

**WORKLOAD FOR
CONSULTANT ANAESTHETISTS
IN IRELAND**

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INTRODUCTION

The Department of Health has offered a revised common contract to all consultants working in the Health Service in the Republic of Ireland after negotiations with the representative medical bodies.

The Irish Standing Committee of the Association of Anaesthetists consider it appropriate to issue guidelines for consultant anaesthetists and employing authorities in relation to this revised common contract.

The Association of Anaesthetists has published a number of documents in relation to workloads for consultant anaesthetists.^{1,2} These documents are relevant since they reflect the principles of safety and professional commitment on which modern anaesthesia is based. However, the terms and conditions of the revised contract in Ireland differ in a number of ways from the terms and conditions of employment of anaesthetists working in the United Kingdom. These differences have been taken into account by the Standing Committee in this publication.

The terms and conditions of the revised contract are set down in the 'The Consultants Contract Document, 1991' (CCD), nine appendices and the 'The Memorandum of Agreement' (MA), these jointly being the contract documents.

The scheduled time commitment for consultants in the revised contract is identical to that in the original common contract (11 sessions/33 hours/week) but a number of new elements are introduced. These include fixed and flexible sessions, the practice plan which encompasses scheduling, resource management and medical audit, and there are new regulations about the conduct of private practice.

The contract represents a professional commitment because consultants, alone among hospital doctors, have a continuing responsibility for patients already in their care.

SECTION I

Work Patterns And Terminology

The scheduled commitment of consultants under the terms and conditions of the revised contract (except for those with part-time contracts) is for thirty-three hours per week, to be discharged during the normal working hours between Monday and Friday. The nature of the consultant's work is such that it cannot be organised into equal periods of time and the contract acknowledges this. It is vital to keep these points in mind when drawing up practice plans and work schedules.

It is unfortunate that the term 'session' is used in the revised contract to describe the consultant's time commitment. One session is defined as three hours, but since very little of the work done by a consultant is completed within three hours (or multiples thereof) the term 'session' has little merit and can lead to serious misunderstandings.

This becomes obvious when operating lists are described in terms of sessions. For example, a morning operating list is not the same as a session and an all day list may not be the same as two sessions although both have, in the past, been described erroneously as such. The anaesthetist must arrive beforehand (to perform a preoperative check of anaesthetic equipment³ and to check drugs) and patients should be assessed afterwards; thus many lists occupy more than one session. Some lists take less than one session. If consultants wish to describe the time devoted to operating lists in terms of sessions, the total duration of lists in hours should be summed and divided by three; this gives a figure for the number of fixed theatre sessions.

SECTION II

Contracts

Four types of revised contract have been offered to all consultants who currently hold the common contract.

1. Existing 'whole-time' consultants

'An existing 'whole-time' consultant will have a scheduled commitment of 10/11 fixed and flexible sessions (an aggregate of 30/33 notional hours) and 2 non-schedulable sessions per week to the public hospitals. The consultant will also be liable for extended duty and emergency services. In addition, he may engage in private practice on-site and off-site'. (MA 3.4.1)

2. Geographically whole-time consultants

A geographically whole-time consultant will have a scheduled commitment of 11 fixed and flexible sessions (an aggregate of 33 notional hours) and 2 non-schedulable sessions per week and will, subject to section 5.1 6 of the Memorandum of Agreement, devote substantially the whole of his professional time including time spent in private practice, to the public hospital(s).' (MA 3.3.1, 3.3.2)

'He cannot treat patients in a private hospital or clinic.'
(MA 5.16.5)

3. Geographical whole-time retained consultants

'Within the geographical whole-time category a consultant may or may not opt to retain his fees from private practice Where he does not retain fees earned in the treatment of private patients, those fees will be divided as follows: the first £1,000 per annum will be placed in a fund to be controlled by these consultants as will 50% of the remainder in excess of £1,000. This fund will be devoted to any or all of the following activities:-

research including items of equipment and continuing education of consultants.’

