WELFARE RESOURCE PACK

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The Association of Anaesthetists of Great Britain and Ireland,
21 Portland Place, London W1B 1PY
Telephone 020 7631 1650 Fax 020 7631 4352
www.aagbi.org

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In times of distress or difficulty the BMA counselling and "Doctors for Doctors" advisory Service is available on 08459 200169

Section 1 Introduction and aims

The AAGBI recognises that a proportion of members will at some time in their career experience difficulties, either personal or professional, of sufficient severity to require external help. The nature of these difficulties will be enormously varied and in many cases the doctor concerned may not realise that they need help or that help is available. The AAGBI Welfare Committee has been created to help members with difficulties.

This resource pack is designed to provide members with a wide spectrum of relevant information. In addition to this publication, regularly updated information will be made available on the AAGBI website, together with links to other useful resources.

Section 2 The nature and background to problems

Modern medical careers combine the stresses and demands of professional life with the difficulties of survival in the human and medicolegal jungle, and the pressures of interpersonal relationships both at home and at work. Thirty percent of the general population will suffer from psychological illness at some point in their lifetime and the medical profession, far from being immune to this, may in fact be more vulnerable.

Individuals will respond to pressures in a number of ways. Some of these may be constructive and will improve their ability to cope and function. Other, more dysfunctional methods of coping with pressure such as increased drinking or smoking, aggression or other behavioural changes, social withdrawal and altered mood, will in the longer term have a destructive effect on the individual.

Doctors do not behave like other patients when accessing health care. Enormous pressure is placed on doctors not to 'give in' to ill health. The doctor who takes time off because of health issues may be viewed as a 'problem'. Doctors tend to be perfectionists, overly conscientious, approval seeking, and need to be in control. They may be self-doubting and are uncomfortable with praise. While any of these qualities may be good for patient care, they are not necessarily beneficial to the doctor's own health.

An inner need for validation - 'a needing to be needed' - may, in some doctors, disguise feelings of poor self-worth and insecurity. A doctor's identity may be so entwined in his or her professional role that, when this is challenged, for example by a complaint, they may feel their whole identity is threatened. The very traits that make good doctors, such as empathy and involvement in patient care, may in fact militate against good mental health of the doctor if the doctor is unaware of the interplay of these factors.

Section 3 The result of these problems

Some doctors will, as a result, experience a breakdown of their abilities to cope with either their work or personal life or both. The difficulties that bring them to that stage will come from a wide spectrum. Where possible, our resource pack aims to provide help to prevent anaesthetists getting to this breaking point.

We accept that in some cases doctors with difficulties may not be able to recognise that there is a problem until a crisis occurs. Part of this resource pack therefore addresses the recognition of potential problem situations and signs of dysfunctional behaviour in yourself and others. The resource pack also aims to give general guidelines to the way forward should such a crisis occur.

Potential pressures

Pressures can mount both at work and at home with resulting conflicts. It may be difficult to sustain the pace of a high-powered and demanding career if you are married to another high-powered professional. If there are also children in the family the pressures increase and may be associated with financial difficulties. Personal or family illness, either physical or mental, and other interpersonal problems including bullying are all potential causes of difficulties for even the most competent among us. Finally, the possibility and fear of medical error and litigation is a shadow that hangs over us all.

Section 4 Changes to look out for in ourselves and others

The person concerned may have an altered emotional state and as a result their **behaviour** may alter. Their time-keeping may be erratic. They may become angry, bad-tempered or aggressive. Alternatively, they may become quiet and withdrawn or show signs of anxiety in situations with which they were previously well able to cope; they may even panic. You may notice that they are drinking or smoking a lot more. Some people will undergo unexpected weight gain or loss; others will have difficulties sleeping, although a few may sleep more than previously.

They may also show **intellectual changes**. Poorer clinical performance or the occurrence of clinical errors may indicate impairment of attention, concentration or judgement. Even if they are not impaired to this level, they may simply appear to be less creative and dynamic than before.

