

# JMO SURVIVAL GUIDE 2017

*Written by Junior Doctors for Junior Doctors*



Postgraduate Medical Council  
of Western Australia

*Photo credit: Dr Rosh Bakmeedeniya*



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of Western Australia

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This Survival Guide is available online at  
[ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council](http://ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council)

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# 1 | INTRODUCTION

## 1.1 | WELCOME

Thank you for taking the time to read this guide. We hope it will help you understand who the Postgraduate Medical Council of Western Australia (PMCWA) is, why they are around and what they do for you. They are always keen for new junior doctors to become involved, so feel free to contact them via the PMCWA website ([ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council](http://ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council)) and click through to the 'WA JMO Forum', or by emailing them directly at [PMCWA.JMOF@health.wa.gov.au](mailto:PMCWA.JMOF@health.wa.gov.au).

## 1.2 | WHO WE ARE

The Junior Medical Officer (JMO) Forum is made up of volunteer, representative and elected members from all of the major tertiary hospitals in Western Australia (WA). It meets once a term and membership of the JMO Forum is determined by representation from the tertiary hospitals' Junior Doctor Societies and elected positions of Co-Chairs who oversee the running of the JMO Forum and its activities. Medical student representatives from Notre Dame University Fremantle and the University of WA also participate in the Forum. The JMO Forum aims to enable effective JMO representation on relevant PMCWA Committees and other bodies to facilitate two-way communication. For more information see section 3.10 – JMO Forum (page 9).

## 1.3 | PURPOSE OF THIS GUIDE

This document can be used as a reference point throughout your junior doctor years. It includes a range of information and contacts and can be used as a guide for where to go for help or advice. It also contains details on the various junior doctor committees beyond the PMCWA JMO Forum. If you are just starting out in the hospital system, this document gives you an idea of the standards and expectations that come with working in the WA hospital environment.

# 2 | DEFINITIONS

## 2.1 | WHAT IS PREVOCATIONAL TRAINING?

Prevocational training is the beginning of postgraduate medical education in which doctors develop competencies after completion of their basic medical qualification.

The first year after graduating from medical school is a compulsory supervised training year known as internship or postgraduate year 1 (PGY1). The following year/s (PGY2, PGY3 etc) are spent working as a Resident Medical Officer (RMO). The PGY1 and PGY2+ years that a doctor undertakes prior to entering a vocational training programme provides the grounding for future vocational training. From PGY2 and onwards JMOs can work in either the private or public system. PMCWA oversees training, accreditation and educational opportunities for junior medical staff in these early postgraduate years.

## 2.2 | DPGMEs, DCTs, MERs AND MEOs

Each hospital has a Department of Postgraduate Medical Education or Postgraduate Medical Education Unit that coordinates education, supports training and offers career advice for doctors. Every hospital that employs interns must have the following officials:

### **Director of Postgraduate Medical Education (DPGME)**

- The DPGME is a consultant who has general responsibility for overseeing hospital-wide postgraduate medical education activities, including orientation of doctors. This person is only available at sites directly employing interns.
- S/he has specific responsibility for overseeing the training of prevocational doctors in accordance with the PMCWA Accreditation Standards, as well as the Australian Medical Council and Medical Board of Australia Standards.

### **Director of Clinical Training (DCT)**

- The DCT is a person to approach in times of stress or difficult situations as they will be able to provide you with support and advice.
- S/he is usually a consultant at the hospital whose role includes assisting with the prevocational training program, providing feedback and advice to junior doctors and liaising with term supervisors regarding JMO issues.

### **Medical Education Registrar (MER)**

- The MER is a good first point of contact for junior doctors in need of help.
- S/he is a registrar employed by the hospital whose role includes teaching, development of educational materials/programs, supporting and advocating for junior doctors and supporting the work of the Postgraduate Medical Education Unit.

### **Medical Education Officer (MEO)**

- The MEO specifically assists with the prevocational education and training experience.
- You will come to know your MEO very well in your intern year as s/he will be present at the intern teaching sessions and will keep you up to date with news relevant to interns.

Contact your Postgraduate Medical Education Unit to identify the DPGME, DCT, MER and MEO at your hospital.

## **2.3 | INDIVIDUAL HOSPITAL ACTIVITIES**

### **Fiona Stanley Hospital**

Fiona Stanley Hospital (FSH) is WA's largest tertiary hospital and primarily serves the south metropolitan area.

FSH has the state's busiest Emergency Department and provides the service of all tertiary specialities with the exception of trauma. It is located 20 minutes from the CBD.

Rockingham General Hospital and Fremantle Hospital operate under the Fiona Stanley Group. In addition to this, FSH gives interns opportunities to work in Albany and Broome.

The Stanley Medical Officers Society (SMOS) is an advocacy, social and support group that represents the interests of all JMOs employed by FSH. It organises key social events including the end of term parties and ensures the



medical staff common room is stocked with coffee and treats throughout the week. This is an important society to be a part of as a new doctor!

### **Royal Perth Hospital**

Royal Perth Hospital (RPH) is WA's longest serving hospital. It has 450 beds and is situated in the CBD. RPH offers an extensive range of services including the state trauma centre.

Armadale Health Service and Bentley Health Service operate under the Royal Perth Group and as a JMO you have the opportunity to work at these sites. In addition to this, RPH gives JMO opportunities to work at Bunbury, Kalgoorlie and Port Hedland.

Socially, RPH has an enthusiastic RMO society with a very busy social calendar: from Milligan's Bar on a Friday evening to numerous cocktail parties and the annual ball.

### **Sir Charles Gairdner Hospital**

Sir Charles Gairdner Hospital (SCGH) provides over 600 beds and is only 4km from the CBD. It is home to WA's only comprehensive cancer centre and is also the state's principal site for neurosurgery and liver transplantation.

The RMO society keeps a busy social schedule with Friday night drinks, cake and patisseries for morning tea twice weekly in the common room and an annual ball.

### **Joondalup Health Campus**

Joondalup Health Campus (JHC) is the major hospital for Perth's northern corridor. It is divided into two sections; a private and public hospital and is Australia's largest public private partnership hospital with over 500 beds. JHC is part of Ramsay Health Care and thus if you elect to work there your salary is dictated by Ramsay Healthcare Awards rate.

As an intern you may be seconded to work at JHC via SCGH. The hospital RMO society is tightly integrated with the hospital executive and other hospital services, allowing for strong representation on junior doctor issues such as welfare, education and training.

### **King Edward Memorial Hospital for Women**

King Edward Memorial Hospital (KEMH) is WA's only public tertiary maternity and gynaecological hospital. JMOs can work at KEMH from PGY2 onwards - although preference is given to PGY3+ and JMOs can apply for either 6 or 12 month contracts. Secondments include Joondalup Health Campus, Osborne Park Hospital, Swan District Hospital and Kalgoorlie Regional Hospital. Skills developed at KEMH are desirable for multiple career paths such as vocational training or diplomas of Obstetrics and Gynaecology, Emergency Medicine and General Practice.

Subiaco train station is a five minute walk from the hospital. The RMO society keeps the doctors common room well stocked with good coffee, as well as organising end-of-term events, regular drinks and the annual KEMH ball.

### **Princess Margaret Hospital/Perth Children's Hospital**

Princess Margaret Hospital (PMH) is the dedicated children's hospital in WA. The hospital is imminently moving site to Nedlands where it will be known as Perth Children's Hospital; it will have 298 beds. Similar to KEMH, JMOs in PGY2 can apply for either 6 or 12 month contracts although PGY3 and above are preferred. Residents may be seconded to other rotations e.g. KEMH for a neonates rotation or JHC for paediatrics.