‘The balance of the fees will be placed in a separate fund and allocated by the retained consultants to the continuing training and education of support staff.’ (MA 3.3.3, 3.3.4)

4. Part-time consultants

‘A part-time commitment will normally be for a range of 7 to 9 fixed and flexible sessions plus 2 non-schedulable sessions per week. The minimum number of fixed and flexible sessions for part-time consultants would not normally be less than 3 per week’. (MA 3.5)

It is clear from the above that the contractual commitment to the public hospital of the whole-time and geographical whole-time consultants including those who do not retain private fees is identical, namely 11 fixed and flexible sessions (an aggregate of 33 notional hours) and 2 non-schedulable sessions per week. The rules governing the conduct of private practice however differ considerably from contract to contract.

All consultants are entitled to engage in private practice on-site.

Consultants with geographical whole-time retained contracts may use private income in a limited way only, but within these limits it is the consultant who decides how such money should be spent.

No other type of contract places restrictions on the use of income derived from on-site private practice.

Only consultants with whole-time or part-time contracts may engage in private practice on-site and off-site.

SECTION III

Options On Contracts

‘Consultants who hold ‘whole-time’ posts under the common contract will be offered the opportunity to opt initially for any one of the categories described in paragraphs 3.3, 3.4, and 3.5 of the Memorandum of Agreement’. (MA 3.8.1)

‘Consultants who hold part-time posts under the common contract will be offered posts with similar sessional commitment under this (revised) contract’. (MA 3.8.4)

‘All existing consultants who take this contract, within the time specified, will have one further opportunity within a period of five years to alter their initial option. Whole-time consultants who at that stage wish to become part-time (or vice versa) may do so subject to the agreement with the employing authority and the approval of Comhairle as above’. (MA 3.8.3)

‘It will be open to an employing authority to propose changes in the categorisation of a post but the final decision on such an application is a matter for Comhairle na nOspideal. Such a proposal may be initiated by either the consultant or the employing authority or authorities but in any case, is subject to the agreement of the consultant concerned.’ (MA 3.9)

‘Where posts occupied by existing ‘whole-time ‘consultants are being replaced (irrespective of whether or not changes are being made in the type of post) it will be open to Comhairle na nOspideal to structure these posts on the basis of either 10 or 11 sessions and 2 non-schedulable sessions per week with rights to off-site private practice which would not impair the fulfilment of the public commitment. It will also be open to Comhairle na nOspideal, where the circumstances so warrant, to structure new appointments on a similar basis.’ (MA 3.4.2)

Consultants who have a 33 hour commitment to a public hospital presently and who accept the revised contract may choose either a whole-time, contract or a geographical whole-time contract with or without private fees. Within five years they will have

one further opportunity of changing their initial option. In making these choices consultants do not require the approval of Comhairle na nOspideal nor the employing authority. Approval of Comhairle na nOspideal and the employing authority will be required should a consultant wish to change from a 33 hour commitment to a part-time commitment or vice versa.

While the choices available to current contract holders are fair and equitable the situation regarding new appointees is quite the opposite. It would appear that neither choice of contract nor option to change will be available to newly appointed consultants. The Standing Committee considers such a restriction quite unnecessary and patently unfair.

In such circumstances, the attractiveness of certain posts will be diminished and serious disagreements between the employing authorities and the hospital, and indeed with the anaesthetic department, could ensue. Since the contractual commitments to the public hospital for whole-time and geographical whole-time consultants are identical we firmly believe that the choice should be left entirely to the consultant concerned and that a reasonable amount of time should be allowed to consider the choice.

The Standing Committee strongly recommends that all who are able to influence job descriptions will consider the new and replacement posts not only for the job content, but also in the context of the contractual position of the existing consultants; this should ensure that nothing that might prove detrimental to the smooth running of the department proceeds to advertisement.

SECTION IV

Private Practice

We welcome the Government's statement regarding private practice.

'The Government is committed to maintaining the position of private practice both within and outside the public hospital system'. (MA 5.16.1)

Rules governing private practice

Consultants who opt for 'whole-time' contracts -

'will be entitled to engage in private practice within the hospital in which he is employed (on-site)' and 'outside the hospital or hospitals in which he is employed (off-site) subject to him satisfying the employing authority that he is fulfilling his contractual commitment to the public hospitals'. (MA 5.16.2, 5.16.3, 5.16.4)

Consultants who opt for geographical whole-time contracts -

'will be entitled to engage in private practice within the hospital or hospitals in which he is employed (on site)'. (MA 6.16.2) 'He will have a scheduled commitment of 11 fixed and flexible sessions including time spent on private practice, to the public hospitals(s)'. (MA 3.3.1, 3.3.2) 'He cannot treat patients in a private hospital or clinic, i.e. off-site'. (MA 5.16.5)

When a geographical whole-time consultant opts not to retain fees earned in the treatment of private patients, 'these fees will be divided as follows: the first £1,000 per annum will be placed in a fund to be controlled by these consultants as will 50% of the remainder in excess of £1,000. This fund will be devoted to any or all of the following activities:- research including items of equipment and continuing education of consultants'.

