

Another area for doctors to consider is the popularity of newer networks, such as Instagram and Vine that focus specifically on alternative forms of media like photos and video. This may cause further misunderstanding as to what is perceived to be a breach of confidentiality.

#Case_1

Dr A, a CT1, wrote on Facebook that he was in close proximity to people using drugs. He joked that he may have attended work whilst affected by such substances after his numerous nights out. His comments were picked up and he was referred to the trust/health board where he had conditions placed on his practice.

Advice

Dr A's attitude and subsequent actions could have put patient safety at risk and brought the profession into disrepute. His trust would have had no choice but to investigate his actions.

#Case_2

Following the death of a patient, Dr S engaged in a conversation with another doctor on his Facebook wall about what happened. The conversation was brought to the trust's attention and both doctors faced internal disciplinary proceedings.

Advice

Most social networking sites have limited privacy settings. Although Dr S did not identify the patient by name, hospital or treatment, the fact the patient could have identified themselves meant that Dr S and his colleague had breached patient confidentiality. It is important not to share identifiable information about patients, even when using professional blogging sites, which are not accessible to the wider public.

#Case_3

While working in emergency medicine, F1 doctor Dr G wrote a blog about her experiences. Although all of her posts were anonymous and she made up a lot of her stories, her trust were unhappy with her comments as it identified key members of staff within the hospital. She was called into a meeting with her trust and the matter was investigated.

Advice

Before setting up a blog tread cautiously and consider all the following pitfalls: breach of patient confidentiality; defamation; breach of contract – your trust or board may not be happy with what you have to say, as was the case with Dr G. It would have been sensible for Dr G to obtain the permission of the trust/board management and their educational supervisor before she created the blog.

Coping with alcoholism

Learning how to manage stress is a huge part of being a good doctor. Consultant anaesthetist Dr Rachel Black opens up about her struggles with alcohol and how she overcame them

How did you celebrate passing your finals? Your graduation? Your last birthday? Chances are that alcohol played a significant role.

How do you relax at the weekend? Pubs, restaurants, meeting friends? Alcohol probably features here too.

What about after a stressful shift? A difficult meeting with your educational supervisor? Do you drink then? Is there anything wrong with that?

Medics are renowned for enjoying a drink or two. From drunken antics at university, to mess parties and conferences, all facilitated by a high income and a stream of new colleagues to have fun with.

Drinking alcohol is fine, in moderation. And therein lies the key word. Moderation. Either you can or you cannot moderate the amount you drink. It took me a while to realise I cannot moderate the amount of alcohol I drink; it took me even longer to accept it. For me one glass of wine on the way home was never enough.

The problem

I tried to restrict my intake, applying new rules after each drunken episode. Only drink with others. Only drink outside the house. Only drink on Fridays and Saturdays. Then Friday became my day off so Thursdays were included. Sundays rounded off the weekend and I deserved it.

As the cycle continued monster hangovers made it difficult to function the following day and I would drag myself through, clinging on, until the time came when I could again relax with another drink. The more I drank each night, the harder it became to cope with normal stressors in daily life: work, family and disappointments without it. The worse I felt, the more I drank, I truly believed alcohol was the solution, not for one moment considering that it could be the problem, or the cause of my discontent.

Alcohol had become a problem.

Escalation

I was never drunk at work. I never drove when drunk. I never did anything illegal. I never drank when on call, but I made sure I could the nights before and after. I avoided driving and pursuits that precluded drinking. I was unable to do important things requiring concentration in the evenings; plan the calendar, banking, shopping. I would either forget or do them incorrectly. I never watched the end of a film, I was always asleep. The more I tried to control it, the less I was able to. Eventually I realised that my best intentions were meaningless; after the first drink, I no longer had control.

Choices

If you cannot moderate your alcohol intake you have two options. The first is continue to drink regardless. This way you will eventually lose all that is important to you: your self respect, your friends, your family, your career, your home. Your alcohol intake will progress to keep pace with your rising tolerance, and will invade further into your life causing dependency and bringing destruction.

The second option is to stop drinking altogether. This is the option I chose. After many failed attempts to moderate, I accepted that I had to stop drinking forever.

How?

It worries me how easily I got into that situation. I drank alcohol normally until I was 30. The next five years were full of pregnancy and breast feeding, but during this time I began to want more wine than was allowed. I returned to work and on paper I had it all: a fulfilling career, enough money, two healthy children, and a supportive husband.

Life was full and busy and I coped by compartmentalising. I was a doctor at work, a mother at home, a friend when socialising. 'Me time' had to be found and protected. Me time was wine o'clock and began as soon as the children were in bed and the chores complete. I would sit down with a glass of wine to allow my buzzing brain to relax.

Over time, wine o'clock started earlier, the volume of wine increased and the treat became first a need, then a dependency. I became concerned I was drinking too much and asked my husband's opinion. "It's not as if you're downing a bottle of wine a night, are you?" he once asked.

