Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

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ADVICE ON RETURNING TO CLINICAL WORK AFTER A PERIOD OF ABSENCE

1. Introduction

Consultants may be absent from their clinical post for a variety of reasons; for example, illness, maternity leave, non-clinical sabbatical leave, secondment to other duties. On returning to work they are sometimes expected to resume their previous clinical activity straightaway, without any acknowledgement of the possible 'deskilling' that may have occurred or recognition of possible anxiety or loss of confidence about resuming clinical responsibility. For this reason, the Professional Standards Committee of the RCOG judged it appropriate to issue advice for consultants returning to clinical work after a period of absence.

2. Support

The consultant returning to work should be encouraged to accept help from a senior colleague or peer to act as a mentor in clinical and managerial matters. This colleague should agree to be available to give advice and support during work time and out of hours but should not be the individual involved in undertaking any assessment prior to returning to a full workload.

3. Return to work

Prior to return to work, the consultant should meet with the medical director and/or clinical director to discuss their integration back into the department. The areas that should be covered during discussion might include:

- changes in management or service provision
- changes in junior staff organisation
- familiarisation with junior staff competencies
- CPD requirements/updating personal portfolio
- the consultant's perception of their needs regarding surgical and decision-making skills
- the consultant must be given the opportunity to voice their anxieties and suggest a suitable programme for reintegration.

At least the first week back at work should be regarded as an induction period, during which time the consultant should ideally be supernumerary. During this period the consultant:

- should shadow consultant colleagues with similar clinical workload to update and familiarise themselves with the routine of outpatients, emergency work, labour ward, etc.
- should not operate with a junior assistant but should either arrange to assist a colleague with their list or operate with the assistance of a consultant colleague
- should not be on-call out of hours.

At the end of the first week, the clinical director and consultant should meet to discuss the timescale for resumption to full clinical workload and on-call commitments. Consideration should be given to restricting the clinic numbers and cases on the operating list until the consultant is confident to resume full responsibilities as outlined in their job plan. This arrangement must be acceptable to the consultant and the clinical director.

It would be appropriate for the medical director and/or clinical director to meet with the consultant after one month, by which time it would be expected that most would have resumed their full workload. A date for the next appraisal should be agreed to ensure planning of the consultant's future professional development.

The above process is not necessarily adequate for doctors returning to work after suspension and more formal arrangements should be considered. The RCOG Working Party Report *Further Training for Doctors in Difficulty* (April 2002) sets out a framework for further training of these doctors. This document is available on the RCOG website at www.rcog.org.uk/mainpages.asp?PageID=1247).

This good practice guidance was produced on behalf of the Professional Standards Committee of the Royal College of Obstetricians and Gynaecologists by Dr Diana Fothergill FRCOG and Miss Heather Mellows FRCOG.

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