Many junior doctors choose to complete the Diploma of Child Health (DCH) while working at PMH, particularly if they are looking to do Paediatric or General Practice training. There are lectures held at PMH on Wednesday nights as well as assignments and exams to be completed.



# 3 | PREVOCATIONAL TRAINING

## 3.1 | POSTGRADUATE MEDICAL COUNCIL OF WA

PMCWA was established in 2003 to provide leadership for early postgraduate medical education and training in WA. PMCWA is primarily funded by the Department of Health.

## 3.2 | AIMS OF PMCWA

- Development of guidelines and protocols for the education and training of prevocational doctors and other medical practitioners not in vocational training programs.
- Setting standards for prevocational training positions within health services.
- Accrediting and monitoring medical training positions for prevocational doctors (PGY1 and PGY2+).
- Monitoring and advising on the supply and demand for the prevocational workforce in WA.
- Supporting clinicians and other professionals involved in the education and training of prevocational and other non-vocational doctors.
- Identifying and advising on matters that impact the health and welfare of prevocational and other non-vocational doctors.

## 3.3 | COMMITTEE AND STRUCTURE

PMCWA members are representatives of the stakeholder organisations involved in the support, training, supervision and administration of prevocational doctors and other non-vocational medical officers.

The Council reports to the Minister for Health via the Director General of the Department of Health. There are representatives from the JMO Forum on the PMCWA Council and all PMCWA committees (Executive, Accreditation and Standards and Education).

### 3.4 | ACCREDITATION

The aim of prevocational training is to further the professional and personal development of medical graduates in their early postgraduate years. The accreditation program sets out to establish and monitor standards for prevocational medical positions and to assist in the attainment of a universally high standard of general clinical training.

Accreditation helps to ensure that health services employing prevocational doctors offer sufficient experience, education, training, supervision, assessment, evaluation, support (including resources) and a safe working environment to enable prevocational doctors to meet the objectives of their training.

Through the process of accreditation, hospitals and other training organisations that employ prevocational doctors are formally evaluated by a survey team using clearly defined and established standards. Survey outcomes often include recommendations for improvements and recognition of excellence. If you are interviewed during a survey, your honest feedback will be sought and valued.

Are you interested in becoming an accreditation surveyor? It's a good way to see what posts are available at other hospitals and how they are run, as well as being the voice for junior doctors in ongoing accreditation for new posts. Email [PMCWA.Accreditation@health.wa.gov.au](mailto:PMCWA.Accreditation@health.wa.gov.au) to register your interest.

### 3.5 | WORKFORCE

PMCWA and the WA Department of Health recognise that workforce planning is fundamental to the delivery of good health care. PMCWA is represented on a number of important workforce planning committees within the Department of Health including the Medical and Dental Workforce Council and International Medical Graduate Advisory Group, committees that monitor the supply, demand and needs of prevocational doctors in WA. A member of the JMO Forum sits on many of these workforce committees.

### 3.6 | EDUCATION

The Education Committee is responsible for the identification, evaluation and monitoring of education and training programs for prevocational medical officers and other non-vocational doctors. The Education Committee reports to the Council on strategies and outcomes.

The JMO Education Committee representative attends both the JMO Forum meetings and the quarterly Education Committee meetings. The role of the representative is to be:

- An advocate for JMOs on all educational issues.
- Responsible for providing feedback on the activities of the Education Committee to JMO Forum members.
- Responsible for undertaking or assisting in education projects with the support of the JMO Forum and Education Committee.

### **3.7 | AUSTRALIAN CURRICULUM FRAMEWORK FOR JUNIOR DOCTORS**

The Australian Curriculum Framework for Junior Doctors outlines the knowledge, skills and behaviours required of prevocational doctors (PGY1 and PGY2+) in order to work safely in Australian hospitals and other healthcare settings. It provides a bridge between university curricula and the curricula that underpin college training programs. It provides junior doctors with an educational template that clearly identifies the core competencies and capabilities that are required to provide quality health care.

A copy of the Curriculum Framework is provided in the orientation materials each year (it is also available as a smartphone app e-book – search ‘ACF LP’).

For more information, please refer to the website for the Australian Curriculum Framework for Junior Doctors: <http://curriculum.cpmec.org.au/>.

### **3.8 | EDUCATION AND TRAINING OPPORTUNITIES FOR INTERNS**

- Teaching (once or twice a week) is compulsory and is protected time from your pager. Divert your pager to your resident/registrar for this hour. It is a good break from the ward and the topics are useful.
- Be proactive – there are a wide range of skills you can learn in your intern year such as chest drains, ascitic taps, nerve blocks, lumbar puncture, suturing, tying, cutting and central lines to name a few.

### 3.9 | EDUCATION AND TRAINING TIPS FOR RMOs

- Resident teaching is available at all accredited sites and is compulsory at most. Support this as it is an excellent opportunity to engage in a wide range of topics that may be outside your area of interest.
- Think about attending courses (EMST, CRISP, ASSET, CLEAR etc) which may be relevant to your area of interest. They provide a good opportunity to acquire skills in a non-clinical setting and may assist you with training program applications.
- If you have suggestions for education activities, please contact your DCT and MEO.

### 3.10 | JMO FORUM

The WA JMO Forum is an initiative to promote better communication between JMOs and PMCWA. It is used to inform JMOs of initiatives and strategies that impact them and to gather information to better inform the PMCWA's JMO activities.

The terms of reference for the Forum include:

- To focus on the participation and involvement of JMOs in the decision making and planning functions of PMCWA and its Committees.
- To provide advice to PMCWA and its Committees on issues of relevance to JMOs.
- To report to PMCWA Committees on relevant issues and where appropriate, forward issues to Council through the Committee reports.
- To assist in the development and evaluation of resources developed by PMCWA and its Committees.
- To educate and inform key stakeholders of the goals of PMCWA.
- To provide representation on PMCWA Committees to support their work in achieving the goals of Council.
- To support members of Council, Executive and Secretariat attending the JMO Forum as a resource on specific issues, when appropriate.

The JMO Forum meets at least once a term. Any JMO may attend and everyone is welcome. Keep an eye out for emails and the PMCWA Facebook page ([www.facebook.com/PMCWA](http://www.facebook.com/PMCWA)) which will advertise the forthcoming meetings.

### 3.11 | HOW TO GET INVOLVED

Representatives from PMCWA will give a talk during the intern orientation sessions at your hospital. At this time there will be an opportunity to provide your name and email address so that PMCWA can contact you about upcoming meetings and events. Alternatively you can email [PMCWA@health.wa.gov.au](mailto:PMCWA@health.wa.gov.au) with your details and the relevant information will be forwarded to you. PMCWA has a Facebook page ([www.facebook.com/PMCWA](http://www.facebook.com/PMCWA)), 'like' the page to keep up to date with all the latest information.

The first JMO Forum meeting is generally held in February each year and subsequent meetings occur approximately every two months.

### 3.12 | LINKS WITH AMA DIT, RMO SOCIETIES

The AMA Doctors in Training (DIT) Committee is closely allied with the JMO Forum. The JMO Forum focuses on the educational, supervisory and training aspects of prevocational training. The AMA DIT looks primarily at the industrial aspects of being a junior doctor. This can include issues with lockers, security or on-site hospital facilities as they arise. DIT also concentrates on the AMA Metropolitan Health Services Agreement and how this is being applied to the work conducted by junior doctors. You might think the payment of doctors should be relatively straightforward but in many areas the AMA needs to ensure fair payment to doctors for the work we perform while ensuring safeguards in terms of hours and workload in relation to patient safety.