No, I wasn't, but by now I was regularly having half a bottle per night (sometimes two-thirds). A colleague then remarked she and her husband would have a bottle of wine each at night; red for her, white for him. This reassured me. This must be normal.

Very soon I too was drinking a bottle of wine most nights, and paying the price during the day; I was tired, irritable, complaining and negative about everything. I began to question the value I contributed to my family and wondered if it would be better for them if I left home and stopped aggravating them.

Depression

I didn't leave home. I knew deep down I must stop drinking to survive and in doing so resign myself to a life of misery, sobriety and deprivation. I never considered wine as a disease. I believed it was the treatment. I never considered there would be anything to gain from giving up.

Giving up

Giving up was not easy and I had a few false starts. I am still challenged by thoughts of "Wouldn't it be nice?" but they are just thoughts. I now know, in fact, it would not be nice.

The resulting magnitude of change in my life, my priorities, my thoughts, my likes and dislikes has astounded me. I now have more time, more attention, better concentration. I am a better mother, wife, friend and doctor. I am happier. I no longer seek parties and big nights out as before. I am content.

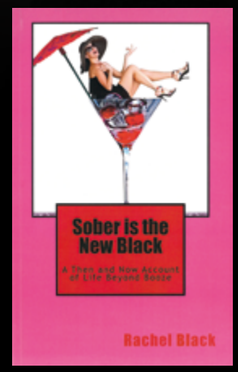
I am productive in the evenings now they are no longer a blur, and can drive my children to their activities without resentment. I am better able to deal with problems and stressors; my first thought being "Thank goodness I'm not hungover too".

Moving on

After more than a year of being free from alcohol I can see that drinking excessively almost crept up on me when I wasn't looking. Friends and colleagues had similar lifestyles and I was not alone or unusual in the amount I drank. It was a gradual change that I didn't notice until it was dictating my life.

Be aware of your drinking patterns. Be aware of the slippery slope. If you think you drink too much, you probably do and one day may have to choose how you wish to spend the rest of your life.

Dr Black wrote a book about her struggles with alcohol. Her book is called Sober is the New Black.



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IN THE SPOTLIGHT

Working in O&G in South Africa

Dr Dorcas (Dee) Obeng shares her observations working in a hospital outside Johannesburg

What	Working in antenatal outpatient clinics, labour and post natal wards, basic facilities
Where	Tambo Memorial Government hospital in Boxsburg and Clinix Private medical centre in Vosloorus, outside Johannesburg
Time	Two months
Demographic	Deprived rural 'townships'

Although I was born in Crawley, West Sussex to a family of six, my parents are from Ghana, so I've had a strong African influence in my upbringing. I've been lucky enough to visit Africa and love it and all its flaws – that's why I wanted to work in a deprived area in South Africa, helping women deliver babies.

It was an eye opening experience, one that I will take with me going forward as an obstetrician.

Medical conditions

I was able to witness pathology I'd only read about in text books; our medical system is better financed and free of some of the socio-economic issues that South Africa has to bear.

Witnessing eclampsia with HELLP syndrome, miscarriages and foetal death due to preventable causes, really opened my eyes. Due to a higher uptake of cervical screening in the UK women are treated early on at a precancerous stage, in contrast women in SA were not offered routine screening and would present later when the only treatment available was palliative.

It has one of the highest prevalences of HIV in the world. I observed many pregnant women on the wards with tuberculosis, PCP and other AIDS defining illnesses. Women of all ages and walks of life were presumed to be retroviral disease positive until proven otherwise.

I will never forget a nurse saying: "You could be negative today and positive tomorrow" and a doctor remarking: "I used to read the obituaries every day and 90% of the people would be under 25."

Paternalism

There was a paternalistic relationship between healthcare providers and patients. Doctors would not introduce themselves or even explain their examinations. The patients would rarely question their doctor or their management. Many did not know the names of their medications or even what they were for.

Midwives would shout at women if they made too much noise or were perceived not to work hard enough during labour. I was told "you have to be tough on these women or they become spoilt and will refuse to push." The absence of kindness, empathy and positivity, was surreal for me. Although the midwives never physically harmed the women it felt barbaric.

The midwives truly believed that their approach was effective, as it would force the women to work harder, ending labour sooner. In a hospital where epidurals were non-existent and pain relief was rationed, I began to understand their thought process, even if I didn't agree with it.

Gender inequality

My biggest inspiration in life is my mother who is a vivacious and successful woman despite being brought up in a culture where gender inequality often stifles females. I noticed the obvious gender inequality in the hospitals, eg, only the patient's male partner, would be addressed by the doctor.

A doctor I shadowed told women not to tell their husbands they were having a hysterectomy because their husbands would not allow the procedure due to a myth that it would feel different for males during sexual intercourse. I met women who refused the Mirena coil (IUCD) because their husbands did not like the idea.

Gratitude

We're all guilty of having a grumble about the state of the NHS, but we're so lucky to have free healthcare. Children who should have survived die in SA due to poverty, poor facilities, HIV and a lack of education.