Reading these lists should provide useful insights. Any change in behaviour that is not for the better is important. Recognition of an individual with potential problems is half the battle, as it enables early access to help and will avert more serious consequences.

The next section looks briefly at ways in which the situation can be changed.

Section 5 Bullying and harassment at work

Definitions:

Bullying: Persistent, unacceptable, offensive, insulting or humiliating behaviour that attempts to undermine an individual or group.

Harassment: conduct that is unwanted and offensive, affecting the dignity of an individual or group, arising from discrimination, e.g. on grounds of race, gender or sexuality.

Bullying and harassment are common in the medical workplace, leading to misery for both parties and potentially serious outcomes for patients. Many definitions exist and most of us will have some ideas and experience of our own. Fundamental to both is a lack of respect for others on the part of the perpetrator, who is usually in a position of power. Doctors commonly bully either other doctors - often those junior to themselves - or non-medical staff. Managers can also be bullies.

As many forms of harassment are illegal, the distinction is important, although there are many similarities between the two.

Why do people become bullies? The aim of the bully is to gain power through fear. A feeling of inadequacy underlies their behaviour. Bullies are commonly successful and charming, choosing their victims with care, criticising competence rather than personal characteristics, often inconsistently.

If you think you or someone else is being bullied you should take action. However, you must remember that justifiable negative feedback can also be unpleasant to receive, especially if it is not delivered sensitively.

Consider your options. Your Trust will have a policy on the management of bullying and harassment – look for it on the intranet. If you are a doctor in training, then your Deanery or School will also have such a policy.

Policies advise some or all of the following actions:

- Seek help and support from others – peers, line manager, Human Resources personnel and senior medical staff. For trainees, the educational supervisor, College Tutor, Programme Director and Regional Advisor are all appropriate people to approach in the first instance. For both seniors and trainees, the BMA or other professional body may be very helpful. The Andrea Adams Trust is a charity committed to preventing workplace bullying.
- Write down the details of any incidents.
- Try to avoid being alone with the bully.
- Some policies advise confronting the bully; this is risky as it may provoke aggression. Consider this course of action carefully and don't do it alone.
- Think about seeking medical help; it may be sensible for the victim to take a period of sick leave.

Remember – bullying is not the victim's fault.

Bullies should also receive help with tackling their unacceptable behaviour via the employing Trust, or the Deanery if the bully is a trainer.

Section 6 Life skills to help you cope with stressful situations

Time management
There are two aspects to this. The first is to ensure that time is used efficiently and effectively. The second is to ensure that it is used wisely. Rushing around appearing 'busy' is not necessarily the best approach. Taking on more than one can realistically cope with in a sustainable way is not good either. We need to be selective and to understand that doing a few things well is better than doing lots of poor jobs. It is also worth assessing how the things we take on will contribute to our CV and our long-term career strategy.

Personal and recreational time should also be factored into the equation as it is valuable in helping us to keep a sense of perspective.

Communication skills
The ability to communicate effectively is paramount in enabling us to manage our lives and our relationships with others. Although most doctors should have well-developed communication skills, some refreshment of these may be beneficial.

Assertiveness and conflict management
Assertiveness is about standing up for our rights and beliefs without violating the rights of others. Even when we are able to communicate well we may still not be able to state our position effectively or resist pressures to do things about which we are not happy. The skills of assertiveness are enormously valuable in a high-pressured professional environment, and ways of saying "no" in a pleasant way can be learned.

Conflict is an inevitable component of life, and we can develop our interpersonal skills still further to become good negotiators and to deal with conflict more effectively. It is much more effective to try these skills out in a tutorial environment than it is to learn by trial and error in a real conflict.