Previous issues that have been tackled by the PMCWA JMO Forum include: inadequate numbers of doctors rostered on for afterhours cover; pager-free protected teaching time; access to library resources; and appropriate rotations for junior doctors. As you might imagine, issues often overlap between AMA DIT, PMCWA JMO Forum and the hospital-based RMO societies.

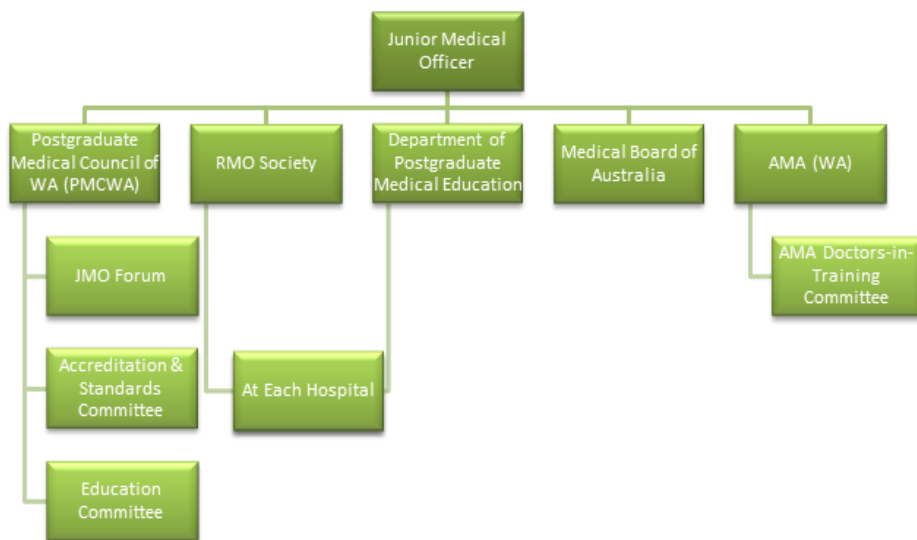
Each of the tertiary hospitals in Perth have their own RMO society with an annually-appointed president and other committee members depending on the hospital. There has been considerable support between groups on issues that affect a group of junior doctors including parking, lack of JMOs at certain hospitals and JMOs having to work long unsafe and unsociable hours. The alliance of all of these groups, including the two medical student bodies (WAMSS and MSAND), creates a very powerful voice for the younger generation of doctors in our hospitals.

# 4 | JMO RIGHTS

## WHAT TO DO IF YOU HAVE A PROBLEM

### 4.1 | SUPPORT NETWORKS

A mud map of the groups working for you in WA



### 4.2 | RMO SOCIETIES

For a small fortnightly fee that comes out of your pay, the RMO societies do a lot of work on a junior doctor's behalf. This includes:

- Liaising with hospital administration staff regarding issues such as leave and rostering. Talk to your RMO Society representative if you are having problems at your site – they may be able to assist.
- Providing social supports and Friday afternoon fun – (e.g. Milligans at RPH, Harry Perkins at FSH, Doctors' Common Room at SCGH).
- Coffee machine, papers, morning tea.

### 4.3 | AMA (WA) DIT COMMITTEE

The AMA Doctors-In-Training (DIT) Committee is a group of doctors committed to advocating the professional and industrial aspects of working as a junior doctor in WA.



### **Who can join?**

Membership is open to all junior doctors - from intern to senior registrar - that are AMA members. The Committee includes a broad range of sub-specialty and prevocational trainees.

### **What issues are discussed?**

The Committee discusses a broad spectrum of issues affecting the education, training, industrial and professional aspects of being a junior doctor. Some are tackled as they arise, such as hospital facilities for junior doctors being withdrawn without notice. Others are prospective initiatives, such as ensuring safe working hours for junior doctors and supporting a healthy work-life balance.

### **Representation to organisations**

The AMA DIT Committee also provides representation to a number of internal and external committees. DIT members represent the interests of all junior doctors to educational groups (PMCWA Education Committee, the Joint Consultative Committee for Medical Student Training, JMO Forum, UWA and NDU Curriculum Committees) and allied PMCWA committees (Executive and Accreditation and Standards), as well as subspecialty interest bodies. A group of General Practice registrars provide contacts and support to WAGPET and Community Residency Program Committees.

The circle of representation is completed by external nominees to the DIT Committee. This includes members of the Resident Medical Officer Societies as well as medical students from both universities (UWA and NDU). Each of these makes the DIT Committee a vital conduit of information from various groups in all areas, from medical politics to the social scene and upcoming ball dates.

### **Workshops and courses**

A number of workshops are available to AMA members, initiated by the DIT Committee. These include:

- Getting Started in Clinical Research – for those interested in getting an edge for their CV by small papers - or for those embarking upon a full Masters or PhD program - potential avenues for funding and mentorship are discussed.
- CV and interview skills workshop for members considering applying for a college program.
- Getting Started in Private Practice – for the DIT nearing the end of their

training in any sub-specialty, the 'business of medicine' is rarely discussed but crucially important for survival in the world of private medicine.

- Presentation skills seminar – junior doctors do more presentations than any other professional in their field. Tips on oral presentations, slides and handouts, format and how to make your message clear are covered in this two-day seminar.

#### 4.4 | MEDICAL BOARD OF AUSTRALIA

In 2010 all states and territories joined the Medical Board of Australia, which is a division of the Australian Health Practitioner Regulation Agency (AHPRA). The Medical Board of Australia has an office in all capital cities, including Perth.

The Board is an independent statutory authority. Its role is to:

- Register medical practitioners and medical students.
- Develop standards, codes and guidelines for the medical profession.
- Investigate notifications and complaints.
- Where necessary, conduct panel hearings and refer serious matters to tribunal hearings.
- Assess International Medical Graduates who wish to practise in Australia.
- Approve accreditation standards and accredited courses of study.

The Board consists of eight medical practitioners, one legal practitioner and three community representatives.

#### 4.5 | MANDATORY EXPERIENCE

As an intern, you hold provisional registration with the Medical Board. Upon successful completion of your internship, you will be eligible for general registration.

All hospitals employing interns provide rosters that include the mandatory core terms. The Medical Board of Australia requires interns to perform satisfactorily under supervision in the following terms:

- *A term of at least 8 weeks that provides experience in emergency medical care*
- *A term of at least 10 weeks that provides experience in medicine*
- *A term of at least 10 weeks that provides experience in surgery*
- *A range of other approved terms to make up 12 months (minimum of 47 weeks full time equivalent service).*

Please keep these requirements in mind if you swap rotations or take leave during one of the mandatory terms.

For further information regarding the Medical Board of Australia please visit their website [www.medicalboard.gov.au](http://www.medicalboard.gov.au) or contact PMCWA for assistance.

## 4.6 | PARENTAL, EXTENDED LEAVE, PART-TIME AND JOB SHARING ARRANGEMENTS

The following arrangements may be accommodated via discussion with your employer. Giving adequate notice (10 weeks) to the hospital (usually medical administration / DPGME) prior to taking leave is important in having leave approved.

### **Parental leave**

As per legislative requirements and the AMA Industrial Agreement (2013), employees are entitled to 52 weeks parental leave in relation to the birth or adoption of their child. Up to 14 weeks of this may be paid, if the employee is the primary care giver.

### **Extended leave**

This leave is organised in consultation with the employer. This may not be possible during your intern year, due to internship requirements of supervised training, but is more easily arranged from PGY2.

### **Part-time**

According to the AMA Industrial Agreement (2013), a full-time practitioner's request to work on a part-time basis shall not be unreasonably refused. Hours worked will be negotiated with the employer.