‘The balance of the fees will be placed in a separate fund and allocated by the retained consultants to the continuing training and education of support staff.’ (MA 3.3.4)

‘The existence of such funds is not intended, and should not be used to relieve the employing authority of its normal responsibilities for the provision of resources in the areas mentioned.’ (MA 3.3.5)

Consultants who opt for part-time contracts -

‘will be entitled to engage in private practice within the hospital or hospitals in which he is employed (on-site)’ and ‘outside the hospital or hospitals in which he is employed (off-site) subject to him satisfying the employing authority that he is fulfilling his contractual commitment to the public hospital(s).’ (MA 5.16.2, 5.16.3, 5.16.4)

During discussions on the revised contract consultant representatives always stressed that the opportunities for off-site private practice and indeed on-site private practice varied considerably from area to area and throughout the country. The Government have acknowledged this fact and offered three separate contracts each with the same commitment to the public hospital but with different rules regarding private practice.

A geographical whole-time consultant relinquishes his right to off-site private practice. He may also agree not to retain fees generated from private practice in the public hospital. These arrangements are intended to benefit the profession as a whole. They are contractual agreements which carry extra remuneration and we urge colleagues to interpret these in the spirit in which they were made.

SECTION V

Duties Of Consultant Anaesthetists

In the revised contract a consultant's scheduled work is classed as that involving fixed commitments and that involving flexible commitments. Other professional activities undertaken by consultants on behalf of the employing authority, and which are of an infrequent and irregular nature, are classed as non-schedulable.

'A consultant's commitment shall comprise a mix of fixed and flexible sessions, the ratio of which will vary depending on speciality.' (MA 2.4.3)

Fixed Commitments

Fixed commitments are those which substantially affect the use of other hospital resources. The fixed commitments agreed with the employing authority will appear in the outline work programme - the work schedule.

For geographical whole-time and whole-time anaesthetists, the number of fixed commitments should not be more than six sessions (eighteen hours) per week. The number of fixed sessions per week will be less than this in situations where there is a heavy on-call commitment and rest days are incorporated into the schedule.

Consultant anaesthetists provide a wide variety of services to hospitals both individually and collectively as members of an anaesthetic department. The list below is not exhaustive, and includes activities which form part of fixed commitments.

(i) Operating theatres

For most anaesthetists the fixed commitments will be mainly in the operating theatres. Other similar commitments will include anaesthetic out-patients clinics, dental department lists, designated emergency lists,^{4,5} ECT sessions and in clinical investigative and treatment areas. Usually these

activities will involve work with designated consultants from other specialities.

(ii) Obstetric analgesia and anaesthesia

Consultants may undertake the organisation, provision and supervision of anaesthetic services to provide analgesia and anaesthesia in the obstetric unit. The consultant may also take personal clinical care of patients.

(iii) Intensive care units and high dependency units

Consultant anaesthetists are involved in progressive patient care which includes the organisation of appropriate clinical management of patients in these units.^{7,8}

(iv) Pain relief

Acute pain teams always incorporate a consultant anaesthetist. Many anaesthetists organise and provide a chronic pain management service, which requires the provision of out-patient, domiciliary, diagnostic and in-patient services.

(v) Anaesthetic out-patient assessment clinics

Many anaesthetists have regular out-patient clinics as part of their preoperative assessment of day case patients.

(vi) Audit

Anaesthetists are expected to audit their activities both as individuals and as members of the anaesthetic department. The Faculty of Anaesthetists of the Royal College of Surgeons in Ireland (RCSI) has issued guidelines for departments of anaesthesia in relation to audit/quality assurance.⁹

Although the commitments described above will normally be regarded as fixed, there may be consultants with responsibilities for emergency cover, e.g. ITU, for whom the commitment will

be flexible. In certain circumstances, a theatre operating session might be considered flexible, e.g. when dealing with urgent cases at the end of a morning list. A consultant's theatre commitment including fixed and flexible duties should not exceed twenty-four hours each week.