The beliefs that govern our behaviour

Even when we know a lot about assertiveness and conflict resolution, something still more fundamental may 'block' our assertiveness. We have thoughts and beliefs about how our assertive behaviour may be perceived or what the consequences may be. We may worry that we would be thought to be lazy if we don't agree to extend the length of an operating list, or incompetent if we don't agree to anaesthetise a patient with specific problems. We may worry that we will lose that surgeon's private practice or get a bad reference.

It is important that we take time to look at the way these beliefs are affecting our behaviour both in our personal and professional lives. We then need to analyse carefully whether these beliefs are true, and even if they are true, whether they should stop us doing what we know to be correct.

The way that our beliefs and insecurities affect us does not stop there. They may also pressurise us to try to attain unrealistic career goals. This will also put pressure on our work-life balance. A reality check is needed. This is where discussions with a senior colleague or mentor who has our interests at heart would be very valuable.

Section 7 Reality checking

Be good enough!
If your work and career are getting on top of you, it may be time for a reality check. Sleep may be disturbed by worries such as a missed deadline for an article, a poorly prepared lecture or an uncomfortable conversation with a colleague. When you feel like this, it really is time for a reality check. If you do not make the deadline or give the lecture perfectly consider what is the worst thing that can happen as a result?

You are allowed to be busy and miss the occasional deadline. Your lectures do not always have to be perfect. Sometimes phone calls can wait. Learn to judge success by your own standards, not those of others.

If you are keeping up to date, enjoying your work, interacting well with your colleagues and giving safe anaesthetics, you are having a successful career that the majority of the population would envy. You do not need to write a textbook or get a Gold ACCEA award to be a success. Just doing your job well can be deeply satisfying. If, as well as doing this, you manage to achieve things outside of the work environment like enjoying a hobby, pursuing a sporting goal or raising children, you are a real achiever. Other people's career goals need not be yours. Set your own realistic goals and work in a steady and sustainable way towards them. Re-evaluate your goals regularly – something you really wanted two years ago may not be quite so desirable now, so there is little point pouring time and effort into achieving it.

You are not alone
There will be times in your career when you feel hopelessly inadequate for the tasks ahead. Worse than this, when you look around you, all your colleagues seem to be self-confident and assured achievers who can balance work and life with both hands tied behind their backs. You can feel remarkably isolated and you may be reluctant to share your feelings with others. However, outward appearances may not represent how other people really feel. You are not alone; anyone who works in a challenging environment feels like this some of the time. Some people spend their whole life feeling this sort of helplessness most of the time. You must believe that you are not exceptional or out of the ordinary.

Talk to people – lots of people

Sharing your goals, successes, failures, thoughts, feelings and concerns with others is a vital way of staying well in any work environment. Find a few like-minded colleagues or people who are in a similar situation to you and arrange to meet somewhere you can talk. Sharing concerns can make things a lot easier and can create lasting friendships. Find yourself a mentor. If you are having difficulty identifying someone who could be a mentor or advisor, your Trust may have a list of suitable trained mentors available. Remember, a mentor does not have to be from your own specialty or even a doctor, and may even be younger than you. Look around you. There may be someone you can identify whom you like, admire and respect, and to whom you can talk. Communication throughout your career is the key to the enjoyment of your work and should extend to your friends and family. Do not try to keep your professional life completely separate from your private life.

Enjoy the success of others and try to enjoy your own success

You will undoubtedly have triumphs at work, from the successful management of a difficult case to the development of a new service in your hospital. Whatever the success is, you will want to share it with your colleagues and enjoy their appreciation of the effort you have put in. It is equally important to listen to your colleagues and congratulate them for their achievements. Doctors are naturally competitive and success too often provokes envy and scorn. Try sharing praise with all your colleagues, it nurtures a team spirit and is good for relationships.

Don't worry – be happy

Work is there to be enjoyed, not tolerated or dreaded. If you are not happy at work, don't just suffer in silence and long for the end of every working day, do something about it. The 'something about it' starts with thinking about what it is at work that stops you taking pleasure in it. Share problems with colleagues and you will find that you are not alone. Not all work-related problems are readily soluble, but talking about them is more than half the solution and, if you cannot change things, at least you can find a way to work around issues so that they do not spoil your enjoyment of work.