### **Job sharing**

Most hospitals will allow for job sharing, particularly when part-time work is requested. This needs to be discussed with your hospital.

## 4.7 | SUPERVISION REQUIREMENTS

WA teaching hospitals believe strongly in supervision for the junior doctor. As an intern, there should always be someone senior on site to refer to if there are difficult or specialist decisions to be made. RMOs and registrars also have supervision, however depending on your experience or specialty this may not

be onsite supervision. The Accreditation and Standards Committee evaluates each intern/RMO position to ensure supervision is adequate.

If you find that you are not receiving the support that you require, speak to your consultant or Head of Department. If this does not improve the support you are receiving or you feel that you cannot discuss this with the department, contact your Department of Postgraduate Medical Education. This can be further addressed to PMCWA via the JMO Forum ([PMCWA.JMOF@health.wa.gov.au](mailto:PMCWA.JMOF@health.wa.gov.au)) and if necessary the accreditation of the rotation will be reviewed and concerns investigated.

In a situation where you have a patient who is unwell on the ward and are not sure what to do, contacting your registrar is often the first thing to do. However if your patient is acutely unwell and meets MET (Medical Emergency Team) criteria, activate a MET call immediately as they can help you stabilise your patient. Your registrar should also be contacted at this time.

## 4.8 | TERM ROTATIONS

Interns and residents generally undertake five rotations of approximately 10-11 weeks duration throughout each year, although some sites (e.g. PMH), have four rotations of a longer duration.

JMOs are able to preference their term selection from a list sent out by the hospitals following the job application process. First year residents (i.e. PGY2) will generally have to do a leave relief and/or emergency term. There are a small number of terms that are available through a separate process; a term in Clinical Service Improvement that is run through the Institute for Health Leadership at the Department of Health (PGY2+) and the Peri-Operative RMO position (PGY2+), a six-month peri-operative/anaesthetics position at SCGH. Speak to your hospital's medical administration staff or PMCWA for details on how to apply for these terms.

## 4.9 | CLINICAL STANDARDS, TRAINING AND ASSESSMENT

As a JMO, you are required to meet certain clinical standards and training/educational objectives.

Your clinical standards will be assessed during and at the end of each term by a senior member of your team (usually a consultant). During these assessments your senior is given the opportunity to highlight areas that need improvement and areas in which you did well. These are aligned with the

Australian Curriculum Framework ([www.cpmec.org.au](http://www.cpmec.org.au)) and global intern outcomes ([www.amc.org.au](http://www.amc.org.au)).

All hospitals provide teaching/training on a regular basis to all JMOs. These are usually once or twice weekly sessions addressing problems that commonly arise on the wards and opportunities to learn specific skills such as using slit lamps, research skills etc. Once in a registrar training program, most specialties have regular teaching sessions.

Some teaching hospitals also provide a 'skills week' in which you will learn skills that you may not learn on the wards. Other hospitals will require you to spend time in theatre, with anaesthetics, ICU or in other settings to learn new skills and procedures.

## 4.10 | PAY ISSUES AND PAYSLEIPS

### HOW TO CHECK YOUR PAYSLEIP 101

Please visit [the HCN Doctors & Medical Administration Intranet page](#) for current payroll information.

Before you attempt to understand your payslip there are a few things you should do first:

1. At the start of each term contact HCN to confirm what your template hours will be. Remember that the template roster for some terms includes afterhours work such as evenings and weekends.
2. Record any work you have done outside the template hours in a diary or on a calendar.
3. Remember to submit overtime forms promptly after completing a shift - weekly or fortnightly is best. If the department says they will submit overtime forms make sure it gets done. If in doubt, submit them yourself.

The worst that could happen is HCN receives two sets of forms. At least that way you stand a better chance of getting paid!

When you receive your payslip each fortnight take the time to look through it. By following these steps you should have a rough idea of whether you were paid correctly. Please note this information is a rough guide only as every payslip is different. If in doubt, contact HCN.

1. Calculate the total number of hours you should have been paid for over the fortnight. Do this by adding your template hours (e.g. 85hrs) to all the

- extra hours you have documented in your diary/ calendar/ phone.
2. Calculate the total hours you have been paid as indicated on the payslip. Do this by adding up the 'full' hours you were paid for (i.e. add up all the hours where you were paid your hourly rate or above. Ignore anything where you were paid a percentage of your hourly rate e.g. 75%).
  3. If the numbers in point 1 and 2 are the same you're doing well! You can now proceed to ensure you were paid the appropriate penalties.
  4. Calculate your entitlement as per the table below

Penalty rates:

Base hours	1 x base rate
Public holidays	2.5 x base rate
<b>Weekdays</b>	
6pm-0000	1.2 x base rate
0000-8am	1.25 x base rate
<b>Weekends</b>	
Saturday	1.5 x base rate
Sunday-8am Monday	1.75 x base rate
<b>Overtime</b>	
Hrs>80/fortnight	1.5 x base rate
Hrs>120/fortnight	2 x base rate

E.g. (if base rate = \$40)

- Monday – **2hrs** = 2 x 40
- Tuesday (public holiday) – **4hrs** = 4 x 2.5 x 40
- Sunday – **2hrs** = 2 x 1.75 x 40
  - Total = 80 + 400 + 140 = \$620

Remember it takes time and practise to be able to decipher your payslip. So do not worry if you are extremely confused at this point!

Other penalties and payments you may wish to check for include on-call allowances, call back payments, meal payments and any breach penalties. Information on these and other entitlements can be found in the Medical Practitioners (Metropolitan Health Services) AMA Industrial Agreement 2013.

If you think you may have been paid incorrectly, contact HCN and ask them to take you through the hours worked each day during the pay period. You can then check this against your own records.



# 5 | WHAT'S MY ROLE?

## WORKING IN THE WA HOSPITAL SYSTEM

### 5.1 | SCOPE OF WORK

As a junior doctor, you are part doctor, part administrator and often the primary point of contact for patients and their families. On a usual JMO job, you are required to:

- Write in the notes;
- Complete ward jobs: cannulas, bloods outside of phlebotomy rounds, med charts, investigation request forms, consult forms to other specialties, discharge summaries;
- Clerk patients (on terms such as ED and the acute assessment units).

Remember that these are your patients. If you take the time to get to know them and the details of their care as opposed to simply being the team's 'paper pusher', you will learn a great deal more.

### 5.2 | TIPS FOR JMOs

Your junior doctor years are an exciting time during which you will be presented with many challenges and learning opportunities. Remember that many have gone before you, so if you feel overwhelmed there is always someone to talk to.

## **Be organised**

- Get a good handover from the previous interns – this is invaluable!
- On day one talk to your team, clarify their expectations of you throughout the term.
- On ward rounds take the time to clearly write down all the jobs you need to do, clarify things as you go.
- Keep a bunch of radiology forms, consult forms, med charts and inpatient notes in a clip board so that you do not need to be running back and forwards unnecessarily. You can also do the forms as you go while the stickers are on hand.
- Pre-empt discharges, when someone is close to discharge make sure their summary is started and their discharge medications are done. This ensures that you are not being chased the following day at ward rounds to get the paperwork done as the patient is walking out the door.

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## **Prioritise jobs**

- At the end of ward rounds prioritise the jobs to be done, if possible sit down with your registrar to quickly run through what needs to be done.
- Get consults done early as registrars tend to get grumpy if consulted after midday and may refuse you, especially later in the week.
- Radiology is also another job to organise early as several processes may need to be organised before the patient goes for their scan.

