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SECTION I: SUMMARY

- 1.** Consultants are responsible for teaching trainees not only the science and practice of anaesthesia but also all the other attributes that make a good anaesthetist.
- 2.** It is the responsibility of the trainee to ensure they obtain full training.
- 3.** There should be a clear line of clinical responsibility and trainees should be able to contact the consultant to whom they are responsible at all times.
- 4.** The attitude of the consultants within a department is crucial to the development of a satisfactory working environment and departments of anaesthesia should work hard to ensure that good consultant : trainee working relationships are maintained.
- 5.** Trainee anaesthetists continue to report stress despite many improvements in training.
- 6.** Reduction in working hours for trainees has resulted in an overall increase in hours and intensity of work for consultants.
- 7.** All anaesthetists should be registered with a local general practitioner.
- 8.** The Association of Anaesthetists recommends that all trainees should have personal professional indemnity.
- 9.** Departments of anaesthesia should appoint key personnel to assist trainees, for example a college tutor, individual educational supervisor and provide a choice of personal mentor.
- 10.** Departments of anaesthesia should have clear guidelines for dealing with the poorly performing trainee.

SECTION II: INTRODUCTION

2.1 The primary relationship between a consultant and trainee, is that of teacher and pupil. Consultants are responsible for teaching not only the science and practice of anaesthesia, but all the other attributes which make a good anaesthetist such as communication, organisation, negotiation skills, and effective time and stress management.

SECTION III: BACKGROUND

3.1 In May 1989 the Association of Anaesthetists of Great Britain and Ireland (AAGBI) published a document entitled Consultant : Trainee Relationships A guide for consultants. This considered stress amongst trainee anaesthetists following the results of a questionnaire to Junior Linkmen in December 1986 [1]. An enquiry was made into the subject by the then Junior Anaesthetists Group which indicated a number of problems. Recommendations were made to departments of anaesthesia, many of which would be considered standard practice nowadays [2].

3.2 Some of the potential problems cited in the previous document have been considerably reduced. Trainees should no longer undertake clinical duties without adequate rest. The Royal College of Anaesthetists (RCA) has provided curricula of teaching for the FRCA examinations which are implemented by Schools of Anaesthesia. Departments of anaesthesia should be well designed, with good accommodation. Despite these changes, trainees continue to report stress related problems [3].

SECTION IV: WORK PATTERNS FOR BOTH TRAINEES AND CONSULTANTS

4.1 Changes have occurred in anaesthetic training since 1989. The task forces of Postgraduate Medical Institutes (PMIs) have ensured reduced hours of work and protected rest periods for all trainees. The implementation of the Calman report has restricted training time. Total training time has been reduced but there has been an increase in the amount of supervision and specific competency based training. Trainees receive more structured training but less clinical experience than pre- Calman registrars and senior registrars which may affect their level of confidence.

4.2 Trainees now undergo regular appraisal and assessment and annual in- training assessment (RITA) leading to the issue of a Certificate of Completion of Specialist Training (CCST). They are required to keep a personal portfolio including a log book. This allows progress to be monitored and provides an opportunity to rectify poor performance.

4.3 The majority of consultants are in favour of more structured training and reduction in hours for trainees, however inadequate expansion of consultant numbers has consequently lead to an increase in their workload. In some units it is necessary for consultant anaesthetists to be resident on call 'out of hours' to cover the emergency anaesthetic service, either because of the specialist nature of the work or insufficient numbers of trainees. Consultant anaesthetists now spend much more of their time in teaching, supervision, audit and management. This results in a substantial increase in intensity and number of hours worked [4]. There is currently a perception by many consultants that they are working harder than the trainees. This has produced a degree of resentment on the part of the consultants and a feeling of foreboding for trainees about to complete their CCST and apply for a consultant post.

4.4 Appraisal and assessment will be introduced in April 2001 for consultants who will undergo an annual appraisal informing the revalidation process. It is currently recommended that consultant anaesthetists keep a Personal Portfolio [5] to inform the appraisal and revalidation process.[6].

SECTION V: THE DEPARTMENT OF ANAESTHESIA

5.1 A good working environment is important to consultants and trainees. The standard of accommodation should conform to that laid down in Department of Anaesthesia: Secretariat and Accommodation published by the AAGBI.

5.2 Trainees should be made welcome on their first day in an unfamiliar hospital. There must be no clinical commitment without immediate supervision until departments are satisfied with the competency of the trainee to undertake tasks to which they are assigned. They should be introduced to all the staff, including the departmental secretary, shown around and be made aware of the names of the college tutor and the person who does the rota (rotamaker) and be allocated an educational supervisor and possibly a mentor. A departmental handbook containing relevant information, for example important telephone numbers, 'who's who' in the hospital, times of teaching sessions and meetings can be very useful. A file containing local clinical guidelines and protocols must be kept available and drawn to the attention of all trainees.