A successful career can be expressed in many ways. You might be an invited lecturer at major meetings throughout the world, an editor of journals, a manager of an anaesthetic department of a major teaching hospital or simply a well-liked, hard-working colleague who turns up for work each day

consistently cheerful and positive. The important thing is to take pleasure in your work and feel satisfied by your contribution; to find a role that suits you and enjoy setting yourself goals and achieving them. This more than anything will earn the respect and admiration of your colleagues.

Section 8 Your rights and responsibilities

When reality checking, you need to be aware of your rights

You have a right to:

- Freedom from discrimination on the grounds of race, gender, sexual orientation, age and disability.
- Freedom from bullying and harassment.
- A job plan that affords reasonable work-life balance, i.e. has a fair distribution of elective and emergency work out of hours, allows adequate SPA and CPD time and allows maintenance of essential skills.
- Be paid for the work that you do.
- Negotiate fewer hours or part-time work.
- Take sick leave when you are sick, either physically or emotionally.
- Retire before or after 65.

With rights come responsibilities

Your employer has a right to:

- The number of hours' work as set out in your contract and job plan.
- Negotiate a fair job plan with you.
- Expect you to look after your health, e.g. maintain hepatitis immunity, wear protective clothing, not come to work drunk or overtired.
- Challenge excessive sick leave by requiring you to attend occupational health.
- Expect you to keep up to date within your specialty and meet CNST criteria.

Section 9 Mentoring

Mentoring is possibly the most cost-effective method of developing talent within an organisation and has been shown to improve retention, increase motivation and decrease stress. Most successful companies regard mentoring as a fundamental part of their culture, and many health organisations are waking up to this fact and are developing mentoring schemes for their employees. However, we must be precise in defining what we mean by mentoring as it is often used to describe many different processes.

What mentoring is not

It is not about making friends, although friendships do sometimes develop. It is not about dependence, control, counselling or supervising. It certainly is not about power, gossip, cliques, giving solutions or assessment.

What the nursing profession refers to as 'mentorship' is more akin to the role of an educational supervisor. Likewise, the 'mentor-protégé' approach (sometimes called sponsorship mentoring) describes what many doctors wrongly perceive to be mentoring. The relationship here is usually based on a more senior and powerful person giving advice and taking charge of a protégé's career development. The trainee merely follows someone else's advice or perception of what is the correct way forward.

Other roles which we might undertake in one-to-one relationships include, teacher, facilitator, coach, counsellor, buddy, friend or father figure. These roles may of course be what a trainee or colleague requires at different times of their career, but they usually rely on a one-way offering of advice and are therefore not strictly mentoring.

In addition, although most doctors regard themselves as good listeners, the reality is that we usually listen 'diagnostically', not openly, so we tend to jump in with solutions. Most of us have a blind spot about this which only becomes apparent when we undergo specific training in reflective practice or true mentoring. Frankly, the authoritarian, didactic advice that has been the cornerstone of so much medical supervision or so called 'mentoring' in the past is extremely limited. Mentoring offers much more.

So what do we mean by mentoring?
In short, it is about self-development. It is a powerful way of encouraging individuals to move things forward by taking ownership of the solution to a situation; it is about developing opportunities as well as solving problems.

An excellent definition is: 'The process whereby an experienced, highly-regarded, empathic person (the mentor) guides another individual (the mentee) in the development and re-examination of their own ideas, learning and personal and professional development.' **[1]**

Thus it is about helping someone to manage their problems and opportunities by developing their unused potential. The mentee takes ownership of the goals and solutions and the mentor helps the mentee to look outside their box by providing a safe, confidential sounding-board off which ideas can be bounced. A skilful mentor guides without offering solutions, empathically challenges assumptions, actively listens and does not judge or advise. Mentors motivate, encourage, support, empower, nurture self-confidence, aid reflection and explore strengths and weaknesses. It is a totally non-judgemental alliance, allowing an appreciation of different perspectives. It is therefore a complex task, but it is one that is deeply satisfying for both the mentee and mentor because of the two-way exchange of learning that occurs.