Flexible commitments

Flexible commitments include all other scheduled activities undertaken by consultants on behalf of employing authorities.

(i) Associated clinical anaesthetic service

Anaesthetic services include the preoperative assessment and preparation of patients, and the provision and supervision of immediate postoperative care including the management of postoperative pain. To maintain good standards, we recommend a time ratio of 3:1 between the time spent in theatre and the time spent on pre and postoperative assessment and the care of patients on routine in-patient operating lists or equivalent. Thus, a theatre commitment of 15 hours will normally carry a pre and postoperative workload of 5 hours.

(ii) Emergency anaesthetic services

When on-call, an individual consultant anaesthetist takes responsibility for the organisation, provision and supervision of the emergency services. Consultants may also take personal clinical care of appropriate cases. A very heavy workload should be reflected in a reduced fixed commitment. This is more likely to occur in very specialised departments or where trainee anaesthetists are few in number or are inexperienced.

(iii) Resuscitation services

The organisation and supervision of, and involvement with, hospital resuscitation services may be part of a consultant's duties. Consultant anaesthetists will also be involved in the

preparation of plans and part of the response to major disasters.¹⁰

(iv) Teaching/training/examining/accreditation

A major element of many consultant's work is the education of trainee anaesthetic staff. This occurs in the operating theatre, the wards and all other clinical areas of consultant work together with more formal aspects of teaching at departments and regional meetings.

When assessing training posts and training schemes, the Faculty of Anaesthetists (RCSI) lays particular emphasis on the willingness and ability of consultants to teach their trainees.¹²

Many anaesthetic departments will have responsibility for teaching and training medical students. All anaesthetic departments will teach and train:

- (a) Nursing Staff
- (b) Non-Consultant Hospital Doctors
- (c) Paramedics
- (d) Others

in the theoretical basis and practical care in anaesthesia, resuscitation, acute pain relief and the immediate care of the suddenly and seriously ill and injured.

(v) Research

Consultant anaesthetists may themselves be involved in research, and will be expected to encourage research associated with clinical activity and to guide trainee anaesthetists into appropriate research methods and projects.

Non-schedulable commitments

'It is acknowledged that some professional activities are infrequent and irregular and cannot be scheduled in advance within the fixed/flexible sessions. The professional time devoted to such activities is being described as non-schedulable.

The equivalent of two sessions per professional time per week will be available for episodic activities such as involvement in planning, interviews and periodic meetings which, if they become regular, will be deemed flexible.' (MA 2.4.2)

SECTION VI

Practice Plans

A practice plan is a detailed description of the duties and responsibilities of a consultant and of the facilities required to carry them out. 'Within a reasonable period of time (maximum one year) of signing this contract a practice plan shall be agreed between you and your employing authority together with an agreed schedule of your service commitment.' (CCD 6.2)

'Because of the variation between specialties the plan will require to be adapted for individual consultants.' (Appendix H1 CCD)

An outline practice plan is given in Appendix H of the Consultant Contract Document. This lists the various headings under which individual practice plans might be discussed.

Although practice plans must be agreed between individual consultants and the employing authority we advise that a corporate response should be agreed within the department so that the anaesthetic services to the hospital are properly covered and the workload is fairly distributed.

The following headings deserve special comment:-

1. Scheduling of time commitments

When drawing up a weekly work schedule of time commitments the following aspects of the contract as well as the advice given above should be borne in mind.

'A consultant's time commitment, which will be personally discharged, will be scheduled during the hours normally worked within the Monday to Friday working week.' (MA 2.4.2)

'A fixed session is a time commitment which must be fulfilled, except by agreement between the consultant and the employing authority or in an emergency, because of the significant impact which such activities have on the

utilisation of other resources and the deployment of other staff' (MA 2.4.3)

'A flexible session which is not fixed (as defined above) is a regular and predictable time commitment, the extent of which can be anticipated, which may be discharged in a flexible manner within a specific time frame e.g. 1 week or 1 month.' (MA 2.4.3)

'The aggregation of fixed and flexible sessions in a given time period shall be on a cumulative basis of notional hours, e.g. 11 sessions per weeks - 33 notional hours per week. This does not imply that consultants' work is necessarily organised in equal periods of time.' (MA 2.4.3)

An example of a weekly work schedule is given in Annex I at the end of this document.