5.3 Departments should encourage social contact. Meetings both within the department of anaesthesia and hospital as a whole, create an opportunity to associate with other trainees and consultants and exchange views. It is important that the departmental work programme is structured in such a way that allows meetings to occur in the normal working day and that the attendance of all members of the department is encouraged. Social contact outside of the hospital in a more relaxed atmosphere can be a good way to introduce a new trainee to colleagues and for consultants to catch up informally with general progress.

5.4 **All anaesthetists must be registered with a local general practitioner[9].** Trainees rotating through several regions or from overseas and, indeed, newly appointed career grade anaesthetists, may neglect to register and instead rely on casual medical advice from colleagues or self-medication. This is potentially dangerous. The clinical director should ensure, through the hospital personnel department that medical staff are put in touch with a local general practitioner.

5.5 **The AAGBI recommends that all trainees have personal professional indemnity as trust indemnity is limited.**

SECTION VI: ROLES AND RESPONSIBILITIES

6.1 Even with designated and interested personnel within the department of anaesthesia, the delivery and supervision of high quality training depends on contributions from **all consultants**.

6.2. To enable optimal use of training time and prompt recognition of problems, it is vital that **all consultants** who are involved with trainees maintain close contact with each other, particularly the tutor and the rotamaker. This may involve setting up a formal meeting or reporting system.

6.3 **It is the responsibility of the trainee to make sure they get the training they require.** They must participate in audit projects and attend appraisal and RITA interviews with the correct documentation. There should be a system in place within the department of anaesthesia to allow the trainee to address perceived inadequacies in their training programme at an early stage. This could include unfair treatment from colleagues such as bullying. Trainees should be encouraged to approach their educational supervisor or mentor for help. Problems can also be dealt with through the appraisal process

6.4 **There must be a clearly established line of responsibility within the department.** All doctors have a duty of care. Consultants are ultimately responsible for the clinical care of their own patients. Trainees, however, are accountable to a consultant and that must be clearly understood. Trainees must be able to identify the consultant to whom they are responsible **at all times**. An open, friendly atmosphere within the department of anaesthesia will encourage trainees to communicate any potential problems, both clinical and personal.

SECTION VII: KEY PERSONNEL INVOLVED IN TRAINING

7.1 Clinical Director or equivalent.

The responsibility of the clinical director is to ensure the safe and efficient provision of an anaesthetic service to the Trust. These responsibilities are chiefly budgetary and organisational although a balance must be maintained between their duty to the Trust and to training. The clinical director must ensure that those delivering the service are competent and well supported and should therefore have a suitable organisational structure in place. This will involve maintaining close links with all those involved in training.

7.2 College Tutor

The College tutor is the prime point of contact for trainees with the RCA and should ensure that training is properly organised, actually happens and is accessible. Although the tutor acts as organiser and co-ordinator, specific tasks related to training can be delegated to other members of the department.

Specific responsibilities include organisation of teaching and training, preparation for examinations, facilitation of audit and research projects, professional development and career advice, liaison with the school of anaesthesia and postgraduate dean, and representing the College [7].

7.3 Educational Supervisor

The educational supervisor ensures that trainees have an appropriate training programme as laid down by the RCA and school of anaesthesia and are making good progress. It may be necessary from time to time for the supervisor to arrange particular placements with the rotamaker.

7.4 Rotamaker

The rotamaker needs to be informed regularly of specific training needs by the College tutor and educational supervisor. It may be that a trainee requires more training in a particular sub-specialty or increased supervision because of poor performance or crisis of confidence.

7.5 Personal Mentor

At different times a mentor may be called upon to be a facilitator, coach, counsellor, sounding board, critical friend, networker or role model [9]. The formalisation of mentoring by allocation can be counter-productive and an imposed mentor may be perceived by the trainee as a supervisor or line manager. Ideally mentoring should be a spontaneous relationship, however not all consultants will wish to become mentors. Mentoring is not a casual occupation and requires commitment and time. There are several training courses available which interested consultants may wish to attend an example of which is given in reference [8]. If possible, several willing mentors should be available and accessible within a department. The department should also foster a culture in which mentoring is favourably viewed and seeking help is regarded as a learning opportunity rather than a sign of weakness or failure.

7.6 Postgraduate Dean

The postgraduate dean is responsible for the management, delivery and funding of postgraduate education and the enforcement of legal work rotas through the local Task Force to ensure adequate rest periods for trainees. The dean also maintains a database for the dual purpose of education monitoring and workforce planning, and a folder containing completed RITA forms for each SpR. The postgraduate dean has the power to withdraw funding and/or recognition if service provision threatens the delivery of adequate medical education and training.

7.7 Regional Advisor

The regional advisor's educational role is to represent the RCA Training Committee in ensuring that training in the individual units within the region reaches the required standard. The regional advisor implements policies through the College tutor for the individual unit, is involved in all visits by the College to the region and approves the job descriptions of all career grade posts prior to advertisement.

7.8 Programme Director

The programme director does not have a direct educational role but is responsible for placing trainees in the appropriate part of the training programme. The programme director also ensures, with the regional advisor and others, that trainees are assessed at least annually and complete their training appropriately before attaining their CCST.