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## **Don't dump on your colleagues**

- Ward cover should be an emergency service, not picking up the pieces from disorganised interns. Make sure you have:
  - prescribed warfarin daily;
  - re-written medication charts on Friday;
  - checked / ordered blood and x-ray results daily;
  - addressed patients who were hyper or hypoglycaemic overnight;
  - written a plan for fluid replacement if necessary.

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## **Writing in notes**

- Minimum information includes names of those on the round (from most to least senior), date, time, your name and signature and pager number.
- A good way to start your entry is to quickly revisit

who the patient is and why they are in hospital i.e. '78 year old female with CAP, day 2 IV ABx'.

- Write legibly (this may become a legal issue).
- Ensure there is an entry for each patient every day, even if only brief.
- If you are ordering a test, try and make it obvious why it is being ordered and document the result when you have it.
- If the patient's problems and care is complicated, write a problem list at the front of the notes to highlight the hurdles to discharge.
- Make your plan very clear. This is what is referred to by nursing and allied health staff to guide treatment for that day – it makes their job easier and facilitates timely discharge if the plan is clearly stated.

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### **Communication**

- Ensure the written plan is verbalised to the appropriate nursing staff, they'll make notes on their handover sheet based on your advice and this will facilitate thorough care of the patient.
- Warn ward clerks regarding impending discharges.
- If you are asked by the ward staff to review a patient, do it! It doesn't look good to have 'Doctor refused to review patient' in the notes. Respect their opinion, many will be far more experienced than you. Furthermore, write in the notes afterward so that there is evidence that you were there and what you did, allowing the next person reviewing them to be up to speed.

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### **Consulting colleagues**

- Make sure you follow up your written consult with a phone call. Make sure you have all notes, blood results and radiology available before you call so that you do not get caught out when they fire questions at you. Make sure your referral refers to a specific clinical question to be addressed.
  - The same goes for radiology requests and it often pays to speak to radiology directly. If contrast is required know the patient's creatinine.
-

## **Learning opportunities**

- Ask to do procedures, even with the grumpiest registrar, if you are enthusiastic they often give in!
- If you are keen on surgery show your face in theatre, the more they see of you the more likely they are to let you assist.
- Take responsibility for your learning, ask lots of questions on ward rounds. If you do not ask why a test is being ordered it will be assumed that you understand why, which is often not the case! It is much easier to order an investigation or arrange a consult if you know the indication for the request.

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## **Managing ward cover**

- Carry a tourniquet, pen torch and a copy of 'On Call'.
- Prioritise jobs! Ward cover is invariably a very busy shift ranging from acutely unwell patients to rewriting medication charts.
- Handover unwell patients to the night cover JMO.

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## **Seek help early**

- Do not be afraid to ask for help. You are a doctor under supervision so do not feel like you have to make all the decisions.
- Stand up for yourself. Do not do anything that you are not comfortable doing, such as running a code or doing a consent form for a procedure that you know nothing about.

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## **Debrief**

- Medicine is an extremely rewarding but demanding profession. It is important that you talk to friends on a regular basis so that you remind yourself that other people also face similar difficulties.
  - Friends outside of medicine are also important, especially if you are having a hard time and may be in doubt over your career choice. Being new in any profession can be tough and friends may have stories that not only put your experience into perspective but also put a smile on your face.
  - Help is never far away – so ask for it if you need it.
-

## 5.3 | TRAPS FOR YOUNG PLAYERS

### Lab results

- If you order a test, it is your responsibility to follow it up.  
Some tests like pathology and microbiology take time to come back so make sure you set yourself a reminder to check (you could put the patient's sticker in a little notebook or put it in your phone).
- Interpret in the context it was ordered. Treat the patient, not the lab test i.e. +ve MSU results in the context of a symptomless patient.
- Remember that all investigations cost money and excessive 'routine' investigations add up for both the Department of Health and the patient (think of all those needles!).

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### Fluid management

- It is harder than you think and can be potentially dangerous, as a general rule do not prescribe fluids without going to see the patient.
- Think about body weight, oral intake (or lack thereof), losses through drains, and electrolytes.
- Ensure you know how to assess fluid balance; there are some useful apps that can assist here.

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### Medication charts

- Do not rewrite blindly – check all medications / doses / routes until satisfied.
  - If unsure of the dose, check with eMIMs, AMH, a colleague or a pharmacist (pharmacy are always happy to be consulted).
  - Remember, some drugs need monitoring i.e. warfarin, digoxin and gentamicin.
  - If patients have completed their course of medication, cease it (i.e. antibiotics and steroids). It's also good practise to write the reason why the medication was ceased as it can be very confusing for subsequent doctors to work out what's going on if things are simply crossed out.
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**Drug levels**

- Do not blindly chart warfarin, refer to INR and consider whether the drug should be withheld in the context of the patient's admission.
- Write the correct info on the request form i.e. when checking drug levels write the specific time the test was taken. If unsure of the timing, check with the lab.
- Remember to consider drugs that are cleared by the kidneys in the setting of renal failure.

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**Radiology on ward cover**

- Know your review spots in a CXR, e.g. the small pneumothorax or subdiaphragmatic free gas.
- Do not clear an NG tube placement until completely satisfied (a clinical review may be warranted).
- If in doubt, seek help or ask your friendly radiologist.

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**BSLs on ward cover**

- You will be called to prescribe insulin for high BSLs, do not just prescribe four units of insulin blindly, consider timing, presentation and reasons for poor control.
  - Review the patient and the insulin chart, look for identifiable causes for hyper- or hypo-glycaemia.
  - Insulin is renally cleared so be wary in renal impairment. Prescription should then be reviewed by the day team.
- 

## 5.4 | WORKLOAD

This will be entirely variable depending on the job. Expect base hours between 40 and 50 hours/week, including a Saturday morning ward round on many rotations. In addition, there is often a separate roster for after-hours ward cover (this tends to be the case on 'quieter rotations') and on-call roster on terms such as ED. You are paid for your lunch breaks (no doubt implying that it is common to not be able to take one but at least always make yourself stop for 15 minutes to eat).

In every term (apart from those involving shift work, such as ED and acute assessment units) you will be rostered to work 'ward cover' shifts on weeknights and weekends. On average, these occur once every one to two weeks. This involves responding to issues after the patient's day team has left. Shifts vary in intensity, you could find yourself sitting in the common room most of the night, or you could be paged all night, occupied with ill patients. How busy you are often depends on whether or not the day intern / resident finished all their jobs! (These shift can usually be swapped amongst other interns / residents).



**Remember, help is always available, even if at times there appears to be none. There is always a medical and surgical registrar in the tertiary hospitals and you can always call ED. If all else fails and you're worried you can call a MET, there is no quicker way to get help!**

## **5.5 | OBTAINING INFORMED CONSENT**

Obtaining informed consent, and whether or not one is appropriately trained to do so, is an issue that commonly affects JMOs. The WA Department of Health's 'Safety and Quality' website addresses informed consent, including the 2011 '[Consent to Treatment Policy for the Western Australian Health System](#)'. Some salient points as related to JMOs are synthesised below:

1. Consent is always taken in the context of patient safety.
2. Prior to obtaining informed consent, the prevocational doctor should be satisfied that s/he is aware of the material risk. S/he should also be able to understand that material which can be reasonably withheld in the patient's interest.
3. The prevocational doctor should know the patient well enough to appreciate the specific risks to that patient. A patient may have special needs or circumstances that may in some cases require special or additional information.
4. The prevocational doctor should have sufficient knowledge of the procedure to explain it to the patient.
5. For each placement, there should be an opportunity for an agreement between the term supervisor and prevocational doctor about those procedures for which they are comfortable obtaining consent, those that they would not and those which may vary depending on the individual patient and the prevocational doctor's experience.
6. Hospital process must not allow unfair retribution to a prevocational doctor from a supervisor for reasonably refusing to take consent.
7. Consent is sometimes taken at the last minute when more senior staff are not readily available. There should be a policy to generally obtain consent during pre-admission clinics or equivalent. Where appropriate it may be reasonable to not allow a case to be booked unless consent has been obtained.
8. Where appropriate, consent may not be delegated and must only be taken by a senior resident, registrar or consultant.