What use is it to individuals and departments?
Not everyone needs a mentor, but mentoring is useful to individuals and departments whenever there are problems that need to be resolved, support needed for colleagues or when there are opportunities to be developed. A trained mentor can help the mentee to explore and choose the right question, then to consider alternative ways of looking at the situation and finally to formulate a plan and commitment to deliver the solution.

The process can take a few minutes or many hours. It depends on the context and the stage the mentoring relationship has reached. It can even be done over the telephone or by email.

We often make career choices and personal decisions because we feel obliged to do so and we end up feeling unfulfilled. By using mentoring, the mentee can, often for the first time, explore their real needs in a safe environment. This is extremely empowering, and goals are much more likely to be achieved when they are aligned to personal preferences and values.

Different mentors may be required at different times for different situations and, although the mentor can be from the same specialty and more senior, there are sometimes advantages in the mentor having no personal knowledge or experience of the problem. When mentoring is available, working environments seem to be happier and more supportive, people more valued and more productive. Mentoring skills are also useful in one's personal life.

How do I find a mentor?

To find your own mentor, you might start by asking colleagues whether there are trained mentors within the department. If not, then perhaps within the Trust; the Medical Director, HR Director or their PA can often advise and the Clinical Tutor may be aware of schemes in other Trusts. If you would rather ask outside the hospital, then a call to your Postgraduate Deanery or Strategic Health Authority, or a visit to their website, would be the next port of call. Such organisations often already have schemes in place and will certainly know of others.

To appreciate the full benefits of mentoring, the mentor one chooses should be trained in, or at least have a passing acquaintance with, one of the various techniques of mentoring. These can be learnt on training courses, which are easy to find on the internet, or are sometimes available through the postgraduate Deanery. However, just reading about the skills necessary, such as utilising the 'Skilled Helper Model' **[2]**, can set one off on a never-ending path of self-discovery! It can even help you develop a new career.

Having a mentor outside the department, Trust or even the NHS, e.g. a GP, dentist, nurse or businessman, can be liberating and can allow you to explore issues that you might be reluctant to talk about within the organisation. If the mentor is properly trained, their background, age or sex should not really be an issue. Many local businesses will already have schemes running and a call or visit to the website of the local 'Business Link' centre might be worthwhile. **[3]**

As a last suggestion, an internet search will undoubtedly come up with many schemes and mentors, and indeed mentoring can be successfully undertaken over the telephone or online in many situations. The key is to find a mentor that you are comfortable with. Services are often free but you should respect the relationship by keeping appointments.

Setting up a scheme

A useful way to start is for one or two people to act as mentoring champions. Read about it and sell the idea to colleagues with talks, a forum or even by running a training course. There are many articles and books available on how to do this. **[4,5,6]**

Of course, mentoring needs to be voluntary and should never be imposed on anyone. Once trained, practise the skills on colleagues or other mentors (co-mentoring). As your confidence and experience improve, you might expand the scheme outside the department. However, there do have to be rules, which include complete confidentiality and setting boundaries with the mentee. As in appraisal, these must be agreed at the start of the relationship to protect both parties. Some schemes use formal contracts but most mentoring relationships are informal and agreement is usually verbal. Of course, the mentor and mentee must be compatible for the relationship to work. As the scheme becomes established, try to have time recognised in your contract to mentor or at least to develop your expertise. Developing networks with other schemes immediately increases the pool of mentors.

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Section 10 Returning to work

Many doctors who have experienced personal or workplace difficulties, or have taken time off for personal reasons, should be able to return to work successfully. It should not automatically be assumed that when they return to work, it will be to their original job plan, as their circumstances may have changed. The structure of the return to work programme will depend on individual circumstances.