SECTION VIII: STRESS

8.1 Although many of the stress factors reported in Consultant :Trainee Relationships 1989 are no longer a problem, some trainees still find training stressful. Unpublished data from the AAGBI stress study shows that the most important stressors continue to be work intensity, including on-call duties, travel, for instance on rotations, exams, pressure to undertake audit and research, poor communications with colleagues, complaints and the threat of litigation. There is evidence that female trainees and doctors from the Indian subcontinent are more vulnerable. Trainees in large district general hospitals appear to be under particular pressure, possibly because of high workload.

8.2 Consultants should recognise that although trainee hours have been reduced, intensity of work is greater and this can cause stress.

8.3 Rotations should be arranged as sympathetically as possible with regard to where the trainee lives.

8.4 Trainees must not be allowed to answer complaints alone. Nevertheless, although the consultant remains ultimately responsible, the trainee should be involved fully in any response process. This will provide a valuable opportunity for training.

8.5 Trainees should have adequate support and supervision, preferably from a chosen consultant, for audit and research projects and should have access to suitable information technology and secretarial support.

8.6 Departments must allow adequate study leave and support applications for suitable examination courses. The trainee should have access within the hospital to library , Internet and search facilities and a quiet room in which to study.

8.7 Trainees should be encouraged to have regular informal 'whinge' meetings without consultant presence. Serious issues should be referred to the directorate meeting.

8.8 Stress management and good organisational skills should be taught at an early stage [9,10].

SECTION IX: FLEXIBLE TRAINEES

9.1 A number of trainees will choose to train flexibly.

9.2 Flexible training should be in line with full-time training and maintain a balance between flexible arrangements and service needs.

9.3 Flexible trainees require an educational supervisor who is familiar with the concept of part-time training and can arrange a training programme which will make optimal use of reduced hours.

9.4 Although flexible trainees report less stress than full-timers [3], there are other pressures. It may be more difficult for them to feel part of the team since they are at work less often. Training opportunities, particularly in the specialist fields can be limited and jealousies may arise within the department if the flexible trainees are seen to be 'cherry picking' the best training slots. It may be more difficult for a flexible trainee to carry out audit and research projects and private study can be a problem with other commitments and fatigue.

9.5 There are numerous misconceptions regarding flexible training which can give rise to resentment within the department. The majority of flexible trainees work almost as many hours as their whole time equivalents, the difference being that the hours worked are more predictable to allow for other commitments such as child care.

SECTION X: THE POORLY PERFORMING OR SICK TRAINEE

10.1 The causes of poor performance in a trainee can be professional, personal, or a combination of both. The demands of training are substantial. Inevitably some trainees will take longer to master clinical skills than others. Supervision appropriate to the grade will enable slow learners to reach a satisfactory standard without feeling demoralised and prevent overconfident trainees from taking on too much responsibility, only to suffer a major setback from which they fail to recover.

10.2 Poor professional performance may result from a failure in communication between trainees and their supervising consultants. Regular meetings with the clinical tutor, educational supervisor or mentor can provide an opportunity to discuss problems and develop better communication skills.

It is important to realise that poor performance can stem from poor health. Other underlying factors include difficulty with relationships and financial problems. Warning signs such as poor time-keeping and inappropriate behaviour have been detailed in previous AAGBI documents [9,11].

10.3 Rarely a trainee may be suspected of, or indeed have, a problem with substance abuse. It is most important that there is an awareness within the department of anaesthesia, a degree of vigilance maintained and such problems dealt with promptly according to the guidelines contained in AAGBI handbook Drug and Alcohol Abuse amongst Anaesthetists: Guidance on Identification and Management [11].

10.4 Departments of anaesthesia should have clear guidelines for dealing with the poorly performing trainee, an example of which is given in appendix 1.

SECTION XI: CONCLUSION

Departments of anaesthesia should work hard to ensure that good consultant : trainee working relationships are maintained. This will involve the fostering of good communications and the active participation of **all** members of the department.

SECTION XII: APPENDIX 1

Action Plan for Poor Performance

If there is a suspicion of any serious problem which may put patient or trainee at risk, the following steps should be considered.

1. All anaesthetists must protect patients from harm.
2. Alert the clinical director and the College tutor to the alleged problem.
3. Together ascertain the facts.
4. Arrange an early meeting with the trainee.
5. Keep a written record of all interviews.
6. Maintain confidentiality.
7. Ensure local support for the trainee.
8. Liase with others as appropriate. The rotamaker, educational supervisor and personal mentor of the trainee, if not already involved, may need to be informed.
9. Consider a range of measures.
10. The trainee may need to withdraw immediately from work or less drastic measures such as cessation of on-call duties and full supervision may be sufficient.
11. Agree clear, achievable goals with the trainee and other involved professionals.
12. Carefully supervise the return to work.
13. Ultimately, a change of work pattern or career may be necessary.

SECTION XIII: REFERENCES

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