2. Cover Arrangements

It is vital to plan holidays and study leave well in advance so that management has a reasonable opportunity of arranging locum cover or cancelling the elective work of the consultant on leave. Some absences cannot be anticipated and a contingency plan should be drawn up for such occasions.

3. Resources

We advise that discussion regarding resources, medical staff, support staff, equipment and facilities should be dealt with at departmental level. Guidelines in relation to minimal monitoring equipment, assistance for anaesthetists, recovery room facilities and high dependency units have already been published.^{7,8,12}

The limits of the anaesthetic service which can be provided safely should be identified clearly to the employing authority and to colleagues in other specialties who avail of the services of the anaesthetic department when the resources supplied are inadequate. Once minimal standards have been

achieved a list of priorities should be drawn up so that a logical approach to the use of scarce finances can be adopted.

4. Requirements for continuing medical education

‘Employing authorities in recognition of the importance of continuing medical education for consultants, will provide, following consultation with individual consultants, an appropriate level of resources to facilitate the pursuance of continuing medical education on a systemic basis. The method of allowing for the expenses involved will be such as to facilitate and support the efforts of the consultant involved. In addition to the existing monies available under this heading a further earmarked fund will be allocated for this purposes.’(MA 4.15)

Clearly, the consultant also has a responsibility to initiate discussions with management so that financial requirements and leave arrangements can be agreed.

5. New developments in the specialty and their effect on practice

The practice plan specifically refers to new drugs, new techniques and new equipment - their costs and which aspects of current practice they might replace. This foresight is commendable, but we emphasise the fundamental importance of proper and regular maintenance of equipment and proper and regular attention to safety procedures for both patients and medical personnel in relation to biological, radiological and other hazards.

6. Arrangements for the conduct of medical audit

The Faculty of Anaesthetists (RCSI) has already issued guidelines for departments of anaesthesia and critical care medicine in relation to audit/quality assurance. The working party commends this document and draws your attention to the following statement:-

‘The lack of protection from disclosure in the jurisdiction of the Republic of Ireland of documents solely for the purpose of Quality Assurance, i.e. critical incident reporting forms, morbidity and mortality review and classification of causes of death, etc. precludes their recommendation, at this time by the Faculty of Anaesthetists. If such critical incident report forms, morbidity/mortality forms and classification of deaths/complications, etc. are to be used by departments of anaesthesia, their utilisation should be voluntary and their completion should be by the individuals concerned in the critical incident or morbidity/mortality case. In the present circumstances, the departments of anaesthesia should consult with and obtain the clear approval of the Medical Protection Society and the Medical Defence Union before embarking on quality assurance programmes which involve findings and judgements relating to causes of death and morbidity.’

SECTION VII

Consultants In Management

We draw your attention to the following aspects of the revised contract. 'Consultants should be involved in the hospital management process in a meaningful way to facilitate the discharge of their responsibilities and those of the employing authority for the provision of services.' (MA 7.1.1)

Consultants will be involved with and in management at three levels:-

(i) As an individual contract holder

The consultant's responsibility to management involves him in discussion and agreement about

'a job description' (MA 7.2.1)

'the practice plans' (MA 7.2.2)

'scheduling' (MA 7.2.3)

'medical audit' (MA 7.2.4)

(ii) As consultant in administrative charge

Anaesthesia is an independent specialty.

'the heads of specialty groupings are part of the representative system in that they are selected to the posts by their colleagues or rotate through in turn. In practice the holders of many such posts perform executive type functions in co-operating with hospital management. This is recognised in the present contract through either a reduction in their clinical commitment or by way of any additional payment in respect of this work.' (MA 7.3.2)

'where the representative structures for consultants do not exist, employing authorities will encourage and support their establishment. The appropriate representative head of such a structure (Chairman or Honorary Secretary) will be

accorded consultative status within the hospital commensurate with his important representative function, on matters of significance impinging on the medical aspects of the hospital service. (MA 7.3.2)