If you do not feel that you are adequately prepared to obtain consent from a patient for any given procedure, it is important that you express this to your supervisor/s (registrars / consultants). If you, at any time, feel inappropriately pressured to carry out consents for procedures you should contact either your term supervisor, DCT or DPGME.

## 5.6 | HANDOVER

Handover is 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.'

Handover is one of the most important skills that you need to acquire as a JMO and is not often taught in medical school. It is important to understand that poor handover ultimately affects patient safety.

The handover tool used in WA is the iSoBAR tool. Handover may include something as simple as asking a colleague to check a blood result or more complex tasks such as handing over patients at term changeover and the more formal handover processes that occur in wards such as the intensive care unit. At the end of your normal day shift you should handover sick patients / those that require review to the evening doctor. If you follow the iSoBAR process you will not miss any vital information.



## 5.7 | DISCHARGE SUMMARIES

Discharge summaries are also a form of handover, in this case to the patient's GP. It is difficult when first starting out to know how much information to include in the discharge summary. At the very least the following should be included:

- Diagnosis (check with your registrar if you are not sure);
- Medication list (most importantly new medications commenced in hospital, if possible state the indication);
- Follow up / plan (how long on those antibiotics?);
- Outpatient appointments (if relevant); and
- Specific (and polite!) instructions to the GP.

A useful approach is to type a short summary of the presenting complaint and management thereof in the box entitled 'Management/Progress' (e.g. 'This 68 year old lady presented to SCGH ED with two hours of central crushing chest pain, which radiated to her jaw. On examination, she was sweaty and pale. Stable vital signs. ECG revealed an acute anterior myocardial infarction...' etc).

Those who have been in hospital for a long period are obviously more complex and their discharge summary should probably be started prior to their discharge. A useful approach is to represent key points in dot point form. e.g. This 81 year old man was admitted to RPH following a fall where he fractured his left neck of femur. Summary of admission:

- Fracture neck of femur;
- Subsequent osteomyelitis; and
- Rehabilitation.

## 5.8 | PROFESSIONAL STANDARDS

### 1. Language

Patients expect a high level of professionalism from doctors. It is good to start a relationship using Mr/Ms – this may change depending on the age of the patient and the rapport you have built. You must always introduce yourself and have your name badge visible. Try to use appropriate language when speaking with your patients, remember that a hospital is a confusing and daunting place – so no swearing, jargon or overly casual remarks!

## **2. Manners**

Be polite to all members of staff, you can't do your job solo.

## **3. Pagers**

You are required to be contactable during your rostered hours and must answer your pager promptly. However, if you are in the middle of a cannula just get it done and then answer (it's not practical to answer the pager every 30 seconds so you need to prioritise – as with everything else you do).

## **4. Punctuality**

It is important that you aim to be punctual. Furthermore, it is often expected that junior medical staff will know the results of the previous day's blood tests etc so it is often useful to arrive at work 10 minutes early. It is important that you have all relevant information available when interacting with other health professionals and for referring patients.

If you find you are left to deal with a situation that is beyond your level of ability ask for help from a senior colleague. It is important to know your boundaries (you can't know everything and you shouldn't feel that your question is silly). If you do not agree with a decision from another doctor do not be afraid to question it.

## **5.9 | PRIVACY AND CONFIDENTIALITY**

To keep patient details strictly confidential you should always be aware of who may be able to see your notes, where you leave them, where you throw them away, what you say and who may be listening. This can be tricky, especially when your team takes the lift during a round and continues to discuss the patients while members of the general public share the lift. Remember, the general public occasionally take the stairs too. When talking to a patient in their room, make sure the curtains are always shut. Every ward has a confidential paper bin near the ward clerk. Throw your lists away there once you have finished with them.

If you take a phone call regarding a patient, ask politely who is calling and their relationship to the patient. If there are guests in a patient's room, ask the patient if they are happy for you to continue talking about their medical conditions. With patients who are unable to communicate, there can be multiple family members involved. Try to convey all information through one family member (usually the next of kin) so that it is clear to all the staff which person can be given confidential information.

Sending pictures of patients via your mobile phone to anyone (even if they are a consulting or treating clinician for your patient) is currently against Department of Health policy and could get you in a lot of trouble (including potentially costing you your job). Whilst the use of smart phones and photography continues to be debated in relation to privacy laws and Department of Health policy, make sure you know the policy before you do it. The job you save may be your own.

Information and professional development sessions are run by PMCWA, AMA and other organisations. Sign up for training in privacy and confidentiality when you can.

## 5.10 | DRESS CODE

Dress code is essentially smart office attire such as the 'clinical clothes' you wore at medical school. Closed-in shoes are expected as part of occupational health and safety. There are some rotations and some hospitals that allow junior medical staff to wear scrubs to work but this depends on which area you are working in. It goes without saying that dress should not be inappropriately revealing and should avoid flashy logos, slogans or anything else that patients might take offense to. Neckties are now out of fashion due to the inherent infection control risk, however, some consultants may insist on it. If in doubt, follow the adage of 'when in Rome, do as the Romans do' or simply ask.

## 5.11 | EQUIPMENT FOR THE WARD

- At least three pens...your registrar will borrow them... forever.
- Clipboards are useful to hold your patient list.
- Extra things in your clipboard such as blank inpatient notes, med charts, radiology forms etc.
- Stethoscope (you'll need this on medical AND surgical terms, surgeons never carry them).
- Pager... especially useful when switched on.
- ID badge to prove that you are no longer another medical student.
- *On Call* by Cadogan, Brown & Celenza. A book written by WA doctors for ward cover.
- Log-ins and passwords for online resources.

## 5.12 | MEDICAL STUDENT PLACEMENTS

Remember, this was you not so long ago! Try and remember your horrible experiences and try to improve this experience for the students attached to you.

## 5.13 | SURVIVING AFTER HOURS

After hours work and night shifts can be the most daunting for junior doctors. However, it is important to remember that you are never alone. The 2016 Medical Education Registrars at each of the sites have provided a few tips to help you face after hours work with confidence.

**PMH** *(please note this information may change when PMH changes to PCH)*

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**Calling switch:** 9 from within the hospital, 9340 8222 from outside the hospital

**Contacting IT support:** via switchboard is the easiest option

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

The Paediatric Medical Registrar on call for ward consults and admissions (pager 2222).

A Senior Registrar or consultant in ED or ICU.

**Who can I call with a difficult cannula after hours?**

Duty Anaesthetist (call 8775) or Medical Registrar (pager 2222).

**Who can I call with difficulties interpreting imaging after hours?**

On call radiologist or Med reg. If it is regarding a neonate contact neonatal ICU SR.

**Are there any teams that default their after hours care to another team?**

Medical teams are all covered by on call med reg. There is also an on call medical consultant of the day/week after 5pm.

Haematology/Oncology covered by After-hours Paediatric Registrar on site with fellow/consultant available for consult via phone.

Other specialty teams have on call fellow/consultant as first port of call.

General Surgery cover Vascular.

Plastics/ENT/Orthopaedics have their own on call registrar.

Burns covered by a rotating roster of surgical registrars. This will be on the roster.