There was one evening when the power cut so no surgeries could be performed. Women who could not afford the transport to the hospitals would go the full length of their pregnancies without ever seeing a midwife.

There were only two neonatal incubators, which were hopeless on the day 21 births took place. And then there was always the question of the children that did survive. What chance did they have of being able to afford an ultrasound scan, medication or doctor's appointment when they fell pregnant?

Respect

What I revelled in most was observing how alike we are as humans. The 43-year-old woman, who hugged me when I confirmed her pregnancy after numerous miscarriages; the wail of the child who was delivered by emergency caesarean after an abruptio placenta, and holding and crying with a woman who lost a baby – these scenes will never leave me. I have huge admiration for the women here and the hardships they suffer.

Lessons learned

I learnt to use a glove as a tourniquet, to line my syringes with heparin before attempting ABGs and to not expect women to know their gestational age. I hope that having the invaluable luxury of time allowed me to make patients feel important and cared for during one of their most challenging and vulnerable times.

I was extremely lucky to have had the opportunity to visit and work in such a beautiful, diverse and culturally rich country and hope to use my experiences to improve my practice in the future.

Dr Obeng is a foundation doctor in Birmingham.

A day in the life of an F2 in neurosurgery

Dr Varun Shankar gives an insight into a busy day on the neurosurgery wards

It's 7:28am and I'm on my way to the big morning handover, where all the doctors and nurses go through every one of 70 patients in the neurosciences ward. Most of my patients are currently stable, so there isn't too much to worry about, however my firm (one of four neurosurgical teams) is on call today, so I know I'm in for a bruiser.

Next it's the neuroradiology meeting where all the referrals from surrounding hospitals are discussed, followed by the NeuroITU meeting – my favourite part of the day (being a budding ITU doctor I lap up all the knowledge I can). My team has four patients; one of them is being transferred to a local hospital, as there is unfortunately not much more we can do for her. I remember when she came in a month ago with a big bleed. Her family have accepted that she won't return to normal, but it is still upsetting that a previously well woman in her 60s will never be the same again.

No time to think or dwell too much, as it's back to the ward for the ward round. My SpR is ruthlessly efficient so this is where I need to move with real purpose. Thank god I mastered how to write and walk during my F1.

During our round we are informed that Ms G has become unresponsive. This isn't good as this patient has severe learning difficulties and has had numerous EVDs put in over the years due to hydrocephalus. She came in a week ago for an EVD replacement as her last one became blocked. Today she is spiking a temperature and it may be time to replace the EVD again. Within the hour I've got to get her theatre ready, get a CT scan and LP done. Luckily, the other patients are all stable.

Ward round over, it's time to look at the jobs – four CT scans, nine bloods and five discharge summaries to sort out. First things first – get Ms G ready for theatre and a full septic screen done. She has notorious veins – luckily there is a small vein in her hand that hasn't been destroyed, so in goes a cannula. I request the CXR, do the LP (her opening pressures are within normal limits) and her urine is clear. While waiting for the portable x-ray I go to the scary neuroradiology consultant to ask whether Ms G's scan can be done first.

The neuroradiologist is not too happy, as is always the case first thing on a Friday. He does however agree and asks me to send Ms G for her scan in ten minutes.

Once the CT is done I call my SpR in theatre. My consultant answers the page and informs me that he will send for Ms G in 20 minutes. Ms G's mother has arrived and asks what is happening. Luckily I know her quite well so I sit her down in an office and explain things. She's used to the swing of things, but is understandably worried.

Ok, now the biggest job is done it's time to sort out the other CTs, then it's the blood round followed by urgent discharges.

I go to lunch at 1pm with my buddy from med school. He's having a relatively calm day and is hoping to finish on time. Lunch is cut short when I get paged that one of the patients from the neuroradiology meeting has arrived.

I wander over feeling buoyed that I'm running on time and not too tired. Mr M has an acute on chronic subdural haematoma and has deteriorated over the last 24 hours. Walking in I can hear his chest from four feet away – they won't operate with his chest sounding this bad. I tell my SpR, who is nonplussed as his parent hospital did not inform us he was this sick. He comes up, having finished Ms G's EVD, and agrees that we need to make him stable first. Another septic screen for me to do. CXR confirms pneumonia. Time to start him on IVABs, but looking at his comorbidities and eGFR, I realise he needs to be on a renal dose.

The scans and the bloods have been done; a few patients have hypokalemia, so time to start replacement therapy.

It's somehow already 5pm. I get things in order for handover. Ten minutes to finish, I get a page from a nurse. Mr M's son is here and is not happy we won't operate. I head over and explain the situation. He calms down after I answer his questions.

As I walk back to the doctor's office at 7pm to handover, exhaustion hits; I think about what I will do this evening. It's nearly 7pm and dinner in front of *Game of Thrones* sounds marvellous. Would I trade in this job for another? No way.

Dr Shankar was working in Leicestershire.

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