Some important definitions used in this section

Return to work programme: A formal, structured re-introduction into the workplace for those doctors who have been out of clinical practice for a prolonged period or about whom there are no longer any serious concerns. At the end of the process there must be a *summative* assessment of whether the doctor is safe to return to practice or not.

Summative assessment: An assessment of competency resulting in a clear statement of success or failure of the doctor reaching a required standard.

Assessment of competency: A potentially wide-ranging assessment of clinical competency covering knowledge, skills and behaviour aimed at deciding whether there are areas of serious concern.

Re-training programme: A structured programme of targeted retraining aimed at addressing specific, pre-identified areas in which a doctor has been found to have serious deficiencies.

Doctors wishing to return to work
There are many reasons why a doctor may take a prolonged period out of clinical practice:

- A natural career break, e.g. child care, travel, research, sabbatical or caring for a relative
- A prolonged physical illness
- A psychological illness
- An addiction problem
- A formal suspension or related investigation

Doctors wishing to return to work tend to fall into one of three clear groups.

1. **An expectation of a return to normal practice in a short period of time.** This is often the case for doctors who have taken extended leave for personal reasons or have suffered a physical illness with no residual deficit in physical or cognitive abilities. This is by far the most common group.
2. **Returning to work for a more prolonged period of supervision and assessment**, where the outcome of the 'return to work period' is less clear. This may occur following a prolonged illness or following a suspension, where it is not yet clear if the doctor will easily be able to perform the duties expected of him or her. This process will usually incorporate an ongoing assessment of competency.
3. **Returning with serious concerns about the competency of the doctor.** This group should not undergo a 're-introduction process'; rather, they will need a formal assessment of their competencies and most likely a re-training programme.

Any doctor who has been out of clinical practice for a prolonged period, who wishes to return to work and about whom there are no serious concerns should ideally undergo a three-part re-introduction to the workplace process.

1. **An introduction period** that allows the doctor time to be re-acquainted with working practices, drugs, techniques and team members. This period should be flexible.
2. **A formal period of re-introduction back into clinical practice.** This should incorporate all aspects of clinical practice, e.g. re-acquiring clinical skills, demonstrating appropriate knowledge and behaviour and an ability to work in teams. This period should incorporate a structured feedback on progress.
3. **A summative assessment at the end of the re-introduction process** by a number of senior experienced consultants to determine whether the doctor is fit to return to full practice or not.

A number of points need to be addressed before the return to work programme starts:

- Most doctors should undergo some form of assessment by Occupational Health and confirmation that they are physically and mentally fit to return to work and do not pose a threat to patients.
- Each person returning to work will have an individual profile that should be fully explored and understood by all parties before a re-introduction to the work place commences.
- There should be an agreement as to who is in charge of the process, how long it is likely to take, what documentation will be needed and what endpoints will be employed to determine fitness to return to work.
- A return to work period should not be used as a method of determining competence in a doctor. A return to work policy should be reserved only for those doctors in whom all major issues have been resolved and there is the expectation of a successful return to work. All other cases should either undergo a formal assessment of competence or a formal retraining programme.

Duties of the clinical departments undertaking the return to work process

- The Medical Director and/or the Head of Department must know of the doctor's status, must agree to their returning to work and should receive a written report at the end of the process.
- Patient safety is of the utmost importance and re-introduction into the workplace must never compromise safety.
- There should be an agreed introductory period with the sole purpose of re-introduction into the workplace. There should be no formal assessment during this period.
- One consultant should be in charge of the process. He or she should ask for help from a small number of experienced colleagues.
- The consultant in charge must understand in detail why the doctor has been off work and how this might impact on their ability to return to work.
- Clear guidelines should be set up, indicating what is expected, how the process will be carried out, when and how feedback on progress will be given and what the formal assessment at the end of the period will involve. Timelines should be set up and adhered to. A programme

should be created that details where and when the doctor is expected to attend the hospital and with whom they will be working.