(iii) As clinical co-ordinator

‘Posts of clinical co-ordinator will be created at hospital level to be held by practising consultants whose sessional commitment to executive work will vary depending on the size and complexity of the hospital. Special remuneration rates will be put in place in order to encourage applications for these posts from as wide a pool of practising consultants as possible. Selection for these posts of clinical co-ordinator, which will involve fixed term contracts, shall be by way of competition. The selection panel will be chaired by an independent chairman (a person not in the employment of the employing authority) and will comprise three representatives nominated by the consultant’s representative grouping in the hospital and three nominated by the employing authority.’ (MA 3.3 (iv))

SECTION VIII

Academic Appointments

‘The future arrangements to apply to the remuneration and conditions of employment of consultants holding joint academic/clinical appointments are being currently addressed by management, the profession and the appropriate academic bodies.’ (MA 3.7)

The importance of clinical research and academic endeavour in the development of the specialty of anaesthesia cannot be overstated. The Association of Anaesthetists of Great Britain and Ireland and the Faculty of Anaesthetists (RCSI) make major contributions in this area by holding seminars, scientific meetings and publishing scientific material. The Faculty of Anaesthetists (RCSI) is also responsible for setting standards of training and examination in anaesthesia.

Consultants who hold academic appointments bear a heavy responsibility for the development of anaesthesia. It is vital therefore that an adequate number of statutory appointments be made at both professorial and senior lecturer level, and that adequate funding, support staff and facilities be provided, in line with similar posts in other specialties.

SECTION VIX

Departments Without Trainees

Experience in private practice and in some medical systems abroad shows that consultant-only services are possible and can be professionally satisfactory. However, what does not seem to be satisfactory is a system in which consultant anaesthetists are required to provide services for a variety of relatively junior trainee surgeons. Providing anaesthetic services in such circumstances often involves an increased amount of out-of-hours work and prolonged operating times, and often gives rise to most unsatisfactory working relationships. The Standing Committee in Ireland and the Association of Anaesthetists advises its members never to accept contracts of employment where such conditions prevail.

If the emergency commitment is a major component of a consultant anaesthetist's workload with much out-of-hours involvement, the time available for day time elective work is necessarily reduced in an unpredictable manner so that as a consequence it is difficult to develop a continuing profession relationship with senior surgical colleagues. It is this factor which leads to a very low level of job satisfaction for some consultant anaesthetists.

The amount of work which can be undertaken safely by consultant anaesthetists who do not have trainee staff is significantly less than that which might reasonable be expected of consultants anaesthetists who do have trainee staff. This point is not always appreciated by other specialties with trainee staff who require the services of the anaesthetic department.

Modifications to Consultant Contract in the Absence of Trainee Anaesthetic Staff

The difficulties, actual or potential, can be overcome by proper arrangements in a department. When a consultant or group of consultants agree (have already agreed or have no option but to agree) to contract to provide all emergency and scheduled services, the worst consequences can be mitigated. The actual

contractual agreements and the outline plans to cope with unanticipated absences are matters which must be clarified unambiguously.

A heavy on-call commitment with a high probability of call-out necessarily restricts the amount of time available for elective work. It is impossible to give rigid guidelines for the amount of time available for elective work in such circumstances and each situation must be assessed individually but the following points are important:-

1. The minimum number of consultants required for a twenty-four hour emergency service is three. The number must be increased in the presence of an obstetric unit.¹¹
2. All consultants are entitled to eight days per month free from continuing responsibilities (MA 5.10, CCD 8.5). We recommend that these days be taken in full and in a planned manner.
3. Two days each week must therefore be set aside, so that consultants who have just completed the weekend on-call duties can avail themselves of this time.
4. The number of consultants available on those two days is one less than the total number of consultants in the Department.

An example of a work schedule for an anaesthetic department with four consultants is given in Annex II.

SECTION X

Other Considerations

Consultants are entitled to thirty-one working days annual leave, as well as leave in respect of public holidays. They may also wish to avail of their entitlement to maternity leave, sick leave or special leave. All consultants are entitled to eight rest days a month in recognition of their emergency commitments and there is provision in the contract for continuing medical education and sabbatical leave. Consequently, each consultant may be absent for up to fifteen per cent of the time. All these factors must be taken into consideration when the workload at a department is being drawn up.