Child protection unit and social work department do not have cover after 2200.

## SCGH

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**Calling switch:** 91 from within the hospital, 64573333 from outside the hospital

**Contacting IT support:** Via switchboard

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

There is always an after-hours onsite medical registrar or HDU registrar.

**Who can I call with a difficult cannula after hours?**

Try your registrar first and then the Duty Anaesthetist

**Who can I call with difficulties interpreting imaging after hours?**

The after hours radiology registrar via switchboard

**Are there any teams that default their after hours care to another team?**

Check the daily roster on CHIPS.

Vascular is covered by General Surgery Registrar.

Haematology and Medical oncology cover each other on weekday.

Gastro and Hepatology cover each other on weekdays and weekends.

## KEMH

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**Calling switch:** 9 from within the hospital, 93402222 from outside the hospital

**Contacting IT support:** Via switchboard

**When I can't get in touch with my team, who can I call with an urgent Medical question, a troublesome cannula or difficulties interpreting imaging?**

For Gynaecology: Gynaecology Registrar pager 3418 or consultant on call via switchboard.

For Obstetrics: Labour ward Registrar pager 3203/ SR pager 3299 or consultant on call via switchboard.

## OPH

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**Calling switch:** 99 from within the hospital, 9346 8000 from outside the hospital

**Contacting IT support:** Dial 1300 170 089

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

1. The Consultant on-call; 2. The Consultant in charge of the patient; 3. The Head of Service; 4. The Medical Co-Director

**Who can I call with a difficult cannula after hours?**

1. The Obstetric RMO/Registrar on-call;  
2. The Consultant Anaesthetist on-call;  
3. The Consultant in charge of the patient

**Who can I call with difficulties interpreting imaging after hours?**

Dial the SCGH Switchboard on 6457 3333 and ask for the Radiology Registrar on-call

**Are there any teams that default their after hours care to another team?**

General Medicine is covered by the RAC Registrar from 1630hrs. The RAC Registrar will attend Code emergencies on the Surgical Ward, but nursing staff will call the Consultant in charge of the patient for any clinical issues.

## RPH

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**Calling switch:** 91 from within the hospital,

**Contacting IT support:** Via switchboard

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

There is an AMU consultant on call and if not the SAFE team would be able to assist.

**Who can I call with a difficult cannula after hours?**

Duty Anaesthetist

**Who can I call with difficulties interpreting imaging after hours?**

The after hours Radiology Registrar

**Are there any teams that default their after hours care to another team?**

SAFE team for medical specialties

## FHHS

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**Calling switch:** 91 from within the hospital, 9431 3333 from outside the hospital

**Contacting IT support:** HIN Helpdesk 1300 170 089

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

1. Medical Registrar;  
2. ICU registrar;  
3. Consultant on-call

**Who can I call with a difficult cannula after hours?**

In-Hours: Anaesthetic Registrar - please ensure local anaesthetic and an USS machine are available for the registrar on arrival.

Afterhours: 1. Medical Registrar; 2. ICU registrar.

**Who can I call with difficulties interpreting imaging after hours?**

Radiology registrar at Fiona Stanley Hospital



### **Are there any teams that default their after hours care to another team?**

All medical teams handover patients to the evening Gen Med RMO at 4pm. All surgical teams handover patients to the Evening Surgery RMO at 4pm Geriatrics/Rehab handover to Gen Med RMO at 9pm

## **FSH**

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**Calling switch:** 2222 from within the hospital, 61522222 from outside the hospital

**Contacting IT support:** via the help desk

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

HOOT med Registrar - 28889 AMU consultant on site until 9pm(ish)

**Who can I call with a difficult cannula after hours?**

Other interns/RMOs (eg HOOT) HOOT med Registrar eg - 28889 Duty Anaesthetist - 28721 (in that order unless clinically urgent)

**Who can I call with difficulties interpreting imaging after hours?**

Radiology Registrar - 25073 HOOT Med Registrar - 28889 General Surgery Registrar – 27731

**Are there any teams that default their after-hours care to another team?**

The Hospital Out Of hours Team (HOOT) covers all inpatients in the evenings outside of AMU/CCU/General Surgery/Ortho. Overnight, HOOT also covers Gen Surgery and Ortho ward issues (with registrar support onsite).

## **PEEL**

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**Calling switch:** 9 from within the hospital, 9531 8000 from outside the hospital

**Contacting IT support:** IT Service Desk - number is displayed on every networked computer

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

ED Team Leader

**Who can I call with a difficult cannula after hours?** ED Team Leader

**Who can I call with difficulties interpreting imaging after hours?** On call radiologist

**Are there any teams that default their after hours care to another team?**

All patients are under the governance of ED after 2200 hours. On call specialists remain contactable for Paeds, Obstetrics, General Surgery

## **ROCKINGHAM**

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**Calling switch:** 9 from within the hospital, 95994000 from outside the hospital

**Contacting IT support:** Via switch

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

Escalate to Registrar /consultant on call

**Who can I call with a difficult cannula after hours?**

Line manager - registrar on call, after hours DNM, Anaesthetist.

**Who can I call with difficulties interpreting imaging after hours?**

On call radiologist at FSH

**Are there any teams that default their after hours care to another team?**

Surgical teams default to medical on call team out of hours

## **ARMADALE**

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**Calling switch:** 9 from within the hospital, 9391 2000 from outside the hospital

**Contacting IT support:** 7:30-5:00pm – 1300170089 after hours on call - 0437698914 (for urgent enquiries only)

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

ICU Outreach available 24hrs extension 2920. Registrar Page 176. Go to ICU in person or call a MET if concerned. MAU 2 Registrar Page 329/285

**Who can I call with a difficult cannula after hours?**

Duty Anaesthetist Page 077 or ICU Outreach extension 2920

**Who can I call with difficulties interpreting imaging after hours?**



ICU Outreach extension 2920. MAU 2 Registrar Page 329

**Are there any teams that default their after hours care to another team?**

After hours ward cover defaults to Gen Med after hours RMO/Intern. JMO page 292 covers Canning ward/dialysis 1600-0800 + Sat/Sun. JMO page 327 covers Colyer, RAC, Maternity, Paediatrics 1600-0800 + Sat/Sun. Mental Health 2330-0800 (except Fri/Sat nights). Supported by: MAU 2 Registrar 24hrs page 329, Paediatrics Registrar Page 336 & Consultant 24hrs, Surgical Registrar 0439527381 until 22:00, on-call O&G Consultant, on-call Consultant Psychiatrist and RAC Consultants.

## MIDLAND

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**Calling switch:** 99 from within the hospital, 94624000 from outside the hospital

**Contacting IT support:** 6800 service.desk@sjog.org.au 'IS After Hours Troubleshooting Guide' available on intranet

**Who can I call with difficulties interpreting imaging after hours?**

CT scans are reported in and after hours for plain films ask your senior team members

## HOLLYWOOD

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**Calling switch:** 91 from within the hospital, 9346 6000 from outside the hospital

**Contacting IT support:** Through the Afterhours Clinical Nurse Manager

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

There is always a senior medical officer available in the afterhours period (evenings, weekends and nights). If for some reason they are not available, the specialists are all available through the switchboard. If they are not available on mobile, Switch can attempt to call their home number for the JMO. If there is still no response, the Afterhours Clinical Nurse Manager can check to see if they have a second contact person and try the same for them. If there is no response, there is an on call General Physician 24/7. If they are not available, JMOs can call the ICU consultant on call.

**Who can I call with a difficult cannula after hours?**

Try other RMOs the doctor in charge (DIC) for the evening

**Who can I call with difficulties interpreting imaging after hours?**

Out of hours x-rays will not be reported. The senior doctor (DIC or SMO) will be available to help for these.