- The doctor should be working only on a one-to-one basis with specified consultants. If the consultant leaves a patient with the doctor, he or she must be available to return immediately if a problem occurs.
- A formal report should be created at the end of the period to which the doctor should have access for comment.
- Notes should be kept of aims, progress and assessments.
- The doctor's confidentiality and dignity must be respected at all times.
- The consultants involved in the process must be open, honest and fair at all times.
- The consultant in charge and the department should recognise the potentially stressful nature of attempting to return to work and, if appropriate, the doctor should be offered a mentor.
- The consultant in charge should be aware that occasionally new problems are uncovered during the process. These must be addressed when found. If deemed sufficiently serious, the re-introduction process should be stopped and replaced by a more formal and thorough test of competence and, if appropriate, a retraining scheme instituted.
- The department should recognise that, if the initial problem was related to the workplace, either by the type of work or the interpersonal relationships between the doctor and his or her colleagues, then returning the doctor to exactly the same environment might not work in the longer term. Consideration of a job plan change with appropriate retraining might be in everyone's best interests.

Obligations of the doctor undergoing a return to work programme

Doctors returning to work should:

- Not attempt a 'return to work' programme unless sure they are well, clinically safe and are confident of success.
- Have insight into why they were off work. If the problem was stress, addiction, poor interpersonal skills, etc, have they changed sufficiently to be able to successfully return to work?
- Set realistic goals for returning to work. If there has been a prolonged illness, consideration should be given to returning part-time and not doing on-call duties.

- Recognise that the process can be stressful. It can also be difficult and embarrassing working with old colleagues. Recognise the natural fear of being assessed and of failing to meet the necessary standard. Do not be embarrassed to raise these issues and discuss them, either with a mentor, the consultant in charge or family and friends.
- Recognise that if the reason you stopped working is because of problems with colleagues or the type of work, these are unlikely to have changed in your absence. Consider either working at another hospital (difficult), or having the job plan sufficiently changed so as not to recreate the problem.
- Seek the support of family, friends and sympathetic colleagues.
- Consider finding a mentor that they trust and discuss the issues as they arise with this person.
- Be enthusiastic, honest and committed to the process.
- Not be put off by setbacks; rather, learn from them and correct the problem.

Maintaining the new situation

It is important that the new situation in which the returning doctor is placed is sustainable. This depends on accurate recognition and assessment of the original causes of the problem and a long-term strategy to resolve these. Unless there are compelling reasons to believe that the doctor's normal coping skills were greatly impaired for reasons that are evident, they should not be pressurised to return to a situation of equal pressure.

Section 11 The training years

The demands and pressures of anaesthetic training are substantial. The information in this resource pack is of equal relevance to trainee anaesthetists and addresses some of the personal problems that can hamper professional development. We hope that reading this booklet and the recommended further reading will help to prevent serious problems developing.

Trainees are, by the very nature of their position, more vulnerable than trained anaesthetists, especially to coercion and bullying. They may feel pressured to take on unrealistic workloads in the hope of gaining a good reference or avoiding a bad one. Mentorship has much to offer in such circumstances and we recommend that all trainees have a mentor. It cannot but help them to formulate a career strategy and at the same time can provide a much-needed reality check. Likewise, we recommend that all trainees have a general practitioner even though this may be difficult if they are moving jobs.

Problems specific to trainees

1. Appointment to a training post
The chaos surrounding the implementation of recent changes to the training programme has resulted in a total lack of confidence in those that govern training. Many trainees have found themselves either without a training appointment or, having secured a post, needing to move residence to a geographically distant location. It is hoped that future appointment processes will take into account the extra stress and insecurity that car be generated by such issues.

2. Rotations
Even where these are arranged as sympathetically as possible, some rotations cover large geographical areas, resulting in the need to move house, home and family, or requiring trainees to commute for long distances.