‘It is particularly important that consultants who continually undertake emergency duties in small hospitals should be in a position to obtain adequate leave with locum cover.’ Locums will be provided for extended periods of leave (i.e. a working week or more) except:-

1. when ‘cross over’ is practical
2. during planned service reductions (MA 5.11.1)

‘... should the leave day be one of commitment to out-patients, casualty, acute or planned admissions, ward rounds, operation sessions or lists then when available and when practical a substitute consultant should be employed to undertake these duties...’ (MA 5.11.4)

It is vital therefore that consultants plan their leave well in advance and inform management so that locum cover can be arranged or planned service reduction implemented.

Cancellation of elective work is necessary when there is a reduction in the number of consultants below the level for which safe provision is planned. Some services may have to be transferred to other hospitals.

The emergency cover must be preserved at the expense of routine commitments and an outline plan should be prepared in

advance for each succeeding level of possible reduction in numbers of consultants.

CONCLUSION

The scheduled time commitment for consultants under the revised Common Contract is identical to that of the original common contract, namely thirty-three hours per week. The concept of fixed and flexible commitments is new however and the Standing Committee recommends that consultant anaesthetists set aside a maximum of eighteen hours per week for fixed commitments.

Many consultants undoubtedly devote far more than thirty-three hours per week to their public hospitals. Indicating this in the work schedule does not compel the consultant to work beyond his contractual agreement but it does afford consultants and management an opportunity to clarify and define the duties of consultants, as well as indicating the disparity between workloads and staffing levels.

The employing authority also has a contractual obligation to discuss and agree with consultants the range and extent of anaesthetic services which can be provided safely having regard to the resources available and the contractual commitments of consultants.

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ANNEX I

Sample Work Schedule I

Recommended outline weekly work schedule for consultant staff

NAME: Dr

SPECIALTY: Anaesthesia

CONTRACT: Whole-time/Geographical Whole-time
Part-time
Other
(delete as appropriate)

Weekly Timetable of Fixed Commitments

	Hospital/Locatio n	Type of Work
Monday	Hospital A	<i>Theatre</i>
Tuesday	Hospital A	<i>ICU</i>
Wednesday	Hospital A	<i>Dentals</i>
Thursday	Hospital A	<i>Theatre</i>
Friday	Hospital A	<i>Pain Clinic</i>

Name: Dr.....

Type of Duty	Average Number Of Hours
Out-patients.....	4
Ward work.....	9
Theatre or special procedures.....	15
Teaching/training/examining accreditation.....	2
Research	
Laboratory/Imaging services	
Medical audit.....	1
Management	
Committees e.g. local or national	
Administration.....	1
Other (please specify).....	1

Note: Completion of this table does not give rise to a contractual duty to work beyond actual contractual commitment.

If the time actually worked on a scheduled session consistently and significantly varies from the notional three hour commitment, there will be a review of the scheduled commitment to ensure that the consultant is not working regularly in excess of or less than his weekly scheduled commitment. Where the commitment is being unavoidably exceeded for reasons of a temporary nature, local arrangements shall be made to compensate the consultant concerned. (MA 2.4.3)

Completion of the schedule is not an invitation to immediately reduce the workload. Duties being carried out today need to be continued for a reasonable time so that management has an opportunity to rectify the disparity between workload and staffing levels.

ANNEX I

Sample Work Schedule II

In this example the Monday and Friday have been set aside in the weekly work schedule to allow for 'rest days'.

Anaesthetist A has just completed weekend on-call duties so therefore has no commitment on Monday or Friday. When anaesthetist B completes his weekend duties, his Monday and Friday sessions will be taken over by anaesthetist A, who will also take the Monday and Friday sessions of anaesthetist B and C in rotation.

The same work schedule can be applied to smaller or larger units by simply adding or deleting from the last rung of the rota.

Number of consultants in the department = 4.

Maximum recommended time for fixed commitments per consultant per week = 18 hours.

Number of rest days per week = 2.

Maximum time for fixed commitments to be provided by the Unit/week = $4 \times 18 = 72 - 12 = 60$ hours.

Sample Weekly Work Schedule of Fixed Commitments for Units with 4 Consultants

Anaesthetists	Monday	Tuesday	Wednesday	Thursday
A		Theatre	ICU	OPD
Average Time (Hours)		6	3	3
B	Theatre	ICU	Theatre	ICU
Average Time (Hours)	4	3	4	3
C	Theatre	Theatre	Dentals	Theatre
Average Time (Hours)	6	3	3	3
D	ICU	OPD	Pain Clinic	Theatre
Average Time (Hours)	3	4	3	4