## JHC

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**Calling switch:** 9 from within the hospital, 94009400 from outside the hospital

**Contacting IT support:** 1800 243 903

**When I can't get in touch with my team, who can I call with an urgent Medical question?**

The consultant of your team via switch if you do not have their numbers

**Who can I call with a difficult cannula after hours?**

Page the after-hours Registrar or the After Hours Nursing staff are extremely helpful

**Who can I call with difficulties interpreting imaging after hours?**

The AH Radiographer on 5181 (internal)

# 6 | HEALTH AND WELL-BEING

## LOOK AFTER YOURSELF FIRST

### **Eat, drink and go to the toilet.**

- Eat regularly and choose healthy options.
- Limit alcohol intake.
- When it is difficult to take a break at work, keep some food at hand to reenergise yourself. Good options are nuts, dried fruit, bananas, plain rice crackers and muesli.

### **Rest**

- Plan your holidays early, it gives you something to look forward to.
- Take a few minutes to stop; focus on your breathing and do some breathing exercises.

### **If you are sick, stay at home**

- Doctors get sick too and are entitled to time off. When at work you are expected to be at your best, so make sure that you feel 100% when you are there.
- If you are sick, contact your registrar and clinical services/medical administration to let them know.

### **Keep active**

- Join a gym or a group that suits your interest, such as a walking group.

### **Health care**

- Source your own medical practitioner to obtain care and medical treatment, including prescriptions and referrals.

**Seek help early** (see section 7).

*Kindly adapted, with permission, from PMCT's 'An apple a day keeps the doctor away: a health and wellbeing guide for Junior Medical Officers'.*

# 7 |

## WHERE DO I GO FOR HELP?

### RESOURCES AND SUPPORT SYSTEMS

It is well known that your intern RMO years are an intense, challenging and frequently stressful time that will test you both clinically and personally. If you or a colleague are finding things overwhelming or are experiencing any difficulties in your personal or professional life, help and support is available. The key message is to talk to someone about it and remember that you are not alone. A good junior doctor is one that knows how and when to ask for help; help is always available.

#### 7.1 | HOSPITAL SUPPORT

Your JMO years can be a challenging time and will test your clinical confidence and knowledge many times over! Other interns can also be a great source of support and learning. Call on your residents for help, they were you not so long ago. Registrars and consultants are always around and are generally approachable and happy to help with any issues. Your MER or MEO can often arrange a bit of extra support or teaching for you. The DPGME is the person to talk to if you have problems with your rotation, personal issues or any other problem affecting your work.

#### 7.2 | PERSONAL HEALTH AND WELL-BEING

If you or a colleague is finding things overwhelming and/or you are unwell, the key message is talk to someone about it.

The second important point is, despite how you feel you are never alone. You may feel as though you're the only one struggling but this is never the case, reaching out will help you to cope and will preserve patient safety.

There are some great points of contact and resources around to help, see table below for specific contact details.

Service	Details
Doctors' Health Advisory Service	<p>An independent, confidential, 24-hour service staffed by experienced doctors. Calls can be anonymous and made by the person themselves, a family member, colleague or friend.</p> <p>(08) 9321 3098 (available 24/7)  <a href="http://www.adhn.org.au/contact/western-australia">www.adhn.org.au/contact/western-australia</a></p>
GP	<p>The AMA(WA) 'GPs for Doctors' program provides information on self-care and a list of GPs who have a special interest in doctors as patients.</p>
Employee Assistance Program (for public sector employees)	<p>A free, professional and completely confidential counselling service is provided, either over the telephone or in person, and is available 24 hours a day. Your employer does not find out who accesses this service.</p> <p><b>Converge International</b>  <b>Website:</b> <a href="http://www.convergeinternational.com.au">www.convergeinternational.com.au</a>  <b>Tel:</b> 1300 687 327</p> <p><b>Optum</b>  <b>Website:</b> <a href="http://www.optum-au.com">www.optum-au.com</a>  <b>Tel:</b> 1300 361 008</p> <p><b>WACHS (Regions)</b>  Contact details for Employee Assistance Program providers vary by region and are available on the <a href="#">WACHS Intranet Page</a>.</p>
Department of Postgraduate Medical Education	<p>The Director of Postgraduate Medical Education and Medical Education Officer at your hospital are always available to discuss any personal or work related concerns.</p>

See the PMCWA JMO health and well-being reference for WA JMOs for further information – available on the PMCWA website (<http://ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council/Publications>)

### 7.3 | INDUSTRIAL

If you are having issues with your pay, working hours, rosters etc, there are a few places you can call on for help. As always, a first port of call may be your immediate senior staff member. Depending on the situation, this may not always be the ideal person to ask for help. The next person to chat to would be your MER or MEO. Industrial issues sometimes go beyond all these resources and in these cases the place to seek help is directly from the AMA. The way to get help from them is easy – all you need to do is be a member and then you can contact them.

### 7.4 | MEDICO-LEGAL

Issues of a medico-legal nature as a JMO can be quite stressful. In general, it is always better to seek advice earlier rather than later, even if you never end up needing the help. Your immediate senior staff members are helpful in these situations for debriefing and support.

Your MEO can help direct you to appropriate staff within the hospital (such as the staff in Legal) for your situation. Finally, always make sure you have an up to date membership of a Medical Defence Organisation and give them a call straight away.

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# QUICK REFERENCE GUIDE

## 8.1 | COMMON ACRONYMS

Acronym	Definition
AHPRA	Australian Health Practitioners Regulation Agency
AMA	Australian Medical Association
DCR	Doctors' Common Room
DCT	Director of Clinical Training
DIT	Doctor in Training
DPGME	Director of Postgraduate Medical Education
FHHS	Fremantle Hospital and Health Service
FSH	Fiona Stanley Hospital
JHC	Joondalup Health Campus
JMO	Junior Medical Officer
KEMH	King Edward Memorial Hospital
MEO	Medical Education Officer
MER	Medical Education Registrar
PCH	Perth Children's Hospital
PEHS	Primary Employing Health Service
PGY	Postgraduate Year
PMCWA	Postgraduate Medical Council of Western Australia
PMH	Princess Margaret Hospital
RMO	Resident Medical Officer
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital

## 8.2 | CONTACT NUMBERS

Organisation	Contact Details
AHPRA	1300 419 495 <a href="http://www.medicalboard.gov.au">www.medicalboard.gov.au</a>
AMA	9273 3000 <a href="http://www.amawa.com.au">www.amawa.com.au</a>
FHHS	9431 3333 <a href="http://www.fhhs.health.wa.gov.au">www.fhhs.health.wa.gov.au</a>
FSH	6152 2222 <a href="http://www.fionastanley.health.wa.gov.au/">www.fionastanley.health.wa.gov.au/</a>
JHC	9400 9494 <a href="http://www.joondaluphealthcampus.com.au/">www.joondaluphealthcampus.com.au/</a>
KEMH	6458 2222 <a href="http://www.kemh.health.wa.gov.au">www.kemh.health.wa.gov.au</a>
PMCWA	9222 2125 <a href="http://ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council">ww2.health.wa.gov.au/About-us/Postgraduate-Medical-Council</a>
PMH	9340 8222 <a href="http://www.pmh.health.wa.gov.au">www.pmh.health.wa.gov.au</a>
RPH	9224 2244 <a href="http://www.rph.health.wa.gov.au">www.rph.health.wa.gov.au</a>
SCGH	6457 3333 <a href="http://www.scgh.health.wa.gov.au">www.scgh.health.wa.gov.au</a>