3. Shift work
It is known that working anti-social hours on a shift-pattern basis can contribute considerably to fatigue. The role of on-call rooms in minimising fatigue is well known and supported by good evidence, but few Trusts now provide adequate rest facilities. A Group of Anaesthetists in Training (GAT) survey has shown that 18.4% of hospitals across the UK have withdrawn at

least one anaesthetic on-call room. This figure rises to 21.4% for the London rotations.

This appears to be due to the erroneous assumption that working shifts of 12-13 hours overnight precludes the need for sleep. In reality, the time of day or night is a much more important factor in determining concentration levels, with significant dips during the night whatever the duration of shift. Short 'power naps' in the horizontal position during night shifts have been shown to decrease fatigue and improve concentrating ability. Another factor is that, whilst trainee hours have decreased over the last decade, the intensity and immediacy of night work for anaesthetic trainees has become greater.

4. Obtaining FRCA status

The examinations remain as challenging as ever while the pressure to pass first time is greater. At present it is not known whether the proposed new training system will have the flexibility to allow trainees who have failed exams to 'tread water' while retaining a training number. Not obtaining FRCA status at all will result in failure at ARCP (Annual Review of Competence Progression - previously RITA), with resulting uncertainty regarding their future career.

Trainees are advised not to attempt the exam prematurely. Have a clear, early plan of action. Prepare well and do not leave this very important requirement to chance.

5. Failure at ARCP

The commonest reason for this is failure to obtain FRCA status. A trainee failing ARCP must be informed of the reason for their unsatisfactory performance. This will allow them to formulate a clear remedial strategy with the help of their educational supervisor.

6. Seniority

With decreasing hours and decreased experience, trainees can feel that they are taking on responsibilities that they are not trained to deal with. Many trainees feel unprepared for their future consultant application. Again a reality check can be useful. Where trainees are aware of serious skill or knowledge deficits they should try to identify ways in which these can be remedied. Here again, the Deanery and Regional Educational Advisors should be approached for help. Where a trainee is placed in a position in which he or she does not have the necessary skills, he or she should call for senior help rather than

put the patient at risk. Even at consultant level it can be valuable to discuss clinical problems with a consultant colleague.

7. Disillusionment

Anaesthetic training is aimed at achieving a consultant position. As a result of NHS manpower changes, this may not be such a predictable attainment in the future. In such circumstances, many may question why they are striving so hard completing audits, doing research and producing publications.

How can trainees help themselves?

Trainees in every Department of Anaesthesia will benefit from meeting regularly without consultant presence. In this way common problems can be identified and discussed, and serious issues can then be relayed to the consultant meetings. Where individual trainees have problems, it will be useful for them to talk them through with family and friends. The next step would be to discuss it with their mentor or another close colleague.

Within any Department of Anaesthesia there will also be others who could be approached: your educational supervisor or a consultant anaesthetist with whom you get along well. Once a problem is identified, it will become necessary to involve College Tutors and the Clinical Director.

If a problem cannot be solved within the department, advice can be sought with the Programme Director or Regional Advisor.

Section 12 Access to other sources of information advice and help

Members in distress, with personal problems and /or requiring urgent advice are advised to call the Doctors for Doctors Number: 0845 9200169

Should they subsequently be dissatisfied with the response, they can revert to the AAGBI secretariat.

Members who need to discuss more practical aspects of their career management or employment or who have problems of a less urgent nature can also call the AAGBI secretariat who will direct their call appropriately on advice from the Honorary Secretary to members of Executive or Council as appropriate.

A further extensive list of sources of help is available on the AAGBI website (www.aagbi.org)

The general AAGBI WEBSITE is a source of a vast range of information. The welfare section has links to other relevant sources of information and advice of a more personal nature.

THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

21 Portland Place, London W1B 1PY
Tel: 020 7631 1650
Fax: 020 7631 4352
Email: info@aagbi.org
www.aagbi.org